MIDWIVES, INFANT AND MATERNAL HEALTH

IN MONMOUTHSHIRE : 1900-1938

JANET KING

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LIST OF ABBREVIATIONS

AMO ............................................................ Assistant Medical Officer
BMA.............................................................. British Medical Association
BMJ............................................................... British Medical Journal
CMB............................................................... Central Midwives Board
CMO............................................................... County Medical Officer
DMO.............................................................. District Medical Officer
DNA............................................................... District Nursing Association
GPA................................................................ General Practitioners Alliance
LGB............................................................... Local Government Board
MCC.............................................................. Monmouthshire County Council
MCWC........................................................... Maternity and Child Welfare Committee
MNA............................................................... Monmouthshire Nursing Association
MO................................................................. Medical Officer
NA................................................................. Nursing Association
Acknowledgements

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Furthermore, I was honoured to experience an insight into the personal lives and private feelings of the women and men who agreed to be interviewed concerning my research. Undoubtedly, their memories and comments enriched the final text. My grateful appreciation is extended to all those who took part. Last but not least, appreciation must be extended to my husband Greg. Without his support in the first difficult year following my emigration to Australia, this thesis may not have been completed.
The purpose of this study is to extend knowledge concerning the health of expectant and nursing mothers and infants in working-class districts of Wales, particularly mothers and infants residing in the county of Monmouthshire during the 1920s and 1930s. The thesis covers the period 1900-1938 and considers the implementation of various Acts of Parliament and the effects of the legislation on the lives of women and infants. The main Acts covered are the Midwives Act 1902 and 1936, the Notification of Births Act 1907 and 1915, the Maternity and Child Welfare Act 1918 and the ‘Special Areas’ Act of 1934. Through the use of mainly primary sources and oral testimony, it will be argued that these social policies did extend the welfare system and bring benefits to mothers and infants. However, at the same time, the implementation of the policies exerted control over the realm of motherhood to such an extent that pregnancy, child-birth and infant care were irrevocably transported from the natural and familiar domestic sphere, into the unnatural and unfamiliar sphere of the public, male-dominated medical world. Furthermore, the policies which were initially introduced to improve the health of both mothers and infants were limited, discriminatory and did little to address the poverty, which was a reality of life for mothers in the working-class districts of Wales.
**INTRODUCTION**

**The Aims of the Study**

This study is centred on the urban and rural districts of one county in Wales: Monmouthshire, from 1900 to 1938. The study focuses on the general health of working-class mothers and their infants. The Maternity and Child Welfare Act (1918) brought about the establishment of child welfare centres and later, in the 1930s, antenatal clinics. The purpose of this study is to extend knowledge concerning the implementation of social policies and the positive and negative impact certain policies had on mothers and infants in one county in Wales. By doing this, the study also contributes towards the history of women in Wales.

The antenatal, birth and postnatal periods remain today, vulnerable times for expectant and nursing mothers. Maternal and infant survival and general health depend, to a great extent, on the care received during this time. In the twentieth century, women’s experience of pregnancy, childbirth and infant care was profoundly affected by removal from the natural and familiar sphere of the domestic, to the unnatural and unfamiliar sphere of the public, male-dominated medical world. The Midwives Act (1902) is an integral part of this study. Traditionally, women attended other women during births prior to the passing of the Act. This study reveals attitudes towards midwives before and after the Act, including ways in which their role altered following legislation. The transfer
from female to male domination of the birth process is generally accepted and has been adequately covered with soundly researched studies displaying a national and international perspective. This study will briefly acknowledge academic arguments concerning the transfer to provide the necessary historical background. Then, following an identification of the main social policies affecting both mothers and infants between 1902 and 1936, the extent to which these policies impinged on, or improved the general health and well being of mothers and infants in Monmouthshire will be assessed. In this way, the study aims to contribute to the knowledge of the ways in which specific government interventionist policies were interpreted at a local level. Additionally, the study illustrates the extent that selected social welfare policies compared to the needs and demands of the mothers and infants in Monmouthshire.

The aims of social policies and the motives for promoting them are rarely clear. This study reveals the complex nature of the interaction between health needs and the implementation of health-related policies. The perceived health needs of infants and mothers led to the implementation of specific social policies. However, in Monmouthshire's industrial valleys, it will be argued that the national perspective obscured the needs of mothers' and their infants. There were endemic problematic issues within the industrial valleys, which perpetuated unfavourable results. In this sense, the implementation of social policies designed for national impact was not able to account for the variables in society. These variables, economic and social, affected the ways in which the targeted consumers of the related services accepted social policies. It is not within the scope of this study to analyse other industrial areas within Britain, which may have had similar complexities to the industrial valleys of Monmouthshire. There is a need for
additional local studies in this context. Nevertheless, this study will suggest certain areas in England where similarities may be found.

The specific Acts which will be examined for this study will be the Midwives Act of 1902 and 1936, the Notification of Births Act of 1907 and 1915 and the Maternity and Child Welfare Act of 1918. One additional Act, the 'Special Areas' Act of 1934, will be looked at for its effect on Glamorgan and Monmouthshire. The former Acts were initially fuelled by concern surrounding the declining birth rate and rising, or at times stationary, infant and maternal mortality rates. These major Acts provided the framework for the extension of the welfare system, and at the same time state control over the whole motherhood experience from pregnancy through to infant care. The national implementation of each Act will be considered briefly to position the framework within which to analyse the implications of each Act in the local context of Monmouthshire. The advantages and disadvantages the accompanying social policies brought to Monmouthshire's midwives, mothers and infants will then be evaluated.

With governmental attention focused on Wales and its infant and maternal mortality rates, the latter in the 1930s in particular, this study sets out to establish the circumstances surrounding the high rates in Monmouthshire. The administrative authority, Monmouthshire County Council, implemented the various Acts of Parliament mentioned earlier, in an attempt to reduce the number of infant and maternal deaths in the county. A system of welfare support for the benefit of mothers and expectant women was established in the county, including Maternity and Child Welfare Centres and later, separate Antenatal Clinics. The system adopted in Monmouthshire was comparatively favourable to other parts of the country. However, it will be argued that government plans
and funds to administer and implement the Midwives Act of 1902 and the later infant welfare schemes did not have the desired results in the industrial valleys of Monmouthshire.

**Monmouthshire**

A brief mention of the industrial and social development of the county of Monmouthshire will set the scene for this study. Additionally, an overview of the class structure within Wales, particularly Monmouthshire, will be included to define the nature of ‘working-class’ in terms of this study.

Between 1700 and 1850 technological and scientific advances revolutionised national industrial production, organisation and development. There is a plethora of academic analyses and discussions surrounding the nature of the continuity and change associated with industrialisation and urbanisation. 3 It is not within the scope of this study to expand on the many aspects that have been covered in some depth elsewhere. However, there are a number of relevant points that will position Monmouthshire in its historical context.

Throughout Britain, the expansion of industrialisation was diverse. Between 1500 and 1700, urban growth was centred on market towns. During the eighteenth century technological developments heralded a new industrial era. This was characterised by a concentration of population in urban centres. Between 1700 and 1801, the number of people living in towns in Britain increased from under a fifth of the total population to almost a third. 4

By 1801, Merthyr Tydfil in South Wales, was the largest town in Wales. The population was 7,705 and by 1821 it had risen to 17,704. 5 Pontypool and Blaenavon in Monmouthshire also returned an increase in population at this time. 6 Glamorgan and
Monmouthshire showed the largest increase of population out of the Welsh counties. The reason for the influx of people into these areas was initially the establishment of the iron industry in the late eighteenth century. The rapid growth period for the coal industry in Wales in the second half of the nineteenth century, and innovations in the iron industry, which made the large-scale production of steel possible, encouraged further growth. Jones claims that the process of industrialisation, although spread over a long period, was ‘the most far-reaching change which has ever affected the people of Wales’. 7 Urbanisation resulted in a concentration of growth around the industrialised areas.

**Class Structure in South Wales**

The character of industry in South Wales created working-class communities. The recent work of J. Davies notes that until around 1930, between a quarter and a third of the male labour force of Wales worked in the coal industry. Adding the number of people involved in services connected to supplying the miners and transporting the coal, Davies claims that almost half the people in Wales were dependent on a single industry, ‘...a situation unusual, if not unique in the history of industrialised Europe’. He continued to explain that the major significance of the coal industry to the historical development of Wales was that ‘...its growth gave birth to a mass working-class...’. 8

Jones’ earlier comment regarding the Welsh middle-class and working-class structure remains as substantiation of Davies’ claim. Jones stated that there had been a small middle-class in Wales since Tudor times. During the period of industrialisation, this class had increased. However, it had remained small by English standards, and its political and social role was restricted in Wales. 9 Jones concluded that ‘...a large industrial proletariat...was created in the iron, steel and coal industries’. 10 Both Jones and Davies
point clearly to a working-class society predominant in South Wales at this time, a situation which continued well into the twentieth century and shaped the character of Welsh industrial history. Therefore, the people of Monmouthshire and Glamorgan were mainly working-class.

The health of expectant and nursing mothers in Monmouthshire is the focus for this study. The evidence found in Monmouthshire, particularly in county and district medical officer of health reports, does not specifically distinguish between working- and middle-class mothers in every report. However, many of the reports mention ‘working-class’ mothers, ‘poor’ mothers and industrialised districts frequently. Given that academic analyses claim that the predominant social class in Wales was the working-class, and this study centres mainly on the industrialised districts of Monmouthshire, it can be argued that the majority of mothers in those districts were working-class. Furthermore, surveys and other relevant reports often refer to economic depression, insanitary conditions, overcrowding, poor housing, malnutrition, infant mortality, maternal mortality, poverty and its effect on mothers and infants. These conditions were prevalent in working-class districts. The scope of this study is limited to the social class majority, the working-class, residing in South Wales and Monmouthshire during the period covered. However, recognising that some of the primary evidence used for this study does not categorically separate the experiences of middle- and working-class mothers, it is intended that unless the evidence suggests otherwise, mothers in working-class districts will be the terminology used, rather than working-class mothers. Finally, it is beyond the scope of this study to discuss the similarities or differences between the experience of motherhood for middle-class and working-class women in England or Wales.
Monmouthshire and the Special Areas Act (1934)

Monmouthshire, a county in South East Wales, was chosen for its geographical mixture of highly industrialised, densely populated valleys and contrasting agricultural districts. There was an influx of people into the Welsh valleys in the nineteenth century in the hope of acquiring work in the iron, steel and tin works, coal-mines and related trades in the docks and railways. The growth in population compounded problems regarding overcrowding and inadequate sanitation, which were partly created by the topography of the areas where industry was situated.

The period covered by this study, 1900 to 1938 saw Monmouthshire's prosperity fluctuate between trade highs and lows. The 1920s and 1930s were the most difficult times for the mothers and infants of the industrial valleys in the county, with many mothers and infants losing their lives. The increasingly high maternal death rate in the 1930s, stimulated the government to pass legislation to aid industrial areas most severely affected by the economic depression. Monmouthshire was one of those counties. The industrial districts were designated as 'special areas' under the Special Areas Act of 1934. Specific foods were supplied to maternity and child welfare centres and antenatal clinics in the hope of improving the general health of both mothers and infants. It was recognised that rural and industrial districts suffered from the depression. However, it was in the coal-mining areas of South Wales that the deprivation was most acute, largely owing to the decline in the coal export trade. It was assessed that four out of every five people in Glamorgan and Monmouthshire lived in the specially designated areas.

Unemployment statistics from the Ministry of Labour, revealed that regions of heavy unemployment in South Wales coincided with regions returning the highest puerperal
mortality rates. However, the 1937 *Report on Maternal Mortality in Wales* pointed out that there had been a high return for maternal and infant mortality in times of trade prosperity in the same regions. The evidence did not lead to conclusive links between the standard of health and conditions of employment. Other factors were at work in these districts detrimental to the health of mothers and infants, with trade depression and low incomes aggravating the effect. Nevertheless, statistics suggested a considerable rise in the puerperal death rate in the Special Areas of both Glamorgan and Monmouthshire.

[See Table 1]

### Table 1

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<th>Puerperal Death Rate in Two Welsh Counties</th>
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<td></td>
<td><strong>Special Areas</strong></td>
<td><strong>Other Areas</strong></td>
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<td>1924-28</td>
<td>1929-33</td>
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<tr>
<td>Glamorgan</td>
<td>5.40 (368)</td>
<td>6.54 (339)</td>
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<tr>
<td>Monmouth</td>
<td>4.41 (144)</td>
<td>6.51 (173)</td>
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Numbers in brackets denote the deaths on which the calculations are based. Source: Ministry of Health, (1937) *Report on Maternal Mortality in Wales* Cd. 5423 p.89.

Statistical evidence points to an increased maternal death rate in the Special Areas in both Glamorgan and Monmouthshire. At the same time, the rate decreased in other areas of the same county, which were not designated as 'special' under the Act. Since the death rates were based on a considerable number of deaths in industrial, or Special Areas of Glamorgan and Monmouthshire, it was stated that

...the evidence is strong that there has been a significant increase in the puerperal death-rate in these areas. 14
The General Health of Expectant and Nursing Mothers in Monmouthshire

High rates of unemployment existed in Wales in the 1930s, particularly in the South Wales coalfields. The government designated certain districts eligible for assistance under the 'Special Areas Act' in 1934 due to the severe economic depression. All the industrial and urban districts of Monmouthshire came under the auspices of the Act. These districts will be identified and an assessment made of the effects of the Act on the health of expectant and nursing mothers in those districts. However, collected evidence points to a high infant and maternal mortality rate before the depression years of the 1930s, in times of industrial prosperity. For this reason, the 1930s will not be looked at in isolation when determining the causes of high infant and maternal mortality rates and the effect of government policies to reduce the rates.

Poverty, inextricably linked to health, was endemic in South Wales, particularly in the industrialised South East, where wages were locked together with trade and demand fluctuations. The reason for the state of poverty in South Wales altered over a period of time. Before 1914 low wages were the cause of poverty whereas in the inter-war years unemployment was the chief cause. It will be argued that the nutritional consumption of expectant mothers affected the way in which they were able to physically cope with, and prepare themselves for, the confinement and the feeding and general care of the infant.

Nutrition studies conducted by John Boyd Orr in 1936, found that the lowest income group consumed far less of the nutritionally sound items, such as milk, eggs, fruit, vegetables and fish, than higher income groups. He concluded that as income increased, disease and death rates decreased, and the physique and general health of both children
and adults improved. The majority of mothers in the industrial districts of Monmouthshire remained in the low-income group for the period covered in this study. Documentary evidence from Maternity and Child Welfare Centres and Antenatal Clinics in Monmouthshire will be examined concerning dietary habits and the link with general health.

Antenatal care and advice was not readily available to all expectant mothers in the country until the implementation of the Maternity and Child Welfare Act in 1918. However, it will be argued that the Act did not bring about an immediate improvement in the health of expectant women through antenatal care. The slow progress in Monmouthshire was mainly due to the lack of facilities for the more intimate nature of antenatal work. Maternity and Child Welfare Centres in general concentrated initially on the health and well being of the infant. Evidence suggests that the initial focus on infants was detrimental to expectant mothers.

It will also be argued that the attitude of some medical men and women involved in the care-giving process, partly worked to deter some women from attending such centres and in this way perpetuated the myth of the ignorant mother who was a danger to her infant. Additional reasons for mothers not attending clinics and centres will be pursued.

Furthermore, it will be shown that inter-professional rivalry persisted nationally, adding to the fractured nature of the overall care and attention offered to mothers. This resulted in a lack of continuity of care in the delivery of social policies and a public service devised to drastically reduce infant and maternal mortality. Finally, it will be argued that maternal mortality rates in Wales did not decrease solely through the extension of antenatal care in the 1930s.
Social policy is an accepted and useful part of society today. Nevertheless, there is a continuing controversy surrounding the effectiveness and value of social policies as expenditure, providers of care and customer numbers increase. This study offers a contribution to the ongoing debate surrounding the implementation and effect of health policies by providing a localised study of the complex interactions between providers, customers and needs.

Some Relevant Arguments

Nationally, medical professionals and politicians often accused midwives and mothers, particularly mothers in working-class districts of ignorance and negligence and blamed them for high infant mortality rates. Carol Dyhouse pointed out

…the belief that the ignorance of working-class women was a major cause of high infant mortality rates moulded the character of the early infant welfare movement in Britain. 17

Dyhouse continued by saying that most infant welfare institutions saw their role as predominantly educational with classes in domestic management and infant care. She argued that medical professionals devaluated working-class motherhood. The devaluation process Dyhouse claims to be illustrated through anecdotes concerning ‘old wives’ tales’. 18 This study shows that there is evidence to suggest that a devaluation of motherhood as experienced by working-class mothers in Welsh industrialised communities was attempted by some medical professionals. Therefore, while this study confirms part of the Dyhouse argument, it probes further into the realities of the issues faced by mothers in working-class districts of Monmouthshire and highlights the complexity of the situation within the national context.
Deborah Dwork criticised Carol Dyhouse, Anna Davin and Jane Lewis’s analyses, which pointed to official concern being directed towards the control of mothers rather than saving infant lives.  

Dwork particularly criticised Lewis’s generalisation concerning the denial by medical officers of health, medical practitioners and government officials to accept that poverty or environmental factors were important variables when assessing the causes of infant mortality. This study complements Dwork’s criticism on this issue. Monmouthshire’s county and district medical officer of health reports highlight the local complexity of the issues involved in child welfare work. The reports show that while certain medical officers were quick to criticise mothers, some medical officers in neighbouring districts of the same county were supportive and recognised environmental hazards and poverty issues. These medical officers worked hard to alleviate unnecessary suffering for both mothers and infants.

A further criticism Dwork directed at Davin and Lewis concerned their comments that motherhood classes were a cheap alternative to comprehensive health care. Davin claimed that the focus on the education of mothers was a ‘cheap way out’. It was cheaper to blame them and to organise a few classes than to expand social and medical services. 

Lewis’s argument supported Davin’s thesis. Lewis claimed that finance was the reason for the introduction of instruction for mothers’ as it was ‘...cheap and could be implemented quickly’. Dwork disagreed and offered an alternative view. She claimed that the establishment of infant welfare centres with classes for mothers was not a cheap and easy solution to the problem of infant mortality. Furthermore Dwork argued that
systems which were established provided a number of social and medical services in addition to instruction'.

This study endorses Dwork's argument using illustrations of the extension of services in Monmouthshire, including dental treatment, dinners for needy mothers and additional food supplements in times of economic depression. The evidence in Monmouthshire suggests that the remedies were not cheap and at times needed the additional assistance of the National Birthday Trust and local voluntary organisations. Voluntary bodies gave their time, pairs of boots and shoes, clothing and local produce such as vegetables to the centres for distribution to needy mothers. This study extends on the work undertaken by Dwork with an in-depth examination of one county and the numerous variations within that county. In this way, the study illustrates the complexity of the nature and impact of the maternity and child welfare movement.

National thought was leaning towards the improvement of the nation's health with the protection of infant lives as its starting point. Midwives and working-class mothers were blamed for infant deaths. This study admittedly uncovers statements made by some medical officers in Monmouthshire, which substantiates the claim that midwives and working-class mothers were held responsible for infant deaths. However, generalisations distort the reality of the experiences of women in South Wales. Evidence found in Monmouthshire points to diverse and varied responses by medical officers and government officials towards mothers in the working-class districts of the county. While some medical officers strongly believed unqualified midwives and working-class mothers to be the cause of preventable infant deaths, other medical officers spoke out against this theory. Alternative reasons were offered as causal links including poor nutrition,
insanitary environment, poverty and overwork. These situations were generally beyond
the control of the mother, particularly in mining districts. As a result, midwives were
often required to attend births in homes with inadequate sanitation and unhygienic
conditions, which implied dangers for the mothers and their infants.
Through an analysis of the work of Monmouthshire’s Maternity and Child Welfare
Centres, the process of home visitation and the philosophy of educating the mother,
evidence suggests that the maternity and child welfare scheme in Monmouthshire did
little to reduce infant mortality figures in the first four weeks of life. Rather than
midwives or mothers being the cause of infant deaths, other factors were at work, which
remained largely out of the control of the mothers and posed a significant threat to infant
survival. Furthermore, the introduction of the maternity and child welfare system, with
the emphasis placed firmly on the health of the infant and the education of the mother,
initially marginalised the general well being and physical condition of the mother. This
situation subsequently perpetuated the continuation of high maternal mortality rates,
particularly in Monmouthshire, into the 1930s.
For the purpose of this study, the facilities and expertise available to implement the
policies in Monmouthshire were examined in relation to the health of mothers and infants
in that county. Interaction and co-operation are necessary components for the successful
implementation of social and welfare policies, therefore the mothers’ reaction to
midwives, medical practitioners and health visitors was also determined. Additionally,
the extent of the co-operation between mothers and medical professionals was taken into
account. Finally, based on the evidence collected, an assessment was made of the impact
of the maternity and child welfare system in Monmouthshire.
The National Perspective

To position Monmouthshire within the context of events nationally, a brief overview of the issues prevalent in Britain prior to and during the period covered by this study is necessary. In nineteenth century Britain, the rapid urbanisation of industrialised districts and the influx of people into overcrowded towns exacerbated problems of inadequate sanitation and housing. This led to concerns regarding the health of the nation. The concern manifested itself into movements to improve the nation's health. However, Richard Brown's recent research noted that the relationship between insanitary conditions and poor health was not fully established until the 1840s. 25

Social investigations into the nation's health claimed a relationship between social class and mortality. Various local studies were conducted in the 1830s and 1840s, such as the Kay survey of Manchester in 1832 26 and the Clark Report for Newport Borough in 1842. 27 Nevertheless, it was the surveys conducted by Edwin Chadwick leading to the publication of the Report on the Sanitary Conditions of the Labouring Population of Great Britain in 1842, which caught the attention of politicians and social reformers. 28

The question of public health was seen by reformers to be linked to national prosperity. Infant and maternal mortality rates were higher among the poor, particularly in urban districts. Illness and general debility were also features of daily life for poorer people. The explanations offered included insanitary living conditions. Personal characteristics were also criticised, including the habits of the poor and general domestic mismanagement. 29

The infant welfare movement established in Britain in the first decades of the twentieth century was initially the response to high infant mortality rates. Although infant deaths
had remained high throughout the nineteenth century, this had stimulated little attention
when the general death rate was also high. However, by the turn of the century it became
apparent that the birth rate was entering a period of decline as the same time as the
general death rate began to fall. Furthermore, infants were still dying in large numbers
during the first twelve months of life. Concern regarding the incidence of infant mortality
escalated following a 1904 report relating to the health and general physique of the army
recruits for the Boer War (1889-1902).
Anxieties about the future of the nation fuelled state intervention into social welfare
issues encompassing education, motherhood, infant health, childcare, public health and
hygiene. Coupled with the focus on the future of the British population were thoughts on
the quality of the race. Strong, fit and healthy parents were needed to reproduce equally
healthy offspring for the sake of the nation. These ideals stemmed from the scientific
theories of Charles Darwin’s *Origin of the Species* published in 1859. The theory of
evolution stimulated discussions concerning inherited traits and characteristics including
physical and intellectual qualities passed down from one generation to another. The quest
for national efficiency began in the 1880s and the ideals were reflected in state social
interventionist policies in the late nineteenth and early twentieth centuries. Issues of
poverty, public health, maternal and child welfare became respectable political platforms.

**The Issue of National Efficiency**

Government statistics concerning the health of army recruits revealed that the average
male physique was weaker than it had been 55 years previously in 1845. An
Intergovernmental Committee on Physical Deterioration was set up in 1904 to investigate
the reasons for the poor health and stature of the recruits. The term ‘national efficiency’
was established and primarily meant physical efficiency. The Physical Deterioration Committee report placed a link between insanitary conditions and national security.

An unhealthy citizenry meant declining national power. Physical weakness meant military weakness.  

Bentley Gilbert argued that as a result, social reform became a quest for efficiency and ‘a respectable political question’.  

In summing up, the Committee’s recommendations included the enforcement of existing sanitary regulations and new rules for the education of girls. The report recommended teaching girls the correct method of infant care and nutritious cooking. It also encouraged physical exercise in schools, medical inspections of school children and a state-sponsored programme of feeding the children of poor parents to ensure that they would be able to take full advantage of the education system. It was proposed that in general, the nation should concentrate on the care of infants and children. However, whereas the report left no doubt as to the state of the nation’s health, it did not address the causes of the situation.

The contemporary debate surrounding the issue of national efficiency brought the notion of inherited racial physical decline to the fore. Eugenicists and Darwinists, some more enthusiastic and vocal than others including George Bernard Shaw and H. G. Wells, advocated that unfit and unintelligent parents should not reproduce. The eugenic protection of the race was called for through the ‘sterilisation of failures’.  

Greta Jones’ research into social hygiene issues in 1986 states

One of the major intellectual changes characterising the late nineteenth and early twentieth centuries was the growth of social Darwinist thought.
She claims that there were several variations on the same theme with two main strands, 'the preoccupation with external racial and national competition'. The phrase 'the survival of the fittest' displays typical Darwinesque terminology.

The Eugenics Education Society, later to be known as the Eugenics Society was established in 1907. The aim of the Society was to improve the quality of the race. Jones states that the Society's philosophy became firmly embedded in Britain and 'remained influential in social policy until the Second World War'. Donald MacKenzie claims that eugenicists were essentially a middle-class professional group drawn from law, religion and medicine, with very few from the ranks of industry and commerce. He links the ideology of the movement with its social character. The emphasis, he says, was placed on intellectual achievement and talent. The protection of a good standard of living for the middle-class was promoted while hostility was directed towards the working-class. MacKenzie interprets this as epitomising the social ambition of the middle-class in society.

Jones points to a wider membership base than MacKenzie. She argues that eugenicism drew on the members of voluntary organisations, welfare and sanitation societies originating in the nineteenth century industrial middle-classes. She claims that by the turn of the century the social composition reflected a wide spectrum of classes from middle-class to aristocrats. MacKenzie's grouping, according to Jones, was characteristic of the London-based Eugenics Education Society. When the philosophy of the Society became more popular and reached further afield, the membership base broadened. Jones mentions a number of famous family names that became linked with the Society including
Cadbury. She concludes by saying that the members were a ‘social mix bound together by a set of ideologies about public health’. 39

Numerous contemporary books were published with the underlying theme of eugenics. William J. Robinson, MD, Fellow and Member of a variety of Associations, editor, critic and author wrote one such book. The title page of the book reflects the thinking of eugenicists: ‘Fewer And Better Babies. BIRTH CONTROL or The Limitation of Offspring by the Prevention of Conception’. The publication was first published in America in 1916 with the 13th edition issued in 1917. This was dedicated to Dr. A. Jacobi, whom Robinson claimed to be one of the few members of the medical profession to be unafraid ‘to hold and express unorthodox opinions on vital questions’. Jacobi wrote the Introduction to the thirteenth edition of the book. He mentioned that he had often ‘praised clergymen for good citizenship who refuse to marry couples without ...a clean bill of health’. He continued

Hereditary influences propagate epilepsy, idiocy, feeblemindedness and criminality. Persons thus affected must not be permitted to propagate their ailments. 40

Robinson’s ideas revolved around the limitation of children within marriage. He advocated that everyone should be able to choose the number of children to have and when to have them. However, the eugenicism influence is apparent throughout his work. He stated that a ‘workingman’ should not have more than two children. ‘Every child after the second...is individually and racially a calamity’. His opinion was that ‘too many children in other than well-to-do families is a crime’, and that ‘unrestricted breeding’ of
the lower classes 'overwhelm the better elements, pollute the race-stock and add to
human misery'.

Spreading information concerning the prevention of conception was considered to be a
criminal offence in America and Britain at the same time as eugenic knowledge was
disseminated without restraint. Marie Carmichael Stopes was a strong advocate of birth
control. Her publications include *Married Love* and *Wise Parenthood* published in 1918
and *Contraception* published in 1923. It is not within the scope of this study to enlarge on
the work of proponents of contraception. However, a brief mention of the work and
influence of Marie Stopes appears in a later chapter in the context of issues related to
Monmouthshire mothers in the 1920s and 1930s. On studying her works it is evident that
eugenicist views were upheld and promoted through her writing and activities in the field
of birth control.

**Mortality Decline**

The controversy surrounding the idea of controlling the number of children born in a
family was fuelled by the knowledge that the overall mortality rate in Britain was
decreasing. Concern for the survival of the nation was uppermost in the minds of critics. It
was revealed shortly after the First World War, that the nation's birth rate was decreasing
at the same time as the overall death rate was in decline. Attempting to identify the
main reason for the decline in the death rates, Professor Thomas McKeown's research in
1976 concerning the rise in population proposed an alternative argument. Contrary to
the popular belief that medical technology, treatment of disease and professional
expertise largely contributed to falling death rates, McKeown argued that the emphasis
centred on the role of increases in per capita nutritional consumption. Advances in
medical science, claimed McKeown, played a minor part in accounting for mortality
decline. Furthermore, most of the major diseases had disappeared in England and Wales
before the date at which the relevant medical innovations occurred. McKeown’s study
was influential in guiding future researchers into this area of importance.

However, Simon Szreter challenged the McKeown theory with an alternative
interpretation of the facts. He argued that

...mortality decline was the result of human agency, in the form of a politically-
negotiated expansion of preventative public health provisions and services, rather
than the result of an impersonal invisible hand of rising living standards.

Although McKeown identified ‘municipal sanitation’ and ‘hygiene improvements’ as
positive factors, these remained of lesser importance than the rising living standards and
nutritional intake assessed to be the main cause of mortality decline according to
McKeown. Szreter concluded that the improvement in the mortality rates of elder
children and young adults in the last third of the nineteenth century ‘reflected
improvement of the urban environment outside the home...’. Nevertheless, Szreter
pointed out that infant mortality rates did not improve until ‘more probing and detailed
regulations’ appeared in the twentieth century. These regulations worked to eradicate
negative influences within the domestic environment of the working-class household and
‘appreciably' improved overall conditions. Significantly, Szreter recognised that his re-
interpretation did not conclusively demonstrate the importance of social intervention on
relevant mortality statistics and suggested that specific local studies were needed to
identify notable effects of such ‘social intervention’.
In agreement with Szreter, local studies would reveal chronological variations in the implementation and application of social policies and sanitary measures, which would then determine the extent to which those collective measures affected the environment and the local communities. This study in part, offers such an insight into Monmouthshire, adding to the debate and allowing comparisons to be made with other relevant local studies. The local evidence collected for this study supports Szreter’s suggestion that infant mortality decline was the result of human agency. However, the evidence found in Monmouthshire extends the current debate on the effect of social interventionist policies on infant and maternal mortality in the first half of the twentieth century.

It will be argued that some district councils portrayed apathy to environmental health that resulted in a higher infant death rate than was necessary relative to comparable districts within England and Wales. Furthermore, evidence suggests that the attitude of middle-class government and medical officials towards mothers in working-class districts initially limited progress towards improved maternal health. However, the point is not to argue that all social policies had negative connotations. On the contrary, evidence in Monmouthshire suggests that the implementation of certain national policies concerning the health of mothers and infants was instrumental in lowering the infant death rates, particularly for infants surviving the first four weeks following birth. Infant mortality rates for the first four weeks of life revealed little improvement. Examples can be found of both positive and negative responses to government policies in reports presented by county and district medical officers of health throughout England and Wales. Specific points are highlighted and analysed in later chapters concerning both mothers and infants in Monmouthshire.
Feminism in the Late Nineteenth and Early Twentieth Centuries

Writing in 1986 Lewis stated that

Women's position in the family has been the central issue to feminist analysis of the nature of and reasons for sexual inequality during the past fifteen years. 48

During the late nineteenth and early twentieth centuries there was a growth in employment opportunities for women in the clerical, retailing and teaching fields. However, Lewis claims that with many women earning wages at this time, 'home and family were always regarded as women's primary responsibility'. While women made progress in the public world, the role of men within the home hardly changed. 49

As Jenny Dale and Peggy Foster pointed out, early twentieth century feminists 'tended to take the private sphere of the home for granted'. These feminists concentrated on two main strands of action, which focused on women's entry into the working world, particularly the professions, and campaigning for the public provision of welfare to suit women's needs.

The vast majority of feminists did not see the sexual division of labour in the home as necessarily oppressive, and many glorified women's role as mother. 50

Lewis supports this thesis concerning the character of early twentieth century feminist activity and adds that in contrast, more recent feminist thinking challenges and questions the 'naturalness' of the sexual division of labour in the home. Lewis claims

...while reproduction and lactation have provided a functional basis for the identification of a domestic sphere, it does not necessarily follow that women should also raise children and take responsibility for managing home and family life. 51
The nature of the early and current feminist movements is not within the scope of this study, neither as a comprehensive background nor to contrast the character of campaigning priorities. Neither is it in the scope of this study to discuss the differences and splits within the movement over a period of time. As Dale Spender argues using a comment made by Mary Stott during an interview with her in the early 1980s, there has always been a women’s movement this century. However, a few points can be made to illustrate the influence feminist groups had on contemporary developments in keeping with the themes in this study.

One strand of feminism in the first half of the twentieth century was termed ‘welfare feminism’ by Olive Banks. Dale and Foster claim that it was in the years following 1906 when the foundations for the Welfare State were being promoted, that these welfare feminist groups were particularly active. There were many issues covered in the campaigns. The most distinctive revolved around maternal and child health. The Women’s Co-Operative Guild (WCG) played a central role in campaigns for improvements and demands for a national maternity service.

In 1914 the Guild sent a questionnaire to its members asking them for their experiences of maternity. The findings published in 1915 revealed the constant health problems and tiredness that were part of many working-class mothers’ lives. The result of the survey added weight to the need for a sound maternity and infant welfare policy. When the Maternity and Child Welfare Act was passed in 1918, which required local authorities to set up local committees to oversee the work of new Maternity and Child Welfare Centres, the WCG continued to campaign for more hospital beds for births and additional maternity and child welfare provisions. Dale and Foster claim that the WCG also actively
promoted women councillors to act as representatives on local maternity and child welfare committees.

In the inter-war years birth control was part of the fight for the rights and needs of women. However, efforts to open birth control clinics were met with hostility. Methods to limit the number of offspring at a time when the prevalent notion was to increase and improve the ‘racial stock’ led to women’s needs being largely ignored. Lewis, Dale and Foster claim that efforts to make birth control more respectable emphasised the needs of married women instead of all women in the birth control debate. Furthermore, social policies during the inter-war period primarily reflected official concern about the state of the nation. The health of mothers and the needs of women were secondary issues. Lewis was forced to conclude with the question that continues to cause debate today. She asked

…whether the decrease in infant mortality could or should be weighed against a subtle strengthening of the ideology of motherhood, or better medical care in childbirth against the loss of control by women over its management. 55

In Wales in the inter-war years the majority of adult women were married and classed as housewives on census returns. Deirdre Beddoe claims that since the dominant ideology of the time placed women in the home, it was not surprising to find that housing was important women. Nationally, there was a shortage of adequate housing since no additional homes had been built in the war years. Conditions were poor and rents high as a number of housing investigations testify. 56 Following the enfranchisement of women in 1928, women became more active in political debates and protests, hunger marches, unemployment protests, demands for adequate housing and pit-head baths for miners.

Taking up her seat in Parliament, Miss Megan Lloyd George emphasised the problem of
housing in Wales and the link between poor housing and women’s ill health in her maiden speech in 1930. 57

The history of women in Wales fits into the overall national perspective. This study explores issues surrounding the health of women in South Wales and in this way, will extend the knowledge concerning women’s experiences in working-class districts. The role of midwives, medical professionals and the health of mothers and infants in Monmouthshire will be examined for this study within the national framework.

**Midwives in Society**

The role of women as birth attendants, or midwives, was profoundly affected by the passing of the Midwives Acts, particularly the first Act in 1902 and the 1936 Midwives Act. The history of midwifery prior to the 1902 Act is characteristic of early ecclesiastical influence and the male dominated medical world. Jean Donnison’s work on midwives 58 is an authoritative analysis, which paved the way for this study’s local context on midwives in Monmouthshire. The evidence concerning the role of midwives nationally substantiates Donnison’s major arguments concerning the antagonism shown towards midwives in the nineteenth century. Additionally, the local perspective on midwifery practise in Monmouthshire, and attitudes towards midwives in the county, extends the knowledge concerning the role of midwives in the twentieth century. Local evidence used for this study suggests that elements of continuity relating to accusations, suspicion and stereotypical images of midwives established by the sixteenth century, remained as late as the 1920s. There is no need for this study to extend its scope to the early history of midwifery, which Donnison has already covered more than adequately. However, to set the scene, a brief account of the main points is necessary to understand this study’s
arguments in later chapters concerning the attitudes towards midwives nationally and in
Monmouthshire in the twentieth century. Therefore a brief synopsis is required
concerning the early history of midwifery using the main academic texts of Donnison,
Anderson and Zinsser, \(^59\) Ehrenreich and English. \(^60\)

The history of midwifery is peppered with antagonism, accusations, negativity and the
denial of a basic human need: that of the mother to have another woman with her at her
most vulnerable time, the moment of birth, to deliver her infant. The village midwife, or
the wise woman as she was known, was involved in the cycle of life, from birth through
fevers and sickness to death. Due to her close proximity to aspects of life and death she
became the target of the Church and medical men. Remedies used by wise women had
been tried and tested over generations. One remedy used to relieve the pain of childbirth
was ergot. Derivatives of ergot are used today to speed the delivery of an infant and assist
the mother’s recovery. However, the use of a pain reliever during birth antagonised the
early Church. It was believed pain was a necessary visitation to women from God, as
punishment for Eve’s ‘original sin’. \(^61\) The Church used this belief to accuse wise women
of witchcraft.

By the mid-1500s many believed that the epitome of a witch was the illiterate, older
peasant woman. Fear was the instrument used to gain public condemnation of
‘suspicious’ wise women. Midwives were particularly condemned due to their intimate
association with the birth process, which was a secret world traditionally guarded from
men. In a sinister way, the witch persecutions linked the idea of evil practices involving
new-born infants in Black Mass rituals with the midwife. \(^62\)
Ehrenreich and English claim that it was partly due to the activities of the Church during the witch-hunts that the medical world gained authority. The denouncement of non-professional healing as heresy marked wise women as evil. Ehrenreich and English argue that through the indirect support of the Church, the male physician was placed in a class vastly superior to the female healer and midwife. The outcome was the triumph of the medical profession and the destruction of women’s support network. A model of expertise was established as the prerogative of a social elite. The control and care of childbirth was traditionally entrenched in the private world of women, who used their combined and cumulative experiences to qualify their role as birth attendants. However, the pattern was changed into a structure of control based on the trained professional. Additionally, the transfer of control accompanied the medicalisation and professionalisation of childbirth from women to men.

The language used by the Church to describe the work of wise women during the sixteenth century persecutions continued to permeate the rhetoric of the medical profession and state officials as late as the early twentieth century. Words and phrases such as ‘suspicious’, ‘evil practices’ and ‘illiterate’ were conspicuous in documentary evidence used for this study. Donnison’s study of the history of midwives confirms their early persecution. She follows the pattern of control enforced on their practice, initially by the Church then the State, from the 1500s to the first Midwives Act in 1902. The first formal control of midwives came with an Act in 1512. The Act aimed to secure nation-wide regulation of medicine and surgery. Responsibility for the implementation of the Act was placed on ecclesiastical authorities. Midwives needed a character reference to register. No formal qualifications were required. However, a midwife found practising
without the required registration could be banned from practice and ran the risk of excommunication from the Church. The pattern of the formal registration of midwives characterised by moral and social control was established in the sixteenth century. It can be argued that legislation concerning midwives in the twentieth century reflects some aspects of the earlier characteristics. This study extends Donnison’s work to include an analysis of the rules set out in the Midwives Act of 1902 and 1936. The analysis establishes the controls placed on midwives, their changing role and status in society, and medical professionals’ attitude towards their work. Due to the nature of midwives’ work, the section on midwives is important to the study of the health of mothers and infants in Monmouthshire.

**The Midwives Bill and the First Midwives Act 1902**

A Select Committee Report in 1892 on the registration of midwives, observed that evidence presented to the Committee revealed that a large number of women were attended by midwives ‘whose ignorance inflicts ...serious and sometimes fatal injuries on both mothers and infants’. The Select Committee’s comment was typical of the attitude of policy-makers and medical men towards female midwives, who were deemed inefficient if they had not received instruction in midwifery skills from medical men. At that time, a woman’s practical experience delivering infants was not considered an asset to the profession.

This is in direct contrast to the attitude shown towards men practising midwifery. Male midwives first appeared in France in the nineteenth century and were often taken on as partners by apothecaries and surgeons. The partnerships gave equal status and rights to the male midwives. Such equality was out of reach to their female counterparts. Evidence
of the practice of male midwifery partnerships was found in Monmouthshire, at Caldicot and Chepstow. The contracts illustrate conclusively the equal status enjoyed by the male midwives.

The continual refusal to accept the role of the female midwife was interwoven with deep-seated resentment and anti-feminism within predominantly male medical and government circles. Committees concerned with policy-making, including legislation directly affecting women, often listed men only. Childbearing became a medical condition severed entirely from the emotional needs and well being of the mother. In the private realm of womanhood, the support of another woman was valued. The evidence suggests it was feared that the recognition of the need for female midwives would automatically open the door to the closed medical world. Penetration in this way would then threaten to weaken the power of male dominance.

The Midwives Bill eventually became an Act in 1902. The Act aimed to centralise the registration of midwives, provide training and improve the standard of midwifery practice in the hope of minimising both infant and maternal mortality. This study will elucidate the concepts underlying the introduction of the Midwives Act (1902). The position of midwives in society was not uniform in all counties nationally. Variations were evident between and within each county according to the geographical and social configuration of the urban and rural districts.

This study briefly traces the implementation of the first Midwives Act in 1902 nationally, then in more depth locally in the county of Monmouthshire. Using both a national and local perspective, the study will identify the proportion and location of trained and untrained midwives, and highlight the attitude of middle-class medical men towards
women midwives. Arguments for and against the involvement of women as birth attendants will also be discussed. Using evidence found in Monmouthshire, it will be argued that midwives were unjustly blamed for high infant and maternal mortality rates in that county.

**Infant Mortality**

In 1904, the Inter-Departmental Committee on Physical Deterioration attempted to set out what they perceived to be the general facts of the 'annual sacrifice' called infant mortality. While the national death rate had fallen, it was found that infant deaths had not decreased. Furthermore, the majority of the deaths occurred in the first three months of life. Educating mothers and girls in the basics of infant care and hygiene was thought to be one of the answers to the problem of infant mortality. As a result Schools for Mothers, 'Babies' Welcomes', domestic science classes and mother-craft for girls in elementary schools were introduced. The education of fathers and boys in parenthood techniques was not thought necessary. The proposed process of education intended to improve parenthood was firmly centred on the education of girls and mothers.

Certain predominant attitudes distorted the view of motherhood and trivialised the personal experience of birth and infant care in a way that was detrimental to the health of mothers and infants. Sir George Newman, (Dr. Newman), Chief Medical Officer of the Ministry of Health, 1919-1935, strongly believed infant mortality to be caused by the ignorance of the mother and agreed that the remedy should be in educating both mother and school-girl. Sir Arthur Newsholme, (Dr. Newsholme), Chief Medical Officer for the Local Government Board, while agreeing with some of Dr. Newman's points, was of the opinion that more complex influences were at work, ignorance being just one. Dr.
Newsholme spoke mainly of urbanisation which encompassed poverty, lack of housing, overcrowding, disease, inadequate sanitation, poor nutrition and diminished or poor quality natural milk supplies that forced mothers to use alternative infant foods with the inherent dangers. Evidence analysed concerning Monmouthshire tends to support Dr. Newsholme's theory in contrast to Dr Newman. Housing, sanitation, domestic milk supplies and the problems faced by nursing mothers will be analysed in Monmouthshire to substantiate the arguments put forward by Dr Newsholme. The evidence used includes reports from county and district medical officers, county and district council minutes, housing committee reports, newspaper articles and oral testimony.

Jane Lewis argues that it was not clear whether working-class mothers were in need of education and advice concerning infant care. In support of Lewis, a search through the primary sources used for this study did not reveal evidence that there was an indisputable need to educate mothers in childcare in the working-class districts of Monmouthshire. However, an abundance of evidence was found to suggest that middle-class medical professionals in the county believed there was such a need.

The comments of the Welsh middle-class medical men and women in Monmouthshire reflected the national perspective and ideals concerning motherhood. Therefore, it can be argued that the national images of mothering and motherhood were partly disassociated from the Welsh mothers' experiences. This is not to propose that the experiences of the mothers in the industrial districts of Wales were unique: industrialised districts in England could have shared similar similarities. The experience of motherhood in England is not within the scope of this study. Nevertheless, the examination of the lives of mothers
in one county in Wales will assist future researchers in their quest for a comparative analysis in a similar field.

**Maternal Mortality**

The classification system used in the enumeration of maternal deaths linked to childbirth for most of the period covered by this study was problematic. This has meant that government statistics in this sphere were not truly representative of the loss of childbearing women to the nation. The reason for the ambiguity was that classification usually appeared under two headings: puerperal deaths and non-puerperal or maternal deaths. Puerperal mortality meant deaths assigned to diseases of pregnancy, childbirth and the puerperal state. In other words, deaths directly due to childbirth. Maternal, or non-puerperal death, was not perceived as death resulting from childbirth, although the death could be attributed to the state of pregnancy. Non-puerperal deaths, where childbirth was a contributory factor, were classed under the main cause of death: influenza, heart disease, cerebral haemorrhage or tuberculosis.

Irvine Loudon stated that maternal deaths through puerperal fever were under-recorded. One of the reasons for this he claims, was caused by doctors refusing to classify a mother’s death under puerperal fever due to the implication of negligence that would be attached to the birth attendant. 72 This study will examine reports and statistics concerning maternal mortality in the county of Monmouthshire to establish whether Loudon’s claim was justified. Loudon’s authoritative research on death in childbirth 73 presents an international perspective, which is outside the limits of this study. However, the investigation into maternal mortality in Monmouthshire as part of this study, complements Loudon’s research by highlighting a specific locality for future comparative
studies and adds to the debate on the causes of maternal mortality in industrialised nations.

The Senior Medical Officer for Maternal and Child Welfare for the Ministry of Health, Dr. Janet Campbell, produced a report on maternal mortality in 1924. In the report she pointed out the high puerperal death rate in Wales. 74 This situation continued into and throughout the 1930s. The maternal mortality rate for Wales remained the highest nationally in the period covered by this study. The high rate caused concern to the extent that in 1936 a special government committee was ordered to investigate maternal mortality in Wales. Dr Dilys Jones, a Medical Officer for the Welsh Board of Health conducted an interim report into the situation in Wales in 1931. 75 Her investigation led to admittance in the final report published in 1937, 76 that an exceptionally high rate was apparent in certain areas of Wales. These areas revealed a large excess over average rates for England and Wales. Furthermore, the final report stated that there was reason to believe that ‘the amount of ill-health and disability among the women of Wales is excessive...’. 77

In this study, maternal deaths in Wales will be set against the national average to create a framework for an examination of the possible causes of the high maternal mortality rate with Monmouthshire as the main focus.

A Brief Note on Oral Evidence

For the purpose of this study, the oral testimony was mainly collected from residents of South Wales, particularly Monmouthshire. Additionally, a number of women residing in England and Queensland, Australia, were interviewed. The majority of the women had original ties with South Wales, either as children, young women or mothers. An
interviewee residing in Wiltshire was employed in South Wales as a midwife for part of the period covered by the study. She spent a short time working in a hospital in the capital city of Wales, Cardiff. The memories and register extracts she shared for the purpose of this study, reveals the work patterns and responsibilities expected of midwives in England and Wales. One of the other interviewees was Welsh-born, and resided in England for part of the period covered in this study. She moved to England when her husband secured a good position with the Royal Air Force. Her testimony was included to illustrate some of the benefits her husband’s secure financial position brought to her as an expectant mother. Such benefits were often out of reach for many mothers in working-class districts of South Wales at times of trade depression and unemployment.

Linked to the oral testimony is the evidence used concerning the experiences of a woman working as a health visitor and midwife in the Plymouth district. The author of this study does not claim to have collected the oral evidence used concerning Plymouth. The comments chosen for inclusion are borrowed from a secondary source and involve the observations of a contemporary Plymouth midwife. The statements are useful to illustrate that many welfare officials in England, as in South Wales and Monmouthshire faced similar problems. Therefore, the use of the oral testimony from the women in South Wales and the additional ones in England and Queensland can be justified. The testimonies add weight to the documentary evidence collected concerning the lives of mothers in South Wales and Monmouthshire during the period covered by this study.
Introduction: Notes

'There have been recent problems in Britain concerning apparent shortage of midwives. In October 1998 midwives presented a 90,000-name petition to 10 Downing Street in London, demanding a pay-rise. Karlene Davis, the General Secretary of the Royal College of Midwives told the British Broadcasting Company (BBC) 'Conditions are at crisis point...'. She claimed that there were not enough midwives to give one-to-one care and the situation would 'threaten the care which mothers receive in labour.' Her argument that 'Babies' lives are at risk' has stimulated continuing arguments in the health field in Britain. The main organisations involved in the dispute are the National Childbirth Trust (NCT), the Royal College of Midwives (RCM), the Royal College of Nursing, and the Royal College of Obstetricians and Gynaecologists (RCOG). Rosemary Dodds, a policy research officer for NCT pointed out that midwives could give advice, help women make choices and should be valued. 'Midwives are highly skilled autonomous practitioners, not handmaidens to obstetricians'. She states that women who have the same midwife throughout pregnancy are better informed and more confident. However, she says more emphasis should be placed on post-natal support for mothers from midwives, particularly to encourage mothers to breast-feed their infants. The debate is ongoing and this study bears a direct link with the current arguments. For a synopsis of the arguments mentioned here, see the BBC News Online Network http://news1.thls.bbc.co.uk. The articles used were 'Babies dying 'unnecessarily'' 19 October 1998. 'Midwives deliver protest' 21 October 1998. 'Midwife shortage: the reaction' 30 July 1999.

The most comprehensive assessment of the position of the midwife in society prior to the Midwives Act of 1902 and the inter-professional rivalry that surrounded the introduction of the various Midwives Bills into Parliament is Jean Donnison's study. A selected list of other titles of relevance to the development of midwifery continues below.

Loudon, I., (1992) Death in Childbirth: An International Study...
Moscucci, O., (1990) The Science of Woman
Towler, J. & Bramall, J., (1986) Midwives in History and Society
Full bibliographical details of the above and additional sources of a more general nature can be found in the main Bibliography.

For an interesting insight into the work of a man-midwife, see the edited version of the diaries of John Knyveton, who was a surgeon in the British Naval Fleet prior to taking up midwifery. The diary entries offer details of the training he undertook, births attended, puerperal fever cases and maternal deaths.

Gray, E., (ed) (1946) *The Further Experiences of John Knyveton, M.D., Late Surgeon in the British Fleet, During the Years 1763-1809*

Numerous articles have also been written concerning the history of midwifery. A selected list of relevance has been chosen for research purposes.


3 For a comprehensive analysis industrialisation and its effects in Britain, see the sources below. There are many more too numerous to mention.

Brown, R., (1991) *Society and Economy in Modern Britain 1700-1850*


Hewitt, M., (1975) *Wives and Mothers in Victorian Industry*


5 Ibid. p.406.


9 Jones, E.J. (1984) (2nd edition) *Modern Wales: A Concise History* p.196. It is not within the scope of this study to analyse the reasons for the suggested restrictions on the growth of the middle-class during this period. See Jones p. 197 for examples.

For the history of Monmouthshire, see Ray Howell's concise study and selected sources of general interest below. A brief note on Journal articles has been added.

Smith, D., (1980) A People and A Proletariat

The essay by Deirdre Beddoe in the above-mentioned book, 'Women Between the Wars', (pp.129-160), is particularly relevant.


The most relevant Journals to address the history of Wales are Llafur and the Gwent Local History Journal previously known as Presenting Monmouthshire. Of specific interest to the issues raised in this study is Gertrude Harries 'From the Valleys I Came' Vol. 4. No. 3. (1985/86) pp.85-88.

Gertrude said 'How hard it was for the women of the family, as well as for the men working in the pits, the men were too tired to do anything for a few hours and often fell asleep before bathing; so it was that most men did not do a thing in the house and the women did not expect them to, they would often take their boots off for them, the men were so exhausted', p.87. Gertrude's memories revealed the hard work faced by the women of mining communities.


13 Ibid. p.88.

14 Ibid. p.89.

15 For an account of the effects of economic change and a list of contemporary documents, see Deian Hopkins 'Social Reactions to Economic Change' in Herbert, T and Jones, G.E., (1988) Wales Between the Wars pp. 52-98. Also see Margery Spring Rice (1939 reprint 1981) Working-Class Wives for an account of women's lives in the 1930s.


John Burnett suggests that Sir William Crawford's study of diet in relation to income was more comprehensive than the one undertaken by Orr. Crawford's research encompassed all social classes from the wealthy to the unemployed and analysed the incomes of 5,000 families, whereas Orr limited his survey to 1,200 family incomes. Therefore, for research purposes, see also Crawford, W. (1937) The People's Food and Burnett, J. (1966) (1990 reprint) Plenty and Want particularly pp.254-288.

18 Ibid. p.261.


20 Dwork, D. (1987) War is Good for Babies and Other Young Children p.228
Dwork was referring to Lewis’s arguments and comments in The Politics of Motherhood p.27, p.68 and p.81.


26 Ibid. p. 424.

27 See the Clark Report on Newport Borough 1842, Newport Reference Library, Gwent.


In 1845, 105 men per thousand recruited for the army were under the standard height of 5‘ 6”’. In 1900, 565 per thousand were under this height. In 1901, the army finally obtained permission to enlist men at a minimum height of five feet.

33 Ibid. p.144.

34 Ibid. p.148.


36 Jones, G. (1986) Social Hygiene in Twentieth Century Britain p.18

37 Ibid. p.18


40 Robinson, W.J. (1916. 13th edition 1917) Birth Control or The Limitation of Offspring p.14. The dedication to Dr Jacobi from Robinson can be seen on page 5.


45 Ibid. p. iii.

46 Ibid. p.4.

47 Ibid. p.32.


49 Ibid. See the introduction by Jane Lewis pp.1-24.


52 See Spender, D. (1983) There’s Always Been a Women’s Movement This Century. The work illustrates the varied nature of the feminist movement throughout the first half of the twentieth century. Spender interviewed Key activists.

53 See Banks, O. (1981) Faces of Feminism


58 Donnison, J. (1977) Midwives and Medical Men


60 Ehrenreich, B., and English, D. (1979) For Her Own Good: 150 Years of the Experts’ Advice to Women

61 Ibid. p.32.


63 Ehrenreich, B., and English, D. (1979) For Her Own Good... Vol. 1 pp. 29-35.

64 See also Anderson and Zinsser A History of Their Own... pp.163-168.


67 Articles of Co-Partnership Chepstow 30 October 1792.
Agreement between Mr. Will Loftus and Mr. Robert Evans. The document declares that Mr. Loftus, who lists his profession as 'a surgeon, apothecary, man-midwife...' was ‘willing to accept Robert Evans as a partner...' in Chepstow.

**Articles of Co-Partnership** Chepstow 1813.
The agreement between John Jones and George Cowley Leach in 1813 contains statements similar to the above Articles, as does the one for Caldicot.
Two Apprenticeship Indentures concerning men-midwives in Usk and Monmouth in the 19th century are also lodged at the County Record Office in Gwent.


75 Dr Dily Jones's report was published in 1932 as part of the Report on High Maternal Mortality in Certain Areas of England and Wales Ministry of Health Reports on Public Health and Medical Subjects, No. 68.


77 Ibid. p.15.
CHAPTER ONE

MIDWIVES: THE IMPLEMENTATION AND IMPLICATIONS OF THE MIDWIVES ACT, 1902

Introduction

The comparative lack of provision for the training and regulation of midwives in England and Wales in the nineteenth century was the cause of concern among the medical profession and politicians. In contrast to England and Wales, several European countries had instigated successful schemes for the instruction and regulation of midwives. A school for midwives was opened at the Paris Maternite in 1802, followed by a similar school in Berlin a few years later. By 1837, it was claimed that 11,000 midwives had passed through these institutions and similar ones in the provinces.¹ The research conducted into European countries suggests that a high level of importance was placed on the regulation and training of midwives in the nineteenth century. The primary purpose was to save lives. This aim does not seem to be the central thrust of discussions concerning regulation in England and Wales until the last quarter of the nineteenth century. The prevailing notion was that medical men were superior to female midwives, which presented a barrier to change. Additionally, inter-professional rivalry underscored the original requests for the regulation of midwives prior to the introduction of the Midwives Bill into Parliamentary debate in 1892. As Irvine Loudon suggests, a general contempt for the practice of midwifery severely interfered with the teaching and therefore education and qualification of midwives.²
In August 1893, the Select Committee on the Registration of Midwives produced its final report based on the evidence of the various witnesses. All members of the Committee who were in a position to examine the witnesses were men. The Midwives Bill affected women working as midwives, intending to train as midwives and women giving birth in the future. There were no women on the Committee to represent the interests of women and help mould legislation, which would directly affect women’s lives. However, trained female midwives were among the witnesses called to present evidence to the Committee. Examining the evidence, the Committee finally accepted that the statements did highlight serious and unnecessary loss of life. Legislative provision for midwives was strongly advocated. The Committee concluded that registration of midwives would not damage the medical profession and recommended that the General Medical Council, subject to the approval of the Privy Council, should frame the rules governing examinations and discipline. Following legislation, the County Councils would be responsible for local implementation and administration. The final report also proposed that there should be an increase in opportunities for training midwives in Lying-In Hospitals and Poor Law Infirmaries throughout England and Wales.

However, the Select Committee’s conclusions did not see an end to the struggle for registration. It was a further seven years before the Bill finally became an Act of Parliament with the passing of the Midwives Act in 1902. During the intervening years there were several unsuccessful attempts to finalise the passage of the Bill through Parliament. Furthermore, a clash of interests meant that the atmosphere remained hostile. The intervening years faithfully reflect the struggle which epitomised the transition of
control of the process of childbirth from women to men. The transfer of control was complete, in theory, with the passing of the Midwives Act in 1902.

The 1902 Act established the formation of the Central Midwives Board (CMB) with the prime purpose of regulating, training and examining the ‘new’ midwives. Prior to the Act, the training and supervision of midwives was wholly unregulated and unsupervised by the state. The Act effectively brought midwifery training and midwives under state control.

The administration of the Act nationally, which came into force in April 1903 was undertaken by the CMB. The Board was directly responsible to the Privy Council until 1919 when the supervisory powers of the latter were transferred to the Ministry of Health. Local supervision of midwives was undertaken by the local authorities such as County Councils, who were responsible for the organisation of services.

However, the CMB was not only responsible for the registration and education of midwives. Rules and regulations set down by the Board required strict adherence to the stated terms. Any infringement of the rules was punished severely and could lead to the name of the erring midwife being struck off the Register of Midwives, or the ‘Roll’. Interpretation of the rules reflected the moral ambience of earlier ecclesiastical controls on female midwifery practice. The evidence suggests that the CMB became a powerful institution for the control of female midwives.

This chapter will firstly identify the attitude of the medical profession and politicians to the Midwives Bill and midwives in general. The way in which the use of language worked to stereotype female midwives will be included. The role and position of midwives in rural, urban and mining communities will be studied to compare the nature
of their work and their relative value to the general practitioner in those communities.

Secondly, the passing of the Midwives Act in 1902 and the implications to the position of the midwife will be assessed in depth. The Welsh county of Monmouthshire will be used as a case study to illustrate the establishment, implementation, administration and operation of the Act by a local authority. The nature and effect of the changes on practicing midwives in the county, which resulted from the passing of the Act, will be assessed.

Midwifery in England and Wales

The Registrar-General’s report in 1841 included statistical evidence of maternal mortality collated by using figures received following the registration of births and deaths under the Act of 1836. The information revealed that in England and Wales over 3,000 mothers, or almost six mothers to every thousand registered births, died each year. Dr. William Farr, the Statistical Superintendent of the Registrar-General’s Office, was moved to comment that well-educated and trained midwives could greatly reduce the mortality rate and the number of women suffering permanent disablement due to inefficient care at the time of, and shortly after birth.

It can be suggested that prejudice and animosity towards the practice of midwifery led to a limited number of institutions with medical professionals to teach the subject adequately to trainee midwives. The Act imposed restrictions and penalties for midwives breaking the rules. However, without extensive training to execute proficiency, any work conducted by midwives would be in danger of criticism.

The comments of the members from both the College of Physicians and the College of Surgeons serve to substantiate this claim. Sir Henry Halford, President of the College of
Physicians, attempted to defend the principles of the College to the Select Committee on Medical Education in 1834. Midwifery, he claimed, was ‘a manual labour’, which would ‘discredit men who had been educated at universities’, and ‘disparage the highest grade of the profession’. Similarly, James Guthrie, President of the College of Surgeons in 1833, explained to the same Committee, that it was acceptable for a young surgeon at the start of his career to be called to a midwifery case. However, he pointed out that the general public would lose faith if senior surgeons did not devote their lives solely to surgery. Both comments illustrate hostility towards midwifery practice.

In contrast, the first President of the Obstetrical Society Sir Charles Clark, who was also a renowned accoucheur, advocated the need for educating all midwives. The Obstetrical Society continually pressured the College of Surgeons to implement a system of examination in midwifery and eventually, in 1852, the College introduced a license in midwifery. The two Colleges also started negotiations in 1859 for a conjoint examination. However, competing interests meant that a complete agreement did not exist for a further twenty-five years.

Finally, the Medical Act of 1858, following the same pattern as the earlier Apothecaries Act, failed to recognise midwifery as part of medicine. Viewed in conjunction with licensing bodies and University policies to admit only men to their examinations, the Act appeared claims Jean Donnison, ‘to put the final seal on the exclusion of women from the profession’. Most women practicing as midwives had no training at all.

The trained midwives were to be found in large towns and cities working in hospitals, charities or in private practice. However, by the 1850s, the number of midwives was diminishing in some major hospitals too. The British Lying-In Hospital in London, once
priding itself on its midwifery training, had reduced its number of midwives significantly, and chose instead to train women to be monthly nurses. This situation would benefit the upper classes who could afford such a service, and doctors who could use monthly nurses to save themselves tedious work and time. 14 Donnison highlights two important consequences to women, which would have materialised if the deterioration in the position of midwives in the late nineteenth century were not improved. Firstly, employment in the field of midwifery, traditionally held by women would no longer be possible. Secondly, regardless of preference women would be forced to engage men to attend them in childbirth. 15

Dr. James Edmunds, District Surgeon for the Royal Maternity Charity and later to become the Honorary Secretary of the Female Medical Society, 16 held the belief that many cases of maternal mortality were caused by the practice of medical men attending childbirth directly following attendance at surgery cases and post-mortem examinations. It followed that he strongly supported the idea that midwifery should be separated from medical practice. Furthermore, he advocated that in turn, this would allow women to choose midwives instead of medical men to attend deliveries thus restoring midwifery practice to women. While offering support to women genuinely wanting to qualify as medical practitioners, he did not believe that anyone; male or female should attend surgery or medical cases and practise midwifery. 17 In addition, Dr. Edmunds expressed the view that the ultimate aim of the Society to secure admission of women to the medical profession might not happen, due to the apathy on the part of women and the consequent lack of numbers this could incur. 18
Dr. James Aveling, a physician at the Chelsea Hospital for Women and an examiner of midwives for the Royal Obstetrical Society, recognised that some midwives desired to attain a higher position. However, he warned that courses for midwives were not comprehensive enough to ensure the complete knowledge that would be required to pass the examinations required for the higher position. He said 'they are right to aim high, but must not expect to reach eminence without painful climbing'. 19 Dr. Aveling stated that he would gladly welcome to the medical profession talent from either sex, providing a woman could pass the same examination required of medical men, concluding that the numbers of women would probably be few since 'there are many impediments to women becoming distinguished'. 20 Both Dr. Edmunds and Dr. Aveling agreed that better training for midwives should be a primary concern. Training offered in Lying-In Hospitals was inadequate and certificates and diplomas held no consistent qualifying element, since state regulation of midwives was not a legal requirement. Finally, as Donnison points out, any further discussion on midwifery training and registration centred on qualifying women to attend normal births. This resulted in midwives remaining at a significantly lower status level than that of the medical professionals. 21

**Concern Regarding the Midwives Bill**

A former Master and midwifery trainer at the Rotunda Hospital in Dublin, Dr. Atthill, expressed his concern regarding a proposed Midwives Registration Bill. Dr. Atthill did not object to a Bill regulating midwifery. His argument was based on the belief that the proposed Bill was 'founded on a false principle'. He claimed that the framers of the Bill seemed to believe that registration would 'improve the present class of midwives'. 22 Education, he insisted, should be put first and registration would come later. Dr. Atthill
severely criticised the lack of training facilities for midwives, which must be to his credit. However, the overall tone of his objection revealed his attitude towards female midwives,

...the Act will have the effect of actually inflicting an injury on the public, for the women who at present act as midwives are known to be uneducated and possess no title to pose as being educated, whereas those who become ‘registered’ will produce their certificates of registration and will pose as qualified practitioners of midwifery. ²³

Additionally, Dr. Atthill insisted that the registered midwives would not be superior to their predecessors except that they might have learnt a few medical terms with which to impress the illiterate poor. Since one of the aims of the Bill was to increase the number of registered midwives attending the poor in urban and rural districts, Dr. Atthill objected strongly to a clause in the Bill promising registration status to women attending births as midwives prior to the passing of the Act. There would be no guarantee, claimed Dr. Atthill, that these bona fide midwives were not drunkards, grossly ignorant and carriers of infection.

Dr. Atthill continued that he greatly feared that these experienced yet uneducated women would gain registration. They would then be able to use their certificate as qualification to practise midwifery. He concluded that adequate training and education of midwives would be preferable than the implications envisaged in the Midwives Registration Bill. According to Dr. Atthill, and in keeping with the general attitude of medical men towards female midwives,

...the process would be slow, but it would be better to be so than to register en masse a number of women, illiterate, ignorant, and in many cases drunkards,
whose presence on the register would lower it in the eyes of the public. 24

As the Bill stood, the legal opinion of a Barrister-at-law pointed out a number of inadequacies. It was not made illegal for a registered midwife to employ an unqualified assistant. An uneducated woman or a midwife removed from the register could continue to practise midwifery. A registered midwife could perform abnormal tasks and receive payment. Additionally, the Bill did not prevent a midwife from prescribing medicine, using forceps, performing midwifery operations, vaccinating and treating medical complaints. 25

It was claimed that the Bill had not been analysed in depth. However, it can be argued that people opposing the Bill interpreted evidence in a way that would support their own objections. This claim can be substantiated through an analysis of the correspondence printed in the BMJ from both opponents to and supporters of the Bill. Documentation reveals a divide in the medical profession concerning the registration of midwives. 26

It can be suggested that the majority of the objections to the Bill concealed the fear that the lower class of less qualified practitioners would undermine the status and position of the general medical practitioner. Moreover, Donnison suggests that from the time that men had become involved in midwifery, they had ‘pursued the midwife with a jealous and unremitting enmity’ and sought to limit her role until female midwives eventually disappeared’. 27

The first of many Midwives’ Bills was introduced into the House of Commons in 1890. It was promoted by the Midwives Institute and based on a draft drawn up by the British Medical Association (BMA) in 1882. 28 However, the Bill was not to reach the statute book until 1902 directly due to the continuing conflict. Calls for a Select Committee to
investigate the need for the registration and education of midwives began to escalate. Mr. Fell Pease withdrew his Bill and it was not until 1892 that a Select Committee of the House of Commons was chosen. Investigative work began and in 1893 the Committee finalised its Report. 29

The members of the Committee included Dr. Farquharson, Mr. Bright, Sir Frederick Fitz Wygram and Mr. Rathbone, with Mr. Fell Pease in the Chair. The Committee sat on numerous occasions prior to the final report in 1893 and attempted to secure evidence from as wide a field and range of opinions as possible to assist in their aims to present an unbiased report. Medical men and midwives, in favour of and in opposition to the registration of midwives, were called as witnesses. The evidence taken led the Committee to state that

...there is, at present, serious and unnecessary loss of life and health, and permanent injury to both mother and child in the treatment of childbirth, and some legislative provision for improvement and regulation is desirable. 30

When the Committee examined Mr. Alexander Napier, a renowned physician, he stated that he was convinced that an improvement in midwifery would lead to an improvement in the general health of women. He believed that many female complaints were the result of inefficient attendance during the birth by midwives and other unskilled persons. He claimed that around twenty to twenty-five per cent of the outpatients at hospitals originated from ‘bad recoveries after labour’. 31

However, it was impossible to calculate the extent of the damage that was suffered by women as a result of a prolonged confinement and difficult delivery. Maternal mortality statistics only revealed the number of women who did not survive the ordeal of
childbirth. One of the major concerns of the Committee which led to the conclusion that some form of certification and registration of midwives was required, was the result of the evidence given on the role of midwives in rural districts. The following section will identify some of the main concerns relating to rural midwifery, taken from the evidence presented to the Committee.

**Midwives in Rural Districts**

One of the major concerns of the Committee was the quality of care offered by rural midwives. Mr. Napier, who was responsible for training midwives in a London Lying-In Hospital where he was the resident MO, pointed out that in outlying country districts in particular, it was difficult for doctors to look after all midwifery cases. Furthermore, Mr. Napier suggested that very few country midwives were skilled or even educated. He claimed that as a result, the practice of midwifery in country places was undertaken by either these unskilled midwives, or neighbours who ‘are certainly very dangerous to trust to’. 32

Mrs. Maria Martin was a country midwife with thirty years experience in Worcestershire. She supported Mr. Napier’s call for the increased training of midwives. The willingness of a woman to support the call for the training of midwives illustrates that it was not entirely a proposal originating from men in the medical profession. Mrs. Martin gave evidence highlighting the situation in her own agricultural district, which consisted of nine parishes and around 7,565 inhabitants. When Mrs. Martin was asked whether local midwives were successful attending births, she replied that there had been
'a very great many melancholy results'. Mrs. Martin attributed these 'melancholy results' to the incompetence of the untrained birth attendants and offered cases as examples to justify her comments. She concluded that in her opinion

...the employment of a trained midwife would increase the practice of a doctor rather than diminish it in rural districts. 34

One of the arguments against the registration of midwives was fuelled by the fear of some medical men that they would lose fees to midwives, rather than concentrating on the need to protect mothers and infants from incompetent help. Mr. Napier firmly believed that no medical man would suffer from having work taken away from him by midwives, partly due to the nature of a midwife's work, which was different to that of a doctor. A midwife was able to attend births and look after the mother, baby and home, whereas a doctor could not undertake those duties. Mr. Napier concluded that a midwife was 'invaluable' in isolated country districts. 35

Extending the argument, Dr. Farquharson questioned Dr. Aveling concerning the workload of country doctors. The suggestion was made that when a doctor treated an infectious case prior to attending a woman in childbirth, infection could be spread to the woman. When Dr Aveling was confronted with the claim, he agreed that it could happen when a doctor attended a delivery straight after treating an infectious case such as scarlet fever. However, attempting to maintain a balance in the argument, he pointed out that a midwife could pass on infection in the same way. 36 Dr. Farquharson was highlighting a relevant point: a rural doctor could not confine himself to midwifery cases whereas a midwife could attend births and help with the household chores.
Mrs. Martin’s evidence revealed that nineteen out of twenty ‘poor women’, wives of agricultural labourers, mechanics, blacksmiths and small farm-holders, employed ‘the woman that goes about nursing’. 37 When asked whether the choice of a female midwife implied a preference for a female, instead of a male birth attendant, Mrs. Martin offered the reason that had been given to her by a woman in her district. The woman’s husband was an engine driver in receipt of a good wage. He was able to pay a doctor’s fee to attend his wife at the time of birth. However, his wife had given birth to nine children and had employed a midwife for each delivery. She pointed out to Mrs. Martin that the doctor’s fee was one guinea for attending the birth and visiting for a few days. In contrast, the midwife charged five shillings to attend to her own and her baby’s needs for up to ten days. Mrs. Martin stated that a poor woman would feel even more strongly about value for money. She added that women with limited means preferred a woman they could depend on to come into the home and help. When relatives and neighbours did not live close by, women would have to pay someone extra to do the household chores in addition to the doctor’s fee. Mrs. Martin pointed out that some cleaning women charged a shilling a day. 38

Dr. Rentoul’s earlier evidence presented to the Select Committee highlighted a different perspective to the one offered by Mrs. Martin. Mr. Bright, a physician and a member of the Committee, had claimed that the public employed female midwives to ‘a very large extent’. Dr. Rentoul disagreed and sharply pointed out that since midwives charged a smaller fee than that of doctors, the issue of public choice of birth attendant had little to do with gender and everything to do with economics. Furthermore, stated Dr. Rentoul with conviction, there was not a demand for female midwives, just ‘cheap labour’. 39
Regardless of the arguments presented to the Committee, the evidence suggests that women, particularly those with limited incomes, looked more to the practicalities of their situation in rural districts, rather than identifying with a gender-related decision to employ a female midwife as birth attendant.

**Additional Concerns**

A conflict of opinion remained concerning the registration of midwives.

Mr. Brown, President of the General Practitioners Alliance [GPA], had been in general practice in London for nineteen years. On behalf of the GPA, he protested strongly against ‘ignorant and partially educated persons being recognised by the law as competent to attend midwifery’. He referred to specific cases he had attended to substantiate his opinion. Mr. Brown concluded his evidence by saying that all midwives ‘should be legally qualified medical practitioners’. 40

Mr. Hugh Woods’s evidence was decidedly more caustic towards midwives than the remarks of Mr. Brown or Dr. Rentoul. After pointing out that by ‘midwives’ he was not referring to ‘obstetric nurses’, clearly differentiating the latter’s preferred role to that of the former, Mr. Woods launched his attack. A midwife, said Mr. Woods, was an ‘obsolete individual’ and a ‘relic of the dark ages’. Furthermore, Mr. Woods believed that the idea of ‘normal’ labours attended by midwives only should be strongly discouraged. He fiercely opposed the notion that *bona fide* midwives should be admitted to the register. He blamed these *bona fides* for a string of offences including bringing the title of midwife into disrepute.

Many...are utterly disreputable, vulgar, drunken women, utterly and absolutely incapable of doing their work properly. 41
To Mr. Woods and other medical men such as Mr. George Thomas, a Member of the Royal College of Surgeons, the term ‘midwife’ was synonymous with a particular type of woman on whom indescribable horrors including infanticide could readily be blamed. Mr. Thomas labeled midwives as ‘ignorant, hardened gin-drinking old ladies’. However, as Donnison points out, in 1876 Dr. Farr’s conclusion in the Registrar-General’s Annual Report claimed that some avoidable mortality of childbirth could be attributed to the less skilful registered medical practitioner. Furthermore, unqualified men attended many births with no qualified practitioners or untrained midwives. Dr. Gregg, physician to Queen Charlotte’s Lying-In Hospital in London, had also stated that more cases of ‘injury and physical disaster’ had been caused by medical practitioners’ use of instruments to speed up deliveries, than by unqualified midwives.

To illustrate the incompetence of practising midwives, eighteen specific cases were offered as evidence by witnesses. The midwives described in the evidence were stereotypically illiterate, old and often fond of drinking alcohol. Mrs. Elizabeth Malleson, a midwife in the rural districts of Gloucester, declared that her examples came from observations of ‘the evils of untrained midwifery’ and were ‘startling instances of an evil system’. She also added extracts of a letter she had received from ‘a medical man in the North of England’. He labeled the midwives he had seen in Mrs. Malleson’s area as ‘specimens of ignorance, filth and unwholesomeness’, with no idea of hygiene and no training in midwifery.

Continuing in a similar vein, Mr. Fell Pease, asked Mr. Althelstan Braxton Hicks, the Coroner for the South Western district of London and the Kingston district of the county of Surrey, if he had experience of ‘any evil resulting from the practice of unauthorised
midwives...'. Mr. Hicks replied that there was considerable danger in unqualified, ignorant people practising indiscriminately as midwives. Mr. Hicks continued by stating that he believed registration would encourage trained midwives to establish businesses which would ‘oust the ignorant and often drunken people’. His statements reflected the common stereotypical image of the ignorant, drunken midwife.

Few medical men acknowledged the different types of women acting as midwives. To medical men, there were only two types of midwife. The preferred type was the good, middle-class, and educated midwife who knew when to call for a doctor. The other type was the evil, working-class, ignorant, drunken ‘gamp’. The latter type would not know when to send for a doctor. Medical practitioners believed that this would jeopardise a doctor’s chance of acquiring a fee.

Strong accusations also came from Mrs. Bedingfeld, a nurse matron and qualified midwife. She referred to the ‘habits of intemperance that are inculcated by these ignorant midwives’. To justify her incriminating remarks, Mrs. Bedingfeld drew on three cases from her own experiences. In each case, she claimed, midwives encouraged women in labour to drink alcohol. She firmly believed that midwives had made many women drunkards and claimed that midwives would often take advantage of the drink themselves. Mr. Hicks’ and Mrs. Bedingfeld’s remarks concerning drunken midwives, took as evidence of proof, the fact that alcohol was present. In Mr. Hicks’ case, the presence of alcohol was enough to label the midwife as a drunkard. Mrs. Bedingfeld’s evidence covertly offers an insight into the reason alcohol was requested at, or taken into a confinement: as a pain reliever and muscle relaxant to aid delivery. Mrs. Bedingfeld, in common with Mr. Hicks, took the view that if alcohol was present, the midwife
participated in the action of drinking. There were undoubtedly some midwives who
deserved the derogatory label of drunkard. However, the label ‘drunkard’ linked to
‘midwife’ was an assumed conclusion that persisted and came into common usage to the
detriment of respectable, conscientious midwives.

The majority of the supporters of the Bill rarely mentioned examples of good practice by
women birth attendants. Omitting to offer examples of successful cases and emphasising
the ‘evil practices’ allegedly caused by distinctive working-class female midwives,
worked to present the impression that employing a midwife automatically meant disaster
to the mother and infant. By instilling a fear of unqualified midwives into the minds of
expectant mothers, medical men could cement their future in the field of obstetrics.
Those against the Bill urged that the proposed legislation would aggravate ‘existing evil’
by increasing the number and extending the practice of midwives. This, they claimed,
would lead to an increase in infant mortality and endanger the lives of mothers.
Additionally, it was believed that the establishment of a competing class of inferior
practitioners would harm the medical profession. Complications in labour could set in
rapidly, particularly if the mother suffered from a medical condition that was not
recognised by the midwife. In these cases, only a doctor should attend. Finally, some
opponents proposed that midwives were unnecessary, arguing that there were enough
young doctors to attend all midwifery cases.

In contrast, the supporters of the Bill argued that an increase in trained midwives would
mean a dramatic reduction in maternal and infant mortality rate. The trained midwife
would recognise danger signs and be more aware of the need to call a doctor in certain
cases. In addition, the trained midwife could take steps to avoid ophthalmia-neonatorum.
Infected secretions in the birth canal commonly caused this condition. When left untreated, the condition often led to blindness in the newborn infant. It was also claimed that trained midwives would be less likely to participate in abortion practices and infanticide. Finally, it was firmly believed that the medical profession would be complimented by trained midwives who would be able to attend the poor and relieve medical men of a great deal of low-paid and tedious work. In many rural districts where doctors were few, it was claimed that the result of a class of trained midwives would be noticed first.

However, Mr. Hewitt, a physician, pointed out that different circumstances relating to childbirth attendants were evident and these varied considerably from county to county, sometimes varying within a county. There were no set rules to calculate the percentage of midwives attending births against the number attended by doctors in villages, towns or cities.  It was impossible to come to a definite statement concerning the number of midwives who were practising and attending labours compared to doctors. Therefore, it was felt that a form of registration for midwives would enable information to be retained on the number of midwives in a particular area and the total number of births attended by midwives compared to doctors in the country. A clear view of the position of midwives in general could then be established.

An analysis of the evidence available points to the polarisation of opinions within the medical profession. One group supported the total ban of all midwives. The alternative measure promoted by the other group, was more training for midwives. It was claimed that training would enable female midwives to safely attend normal confinements.
Midwifery Practice in Contrasting Rural, Urban and Mining Districts

The evidence presented in the Select Committee’s 1893 report highlighted many differences concerning the work of midwives in various parts of England and Wales. The extent to which midwives practiced, were trained or unqualified, accepted by doctors or disliked varied considerably. The differences were wide, with sharp contrasts from one district or county to another. Mr. Bott, medical officer of health for Brentford in England, described Brentford as a ‘typical town for midwives’ where they could do ‘an immense amount of work’. The population was estimated as being 14,000 and ‘nearly all poor people’. Mr. Bott related how ‘two or three old women’ attended the poorest cases, charging very small fees. He added that it was difficult to keep a check on their activities since ‘it is all done so quietly’. However, he claimed that ‘children’s lives were lost through the ignorance’ of the old women.

There were 492 births in Brentford in 1892. One certified midwife attended 181 births, ‘the others’, meaning the old women attended around fifty births, which left 261 births for the ‘five or six medical men in the town’. This meant that the certified midwife could have attended an average of three births each week, probably more than each of the medical men, while the old midwives would have attended a maximum of one birth a week.

Mr. Bott’s evidence revealed that the unqualified midwives charged two shillings and sixpence, while the qualified midwife’s fee was five shillings. Furthermore, Mr. Bott had a long-standing agreement with the latter, that he would assist, free of charge in cases of difficulty. The arrangement illustrates a good working relationship between the medical officer and the trained midwife. Additionally, Mr. Bott seemed to display an
empathetic attitude towards the poor mothers of Brentford. The attitude of Mr. Emmerson, medical officer for the rural district of Biggleswade was similar, with the emphasis more centred on the economics of the situation. 52

As a complete contrast to the rural districts Mr. William Williams, medical officer of health for Glamorgan offered an insight into childbirth in the closely packed mining valleys in South Wales. Mr. Williams concentrated on the Garw and Ogmore districts with the occasional reference to Cardiff and Merthyr. The Garw and Ogmore were mining districts with a population of around 13,000. Mr. Williams stated that

...nearly all the confinements in this and similar districts in the county are attended by midwives - professed midwives as they are called - but not trained, and with no certificate and whose knowledge of infection and antiseptics is nil. 53

Furthermore, there was an excessively high rate of puerperal fever, related cases and maternal mortality in the district compared to the whole of England and Wales. The Garw and Ogmore district maternal mortality rate from puerperal causes appeared to be almost ten times higher than the rate for England and Wales. [See Table 2]

Mr. Williams was of the opinion that trained midwives would be an advantage to the medical men by recognising when to call for assistance. An added bonus would mean that training would educate the midwife in sanitary and antiseptic procedures, which could help to reduce the excessive maternal mortality rates of the Welsh mining valleys. Mr. Williams offered the Committee information contained in a report sent to him from the MO for Merthyr, which revealed the nature of the type of work covered by unqualified midwives in heavily populated districts.
TABLE 2

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<th>Average Mortality Rate in Childbed per 1,000 Births</th>
<th>Deaths from Puerperal Causes: 1881-1891</th>
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<tr>
<td>England and Wales</td>
<td>25.9</td>
<td></td>
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</tr>
<tr>
<td>The Garw and Ogmore</td>
<td>229.0</td>
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</tbody>
</table>

Source: Minutes of Evidence taken before the Select Committee on the Registration of Midwives. Evidence of Mr. William Williams 7 July 1893 pp14 - 15 (232 - 233)

Dr. Dyke was the District MO for Merthyr in 1893. His report contained a description of specific cases of infectious diseases in the Merthyr district and included the comment from Dr. Dyke that

...disease and deaths have resulted from the attendance of females who had engaged in laying out the bodies of persons who had died of infectious maladies...\(^{54}\)

The examples given by Mr. Williams from Dr. Dyke’s report reveal the intimate nature of the work of the community midwife before legislation altered her position. Since there were no legislative restraints to ensure that an unregistered midwife would not be able to practice, there were no constraints on the nature of her employment. The tradition of laying-out the dead had long been designated to the ‘wise woman’ of the village. She was the person to call on at the moment of birth, death and any period of sickness in between. Moving on, Mr. Williams reserved the opinion that a trained midwife would be of great value to a doctor.\(^{55}\) When questioned on the character of the midwives practicing in his area, a line of enquiry felt necessary because ‘...in many cases in large towns they are not of a respectable class’, Mr. Williams supported their respectability and claimed that they
were 'the wives of working men generally'. Mr. Williams' evidence further reveals that he personally interviewed the midwives in his district and found that they felt they would appreciate some form of training. From his description, the indications suggest that the midwives were respectable working-class women, eager to learn and improve the skills acquired through experience. Finally, Mr. Williams stated that he could not foresee any difficulty in the future concerning 'rivalry' or 'hostility' if a 'superior class of midwives' were introduced among the medical men of his district.

Mr. Williams' initial startling claim of the excessively high maternal mortality rates and the link with puerperal fever cases and midwives, was not so much a condemnation of the midwives as a call for training, particularly in the use of antiseptics. Overall he recognised and valued the work of the midwives in his district. Mr. Williams' comments highlight a more open response to the question of the role of midwives in relation to medical men than can be found elsewhere in evidence given by other medical men. Dr. Rentoul, for example, stated that all midwives, whether qualified or untrained, should be classed as an 'unqualified evil'.

However, it was not only medical men who were found to harbour derogatory feelings concerning female midwives. Mrs. Bedingfeld, mentioned previously in connection with the link between midwives and drink, claimed that she was fighting for registration mainly because people 'do not recognise the difference between qualified and unqualified ones (midwives) at present'. Her argument highlighted the antagonism towards unqualified women practising as midwives. It was claimed they were keeping work away from qualified midwives. With nothing to prevent 'the others' from practising,
particularly if they were already well known in the district, women would turn to the unqualified before the qualified woman who may be a stranger to the area.

Mrs. Bedingfeld was asked what she would do about the unqualified women in practice when the Bill was passed. She replied that they should still have to pass an examination to continue and if they could not or would not do that, they should be banned from practice. The Chairman of the Select Committee pointed out to her that the solution would be too hard on many old women who had been practising for years and had built up a great deal of experience. Mrs. Bedingfeld was adamant and fiercely defended her opinion with a final comment.

Which is of the most consequence, the lives of mothers and children, or of one or two old women? 60

In August 1893, the Select Committee produced its conclusions based on the evidence it had received. The evidence presented to the Select Committee illustrated a wide variety of opinions concerning the registration of midwives. Many of those questioned seemed to concentrate on the way in which legislation would affect their own position, rather than attempt to identify some of the benefits training opportunities may have on the lives of both mothers and infants in England and Wales.

It was agreed that some form of legislation was necessary in an attempt to gain training and instruction for midwives and to provide higher quality care for women at their confinements. The Committee was convinced that legislative controls relating to the work of midwives would not damage the medical profession or take work away from them. It was suggested that rules and regulations should be set down clearly embodying the principles of examination procedures in addition to training. Furthermore, it was stated
that there should be disciplinary rules governing midwives. Many of the Committee’s suggestions were supported and opposed in the intervening years before the Bill finally passed through Parliament.

**A Summary of the Provisions of the 1902 Midwives Bill**

The full text of the Midwives Bill was published in the *BMJ* in February 1902. It was called ‘A Bill to Secure the Better Training of Midwives and to Regulate their Practice’ with the short title of Midwives Bill. The term ‘midwife’ was defined as ‘a woman who is certified under this Act’. The clauses of the Bill included provisions for qualified and unqualified practicing midwives. The terms of the legislation stipulated that from 1 January 1905 ‘no woman’ was entitled to use the description ‘midwife’ unless she was certified as such under the Act. Any woman doing so would be liable to a summary conviction.

To become certified under the Act, a woman had to comply with the rules and regulations laid down in the Act and once certified she could not employ an uncertified person to act in her place. However, the certificate would not confer on the midwife the right to act as a medical practitioner, grant a death certificate or take on ‘cases of abnormality or disease in connection with parturition’. A woman holding a qualification in midwifery from the Royal College of Physicians in Ireland, the Obstetrical Society of London or another recognised and approved body would be able to gain certification under the Act.

Additionally, *bona fide* birth attendants who were practicing prior to the Act and who could provide evidence of good character could gain certification. Finally, women requesting certification or examination were required to pay a fee of ten shillings to a centralised regulating authority. 

61
One of the main objections forcefully raised as the Midwives Bill approached its third reading in Parliament was that it created ‘a new class of midwifery practitioners less trained than medical men’. The Bill, it was claimed, did not set out to abolish the ‘untrained and dangerous persons’ who were practising midwifery among the poorer classes. 62 Concern had been voiced earlier in the BMJ with regard to the probability of two distinct classes of midwives appearing following the introduction of the Act; the certified, registered midwives on the Midwives Roll and ‘those other persons’. The latter category was claimed to be the bona fide midwives. Although these women would not be able to call themselves ‘midwives’, they would be able to continue to practise under the Act ‘with as little knowledge as the Gamps of the present day’. 63 The certificate available to midwives would follow two or three months instruction, which opponents of the Bill claimed to be inadequate when compared with the two years training required of midwives in France by French law. 64 Arguments concerning midwives’ training persisted after the passing of the Act.

The regulating authority was to be named the Central Midwives Board (CMB) and would be responsible for carrying out the provisions of the Act. It was decided that the Board would consist of seven members 65 including one woman. The duties and responsibilities of the Board encompassed a wide range of issues including framing the rules, regulations and subsequent amendments to the Act. Concerning the regulation of midwives, the Board would be responsible for issuing certificates, admitting midwives to the Midwives Roll, supervising and restricting the practice of midwives within the limits of the Act. The Board would also be responsible for decisions to remove midwives’ names from the
Roll, and allow reinstatements. Additionally, regulating training courses and examinations were an important part of the responsibilities of the Board.

The Bill included details of the compilation of the Midwives Roll, the process of notification to practice midwifery, the penalties for not complying with the rules and regulations set down by the Board and the method of appeal for an 'aggrieved' midwife. Finally, the duties and responsibilities of the local supervisory authorities were outlined.

The local authorities were expected to supervise the implementation of the Act within their own administration area. The Bill was approved and the first Midwives Act received its Royal Assent on 31 July 1902. It came into force on the first day of April 1903.

The CMS and the Social Control of Midwives

The CMB became a powerful institution for the regulation of the practice of midwifery. It maintained the control of the midwives under its jurisdiction. Apart from the rules and regulations of the CMB related to the professional expertise and responsibilities of the midwives, evidence suggests that the CMB also policed the private lives of midwives on the Roll.

A midwife's character was expected to be impeccable otherwise she was not allowed to practice. In the medical profession, as in other professions at the time such as teaching, it was not unusual for the practising professional to be required to be of sound character. Nevertheless, the following examples of controls and subsequent penalties that were placed on the midwives substantiate the argument concerning social and moral control.

Under Section 2 of the Midwives Act, *bona fide* midwives of sound character who had been practising prior to the passing of the Act were allowed on to the Midwives Roll for a limited period of time. Sarah Ann Marsh of Eccles had applied for and was granted a
certificate in March 1905 to practice midwifery under Section 2 of the Act 'in virtue of
good character'. Dr. Sidley, a local general practitioner signed her certificate that year
and confirmed her good character. The CMB discovered that Mrs. Marsh was frequently
convicted of drunkenness before the date of the certificate and repeatedly since the
award. Consequently, her name was removed from the Roll and documents sent to the
Director of Public Prosecution (DPP). Proceedings were instituted against Dr. Sidley and
Mrs. Marsh. The case was dismissed against Dr. Sidley. However, Mrs. Marsh was
committed for trial at the Salford Hundred Quarter Sessions. At the court hearing, Mrs.
Marsh's 'not guilty' plea was ignored. She was convicted and barred from practising as a
midwife. 68

The Marsh case reveals the importance placed on a midwife's moral standing. It seems
probable that the CMB endeavoured to create a special class of midwives that would
deconstruct the image of the drunken gamp prevalent in eighteenth and nineteenth
century rhetoric directed towards unqualified female midwives.

Mrs. Marsh was one of 9,643 midwives who were admitted to the Roll in view of 'prior
certification' under Section 2 of the Act. A further 8,147 had passed the CMB
examination, giving a total of 29,209 names on the Roll by 1910. This was an increase of
1,928 from the 1909 figure. With 17,790 trained and 11,419 untrained, the percentage
was 61 against 39 in the early years following the passing of the Act.

The number of disciplinary hearings in 1910, which were termed 'penal cases' totaled
fifty-three. Out of this number, twenty-three midwives were struck off the Roll, fourteen
were censured, thirteen cautioned and three permitted to resign voluntarily. The number
of cases in 1910 showed a reduction on the year before, which saw ninety-two cases
appearing before the Board. A total of fifty-three penal cases out of a potential work force of 29,209 midwives seemed negligible. However, the incompleteness of returns by local supervising authorities made it difficult to accurately count the number of practising midwives, trained or untrained. Nevertheless, the CMB noted that untrained practising midwives were ‘largely in excess of the trained’. Qualified midwives were as restricted by the CMB’s moral code as were the untrained bona fides. Value judgements constantly threatened a midwife’s livelihood and invaded her personal privacy. The CMB could dismiss a qualified midwife by removing her name from the Roll when it was decided that her character was not equivalent to the standard set by the Board. ‘Misconduct’ covered more than technical and medical misdemeanours. Charges of immorality and drunkenness could also jeopardise a midwife’s position. The circumstances leading to Mrs. Stock’s conviction and later appeal can serve to illustrate the system of moral control further.

In 1915, Mrs. Stock, a practising midwife who had been struck off the Roll for ‘misconduct’, appealed to the King’s Bench Division for her name to be restored. The CMB’s ruling to remove Mrs. Stock’s name was decided after using unsubstantiated information of a highly personal nature. It can be suggested that moral judgements were made regardless of the professionalism and experience of Mrs. Stock as a qualified midwife. The charge arose over a decision made by Mrs. Stock to continue working as a midwife when her husband left her and their two children.

In 1912, Mrs. Stock met Mr. Hill, formed a relationship with him and subsequently gave birth to his child. Mr. Hill found work in the district covered by Mrs. Stock as a midwife. In order to be close to his own work, Mr. Hill moved in with his sister who lived in the
same area. Mrs. Stock, finding her own economic situation strained, accepted the sister’s offer to become her lodger. Mrs. Stock claimed that she shared a bedroom with the sister. Nevertheless, in 1914 the CMB issued a notice to Mrs. Stock charging her with ‘misconduct in cohabiting with Hill, who was not her husband’. 71 The juxtapositioning of the words ‘misconduct’ and ‘cohabiting’ offer no doubt as to the interpretation bestowed on Mrs. Stock’s private life by the Board. Mrs. Stock was called to appear before the Board who interrogated her on similar lines to a criminal investigation. Mr. Hill’s sister adamantly denied that an immoral relationship existed between Mrs. Stock and her brother. However, the sister’s evidence was not accepted and Mrs. Stock was barred from further practice.

Mrs. Stock decided to appeal against the decision, claiming that the charge of ‘misconduct’ did not coincide with the definition of the term as stated in Section 3 of the Midwives Act. Lord Robert Cecil, King’s Council, speaking for the respondents, noted that the Act’s main aim was to provide a supply of midwives of reliable character. He stated that although the Board should not be a judicial body, the court should take into account the Board’s expert decision. The Board had found that Mrs. Stock’s ‘immorality’ did make her unfit to act as midwife. Lord Robert Cecil continued to define the decision.

A woman of immoral character is not suited to be a midwife (1) because she may corrupt anyone in the house, and (2) because it cannot be right that a person whose reputation is bad should be allowed to remain on the Roll. 72

His remarks illustrate the concept of woman as angel or whore. It was necessary for a woman to fit the Victorian ideal of perfect wife, or angel. The labels associated with a woman deemed to be outside the ‘ideal’ included vamp, seductress or whore. Such a
woman was believed to hold the power to corrupt anyone that came into contact with her. Margaret Sanger, an American feminist, writer and birth control advocate, believed that sexual morals were fixed by ‘male agencies’ seeking to keep women enslaved. She came to the conclusion that ‘any attempt on the part of women to live for themselves has been attacked as ‘immoral’ by these selfish agencies’. According to Lord Robert Cecil, Mrs. Stock was a divorced woman associating with a man who was not her husband therefore she must be immoral. Lord Reading, the Chief Justice, while supporting Lord Robert Cecil, made certain comments regarding the case which serve to further illuminate the position of women in society in relation to men at that time. Lord Reading stated that one of the objects of the Midwives Act ‘was to place midwives under a Board consisting of men of experience and repute...’. Using the argument that language constructs reality it can be suggested that Lord Reading’s words firmly positioned midwives beneath ‘men of experience...’.

Continuing, Lord Reading insisted that in his opinion, ‘misconduct’ as stated in Section 3 of the Act was not limited to professional misconduct. The Board, he said, had a right to decide whether a midwife’s behaviour tended to make her unfit to undertake her duties and should be allowed to decide the ‘penalties’. However, Lord Reading reflected that in Mrs. Stock’s case there appeared to be irregular and incorrect information regarding her previous situation before meeting Mr. Hill, which led the Board to believe that she was immoral. The evidence had not been verified by a statutory declaration and therefore was in breach of the Board’s own rules.

Lord Reading came to the conclusion that if the Board had had the correct information before them, the ‘immoral’ conclusion may not have been an issue and Mrs. Stock’s
name would have been restored to the Midwives Roll. The restoration of Mrs. Stock's name came about through incompetent bureaucracy and not through the acceptance of Mrs. Stock's moral character by the Board. The evidence suggests that her dilemma is an example of the moral and social control the CMB exerted over female midwives.

A Welsh midwife was not so fortunate when she found herself struck off the Roll for negligence in 1919. Her appeal was dismissed in the first instance. It was claimed that Gertrude Davies of New Tredegar in Monmouthshire, was guilty of negligence for omitting to call a doctor when it was apparent that the infant she had delivered was suffering from *opthalmia-neonatorum*, inflammation of the eyes which could lead to blindness. Mrs. Davies was charged with 'misconduct', her name removed from the Roll and her certificate cancelled. The above case is an example of professional misconduct and for this reason it can be argued that the decision of the Board was justified.

The Minutes of Monmouthshire County Council's Public Health and Housing Committee for July 1919, referred to Mrs. Davies’ application to restore her name to the Roll and resolved that consideration of the matter be deferred for a further six months. Subsequently, in January 1920, the Committee recommended that the CMB 'consider favourably the application of Mrs. Davies for her name to be restored'. Correspondence finally arrived from the Secretary of the CMB confirming the restoration of her name. The Public Health and Housing Committee decided to pursue 'further enquiries' into the conduct of Mrs. Davies during her period of enforced inactivity. The decisions imply that cautionary measures were taken by the Committee to ensure that the rules of the CMB were maintained. It is an illustration of the way in which one local authority undertook the administration of the Midwives Act and how that local authority
reacted to a charge of ‘misconduct’ placed on one of its midwives. The above cases also reveal that the procedure of imposing penalties on midwives was highly formalised and characterised by the use of legal language such as ‘appellant’, ‘respondent’, ‘evidence’, witnesses’, and ‘affidavits’ as used in courts of law for criminal cases.

Dr. Janet Lane-Claypon, Dean and lecturer on hygiene at the Household and Social Science Department of King’s College for Women at the University of London, mentioned in 1920 that strict standards needed to be upheld. However, she noted that the duties placed on midwives were becoming more demanding and claimed that it was impossible for midwives to learn everything in their training period. Nevertheless, she stated that since there was no control over the practice of midwifery by the medical profession, it was vital that the work of midwives ‘should be of such a character as to render any question of control unnecessary’. 82

The Training and Supervision of Midwives

A paradoxical situation arose with the passing of the Act. Midwifery training became available to all women, which opened up new opportunities for women in work to gain status in a period of limited choice. 83 However, the cost of training to become a midwife was invariably too high for women with low incomes in the formative years of the Act. These women generally lived in working-class districts. It can be argued that an artificial class barrier was erected by the politics of economics.

The trained midwives should have been familiar with the rules published by the CMB in 1903. Nevertheless, they would have had barely three months training before taking the Board’s examination. The examination was partly oral and practical, and partly written covering a wide range of areas including the duties and responsibilities of midwives. The
latter point for example, involved recognising the signs and sending for a registered medical practitioner in the event of inflammation of an infant’s eyes. This was only one of a large number of subject areas covered in the short midwifery course.

The course included the delivery and nursing of maternity cases; instruction in elementary anatomy, physiology and hygiene; the management of labour; the care of the infant during and following birth; and the recognition of complications and diseases associated with pregnancy and birth. It can be suggested that following a brief three-month training period, some situations encountered by midwives would still be beyond the knowledge of their limited experience. In 1916, the training period was extended to six months for trainee midwives without nursing experience. Concern was expressed that the extended training period remained inadequate.

It is not possible for a midwife to learn all she should know in six months, and when she has completed that, or even a longer course, she will still need experience before she becomes a reliable midwife.

The above comment was made by Dr. Lane-Claypon who was writing and commenting on midwifery training in the first quarter of the twentieth century. However, as recently as the last year of the twentieth century similar observations were being made concerning the lack of experience of newly qualified nurses and midwives.

Dr. Janet Campbell, Senior Medical Officer for Maternity and Child Welfare with the Ministry of Health, noted that the average fee at a training institution was thirty-six pounds. A grant of twenty pounds might be awarded to some pupils from the Board of Education. Fortunate midwifery pupils were sent for training by Nursing Associations, which were partly funded by County Councils and County Education Committees.
Nevertheless, Dr. Campbell pointed out that the majority of pupils were expected to pay for the full cost of training, including tuition and maintenance.\textsuperscript{88} She noted that the stated fee was for a six-month training period.\textsuperscript{89} However, when an extended twelve-month training was considered, questions regarding increased fees and maintenance costs highlighted economic difficulties for many pupil midwives.

Pupils who pay their own fees are not often well-to-do, and an increased fee, coupled with a longer training, might make it difficult or impossible for some of them to enter the profession and might still further reduce the number of midwives prepared to enter independent practice.\textsuperscript{90}

Dr. Campbell’s concern, voiced in 1923, echoed the fears of some rural district councils in the initial years of the Act.

Certification and registration continued to be a financial barrier for many women. The formal bureaucracy, specialised training, financial costs and restrictive practice requirements perpetuated the class differences between prospective midwives.

Nevertheless, midwives were gaining employment in a variety of places, such as maternity hospitals, departments of Poor Law Infirmarys and small Maternity Homes. Local authorities and Nursing Associations employed district midwives, while some midwives became independent practitioners.\textsuperscript{91} The latter group faced difficulties, particularly in rural areas, as did district nurses and nurse midwives employed by Nursing Associations. Furthermore, working as a salaried midwife did not necessarily mean a guaranteed living wage.\textsuperscript{92} The evidence suggests that the professional life of a midwife was not immediately improved financially following the 1902 Midwives Act, neither was her social status.
Nursing Associations

The aims of Nursing Associations (NAs) were to provide nursing for the ‘sick poor’ and to obtain funds to pay for the services of a nurse. District Nursing Associations (DNAs) were widely spread in some counties, however, due to the prohibitive expense of establishing such a body, by 1920 ‘only two or three counties’ had a service extending over the whole area. Dr. Lane-Claypon mentioned that the existence of NAs depended entirely upon the financial position and inclination of benefactors. An example of a ‘well-disposed’ person as referred to by Dr. Lane-Claypon, was Lady Mather Jackson of Monmouthshire, who was a leading figure in the establishment of the Monmouthshire Nursing Association (MNA). The larger South Wales NA was inaugurated in 1911 and was set up by a number of ‘influential people’ including Lady St. David.

The majority of the nurses’ salary was paid by the NA employing them, with a small part of the salary met by the fee charged to people for their services. The nurses were under the control of a Committee for all matters except when called in by the doctor of the people concerned. The nurse then complied with the medical professional’s regulations. Many NAs provided midwifery aid particularly in rural areas where independent midwives found it difficult to cover the area. Ironically, more DNAs were found in urban districts and towns than in rural districts where the need was often greater.

NAs encountered a number of problems. Firstly, finding a nurse qualified in general nursing and midwifery was difficult. Secondly, the cost of training was high and few women were financially able or willing to pay for themselves in view of the low and often unstable salary on offer at the conclusion of training. Finally, when a nurse was
unable to work due to illness, holidays or the risk of spreading infection, it could be
difficult to find a replacement. 100

Affiliation of DNAs led to the establishment of County Nursing Associations (CNA),
which could then act as an influential central body. The CNAs helped to provide and
obtain funds for the training of women as nurse-midwives and assisted DNAs in practical
ways. 101 Lady Mather Jackson identified the advantage of affiliation in situations when a
district nurse became unable to attend general nursing cases due to infectious midwifery
cases that she might have visited. 102 However, the existence of a CNA did not mean that
midwives adequately covered the county, only that a central body was in place to support,
advise and assist. Some districts within counties, particularly rural areas of the county,
did not have an adequate supply of midwives to meet the needs of the mothers. 103

The Monmouthshire Nursing Association

In 1908, Lady Mather Jackson submitted the draft of a scheme to the newly-appointed
County Medical Officer (CMO) Dr. Rocyn Jones. The plan involved the provision of
district nurses in Monmouthshire. The draft was duly amended and then submitted to the
Monmouthshire Higher Education Committee. It was passed to the Council for final
approval in November of that year. 104 Lady Mather Jackson stressed the importance of
the scheme to the health of mothers and infants in Monmouthshire, which was recognised
by the County Council.

A public meeting was arranged to discuss the issues involved. Lord Tredegar, a popular
and wealthy public figure, chaired the meeting in Newport. His involvement supports Dr.
Lane-Claypon’s claim that ‘financial position’ was influential in the establishment of
such associations. 105 A unanimous decision was taken to proceed with the scheme to
establish a CNA, proving that the plan was popular. In order to function efficiently local committees were required in both urban and rural areas. It was decided that in the industrial areas where there were adequate numbers of midwives to cope with actual deliveries, district nurses would be appointed to undertake only medical and surgical nursing. In contrast, the rural districts with fewer midwives needed additional assistance. Therefore, the work of the nurses employed by rural NAs included general and midwifery nursing. 106

The first urban district NA to be established in Monmouthshire was in Newbridge, while Llantilio-Pertholy had the first NA in the rural districts. By 1910, DNAs had grown and flourished to such an extent that the county needed a main supervisory body. Affiliation of the local associations led to the formation of the Monmouthshire Nursing Association (MNA). 107 The MNA initiated a plan to acquire funds to provide midwifery training within Monmouthshire for ‘suitable women’. An annual grant was received from MCC and the Monmouthshire Education Committee to assist with the incurred expenses of the training and provision of midwives in rural districts.

The MNA based its Head Office at Tredegar where a Nurses’ Home and Training Centre was established. Pupils were trained in midwifery with the help of scholarships from the Higher Education Committee. The Nurses’ Home at Tredegar was recognised by the CMB as a training establishment for midwifery pupils. Six scholarships were awarded in 1919, all six were successful and received the CMB certificates. In 1920 the midwifery scholarships were increased to eight.

The highest proportion of the annual grant from the Education Committee to the MNA was allocated to midwifery scholarships. General nursing training received the lowest
overall percentage. The total grant from the Monmouthshire Education Committee that year was 350 pounds. Additionally, 480 pounds was offered by the County Council to meet the expense of providing midwives in the rural districts. However, many comments in Monmouthshire County Council’s Maternity and Child Welfare Reports from 1916 to 1934 hold testimony to the difficulty in obtaining registered midwives for the rural districts. The evidence reveals continuity rather than change in rural midwifery in Monmouthshire regardless of an improvement in training opportunities.

**Unregistered Women Acting as Midwives**

From the first of April 1910, uncertified women were forbidden to act as midwives ‘habitually and for gain’ except under the supervision and direction of a medical practitioner. In 1926 a revised Midwives Act attempted to strengthen the law against an unqualified person acting as a midwife. The 1926 Act made it an offence to attend a woman in childbirth when unqualified, unless directed by a medical practitioner. Furthermore, an allowance would be made only when it could be proved that the action was taken in an emergency.

Prior to the 1926 Act, Monmouthshire County Council’s (MCC) Public Health and Housing Committee Report in 1914 included a list of complaints respecting the practice of unqualified midwives. In one case, following ‘repeated warnings’ it was ordered that the Clerk take the necessary proceedings under the Midwives Act of 1902 against an unregistered midwife from Llanhilleth. In 1919, unregistered women acting as midwives attended fifty births. Eleven of those cases were without a medical practitioner present. The CMO made the following statement.
On compassionate grounds, some cases must be countenanced in the rural areas, where it is difficult and often impossible, to obtain a registered midwife. 112

Regret was expressed that the unqualified practice by midwives in rural districts was ‘covered’ by some medical practitioners. Generally, the doctors were unable to reach midwifery cases when attending medical ones in other parts of the district. It was claimed that doctors valued support from the local midwives, whether qualified or unqualified. The South Wales Nursing Association echoed this sentiment in 1921. The feeling was expressed that it would be a ‘calamity’ for rural areas if the Midwives Act necessitated all unqualified midwives to retire from practice. 113 Opponents of the Midwives Bill had loudly promoted this requirement before the passing of the Act. The evidence collected does point to a shortage of qualified midwives in many rural districts, which perpetuated the problems faced by local supervising authorities attempting to follow the regulations of the CMB. However, the industrial districts also had a fair share of unregistered and unqualified birth attendants practising as midwives for a number of years after the passing of the Midwives Act.

Dr. Janet Campbell, discussing the training of midwives in 1923, said that she knew medical practitioners knowingly engaged unqualified and unregistered women to act as maternity nurses to attend births.

It is unfortunately true that certain medical practitioners are willing to work with handy-women as midwifery assistants. 114

Dr. Campbell pointed out that whereas the woman prepared to train as a monthly nurse was ‘...invariably less intelligent and able than the average student of midwifery’, the handy-woman was likely to be far less suitable. 115 Dr. Campbell defined the handy-
woman as a midwife whose name had been removed from the Roll for an infringement of
the rules of the CMB. Additionally, she said that the handy-woman could be a woman
who had gained her knowledge through assisting midwives, or a neighbour who might be
paid a small amount for attending local births. Dr. Campbell remained firm in her
opinion.

As long as she undertakes any form of nursing or personal care of the mother she
is a potential danger and the more she knows the more dangerous she is, because
she is more tempted to interfere and even act as a midwife. 116

Without a recognised qualification, the handy-woman did not come under the jurisdiction
of the local authority and was not subject to inspection. If a doctor was obliged to enlist
the help of an unqualified woman, then it was in his interest to ensure that she was
capable and clean. Dr. Campbell suggested that it would be advisable to incorporate the
inspection of handy-women into the regulatory framework of standards set for registered
midwives. Many doctors, she said, did not have the time to supervise such details
adequately. However, Dr. Campbell stated that an inspector would need to carry out
supervisory duties in a way that would not interfere with a doctor’s ‘professional
relations either to patient or ‘nurse’’. 117

The General Medical Council had voiced disapproval of the ‘covering’ of unqualified
midwives earlier in 1916. A warning was issued to medical practitioners pointing out that
such cases were ‘contrary to the law’ and ‘discreditable to the profession of medicine’.
Medical practitioners found to disregard the rules were liable to find their names removed
from the Medical Register. 118 This suggests that similar rules to the ones issued by the
CMB concerning midwives were in force for doctors. However, the difficulty of proving
a case of ‘covering’ by a doctor was often too great to overcome. Dr. Campbell stated that the employment of unqualified women was

...at its best, unsatisfactory, and at its worst a serious menace and source of danger to the mother and child.

She pointed out that it was essential to control handy-women and suggested two ways to realise this. Firstly, by amending Section 2 of the Midwives Act and eliminating the words ‘habitually and for gain’, which would then ensure easier conviction. Secondly, by requiring local authorities to register and supervise all women not qualified as midwives who undertake such work for gain. Any women found to be exceeding the regulations would be taken off the Roll. In this way, claimed Dr Campbell, the ‘least satisfactory of the handy-women would be eliminated’ and the work of midwives would be brought under too much supervision to remain attractive to unqualified women.

Births attended by unregistered women in Monmouthshire did decline from a total of 155 in 1916 to only one in 1931. (See Table 3)

Table 3

<table>
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<th>Year</th>
<th>Births Attended by Unregistered Women Acting as Midwives in Monmouthshire 1916-1935</th>
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Sources: Monmouthshire County Council, Maternal and Child Welfare Committee Annual Reports for individual years from 1916 to 1935.
Nevertheless, prior to the revised Midwives Act in 1926, the number generally remained in double figures. In 1921, the CMO had stated that the position regarding unregistered women remained unsatisfactory.

The women are known, but it is difficult to obtain the evidence which will lead to their conviction, for it must be proved...that they practise the art of midwifery habitually and for gain.\textsuperscript{122}

The medical practitioners involved in cases concerning the attendance of unqualified and unregistered women at confinements were deemed to be 'greatly to blame' and risked a report being sent to the General Medical Council on their unco-operative behaviour.

According to MCC the risk involved by allowing an unregistered woman to practise as a midwife was two-fold. Firstly, it was dangerous to the expectant mothers, and secondly, it was unfair to trained midwives. MCC strongly supported the scheme to tighten legislation regarding the practise of unregistered women.\textsuperscript{123}

When cases of illegal attendance at births were reported, the final accusatory finger was pointed at the midwife and not the medical practitioner. The midwife was bound by the Midwives Act whereas the doctor was exempt from blame under the Act. Section 1 (2) of the Act stated ‘...this section shall not apply to a legally qualified medical practitioner...’.

\textsuperscript{124} Under this sub-section it was claimed that

...a considerable number of prosecutions has taken place in different parts of the country, and fines varying in amount have been imposed on the offenders.\textsuperscript{125}

Any woman found acting as a midwife without certification, unless with a doctor’s permission, was liable to a fine of up to ten pounds, which was a substantial amount to an
unqualified midwife. The following examples illustrate some of the difficulties referred to by Dr Campbell.

One certified midwife, whose certificate had been withdrawn attended five confinements alone. The retained medical practitioners were aware of her involvement. They paid one or more visits to the mothers following the confinement in each case. In none of the cases did a medical man visit the patient professionally, before or at the time of confinement. Furthermore, it was claimed that in none of the cases were specific instructions given to the midwife concerning the treatment or care of the patient. The medical men involved spoke highly of the midwife’s strengths. They reported that she was a capable and trustworthy woman, able to attend a normal birth without specific instructions. The Justices’ decided that the midwife did comply with the Midwives Act and stated that she had acted ‘under the direction of a qualified medical practitioner’. In each case it was decided that the information against her was dismissed. \(^\text{126}\)

However, an appeal against the Justices’ decision was lodged by the CMB on the grounds that

\[\ldots\text{there must be real and not merely nominal direction of a qualified medical practitioner... A mere qualified practitioner in the background is not enough.}\] \(^\text{127}\)

According to the appellant, the interpretation of ‘under the direction’ of a medical practitioner had a specific meaning. It meant that in every confinement ‘actual instructions’ should have been given to the respondent. The three medical men involved were questioned further. It was finally concluded that the original decision of the Justices’ should be overturned. The appeal by the CMB was allowed and the case remitted for ‘conviction’. It was suggested that the male medical practitioners involved in
the case were negligent. However, they were not charged nor chastised. The appeal by the CMB led to the midwife being 'convicted' of the offences. Part of the midwife's 'crime' was to continue to attend expectant mothers when her certificate had been withdrawn. It was the choice of the mothers involved to employ the midwife in question. However, it is difficult to establish the extent of the knowledge of the mothers regarding the qualifications of the midwife. Additionally, the midwife had attended the births alone, without the presence of a more prestigious qualified medical man. Attending births alone in this way had broken the rules of the CMB. In all five confinements, the doctors concerned were confident in the midwife's skills. Nevertheless, the CMB would not take into account the recommendations of the doctors.

The CMB strictly controlled the activities of midwives and limited the choice of midwife for doctors and mothers. It can be argued that in this way, the CMB impinged on the right of the mother to choose a female midwife whom she knew and trusted to be with her through her confinement. Additional examples were found in the reports of Monmouthshire's CMO, and will serve to illustrate that problems and difficulties continued after the 1926 Midwives Act, which aimed to strengthen the legislation concerning unlawful attendance at births.

In Monmouthshire in 1928, one woman whose name had been removed from the Midwives Roll a few years previously was found to have attended seven confinements without a medical practitioner. Then in 1929, the same midwife was charged with three similar offences. She was fined twenty shillings on each charge. By the following year, evidence shows that the number of offences were lower again; she was noted as having attended only one rural delivery in an emergency. The CMO mentioned that the
woman was well known by the County Council and in her own district. It is possible that
the midwife’s unlawful attendance at births became less frequent when she found that the
repeated fines were causing her financial difficulties and she was eventually forced to
give up her unregistered practice. The above examples also reveal that the rules of the
CMB relating to unregistered women caused some administrative problems for the local
supervising authority.

In 1924, Monmouthshire’s CMO had confidently reported that unregistered practice was
‘now being definitely checked’. The evidence shows that he was mistaken. It took a
further eight years before he was able to say that the practice ‘appears to be checked’
with no unregistered midwives practicing in the county to his knowledge. In 1933, a
sudden rise to seven cases concerning unregistered women attending births came to the
notice of the CMO. However, it was claimed that since all the births had taken place
before a doctor arrived, it constituted an emergency in each situation. Nevertheless, in
keeping with the rules of the CMB, the CMO issued warnings to all the doctors and
midwives involved. Convictions were designed to eliminate unqualified and
unregistered women from the practice of midwifery. The initial privilege within the 1902
Act to maintain bona fide midwives often resolved itself in this protracted manner.
Throughout the many instances of charges brought against unregistered midwives in
Monmouthshire, there does not appear to be any evidence of similar charges against
colluding doctors. The regulation and control of midwives by the state became more
widespread and organised.
The Registered Midwife

The Midwives Act of 1902 created two classes of midwives; those who had received training and a certificate, and women who could provide evidence to show that they had practised as a midwife prior to 1902. A midwife in the latter class was identified by the term *bona fide*. None of the *bona fides* held certificates, although some may have received limited training. Both classes were required to register and their names were then added to the Midwives Roll, which was revised annually.

The first Midwives Roll was compiled in 1905 and published in 1906. The first Roll contained 22,308 names of which 9,787 were trained midwives and 12,521 were *bona fides* and untrained. By 1911, the number of names on the Roll had increased to 31,673. The CMB noted that a large number of the trained midwives were not actively in practice and that the untrained were in a considerable majority. A clearer indication of the number of practising midwives could be identified in the local authorities' returns to the CMB concerning the number of midwives who had registered their intention to practice. (See Table 4)

**Table 4**

| Local Supervising Authorities’ Returns to the CMB : Notifications to Practice |
|-------------------------|----------------|
| 1907                    | 12,964         |
| 1908                    | 13,348         |
| 1909                    | 13,608         |
| 1910                    | 14,622         |


In 1910 there were 29,209 names on the Midwives Roll and yet the considerably lower number of 14,622 had registered their intentions to practise midwifery. There was a gradual increase in the number of notifications received by the CMB, which the latter
considered mainly due to 'increased activity on the part of some of the Local Supervising Authorities' in motivating their practising midwives to notify intention. Nevertheless, the CMB stated that 'a very large proportion' of the *bona fides* admitted to the Roll 'were incapable of taking a temperature, or of being taught to do so efficiently'. 135 With this in mind, the CMB introduced a rule in 1912 making it obligatory for a midwife to take and record the temperature and pulse of her patients. 136 This ruling caused problems for midwives who were untrained and illiterate. It was partly the reason for the reduction in the number of illiterate midwives on the Rolls kept by local authorities.

**Midwives Practising in Monmouthshire**

Acting as a local supervising authority, MCC was responsible for collating information regarding the midwives practising within the county. The statistics in Table 5 (see below) were compiled from information found in the individual annual reports for the years 1911 to 1936. The information recorded by MCC was detailed and illustrated the proportion of trained to untrained, literate to illiterate midwives between 1911 and 1936. These figures show that from 1911 to 1915 more untrained midwives attended births than those with training. The number of midwives receiving training continued to rise while the number of untrained midwives on the Roll gradually declined. By 1936, the qualified midwives constituted the majority.

Names were removed each year for a variety of reasons. For example, in 1919 ten names were removed; one through old age and ill health, five midwives had left the county, two midwives had died and two were removed from the Roll by the CMB due to misconduct. 137 The decline in the number of midwives over the age of sixty was probably the result of the increased opportunities available for younger women to train to become midwives.
It also seems probable that the gradual reduction in the number of untrained registered midwives was partly the result of an increase in the number of young women gaining qualifications in midwifery.

Table 5

<table>
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<tr>
<th>Year</th>
<th>Literate</th>
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<th>Untrained but registered</th>
<th>Number over age of sixty</th>
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Sources: Monmouthshire County Council, Maternal and Child Welfare Reports
Individual reports from 1918 to 1936 inclusive.

A final observation can be made concerning the decline in the number of illiterate midwives on the Roll. When the rules concerning temperature and pulse readings were introduced, it became increasingly difficult for a woman without basic education to remain on the Midwives Roll.
Monmouthshire's 1914 Register of Midwives

One surviving Register of Midwives practising in Monmouthshire in the year 1914 gives specific information on the midwives listed. Apart from the name, address and locality in which the midwife practised, the date of certification, the qualification recognised by the CMB, the age, marital status and literacy of the midwife can be found. Reference number 42 shows that Gertrude Davies of New Tredegar, mentioned earlier in the chapter with regard to a charge of 'misconduct', was thirty-one, married and literate when she registered for certification. She held a CMB qualification and the date of her certificate was 30th October 1909. Gertrude entered the profession after the Midwives Act of 1902 as a trained midwife, in contrast to other midwives in Monmouthshire, such as Caroline Allen and Jane Brown. Both women were sixty-two years of age, illiterate and in practice prior to the Midwives Act. These two women were able to register under the Midwives Act as bona fides. (See Appendix 1)

Inspection of Midwives

The 1902 Midwives Act established a framework for local authorities to appoint an Inspector of Midwives to ensure the observation of the rules of the CMB. Inspection initially concentrated on the satisfactory implementation of the rules of the Board, rather than on aiming to improve the general health of mothers and infants. Given the evidence, it can be suggested that part of the inspection process led to the invasion of the private sphere of the midwife. Part of the work of an Inspector was to enter a midwife's home and comment on the cleanliness and appearance of her home and clothing. The Inspector could call on the midwife without prior warning. Inspection of a midwife's work was necessary to ensure that the midwife maintained the rules of the CMB. However, an
uninvited inspection of her own home, when births were attended in other women's homes, might have been an invasion of her privacy.

Local supervising authorities appointed Inspectors in different ways since there were few universal criteria used in the appointment procedure. Some authorities appointed their own medical officer of health as Inspector. However, this arrangement could be fraught with difficulties if the MO could not spare the time to undertake the additional responsibilities of the position. County NAs were firmly established by 1918 and had their own Superintendents to inspect the midwives in their employment. With this situation, problems could also arise. NAs employed and inspected trained midwives, which meant that many untrained or *bona fide* midwives were outside the inspection process. Some authorities appointed the NAs Superintendent to cover the whole county in an attempt to rectify the situation. However, when a county appointed its own Inspector, other problems could arise from the dual system of inspection that resulted from this framework.

For instance, a CMO may not have time to efficiently carry out the duties of Inspector of Midwives and may not have had midwifery experience. Additionally, health visitors may not have had training in midwifery skills, particularly in the early years of the implementation of the Midwives Act. Therefore, officers of less experience than themselves could inspect practising midwives. Furthermore, the health visitor would have too few midwives in her allocated district to allow her to keep in touch with midwifery work.
A 1919 circular from the Ministry of Health was sent to all county councils urging the local supervising authorities to appoint medical women as Inspectors. An essential qualification for the post was identified which meant that applicants

...should not only possess the certificate of the Central Midwives Board, but should have had substantial experience as a practising midwife. 141

It was hoped that inspectors and health visitors undertaking the task of inspection would then be aware of the regulations of the CMB and more easily identify breaches of the rules. Arguably, the inspection process reflects the control and power of the CMB.

**Inspection of Midwives in Monmouthshire**

In 1920, Dr. Lane-Claypon pointed out that arrangements for the systematic inspection and instruction of midwives were highly important to the improvement of midwifery. She said that some districts carried out their responsibilities ‘with zeal and efficiency’. However, she continued, it was regrettable that many remained ‘sadly deficient’ in inspection and instruction. 142

The question of the training, supervision and inspection of midwives under the 1902 Act was addressed by MCC’s Public Health and Housing Committee in 1904. It was decided that the Joint Committee should manage the practical work. 143 However, there was a delay of three months before a decision was made to advertise the position of a County Executive Officer to act as Inspector of Midwives at a salary of sixty pounds a year plus expenses. 144 Nineteen applications were received and following the short-listing and interview procedure, Mrs. Minnie Dore from Barnet was appointed. 145

The position proved to be taxing according to the comments of the Committee a few months later. Mrs. Dore’s salary was increased to one hundred pounds a year. Her wage
was claimed to be ‘wholly inadequate’ for the duties she performed in the county. In 1919, Mrs. Dore remained the only ‘Inspectress’ employed by the county. During that year, she paid 1,512 visits to midwives and conducted 737 examinations. This was additional to following up notices of calls for medical aid and cases of puerperal fever or *ophthalmia-neonatorum*. Mrs. Dore carried out her duties as the only Inspectress of midwives until Nurse Griffiths was appointed to share the work in 1930. She then continued her work in the urban districts while Nurse Griffiths covered the rural areas. Mrs. Dore retired in 1932 and from 1st January 1933, Dr. Mary Scott, assistant medical officer for Monmouthshire, took over the duties of Chief Inspectress of midwives accompanied by three District Inspectresses.

The available statistics reveal that from 1919 to 1929, before Nurse Griffiths took over the inspection of the rural districts, Mrs. Dore averaged 1,425 visits to midwives each year, with between 211 to 253 midwives to visit regularly on the Roll. (See Table 6) The evidence suggests that an average of six visits were paid to each midwife on the register every year. When analysing the statistics collected from the seventeen annual MCC reports, Mrs. Dore could have conducted an average of three to four examinations for each midwife. Although the averages stated cannot be taken as correct, Dr. Lane-Claypon’s advice that midwives should be visited at least three or four times a year highlights Mrs. Dore’s dedication to the work in Monmouthshire.

There were problems with the visits made to midwives as the inspection reports testify. Some visits were not successful and not all the visits resulted in a full examination of the midwife’s equipment, skills and cleanliness. The reasons reported for unsuccessful visits
varied. The most common reasons for the absence of the midwife included moving away, nursing private cases, illness, or not being in practice at that time. The visits often revealed instances where unsatisfactory conditions were found. The main errors seemed to be caused through some midwives' inability to take and record the pulse and temperature of their patients.

Table 6

<table>
<thead>
<tr>
<th>Year</th>
<th>Total no. of midwives on Register</th>
<th>Visits Made</th>
<th>Examinations Conducted</th>
<th>Unsatisfactory Conditions Found</th>
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**Mrs. Dore with Nurse Griffiths for Rural Districts**

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<th>Year</th>
<th>Total no. of midwives on Register</th>
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<th>Examinations Conducted</th>
<th>Unsatisfactory Conditions Found</th>
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**Dr. Mary Scott plus Three District Inspectresses**

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Figures marked * exclude rural districts.

Sources: Monmouthshire County Council, Maternal and Child Welfare Reports
Table compiled from information in the individual Annual Reports 1919 to 1936 inclusive.

Overall, the number of unsatisfactory conditions decreased except for the year 1922. Significantly, this corresponded with the rise in the number of trained midwives on the role and the decline in untrained midwives practising in the county. In 1929, it was recognised that the county was "...gradually reaching the realisation of the ideal of a
skilled midwifery service' and that a 'better educated type of woman is taking up the work'.

An incident in 1934 urged the CMO into preventative action. A midwife was suspended and severely reprimanded by the CMB concerning her lack of skill taking and recording pulse and temperature. This led MCC to suggest that the county AMO visit all midwives in the county to issue instruction on the standard techniques and remind them of the rules of the CMB. The CMO subsequently noted that in 1936, the standard of the midwives' work was generally improving. He claimed that several midwives who previously could not, or would not take the pulse and temperature readings, had mastered the technique.

As the number of trained midwives increased, a subtle change in the language used by medical officers can be identified. Prior to 1933, letters of 'warning' were sent out to any midwife found to be contravening the rules of the CMB. In 1933, letters were still sent to erring midwives. The rhetoric suggests a change in the attitude of some medical men towards midwives in the county. A relatively high number of midwives received letters compared to earlier years. Thirty-three midwives were recipients of letters in 1933. However, instead of being classed as letters of 'warning', the correspondence was 'drawing their attention to minor breaches of the Rules of the Board'. It could be argued that the milder language used reflected the minor nature of the deviation from the Rules of the Board as more trained midwives entered the profession. With an increase in trained midwives, the medical profession generally appeared to tolerate the existence of female midwifery practice. However, midwives had to wait until the passing of the 1936 Midwives Act before they gained any significant recognition and status.
The first Midwives Act in 1902 created the framework for the control of midwives, professionally and socially, in the public and private sphere. The Act altered the way in which childbirth was conducted with little regard for the personal choice of the mother. All female birth attendants were strictly regulated and their practice controlled by the rules the Board set in place. There appeared to be scant recognition of the conditions within which midwives worked in both urban and rural districts. In general, medical practitioners attended women in childbirth in the relatively clean, though institutional surroundings of a hospital or Nursing Home. In contrast, midwives were often faced with atrocious housing conditions such as inadequate sanitation, poor light, ventilation and heating, when delivering an infant, as the following chapter will substantiate.

Furthermore, the first Act generated many changes in the work and responsibilities of local administrative authorities.

New positions were created such as Inspectors of midwives and the work of health visitors, public health officers and medical officers was extended. The county and district medical officers and the new officials policed the legislation for the state. The Midwives Act of 1936 brought about fundamental changes again in the profession of a midwife. Local authorities were committed to provide a salaried domiciliary midwifery service. The midwives appointed under the new Midwives Act were required to be physically fit. Particular attention was paid to condition of the nose, throat, gums and teeth. Midwives' homes were still to be the centre of the inspection criteria and appointment made ‘...only where home conditions are satisfactory’. Evidence suggests that the social control of midwives by the state through the vehicle of the CMB was perpetuated by the continuing
invasion into the private lives of midwives. This situation materialised with the enactment of the first Midwives Act in 1902.

Chapter One: Notes

1. Donnison, J. (1977) Midwives and Medical Men p. 53


3. The Report of the Select Committee on the Registration of Midwives was in 1892, and the Final Report of the Committee was published in 1893.


9. Loudon, I., (1992) p. 188. Loudon refers to the evidence of James Guthrie as being "slightly muddled".

10. Ibid. p. 189.

11. Ibid. p. 190.


15. Ibid. p. 61.

16. Ibid. p. 73.

17. Ibid. pp. 74-75.

19 Ibid. p.159.

20 Ibid. pp.159-160.


Correspondence from Lombe Atthill concerning the Midwives Registration Bill.

23 Ibid. p.41.

24 Ibid. p.41. See also Donnison, J., (1977) pp.90-92 for information concerning midwifery training in Ireland. The BMJ 10 January 1891 pp.87-88 and 31 January 1891 p.252 contain additional comments and arguments relating to the concern that female midwives were a threat to the male-dominated medical profession.


26 As an example, see correspondence from Dr. Farquharson in the BMJ 31 January 1891 p.256 and other issues mentioned in the above notes.


28 Ibid. p.117.


31 Ibid. p.4. Evidence of Mr. Alexander Napier.

32 Ibid. p.1.

33 Ibid. p.41. Evidence of Mrs. Maria Martin.

34 Ibid. p.42. See also p.41 for Mrs. Martin’s testimony and case studies.


36 Ibid. p.19. Dr. Farquharson’s question to Dr. Aveling, (Q.342).

37 Ibid. p.41. Evidence of Mrs. Martin, (Q.691).

38 Ibid. p.41, (Q.694-695)

Ibid. pp.120-122. Evidence of Mr. George Brown, (Q.1659-Q.1664).


Ibid. p.117. Evidence of Mr. George Thomas, (Q.1606).


Ibid. Mrs. Martin, 2 cases, pp.41-42 (Q.698-700).
Dr. Hayward, 4 cases, p.67 (Q.932-939).
Dr. Humphreys, 5 cases, pp.72-73 (Q.983-984).
Dr. Thomas, 2 cases, p.117 (Q.1599-1605)
Dr. Brown, 3 cases, p.121 (Q.1659-1660).
Mrs. Malleson, 2 cases, p.82 (Q.1123).

Ibid. pp.81-82, evidence of Mrs. Malleson, (Q.1123)

Select Committee on Midwives Registration, Minutes of Evidence Vol. X111 (1893), p.1. Evidence of Mr. A.B.Hicks, (Q.3).


Select Committee on Midwives' Registration, Minutes of Evidence (1893) p.29 Evidence of Mrs. Bedingfeld, (Q.537-539).

See also summary of evidence, Appendix pp.144-146.

Ibid. pp.4-5. For Mr. Bott's evidence, see Q.32-57.


Ibid. p.15. Evidence of Mr. William Williams, (Q.223).

Ibid. p.16. (Q.273). Mr. Williams read out examples from Dr. Dykes' report on puerperal fever cases.

Ibid. p.16. (Q.263).


Ibid. p.19. (Q.339 and Q.344)
Four of the members were required to be medical practitioners with one appointment being made by each of the following; the Royal College of Physicians, the Royal College of Surgeons, the Society of Apothecaries and the Incorporated Midwives Institute. The Privy Council would appoint two people. The Association of County Councils would appoint one other person. The appointments to the Board represented the groups with an interest in the certification and regulation of midwives.

Ibid. p.417.


Ibid. p.1.

Justice of the Peace Reports, King’s Bench Division Vol. 79. 28 August 1915 p.398. Stock v. Central Midwives Board.

Ibid. Lord Robert Cecil, K.C.


Justice of the Peace Reports, King’s Bench Division Vol. 79. 28 August 1915 p.398. Lord Reading C.J.

See Dale Spender ‘Language and Reality: Who Made the World?’ in

76 Justice of the Peace Reports  King’s Bench Division  
Vol. 79. 28 August 1915  p.398. Lord Reading, C.J.

77 Ibid. p.399.

78 Justice of the Peace Reports  King’s Bench Division  
Vol. 83. 22 March 1919. Davies v. Central Midwives Board.

79 Monmouthshir County Council (MCC )  *Minute Book*  

80 Ibid. 19 January 1920.

81 Ibid. 29 March 1920.


84 Campbell, J., (1923) p.3.

85 Ibid. p.2.

86 Lane-Claypon, J., (1920) pp. 135-136.

87 The Central Council for Nursing, Midwifery and Health Visiting in the United Kingdom (UKCC), was called on to respond to criticism concerning the lack of experience noticed in newly-qualified nurses and midwives. A commission was set up to examine the current training system. The published report ‘Fitness to Practice’ recommended that more practical work should be covered in the courses offered for nurse and midwifery students. The chairman of the commission, Sir Leonard Peach, confirmed that re-structuring seemed to be needed in some areas. The commission recommended that in addition to a three-month period of ‘supervised clinical practice’ at the end of their course, nurses and midwives needed ‘a proper induction’ in their first job. The Royal College of Nursing welcomed the report and suggested that colleges offering nurses’ courses should implement the recommendations. See BBC News Online: Health. 10 September 1999. http://194.130.56.40/low/english/health/newsid

88 Campbell, J., (1923) *The Training of Midwives*  Reports on Public Health and Medical Subjects, No. 21 p.16.
Initially, the training period was for three months. This was extended to six months during the First World War. See Towler, J. and Bramall, J., (1986) *Midwives in History and Society* p.199.

Campbell, J. (1923) *The Training of Midwives* Reports on Public Health and Medical Subjects, No. 21 p.16.


Lane-Claypon, J. (1920) *The Child Welfare Movement* p.94.

Ibid. p.95.

Ibid.

MCC, Public Health Department, *Report upon Maternity and Child Welfare* for the year 1938, p.48. The Report was presented to the Chairman and members of the Maternity and Child Welfare Committee (MCWC) on the 20th July 1939. All further Annual Reports will be referred to as MCC, MCWC for easier identification.

*Western Mail* 4 January 1921.

Lane-Claypon, J. (1920) p.94.

Ibid. p.95.

Ibid.

Ibid. p.96.

*Free Press of Monmouthshire* 26 March 1915.

Lane-Claypon, J. (1920) p.96.

MCC, MCWC *Annual Report for 1938* p.46.

Lane-Claypon, J., (1920) p.95.

MCC, MCWC *Annual Report for 1938* p.46.

Ibid. The aims of the Association were printed in the MCC reports and included two grades of nurses.

MCC, MCWC *Annual Report for 1919* p.46.


111 Ibid. 16 April 1914.

112 MCC, MCWC *Annual Report for 1919* p.6.

113 *Western Mail* 4 January 1921.

114 Campbell, J. (1923) *The Training of Midwives* p.34.

115 Ibid.

116 Ibid.

117 Ibid. p.38.

118 Ibid. p.35.

119 Ibid. Dr. Campbell gave details of three cases involving the engagement of unqualified women by medical practitioners, pp.35-36.

120 Ibid. pp.36-37.


122 MCC, MCWC *Annual Report for 1921* p.8.

123 Ibid.


125 Ibid.


127 Ibid. p.84.

128 Ibid.


133 See all court cases mentioned and also refer to Towler, J., and Bramall, J. (1986) p.192.


137 Ibid.


139 Lane-Claypon, J. (1920) p.132.

140 Ibid. p.133.


142 Lane-Claypon, J., (1920) p.131.

143 MCC, *Minute Book*, Public Health and Housing Committee, Vol. 1, 14 October 1904

144 Ibid. 13 January 1905.

145 Ibid. 3 March 1905.

146 Ibid. 14 July 1905.

147 Ibid. p.133.


149 Ibid. *Annual Report for 1932* p.54.

150 MCC, MCWC *Annual Report for 1919* p.44.

151 Ibid. *Annual Report for 1929* p.47.

152 Ibid. *Annual Report for 1934* p.43.


154 Ibid. *Annual Report for 1922*, seven letters of warning, p.39. ........................ for 1923, twenty ... ... ... ... p.41.
106

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<td>six</td>
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156 MCC, Midwives Act 1936 C. Misc. R. 0059.
CHAPTER TWO

INFANT MORTALITY

Introduction

The previous chapter traced the changing role of the midwife in society following the implementation of the Midwives Act in 1902. The framework of control, regulation, registration and training that accompanied the legislation was also analysed. This chapter will explore further the role of the new midwife in relation to infant mortality. The evidence suggests that the attitude of medical professionals and politicians to both midwives and mothers in connection to infant deaths, worked to divert blame from primary dangers such as poverty, inadequate housing and insanitary conditions. These dangers perpetuated the continuance of infant and maternal deaths instead of solving the problem.

During the early twentieth century, a decreasing birth rate and the recognition of the poor physical condition of babies born to mothers in working-class districts, increased anxiety among the medical profession and government officials. The result was that doctors and medical officers of health directed attention to the management of childbirth, the quality of motherhood and child-rearing practices, to solve the problem of infant mortality.

To assess the outcome of government policies related to infant mortality in England and Wales, it is necessary to review selected research concerning death rates, including infant deaths. This will enable the incidence of infant mortality in England and Wales to be set in context. The Welsh counties of Glamorgan and Monmouthshire in particular will be used to compare infant death rates with counties in England. Finally, the situation in
Monmouthshire concerning trained and untrained midwives and mothers in working-class districts will be evaluated in the light of contemporary arguments relating to infant mortality.

**Selected Research into Death Rates**

The general death rate in England and Wales in the last half of the nineteenth century was declining. At all ages the decrease for males was fourteen per cent and females nineteen per cent between 1851 and 1860, with a similar pattern repeated between 1896 and 1900.

1 The infant mortality rate did not experience the same respite as the general death rate. One in six infants' born was destined to die before their first birthday. 2 The annual reports of the Local Government Board confirm that infant mortality rates remained, in general, stationary for this period. 3 The statistics reveal that while allowing for yearly fluctuations, there was little difference in the rates shown for 1851 and 1900 for England and Wales. However, London’s infant mortality rate was higher in 1900 than in 1851. 4 Nationally, there were great variations from county to county and district to district within those counties. The specific number of infant deaths out of the total number of births each year in a community is a vital indicator to the general health of that community. As a cautionary note, infant mortality rates should not be looked at in isolation. The diseases and illnesses suffered, which limit the strength, vitality and general health of surviving infants also needs to be addressed.

Sir George Newman, (Dr. Newman) Medical Officer of the Board of Education, speaking at the beginning of the twentieth century, identified the severity of the problem of infant mortality. He pointed out that since a nation depended on its children, if thousands of children died in infancy
...it means that the sources of a nation’s population are being sapped, and further that the conditions which kill such a large proportion of infants injure many of those which survive.  

Dr. Newman stated that a quarter of all deaths in 1905 were infants, concluding that ‘this enormous sacrifice of human life is being repeated year by year’ and was not seen to be declining. Sir Arthur Newsholme, (Dr. Newsholme) Medical Officer of Health for the Local Government Board in 1910, strongly advocated that infant mortality was a sensitive index of social welfare and sanitary administration, particularly in urban conditions. However, infant mortality statistics were unreliable prior to the compulsory registration of stillbirths in 1914. Registration of deaths was compulsory from 1837 following the establishment of the office of the Registrar-General in 1836. The later Births and Deaths Registration Act of 1874 included the stipulation that it was compulsory to register births within forty-two days. Prior to this Act, when an infant died within six weeks of birth, the death was probably unregistered and consequently hidden from the death statistics. It can be argued that infant mortality rates prior to 1874 were considerably higher than official figures suggest.

Concern regarding the high percentage of infant deaths did not materialise until early 1900. It had become apparent that young men signing up for recruitment to fight for their country during the South African Boer War were physically unfit and unable to perform duties with efficiency. The Inspector-General of Recruiting voiced his concern about the ‘gradual deterioration of the physique of the working-classes’, which formed the main recruitment source. His comments focused governmental attention on the initial predicament of an inadequate fighting force and consequently on the working-class as the
reproducers of the nation. Concern was cemented by the disclosure that the nation’s birth rate was decreasing at the same time as the overall death rate was in decline. Between 1876 and 1897, the crude birth rate per thousand of the population had dropped from 35.5 to 30.5, which was a decrease of 14.1 per cent. It did not seem to be of any consolation to the British government that internationally, statistics were similarly showing a decline.

The physical and intellectual qualities of a nation’s population were deemed to be highly important to the survival of that nation. The British Medical Journal succinctly summarised the overall concern in 1901 through its editorial.

There has been for some years past a steadily declining birth-rate, which requires the consideration of all who have the well-being of the country and of the empire at heart.

With the birth and death rate decreasing while the infant mortality rate remained stationary, it meant that overall, fewer babies were being born to replenish the nation. Proportionate to the population in 1905, there were four births less in every thousand people than in 1851. Dr. Newman claimed that if the birth rate had been the same in 1905 as it had been in the mid-nineteenth century, there would have been ‘more than 60,000 additional infants born’ annually. Concerning the declining birth rate, the Registrar-General stated that seventy per cent of the decrease from 1870 was the result of the decreased fertility of married women of conception age and ten per cent was associated to falling illegitimacy rates nationwide.

The Incidence of Infant Mortality

It was a harsh reality that in England and Wales in 1904, out of 100,000 infants born 17,139 would not complete twelve months of life and nearly 25,000 more would die
before they reached their fifth birthday. A report on infant and child mortality in 1910 assessed the incidence of infant mortality in different parts of England and Wales. The report stressed the national importance for a reduction in infant deaths, pointing out that an excessive infant mortality rate consequently led to an equally high death rate during the subsequent four years of life. Additionally, communities with excessive mortality rates for the first five years of life reflected to a certain degree, high death rates in adult life. Furthermore, communities with low infant mortality rates exhibited continuing low death rates in adult life. The evidence suggested that these communities enjoyed a higher standard of general health than experienced in communities with excessive infant mortality rates.

**England**

In 1908, the three counties in England with the highest infant mortality rates for the first week of life were Durham, Northumberland and Norfolk. In Durham and Northumberland it was found that one in every thirty infants born would die within one week of birth. One in every thirty-two or three infants born in Norfolk would meet the same fate. The counties of Hereford, Berkshire, Kent, Surrey and Hertford appeared more favourable to infant survival with one in every fifty to fifty-five dying within the first week. The counties named above appeared consistently in the relative positions at the highest or lowest points of the scale for the infant mortality rates in the first months of life, the first three months and each trimester following. Stafford, seventh highest rate for the first week of life, joined Durham and Northumberland to become the third highest rate for the first month with one in every twenty-one infants dying. At the lower level of the scale, Oxford joined the list with one more infant dying in the first month than was
recorded for Berkshire, Kent and Surrey: one in thirty-two and thirty-one respectively.  

The patterns continued in the following trimesters. A significant feature of the counties found to have the highest rates was the existence of industries such as mining or textiles. The counties with the lowest rates were mainly rural. The report's findings supported Dr. Newman's research, published in 1906, concerning infant mortality and its distribution.  

Dr. Newman noted that by examining the geographical distribution of infant mortality it became evident that there was no uniformity to the statistical evidence. Some parts of the country showed a high rate while others displayed low rates. Using information furnished by the Registrar-General's office, Dr. Newman compiled a useful Table presenting the infant mortality rates of counties in England and Wales for decennial and one quinquennial period spanning a total of sixty years from 1845 to 1905. He concluded that the industrialised areas remained in the top infant mortality rate bands while the mainly rural areas were to be found in the lower bands for the whole of the sixty-year period covered. However, he was convinced that physical or geographical conditions were not creating the characteristic variations in distribution of infant mortality. He justified his claim with the following comment.

The climate of Lancashire, its temperature and its rainfall, is not greatly different to that of Cumberland, or that of Shropshire from Staffordshire, or that of Herefordshire from Warwickshire and yet these districts are pole-wide asunder in regard to infant mortality.  

Additionally, Dr. Newman dismissed the question of disparity among the populations of different areas stating that in a relatively small country such as England, customs, habits,
housing, diet and clothing were identifiably similar. He said that the people ‘...on the whole even treat their infants the same’. 21

The two main features Dr. Newman recognised as common to high infant mortality districts were firstly, a high density of population and secondly, considerable industrial activity. He conceded that a high density of population was not the sole consideration for variants, since if that had been the pivot, the more densely populated an area, the higher the infant mortality rate would be. Consequently, London would then rate highest, and figures reveal that was not the case. In central boroughs of the metropolitan districts of London, the average infant mortality rate for 1901-05 was 144. The boroughs on the circumference averaged 120 for the same period. This compared favourably to Manchester’s central districts, which gave an infant mortality rate of 208 with Northern districts standing at 166. 22 However, a further commonality can be found in the above figures. The inner town districts had a higher rate than the outer town districts. Therefore to a certain extent density of population was a contributory factor to high infant mortality rates.

The summary of the Registrar-General in preparation for the Annual Report pointed out that excessive infant mortality was not a necessary occurrence in towns. In both groups of great towns and smaller towns, wide variations existed. 23 Dr. Newman reminded the Local Government Board that in every country, in most districts and towns returning low infant mortality rates, there could be found pockets of high numbers of infant deaths. 24

Urban and Rural Considerations

The Registrar-General’s returns for 1889-91 examined aspects of urban and rural counties in relation to infant mortality. Three rural counties, Hertfordshire, Wiltshire and Dorset
and five mining and manufacturing counties, Staffordshire, Leicestershire, Lancashire, Yorkshire [West Riding] and Durham were chosen as typical examples for comparative purposes. The differences distinctly emphasised that infant survival rates were much higher in agricultural districts. The Registrar-General concluded that the returns revealed that there was a 'progressive increase in the deleterious effects of town conditions on infant life'. The distribution of infant mortality in England followed by the pattern of urbanisation, which was characterised by industrial conditions, a high density of population in towns, overcrowding and inadequate sanitation provision. Comparing the 1891 returns with the Registrar-General's returns for 1908 for the same rural, mining and manufacturing counties the pattern replicated the earlier returns. In all but one of the selected counties, the rural infant mortality rates remained significantly lower than the urban districts. Rural Durham returns for 1908 did show a higher infant mortality rate than the urban districts. However, for the whole of Durham county the infant mortality rate of 151.0 was twenty-five per cent in excess of England and Wales. The evidence points to the infant mortality rates varying from county to county in England, and between districts within those counties.

A similar pattern emerges when analysing infant mortality rates in Wales, particularly in counties where heavy industries and a high density of population were evident. The counties of Glamorgan and Monmouthshire were host to industries such as coal mining and had heavily populated areas. Both Glamorgan and Monmouthshire returned higher infant mortality rates than the whole of England and Wales in 1908. However, as Dr. Newman pointed out, a high density of population combined with industrial activity was not the sole contributor to excessive infant mortality rates.
The Position in Glamorgan

During 1908, the administrative county of Glamorgan had an infant death rate, which was 28.2 per cent in excess of that of England and Wales. In keeping with the findings of the Registrar-General, the rate in the urban districts was higher at 164.8 than in the rural districts of Glamorgan, which returned a rate of 124.5. Furthermore, the rural districts with the highest rates, Gelligaer and Rhigos at 159.0 and Pontardawe at 141.0 were still lower than the aggregate of the urban districts. Among the highest urban districts was Aberdare (213), Rhondda (177), Merthyr Tydfil (173), Maesteg (173) and Pontypridd (169), which were all coal-mining areas. Aberdare and Pontypridd experiencing a rise in infant mortality compared to the previous five-year average for those districts.

Dr. S. W. Wheaton was engaged to submit reports to the Local Government Board concerning the sanitary conditions of various districts in England and Wales. Dr. Wheaton’s report on the sanitary circumstances of Maesteg Urban District in 1908 reveals some disturbing insights into life in a South Wales coal-mining community at the turn of the century.

Dr. Wheaton’s perception of Maesteg was that it had ‘the typical appearance of a South Wales coal-mining town, the people being prosperous, wages high, and no empty houses.’ However, industrial prosperity was not synonymous with a high standard of living and quality accommodation for the workers and their families, as Dr. Wheaton’s evidence reveals. He claimed that apart from the dear rents charged for a decent property, a large number of the remaining cheaper dwellings were ‘in such a filthy condition that no self-respecting person could use them.’ An additional comment of his reflected poorly
on the colliery owners. Dr. Wheaton stated that the oldest and most dilapidated houses in
the district generally belonged to the coal companies. 29

Dr. Duncan, Medical Officer of Health for Merthyr Tydfil Borough, confirmed Dr.
Wheaton’s impression that housing conditions were far from satisfactory. 30 Furthermore,
Dr. Duncan’s comments covertly point to the reason these circumstances prevailed. In
Merthyr Tydfil, as in other urban districts in Glamorgan, it was difficult to find houses
with a sufficiently low rent to be able to re-house occupants living in slum conditions.
Many families were residing in houses condemned as unfit for human habitation. Certain
areas such as Crystal Palace Court, the name of which was far removed from the reality
faced by the occupiers, had relatively low rents between eight and twelve shillings a
week. However, due to the acute shortage of housing with comparable rents, closing
orders were often postponed until the tenants could find alternative accommodation. This
was often impossible owing to the lack of housing throughout Glamorgan.

The consequence was that families found themselves exposed to deteriorating conditions,
which had an equally debilitating effect on their overall well being. Dr. Wheaton, with
the liberal use of the words ‘filth’ and ‘filthy’ whenever mentioning the houses, back
streets, yards and water-closets, was convinced that when faced with such conditions and
the inability to alter them, the occupants ‘often lose their self-respect, take to drink, and
become degraded’. 31

More significantly, pointed out Dr. Wheaton, the ‘deteriorating influences’ were felt more
powerfully by women than men. With little or no employment for women in Glamorgan,
housewives found themselves constantly at home. Dr. Wheaton claimed that the
condition of the homes did little to encourage women in their fight against dirt. Husbands
and perhaps sons and lodgers returning from the pit constantly trod 'Filth' into the home from the 'stinking' back streets. Work clothes, thick with coal-dust, had to be worn home after the shift due to the lack of bathing facilities at the collieries. To further compound the problem of coping with dirty work clothes and equally dirty bodies, the homes were without baths. The constant coal dust made the daily chores of the housewife a constant battle in the mining communities.

The extent of the continuing shortage of adequate housing in Glamorgan was revealed in a Royal Commission Report on the Coal Industry eleven years later. Mrs. Elizabeth Andrews, who gave evidence before the Commission, was well qualified to speak on the state of industrial housing. She told the Commission that she had spent her life in mining areas. As a miner's wife and a member of the Labour Party and the Co-operative Women's Guild, she had the opportunity to speak to women concerning housing conditions. Mrs. Andrews, using the Rhondda as an example, revealed that for the ten years prior to the Commission’s inquiry, there had been high rent increases for the same poor housing stock. Houses condemned before the war were still occupied by large families due to the shortage of homes.

Dr. Williams, the County Medical Officer of Health for Glamorgan, reiterated the point that overcrowding and insanitary conditions were an important factor relating to the incidence of high infant mortality rates in the industrial districts of Glamorgan. He believed that

...as these evils are capable of being remedied, no efforts should be spared by sanitary authorities to cope with them.
However, as the evidence of Mrs. Andrews suggests, housing remained inadequate in industrial Glamorgan for many years. Furthermore, homes were the birth places of infants. The poor and insanitary environment, both within the home and outside, placed infants and parturient mothers in a vulnerable position.

Analysing the evidence contained in county and district medical officer of health reports for Monmouthshire, the situation regarding housing appears similar to that of Glamorgan. Infant mortality rates reflect the continuing neglect of local authorities to recognise and act upon the root cause of the loss of infant lives. Furthermore, a high infant death rate implies serious risk to the survivors through infancy, into childhood and later adult life. Finally, it should be pointed out that a brief cameo of the sanitary conditions in one year in one county regarding infant mortality, is not sufficient evidence to suggest causal links.

However, using Monmouthshire as the chief example, fluctuations in infant mortality rates in both urban and rural districts can be analysed in relation to government, medical and academic research into some of the suggested causes of infant deaths. Firstly a comparison will be made between Monmouthshire and Glamorgan in 1908. Then the study will be expanded to include an analysis of the interim period up to 1938.

**Case Study: Monmouthshire**

In the administrative county of Monmouthshire, infant death returns resulted in an infant mortality rate of 140.3 in 1908, which was 16.5 per cent in excess of England and Wales compared to Glamorgan’s 28.2 per cent excess. [See Tables 7 and 8]
Table 7

**Infant Mortality per Thousand Births: Selected Welsh Counties 1908**

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<th>County</th>
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Compiled from statistics contained in Appendix 111 pp132-133.

Table 8

**Infant Mortality per Thousand Births Selected Welsh Counties: Urban/Rural 1908**

<table>
<thead>
<tr>
<th>County</th>
<th>Urban Rate</th>
<th>Rural Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glamorgan</td>
<td>164. 8</td>
<td>124. 5</td>
</tr>
<tr>
<td>Monmouth</td>
<td>147. 0</td>
<td>91. 3</td>
</tr>
<tr>
<td>Carmarthen</td>
<td>129. 5</td>
<td>146. 9</td>
</tr>
<tr>
<td>Caernarvon</td>
<td>133. 0</td>
<td>109. 6</td>
</tr>
<tr>
<td>Cardigan</td>
<td>111. 8</td>
<td>105. 5</td>
</tr>
<tr>
<td>Merioneth</td>
<td>107. 6</td>
<td>102. 9</td>
</tr>
<tr>
<td>Pembroke</td>
<td>123. 5</td>
<td>90. 8</td>
</tr>
<tr>
<td>Radnor</td>
<td>60. 3</td>
<td>106. 0</td>
</tr>
</tbody>
</table>

Compiled from statistics contained in Appendix 111 pp132-133.

In the urban districts of Monmouthshire statistics reveal the same pattern of a higher rate than the rural districts. The urban returns stood at 147.0 compared to the rural infant mortality rate of 91.3. In both Glamorgan and Monmouthshire, an infant born in the industrialised districts in 1908 would have less of a chance of survival than those born in
rural districts. The most vulnerable time for infants in the whole of Monmouthshire in 1908 was the six to twelve month period. In the county of Glamorgan, the three to six month period returned an excessively high incidence of infant deaths compared to England and Wales. [See Table 9]

**Table 9**

**Total Infant Mortality Rates by Age During the First Year of Life for 1908**

<table>
<thead>
<tr>
<th>Age</th>
<th>Monmouth</th>
<th>Glamorgan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 week</td>
<td>- 4.5</td>
<td>+ 2.1</td>
</tr>
<tr>
<td>Under 1 month</td>
<td>- 1.5</td>
<td>+ 14.4</td>
</tr>
<tr>
<td>Under 3 months</td>
<td>+ 9.8</td>
<td>+ 19.1</td>
</tr>
<tr>
<td>3 to 6 months</td>
<td>+ 20.3</td>
<td>+ 46.2</td>
</tr>
<tr>
<td>6 to 12 months</td>
<td>+ 27.3</td>
<td>+ 33.0</td>
</tr>
<tr>
<td>Entire 1st year</td>
<td>+ 16.5</td>
<td>+ 28.2</td>
</tr>
</tbody>
</table>


Translating extremes of mortality rates into actual figures it was found that in the first three months of life, out of every thousand births in Glamorgan, one in every thirteen would die. The equivalent figures for the second trimester of life gave one in every twenty-nine infants dying in Glamorgan and one in thirty-six for Monmouthshire. Finally, the last six months brought the incidence of infant mortality closer between Glamorgan and Monmouthshire, with one in twenty-three for the former and one in twenty-four for the latter county. The registered causes of death for both counties given in the 1908 report were premature birth and congenital defects; atrophy, debility and
marasmus; convulsions; diarrhoeal diseases; measles and whooping cough; bronchitis and pneumonia. [See Table 10]

Table 10

Diseases Causing Infant Deaths in Monmouthshire and Glamorgan :1908
Variations with England and Wales

<table>
<thead>
<tr>
<th>Disease</th>
<th>Monmouthshire</th>
<th>Glamorgan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
<td>+ 26.3</td>
<td>+ 89.5</td>
</tr>
<tr>
<td>Whooping cough</td>
<td>+ 76.0</td>
<td>+ 34.0</td>
</tr>
<tr>
<td>Diarrhoeal diseases</td>
<td>+ 11.1</td>
<td>+ 36.2</td>
</tr>
<tr>
<td>Atrophy , debility, marasmus</td>
<td>+ 35.3</td>
<td>+ 64.7</td>
</tr>
<tr>
<td>Convulsions</td>
<td>+ 46.3</td>
<td>+ 103.7</td>
</tr>
<tr>
<td>Bronchitis, pneumonia</td>
<td>+ 4.0</td>
<td>+ 21.2</td>
</tr>
<tr>
<td>Prematurity</td>
<td>- 16.1</td>
<td>+ 22.1</td>
</tr>
<tr>
<td>Congenital defects</td>
<td>+ 41.8</td>
<td>+ 11.9</td>
</tr>
<tr>
<td>Tuberculous diseases</td>
<td>- 12.8</td>
<td>+ 12.8</td>
</tr>
</tbody>
</table>

Monmouthshire p98, Glamorgan p83.

Since premature births and congenital defects tended to overlap as considered causes of infant deaths, it was difficult to accurately separate these conditions. Under these headings there seemed to be an apparent increase in registered infant deaths for the whole of England and Wales, from 20.3 for the period 1886-1890 up to 27.0 for 1906-1908. The increase was suggested to be partly due to the transference of causes of death from other headings, and partly to some infants being registered as dying of prematurity who would formerly have been buried as still births. However, Dr. Newman refuted these explanations stating that ‘the deaths from premature births have increased too greatly to be explained in this way’ in both urban and rural districts containing a wide variation of external conditions.
The source of the inaccuracy continued until the Notification of Births Act of 1907. This was an adoptive Act and was finally relieved following the Notification of Births (Extension) Act in 1915, which brought all counties into its jurisdiction. The medical officer of health summed up the confused nature of birth and death details for the Local Government Board.

It is unfortunate that the certification of causes of death in infants is so imperfect.

Furthermore, the number of infant deaths ascribed to convulsions and to the group known as ‘atrophy, debility and marasmus’ referred to symptoms, which then led to death. This effectively concealed fatal diseases of different origins, which included congenital causes, injury at birth, syphilis and improper feeding. It can be suggested that, at least prior to the Notification of Births Act of 1915, returns showing a low death rate from prematurity did not necessarily mean that infants were any healthier at birth than in counties exhibiting a higher incidence of premature infant deaths.

Mortality statistics as a whole are indicative of the relative state of life and death. However, statistics cannot reveal the health of the surviving infants. Babies surviving births are not necessarily healthy. It is beyond the scope of this thesis to examine the whole range of diseases in relation to infant mortality rates. Therefore, it is the intention to examine the factors influencing infant mortality in the natal and post-natal period in Monmouthshire.

The main sources for such an analysis include the annual reports of the Maternity and Child Welfare Committee covering the years 1916 to 1938. The reports contain the evidence of the County Medical Officer (CMO), district medical officers and health
visitors. The period begins with the implementation of the Notification of Births Act of 1915 and ends when the records become incomplete due to the continued disruption of the Second World War.

Influences affecting infant mortality including the quality of help given at birth and the 'ignorance and fecklessness of mothers' will be examined in connection with Monmouthshire. The ignorance of mothers tended to be perceived as the main cause of infant deaths, with the quality of help offered during the birth also mentioned frequently as influencing infant mortality rates. Environmental factors including urban and rural conditions, domestic and municipal sanitation and the quality of housing were included as further influences. The above factors infiltrates and mingles with any discussion concerning the two main categories, as does the major issue of poverty and will be included in the analysis of the situation in Monmouthshire.

The Question of the 'Quality of Help'

The 47th Annual Report of the Local Government Board for 1917-1918 expressed concern that the inspection of midwives in many counties continued to be 'relatively unsatisfactory'. It was a cause for concern that generally in the more heavily populated urban districts, half or more than half of the practising midwives were bona fides. It was claimed that the provision of midwives was progressing satisfactorily since the implementation of the Midwives Act of 1902, particularly in districts where there had been few midwives. However, it was reported that many districts found difficulty employing additional trained midwives. It was claimed that reasons for the continuing problem included the increased cost of living for a midwife. The longer training period that was required before a midwife could begin to earn money was part of the problem.
Additionally, changes in the nature of women's employment prospects offered women a chance to earn more money with less anti-social hours than those faced by midwives. Consequently, it was problematic to secure sufficient women to train as midwives or to remain in the profession and continue to practice after gaining qualifications. Of the 30,543 trained midwives on the Midwives Roll in 1917-1918, only 6,754 were returned as being in active practice. Furthermore, it was suggested that in many industrial areas, regardless of the number and qualifications of attendant midwives, 'the older bona fide is preferred'. The issue of concern emanating from this situation was that the untrained midwife was not able to detect conditions endangering the life of both mother and infant, consequently medical help would be delayed. The anxiety expressed in the 47th Annual Report of the Local Government Board (1917-1918) reflected the earlier comment in the 39th Annual Report (1909-1910) regarding the quality of help given at birth.

The extreme disparities between counties in the number of infants dying within a week of birth suggested to Dr. Newsholme, writing for the 39th Annual Report (1909-1910) '...that differences in care at birth may bear an important part'. Dr. Newsholme also suggested another reason, particularly relevant to rural districts. In these districts it remained difficult to obtain sufficient help for women in labour, which implied that there was a need to address the provision of trained midwives in rural areas. In the 39th Report (1909-1910) Dr. Newsholme stressed the importance of the midwife in relation to infant life, particularly in the first week following birth. He pointed out that it was the midwife's advice concerning the feeding of the infant that would be followed by the mother. Offering recommendations to reduce infant mortality, it was concluded that even with the limited information available from the passing of the Midwives Act in 1902 to 1910,
evidence suggested that infant mortality could be reduced 'by giving adequate training and help to midwives'. Both the 39th Report (1909-1910) and the 47th Report (1917-1918) pointed to the ineptness of *bona fides* and cautiously linked a high infant mortality rate to untrained attendance at the point of birth.

**The Quality of Help in Monmouthshire**

In Monmouthshire in 1908 there were 209 midwives which included twenty-five fully trained and qualified. Eighty-seven stillbirths had been recorded in the twelve-month period with an infant mortality rate of 140.3, which was the second highest in Wales. The 'Inspectress of Midwives', Mrs. Dore, reported that in 109 cases, extra medical help was needed during or following the birth. Her report suggested that given the number of stillbirths, the situation was problematic and more trained midwives were required in Monmouthshire. The extent to which the remaining 184 untrained midwives influenced the infant mortality rate in Monmouthshire in 1908 is impossible to assess due to incomplete returns. However, one remaining *Register of Midwives* listing the qualities of all midwives practising in the county of Monmouthshire in 1914 was available. (See Appendix 2) When analysed together with material taken from the annual reports of the Maternity and Child Welfare Committee (MCWC) of Monmouthshire County Council (MCC) and district medical officers’ reports for the same year, certain conclusions can be suggested.

The total number of midwives registered to practice in Monmouthshire for the year 1914 was 260. Fifty-three of these were registered as illiterate. The majority of the midwives were known to be literate. The illiterate midwives were among the 154 *bona fides* who had been practising as midwives prior to the passing of the Midwives Act in 1902.
Between 1911 and 1914, for the whole of Monmouthshire the average annual number of infants dying before reaching the age of twelve months was 1,184. The annual average for births in England and Wales for the same period was 9,960. Urban districts in Monmouthshire recorded the highest average infant death rate with Blaenavon the overall highest at 141.0, closely followed by Tredegar (140), Rhymney (138), Ebbw Vale (137), Bedwellty (136), Mynyddislwyn (127) and Abertillery (124). Nine out of the twenty-one urban districts had an average infant mortality rate above 120, while all six rural districts remained below 88. By 1916, midwives attended around ninety-five per cent of the births in the county. Articles in the BMJ in 1902 had expressed concern that unqualified women would be able to practice having as little knowledge as the ‘gamps’, untrained being synonymous with ‘dangerous’. However, with pupil midwives undertaking a brief three-month period of training to be able to take the CMB Certificate and become qualified midwives, it is possible to suggest that the older bona fide midwives would have had more practical experience than newly-qualified midwives. Furthermore, without bona fides, some districts would have been left with few midwives to cover large areas. The infant mortality rate for the whole of Monmouthshire in 1914 was high and stood at 106.0, although the Registrar-General’s calculation was stated as being 108.0 for that year. The discrepancy related to the adjusted figures once births occurring in the county of mothers residing outside and births outside the county of mothers residing within, had been calculated. Fluctuating rates from 1909 to 1914 suggested that even though 1914 did show a decline in infant mortality from the previous year, the figure was still higher than five years earlier in 1909. Monmouthshire did not seem to be in control of the causes of infant deaths in the county.
In Monmouthshire, the Midwives Act was administered by the CMO and nursing arrangements were conducted under Lady Mather-Jackson’s Nursing Scheme. By 1913, fifteen constituent associations were affiliated to the Monmouthshire Nursing Association (MNA). However, financial restrictions meant that some areas remained without adequate provision through the Scheme. When two new local branches were formed in 1913 one other branch had to be discontinued. Nevertheless, a Nurses’ Home was opened in Tredegar that year and recognised by the CMB as a training centre for midwifery pupils. Training began in October 1913 and six midwifery scholarships of sixteen pounds each were granted to the MNA by the Education Committee to train six new midwives for the county. Once the midwives completed their training and examination successfully, it was planned that they would work in the county of Monmouthshire, which would then have six more trained midwives on the Midwives Register. However, it can be suggested that an addition of only six trained midwives would not have made a significant impact on the quality of care offered at births and consequently the infant mortality rate of the whole county. At that time *bona fides* were a necessary, and it can be claimed, a vital part of the midwifery services in Monmouthshire.

**Urban Rhymney, Tredegar and Ebbw Vale**

In 1914 the urban district with the highest infant mortality rate was Rhymney at 143.2. Ten midwives served the district with six holding the CMB Certificate and four allowed to continue practising as unqualified *bona fide* midwives. However, only two of the midwives were registered as illiterate. Therefore, it can be suggested that the majority would have been able to read the information leaflets given out to midwives by the Inspectress of Midwives, although *bona fides* might not have understood the medical
terms in midwifery text books used for training purposes. Evidence suggests that in
Rhymney urban district, illiteracy among birth attendants was not a factor influencing
infant deaths. Other districts in Monmouthshire can be examined in the same way.
Tredegar, with the fourth highest infant mortality rate of (125.0), reflected the pattern in
Monmouthshire as a whole. The majority of infant deaths occurred in the first week after
birth from prematurity and wasting diseases. 64 Nineteen midwives were practising in the
Tredegar district. Twelve of the nineteen were qualified midwives. Out of the seven
unqualified midwives, only two were illiterate. 65 Ebbw Vale had the fifth highest rate in
the county (121.9) and lost eighteen babies due to prematurity and fifteen to wasting
diseases in the first week of life. 66 However in Ebbw Vale, the majority of midwives
were unqualified. Seven held qualifications out of a total of twenty-one midwives.
Furthermore, two of the qualified midwives practised in a Nursing Home and not in the
community, 67 which effectively reduced the number of active qualified midwives to five.
The medical officer of health for Ebbw Vale urban district, Dr. J. W. Davies, made no
reference to the number of practising midwives in his community, whether qualified or
unqualified, in his Annual Report in 1914. The absence of comment suggests that Dr.
Davies did not place significant relevance on the link between the lack of midwifery
qualifications and infant deaths. On the contrary, his comments concerning the ‘heavy
infant mortality’ prevalent in his district in June 1914 emphasised maternal ignorance and
the need for mothers to gain instruction through ‘lady health visitors’. He believed that
educating mothers would ensure that they were knowledgeable in maintaining ‘a healthy
condition in themselves and their surroundings’ both before and after birth. 68
The medical officer of health for Tredegar, Dr. Edwin T. H. Davies also gave no indication of a dissatisfaction in the ratio of qualified to unqualified midwives practising in his district. The high infant mortality rate in 1914 in Tredegar urban district was, according to Dr. Edwin Davies, partly accounted for by a measles epidemic. However, measles only claimed ten infant lives between the ages of three and twelve months. The main cause of infant deaths in the first week of life was given as premature birth.

Fourteen out of the twenty deaths were registered under this heading. Two deaths were attributed to ‘atrophy, debility and marasmus’, which were also conditions associated to weakness and premature birth. It can be argued that there was a lack of concern by some district medical officers in Monmouthshire regarding qualified help at births. A closer look at the Register of Midwives together with infant mortality rates in the county, leads to a possible conclusion on the relationship between infant deaths in the first week following birth and birth attendants.

**Observations**

Out of a total of twenty-one urban districts, only five had more qualified than unqualified midwives and two districts had equal numbers of each. Two out of the three districts with a larger number of qualified midwives, namely Rhymney (six to four), and Tredegar (twelve to seven), returned infant mortality rates far exceeding that of Monmouthshire as a whole, with 143.2 and 125.0 respectively, to Monmouthshire’s 106.0. Abercarn, with an eleven to seven ratio, produced a lower than average return with a rate of 100.0. Eliminating districts with very low numbers of midwives and districts with an equal number of qualified and unqualified help, (Blaenavon, Caerleon, Chepstow, Pontypool and Usk), out of the remaining seventeen, which also excludes Abercarn mentioned
above, eight districts had more unqualified than qualified midwives. These districts returned favourable infant mortality rates when compared to Monmouthshire. In only five out of the twenty-one urban districts, a higher rate was apparent with more unqualified help. Therefore the evidence does not suggest that a higher ratio of unqualified help at births necessarily led to a higher infant mortality rate. The rural districts produced similar results. Finally, illiteracy among *bona fides* had no significant bearing on high infant mortality rates. Only two urban districts had more illiterate than literate *bona fides* practising in the county of Monmouthshire. These districts were Abergavenny with one more and Abersychan with a higher proportion at five more illiterate than literate *bona fides*. It can be argued that one of the reasons for the continuing high infant mortality rates in the urban districts of Monmouthshire, was not the number of unqualified birth attendants practising in any one district. It was the combination of the inadequate duration of the training period for qualification, which produced young midwives with little practical experience and the total lack of formal training of the older *bona fides* with a great deal of practical experience.

**The 'Ignorance and Fecklessness of Mothers' 22**

Untrained midwives continued with their work in both urban and rural districts. Particularly in rural districts, their help was often given in collusion with the local doctor who could not physically attend all the births in his district. To banish every *bona fide* would cause severe problems. Furthermore, given that it has been reasonably proved that lack of qualifications and illiteracy among midwives was not the main cause of infant mortality rates in Monmouthshire, other identified causes need to be examined to assess the extent to which they may be influential in perpetuating high infant mortality rates.
There is little doubt that the causes of infant mortality are highly complex. Government officials, members of various committees enquiring into infant mortality and medical professionals, including county and district medical officers of health identified multiple influences.

However, as Jane Lewis points out, these were reduced to one 'fundamental' cause perceived as being 'maternal ignorance'. Educating mothers and girls in schools became of primary importance. The blame was firmly placed on the mothers’ care or lack of care of the infant following birth. Whereas mothers came from all classes in society, it was the mother living in a working-class district who found herself targeted most harshly. Personal hygiene, the control of domestic dirt and methods of feeding infants were claimed to be inadequate to the point of creating a danger to the lives of infants of mothers in working-class districts.

The educational process designed by the state and implemented by local authorities reflected middle-class contemporary practises concerning motherhood and childcare. The attitude of county and district medical officers expose class bias and often reveal the opinion that many mothers in working-class districts were ignorant concerning infant care and hygiene, lazy and incompetent in the skills of housewifery. However, blaming the mother in this way, diverted attention from the reality of the situation in working-class districts. Many mothers in these districts welcomed advice offered at infant welfare centres and by health visitors. Nevertheless, mothers could not remedy poor living conditions caused through overcrowded and insanitary houses.

With the focus on inadequate mothering in the first instance, some local authorities were slow to improve living conditions in the working-class districts. By laying the blame
firmly on the mother, the situation perpetuated infant mortality and the myth of the
gnant working-class mother. In 1913, Dr. Newman argued that the problem of infant
mortality was ‘mainly a question of motherhood and ignorance of infant care and
management’. 74 Lewis, analysing the development of this idea, notes that by 1916 it had
been established that ‘infant mortality was due more to people themselves than to their
external surroundings’ and that ‘faulty maternal hygiene’ was deemed the ‘primary cause’
of infant deaths. 75

As early as 1904, the Duke of Devonshire’s Committee on Physical Deterioration
expressed the opinion that among younger women, there was evidence to suggest
increasing carelessness and a deficient sense of responsibility ‘which can only be
disastrous to the rising generation’. 76 This opinion was reflected later by Dr. Newsholme
in the 39th Report (1909-1910) when he referred to the mother as ‘the natural guardian’ of
her child. 77 Dr. Newsholme profoundly criticised the feeding regime of infants. His
criticism included the habit of mothers to offer ‘tastes’ of their own food to babies; the
substitution of artificial for natural feeding; ‘mischievous advice’ given by ‘ignorant
neighbours’ and preparing and storing artificial food in unclean surroundings. Dr.
Newsholme claimed that the majority of mothers

...are profoundly ignorant of the relative nutritive value and digestibility of
different foods; and health visitors as well as doctors are needed to explain such
points in detail, if the present unnecessary sacrifice of infant life and of efficiency
in those who survive is to be avoided. 78

Dr. Newsholme stressed the need to encourage mothers to breast-feed infants, which
would offer them the best possible start in life. Where milk depots were used to provide
pasteurised milk for mothers unable to breast-feed, he acknowledged the role of the medical officers of health in those districts in ensuring that the depots would not serve to encourage the mothers to abandon breast-feeding for artificial food. However, he was convinced that if breast-milk, or failing this, good quality artificially prepared food could be provided for infants, 'a chief cause of excessive infant mortality would have disappeared'. 79 It was believed that artificial feeding created the danger that babies fed this way were slowly being starved in respect of the essential fat in their food.

**Milk Samples Taken in Monmouthshire**

Evidence of adulterated food including milk can be found in reports of medical officers in respect of their individual districts and counties. The extent and type of adulteration varied throughout England and Wales. Samples of milk and other foods were taken regularly by county analysts and examined to assess quality. The *Annual Report of Monmouthshire County Council* in 1915 provided a list, which included the results of samples of milk taken from districts within its jurisdiction.

A sample of milk taken in the Nantyglo and Blaina urban district was found to have sixty-seven per cent added water. A second sample revealed more than forty-six per cent added water. Since both samples were from the same distributor and it was the third offence, the guilty party was fined twenty pounds by the County Police Court. 80 In several urban and rural districts in Monmouthshire milk samples were found to be deficient in fat content and were fined accordingly. Court proceedings against repeated offenders were taken under the *Sale of Food and Drugs Act* of 1899.

The examples in Table 11 were taken from a total of ten urban and three rural districts from which milk samples were collected. Eleven of the samples showed that water had
been added to the milk; nine samples had deficient fat content and one of the samples had extra water and was deficient in fat. One farmer was prosecuted for a false warranty and out of twenty cases heard, only two were dismissed. Each year the Annual Reports provided evidence to suggest that the situation was slow to improve even with the deterrent of police action. The comments of the medical officers in Monmouthshire concerning adulterated milk in particular, reveal the concern felt regarding the use of such milk to feed infants. The results, it was claimed, were detrimental to the health and well being of infants.

Table 11

<table>
<thead>
<tr>
<th>District</th>
<th>Nature of Sample</th>
<th>Extent of Adulteration</th>
<th>Result of Proceedings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abercarn Urban</td>
<td>Milk</td>
<td>9.48% added water</td>
<td>Ordered to pay costs £ 5. 5s. 0d.</td>
</tr>
<tr>
<td>Abergavenny Rural</td>
<td>Milk</td>
<td>38.67% deficient in fat</td>
<td>Fined £ 5. 0s. 0d.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Two offences</td>
<td>Second offence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>67% added water</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>46.47% added water</td>
<td></td>
</tr>
<tr>
<td>Nantyglo and Blaina Urban</td>
<td>Milk</td>
<td>Two offences</td>
<td>Third offence in total.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>67% added water</td>
<td>Fined £ 20. 0s. 0d.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>46.47% added water</td>
<td></td>
</tr>
</tbody>
</table>

Source: Annual Report of the County Medical Officer of Health for Monmouthshire 1915 p73. Selected examples of adulteration of milk in Monmouthshire, 1915.

Selected Comments of Medical Officers

Dr. Griffith, medical officer of health for Abercarn in 1919, mentioned that few babies in Abercarn were fed on cow’s milk alone ‘as the quality and quantity are both unreliable; nearly all the milk sold in the district is imported and comes by train’. Abercarn’s infant mortality rate stood at 90.0 in 1919, which was the tenth highest out of the twenty-one urban districts. Chepstow urban district produced the highest rate that year at 147.7.
Dr. Drapes, Chepstow’s medical officer, stated that the majority of infants attending the infant welfare centre in 1919 were artificially fed. However, due to the ‘uncertain quality of the supply of cow’s milk’ in the district, Dr. Drapes did not advocate the use of cow’s milk for babies until they reached the age of nine months at least. 82 It is not intended to infer that in districts where a high number of infants were fed poor quality cow’s milk there was generally a high infant mortality rate. Many other factors were at work to influence fluctuations in district rates.

However, from the two reports of the district medical officers and the lists of offences each year for adulterated milk, it can be argued that the quality of cow’s milk in Monmouthshire was not adequate for infants. The evidence substantiates the comment of Dr. Newsholme in the 39th Report (1909-1910) regarding artificial foods including cow’s milk for infants, as containing an insufficient proportion of fat to enable healthy bodily growth to be made and maintained. He concluded that a ‘weakly childhood associated with rickets commonly results if the infant survives’. 83

Dr. Rocyn Jones, the CMO for Monmouthshire, agreed that natural feeding of infants was associated with a low infant mortality rate. However, he also warned that when infants were breast-fed ‘want of personal cleanliness on the part of some of the mothers’ together with the use of the ‘dummy teat’ between feeds caused problems. He explained that this kind of combination afforded opportunities for infection to take hold, which caused digestive troubles and diarrhoea. In infants, diarrhoeal disease, especially the form known as ‘acute summer diarrhoea’ was classed as ‘one of the gravest and most fatal diseases of infancy’. Furthermore, it was stated that diarrhoea was essentially a disease related to bottle-fed babies. If the infant survived the initial disease, it would leave the survivor
open to attack from, for instance, convulsions or pneumonia, which were serious and
generally fatal for a weak infant. 84

**The Link Between High Infant Mortality Rate and Diarrhoea**

In the 39th Report (1909-1910), Dr. Newsholme pointed out that in counties with the
highest total infant mortality rate, the percentage of deaths due to diarrhoea was also high.
Northumberland displayed the highest percentage of infants dying from diarrhoea at 18.2
per cent, with Glamorgan the second highest with 17.8 per cent. Monmouthshire was
sixth on the list with a percentage of 14.4 infants dying from diarrhoea. When comparing
the deaths of infants per 1,000 births from diarrhoeal diseases, it was found that
Glamorgan’s rate was the highest in the country for both the administrative county (27.1)
and the aggregate urban districts (31.2). In comparison, Monmouthshire came fifth
highest in England and Wales at 22.1 and 23.1 respectively. 85 Both Glamorgan and
Monmouthshire had a high death rate from diarrhoeal diseases and it can be assumed that
the incidence rate was higher still.

**Concern in Monmouthshire**

Dr. Rocyn Jones had cause for concern when he was forced to report that the infant
mortality rate in the administrative county of Monmouthshire was not declining. The rate
had risen to 140.3 in 1908, which was 16.5 per cent in excess of that for England and
Wales. 86 It was six per thousand higher than that of the county for 1907 and almost nine
per thousand higher than in 1906 for the whole county. 87 Furthermore, in urban districts,
a percentage of 27.5 of infant deaths occurred during the first month of life and 55 per
cent of these were in the first week after birth. A smaller number of births were registered
in the rural districts but the pattern of loss close to the birth was repeated. Out of the
infant deaths in rural districts, thirty-four per cent happened in the first month, while sixty-six per cent of these deaths occurred in the first seven days. 88 Dr. Jones classified the causes of infant mortality into three main headings, ‘Sanitary’, ‘Social and Personal’ and ‘Illnesses’. 89 His summary of causes and recommendations was reported to the Local Government Board and is an illustration of the involvement of county medical officers in public health matters. Under the ‘Social and Personal’ heading, Dr. Jones’ list included a number of derogatory inferences attacking parenthood in working-class districts. Intemperance by the parents and venereal disease, particularly syphilis in either or both parents, was given as antenatal conditions affecting the unborn infant through the mother. Incorrect feeding, improper clothing, neglect of the infant and indifference of the parents to the dangers of certain diseases, including diarrhoea, were added as causes of infant deaths. It was claimed that many of the illnesses and diseases of infancy were preventable, ‘were the parents to feed and clothe their children properly and avoid exposing them to cold and infection’. 90

Dr. Williams, the medical officer of health for Glamorgan, also gave a summary of the suggested causes of infant mortality in his county, which was almost identical to Dr. Jones’ list. Dr Williams mentioned the indifference and neglect of some parents and included the ‘important factors’ of insanitary conditions. Significantly, apart from the improvement of municipal sanitation, among the remedial measures indicated was the education of mothers. School girls, viewed as the nation’s future mothers, were also addressed.

The first suggestion to improve infant mortality rates included in the list offered by Dr. Williams, highlighted the importance placed on education.
Instruction in the laws of health, including the feeding and care of infants, thrift, temperance, and moral instruction to the higher standards for the girls, and the formation of continuation classes in these subjects. 91

Dr. Williams also encouraged the education of the expectant mother with reference to personal health, the importance of 'suckling' and the general care of the infant. Additionally, he pointed out that the work of reducing infant mortality should not be left to sanitary and education authorities. Parents, he said, 'should be made to realise their responsibilities'. With reference to the latter point, Dr. Williams claimed those social, philanthropic and religious organisations and institutions should exploit opportunities to assist, since it was only with 'hearty and intelligent co-operation' that the best results could be obtained. 92

Among the evidence given by medical officers Dr. Kirby of Maesteg referred to the ignorance of parents. Dr. Thomas of Caerphilly specifically pointed to the mother and improper feeding, as did Dr. Mitchell of Swansea rural district 93 and Dr. Reid of Staffordshire. 94 Dr. Hill, CMO for Durham, insisted that the local authorities' attempting to protect the infant after the birth could not prevent many infant deaths. The reason Dr. Hill gave for this belief was firstly, that a high proportion of infant deaths occurred in the first week from prematurity. Secondly, a large proportion of infants dying in the first three months could not be prevented by any action of the sanitary authorities, since

...owing to abnormalities, want of development, or lack of vitality, neither careful attention nor proper feeding can save their lives. 95

Dr. Hill thought that it was 'highly probable' that had the mothers taken care of their own health and lived in more hygienic conditions, their offspring would have stood more of a
chance for survival. The chief causes of infant deaths as identified by Dr. Hill reflected the general concept that mothers were to blame mainly through improper feeding, neglect and inexperience. The medical officer for Newburn was even sharper in his condemnation of the mother.

The chief cause of malnutrition in infants is the ignorance of the mothers, resulting in the child being deprived of its proper nourishment, and in its being supplied with food which it cannot assimilate, resulting in a condition of semi-starvation and, too frequently, in death...

A final indictment against mothers came from Dr. Howard Jones of Newport Borough in Monmouthshire. Dr Rocyn Jones, the CMO for the county had already stipulated that one of the means of reducing infant deaths lay in education. Dr. Howard Jones emphasised the point further when answering the question as to the extent that infant deaths could be prevented. He listed ten diseases and conditions he believed to be preventable including epidemic diarrhoea, enteritis, whooping cough, inflammatory infections, debility, prematurity, convulsions and defects of birth. He concluded with the following statement.

Such a record surely points to the necessity for some radical changes in the education of our girls so that they may be better prepared for their life work as wives and mothers of the nation. It also shows the necessity for organised attempts at improving the present standard of home and infant hygiene.

Dr. Newsholme, in the 39th Report (1909-1910), stressed that there was a need for ‘strenuous action in a propaganda of education’, aimed at the moral and hygienic aspects of motherhood. He advocated that the teaching of the principles of health should be offered in all elementary schools, and that older girls should receive instruction in
domestic skills. An added benefit, he claimed, would be realised by the teachers through acquiring knowledge pertaining to pupil health. Linked to the medical inspection of schools, it was suggested that the training of both teachers and pupils would have long term effects for the future generation of infants. In this way, the introduction of matters of health, hygiene and domesticity into the school curriculum placed the onus of policing health on the educators, particularly in working-class districts. It was in keeping with contemporary ideas that when medical officers blamed parents for high infant mortality rates, the main remedy was the education of mothers and girls in parenthood, hygiene and infant care. Fathers and boys were not included in the parenthood equation. The health and well being of infants remained the responsibility of mothers throughout the twentieth century. Recently, there has been an added interest in the role of the father during the pregnancy and birth.

**The Position in Monmouthshire Schools**

Dr. Rocyn Jones' report in 1909 traces the implementation of practical hygiene requirements in the educational system. During July 1908, Dr. R. Jones advised the Monmouthshire County Education Committee to grant free studentships for a course of lectures in practical hygiene held at the University of Wales College, Cardiff. It was hoped that about twelve masters and mistresses would attend each year until at least one teacher out of each school in the county had taken the course. In 1909, fifteen males and seven females sat an examination for proficiency in hygiene. The result was that twelve of the males and two females gained the Certificate of Proficiency. The CMO’s report did not reveal the reason for male teachers receiving a higher accolade of passes than female teachers in that year.
The County Education Committee decided that from 1909 onwards a programme containing instruction in hygiene would be given in all elementary schools. Both boys and girls were to be instructed in health, hygiene and good habits. Imparting knowledge in this way ‘will be an important asset for the ultimate reduction of the Infant Mortality Rate of our country’ concluded Dr. Jones. The annual reports issued by Dr. Jones did not mention the education of boys in this manner again, which reflected the attitudes and gender divisions of the time. Parenthood and infant care classes were not taught to boys. Whenever education relating to parenthood was mentioned, the emphasis was firmly placed on girls. Older girls were shown how to bathe and care for a baby using a doll for practise. The text used in the county schools was The Care of the Baby by Mrs. Crighton Davies. In 1919, it was reported that a live infant was to be used in place of the doll when the scheme was initiated. The Board of Education believed that the use of a live infant instead of a doll would appeal to the motherly instinct of older girls.

A doll is not likely to appeal to the deeper feelings and instincts of girls of this age... The frailty and helplessness of a baby appeals to these girls as perhaps nothing else can.

As Dr. Howard Jones indicated in the 39th Annual Report of the Local Government Board earlier in 1909, girls were being prepared for their future role as mothers. Girls continued to be taught the ‘rudiments of infant care and hygiene’ in elementary schools with the school nurse demonstrating the skills of bathing and dressing an infant. Male and female teachers with proficiency certificates conducted the personal hygiene lessons with boys and girls. The male teachers taught the boys and the female teachers instructed the girls. Mrs. Bath, born in Blaenavon in 1908, started at Hillside Infants
School when she was five years old. When she had progressed to elementary level, Mrs. Bath remembered that she had to walk from the Hillside site ‘a good mile’ to Cwmavon Road for cookery lessons, as there were no facilities at Hillside. 107 The girls took their cookery classes upstairs, while the boys had carpentry lessons downstairs. 108 It can be suggested that education in domestic and infant management were channelled through the daughters to the mothers as a result of this process of motherhood education. Dr. Jones’ reports confirm the existence of cookery, infant care and hygiene lessons as part of the curriculum offered to girls throughout the 1920s and 1930s in Monmouthshire. However, the extent of the influence on both daughters and mothers is questionable and difficult to assess.

**The Instruction of Girls in Infant Care**

It was the 1904 Committee on Physical Deterioration and the Conference on Infant Mortality in 1909 that urged the Board of Education to adopt measures for educating girls in hygiene and infant care. The Board’s **Memo on the Teaching of Infant Care and Management in the Public Elementary Schools** was circulated in 1910, rewritten in 1925 and remained in use until the outbreak of World War Two. 109 Although it was claimed that the teaching of infant care was simply executed using popular texts and practical demonstrations, Lewis argues that the content of the texts used portrayed middle-class values. Therefore, Lewis suggests, the use of such manuals ‘provided the means of transferring middle-class ideals of infant care to working-class girls’. 110 The teaching of domestic subjects in schools was criticised. In 1918, author and journalist, Rebecca West, decried the inclusion of domestic education into the curriculum for girls as perpetuating the role of girls in service. Lewis suggests that West’s criticism could be justified since
the Board of Education at the time linked the need for more domestic education to the shortage of servants. 111

Substantiation of Lewis’ and West’s claim that the domestic education of girls in schools perpetuated the role of girls in service was found in the annual reports of a Hostel for Unmarried Mothers in Nanterderry, Monmouthshire. The Hostel was opened in 1919 through the initiative of Lady Mather Jackson, Honorary Secretary of the Monmouthshire Nursing Association. The aim was to save infant life and to provide a safe haven for unmarried girls about to become mothers. The girls were admitted a short time before the baby was due and remained at the Hostel for at least six months following the birth. As soon as the girls were able, they were expected to undertake domestic chores at the Hostel ‘to train them to earn a livelihood’. After receiving such training, many of them were found ‘situations’ with employers as domestic servants. The annual reports of the Nanterderry Hostel for Unmarried Mothers listed the number of girls admitted and discharged, found ‘situations’, returned to relatives or admitted to hospitals, Workhouses or other Homes each year. The reports also mentioned the number of babies who remained with mothers, were adopted by grandparents or other families, and those who joined their mother in her new place of employment. It seems that the only work found for the girls at the Hostel was domestic work. The training they received at the Hostel was in keeping with the theory of the education of working-class girls in schools at the time. 112 The Board of Education strongly encouraged the inclusion of domestic science throughout the period 1906 to 1939. When a questionnaire was sent to 316 local authorities asking how many included mother-craft in their syllabuses, out of 157 replies,
Domestic science became a recognised examination topic for girls in 1931, which further endorsed the future role of girls as mothers and housewives.

**Educating the Mothers**

Parallel to the education of girls was the teaching of mothers in 'Schools for Mothers' or 'Babies' Welcomes' as some places of instruction were called. The establishment of these Schools for Mothers was significant. The schools were formed before the government intervened with the Maternity and Child Welfare Act of 1918, which made maternal and infant welfare centres compulsory. The existence of the early schools were examples of the forward thinking of the medical officers and voluntary organisations in those areas. A School for Mothers was introduced into Newport Borough in Monmouthshire. Through the reports of the medical officer Dr. Howard Jones, it is possible to discern the reasons for and the development of a plan to educate Newport's mothers in infant care.

In 1907, Dr. Jones expressed his deep concern for the borough's high infant mortality rate and reflected on the movement towards the education of girls and mothers. Dr. Jones reiterated other medical officers' conclusions that the education of all girls in domestic hygiene was necessary to improve infant mortality rates. In addition, he believed that the education of the mother in personal hygiene and breast-feeding was essential. He hoped that with these improvements in place, the borough would see a higher standard of responsibility overall and earnestly appealed to everyone to co-operate. The Sanitary Committee of the Health Department had been attempting to produce satisfactory results through the co-operation of social, philanthropic and religious institutions, yet the infant mortality rate was climbing rapidly. [Table 12]
Table 12

Infant Mortality in Newport Borough 1891-1906

<table>
<thead>
<tr>
<th>Year</th>
<th>Deaths per thousand births</th>
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<tr>
<td>1891-1895</td>
<td>60</td>
</tr>
<tr>
<td>1896-1900</td>
<td>** ** ** **</td>
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<tr>
<td>1901-1905</td>
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<tr>
<td>1905-1906</td>
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Source: Annual Report of Newport Borough, Medical Officer of Health for Newport, 1907.

Out of the 350 infant deaths registered in Newport for 1905-1906, twenty per cent was due to diarrhoeal diseases; thirty-five per cent from 'wasting' diseases and seventeen per cent died from bronchitis and pneumonia. A total of 118 infants died before reaching one month and of these, sixty-four died within a week of birth. Overall, seventy per cent of the infants died from prematurity and those deaths were mostly preventable, stated Dr. Jones. He issued a startling warning concerning the situation.

If this appalling death rate continued during subsequent weeks, all the infants born in Newport during 1906 would have died within 38 weeks of birth. 115

Dr. Jones stressed that the artificial feeding of infants was chiefly responsible for the 'terrible wastage of life'. Continuing, he said that those who recover and 'survive the evil effects of injudicious feeding' were frequently seriously injured in health. The implication was that by teaching the mother the correct way to feed her infant, the general health of the infant would be improved and infant mortality would decline.

Working towards the education of the mother, a special committee was formed in Newport. Its main aim was to concentrate on improving infant health. It was named the Infantile Health Central Committee. Its first report recognised the complex environment of urban Newport with its industries, railways and docks and the dangers that
accompanied the crowding together of people in towns and the serious threat to infant life that this implied. However, the Committee was not able to offer a solution to the problem of overcrowding in the borough. In the same report it was noted that the Reverend C. Bennett had given the Mission room in Lyne Road, rent-free for mothers’ meetings as a School for Mothers. 116

The pattern and character of the meetings in the Newport School were similar to the first School for Mothers established in England. This first school for mothers was initiated by Mrs. Alys Russell and Miss Dora Bunting at St. Pancras in 1907 with the help of Dr. Sykes, the medical officer for the area. The St Pancras school was rapidly followed by others of its kind and by 1917 there were 321 voluntary societies operating a total of 446 centres, with a further 396 centres run by local authorities. 117

Alys Russell was a member of the Women’s Co-operative Guild. Due to her interest in the welfare of mothers and infants, she visited Belgium to study the work of other groups concerned with infant welfare. On her return she published an article on the Ghent School for Mothers in journal called The Nineteenth Century. The article raised a great deal of interest and in May 1907, a meeting was held for people interested in starting a similar scheme in St. Pancras. The group, named the St. Pancras Mothers’ and Infants’ Society opened the Mothers’ and Babies’ Welcome on 4 June 1907. Reports from the Welcome suggest that the sessions were well attended. 118

At the school in the Lyne Road Mission in Newport, Monmouthshire, talks were given by a health visitor on topics believed to be of interest to the mothers, including hygiene, feeding, clothing and general care of infants. Babies attending the Mission with their mothers could be weighed regularly and as an added incentive to attend, tea and biscuits
were provided free of charge. Only six mothers took advantage of the opportunity to meet with other mothers and receive advice from the health visitor when the Mission first opened. However, it seems that as word spread about the Mission more mothers took advantage of the service. By September 1907, the same year that the St Pancras Mothers’ and Babies’ Welcome was established, seventy-seven mothers were attending the Lyne Road School for Mothers on a regular basis. This was the only school for mothers in Newport in 1909. Furthermore, reference to similar schools was not found in other medical officers’ reports in Monmouthshire for the same year. Therefore, it can be suggested that the existence of Newport’s school for mothers was significantly important. It is an illustration of the early involvement of one local government and voluntary group in maternal and infant welfare, prior to the statutory obligations following the Maternity and Child Welfare Act in 1918.

The main purpose of the Lyne Road Mission was shared with other institutions of its kind in England and Wales; to pass on information to mothers regarding infant feeding, general care, domestic and personal hygiene. Questions asked by mothers ranged from advice on feeding, the use of the dummy, sleeping arrangements for the infant and the frequency of baths and outings. The evidence reveals that the mothers’ questions focused on the general care of the infant. Advice offered to mothers centred on personal hygiene and the control of domestic dirt, which was believed to be the main cause of infant death.

Health visitors became the educators of the mothers in the working-class districts. The nature of the mothers’ education was criticised by some women’s movements, particularly concerning the attitude of voluntary workers involved with the early schools
for mothers, whom Lewis describes as being patronising. Furthermore, Lewis argues that the institutions established to school mothers in the principles of infant care were designed for the working-class and combined middle-class philanthropy with the state’s desire to solve infant mortality by the cheapest method.

An example of the patronising attitude mentioned by Lewis can be found in the Newport Infant Health Committee Report in 1909. When describing the work covered by, and attendance at, the school for mothers in Newport, it was mentioned that although sixteen of the mothers came from ‘one of the dirty streets’ and were dressed in ‘poor clothes’, the mothers and babies were ‘clean’. It can be suggested that middle-class perceptions of mothers in working-class districts were reflected in the ideas of some of the workers at the schools for mothers. The 1911 report reveals further evidence of this in a comment given by the ‘lady superintendent’ of the school.

We are afraid that some mothers have been rather offended when talked straight to about some of the bad habits they allow themselves and their infants to indulge in.

It can be suggested that the lady superintendent’s comment in 1911 reveals a conflict in the interaction between mothers and health advisors attached to the schools. It is possible that conflict arose in two distinct areas: the identity of the expert and the way in which information was passed to the mothers. To address the question of the identity of the expert, it can be suggested that the ‘teacher’ adopted the role of expert, which seemed to conflict with the mothers’ idea of self. To pursue this suggestion, Carol Dyhouse’s argument will be discussed.
As Dyhouse points out, the medical profession’s growing interest in infant care and hygiene ‘implied a devaluation of the knowledge and experience mothers in working-class districts had inherited on the subject’. Dyhouse claims that the devaluation of a mother’s knowledge was clearly shown in anecdotes concerning the ignorance of mothers and the stereotypical ‘old wives tales’ mentioned often in medical journals. Dyhouse offers three examples to substantiate her claim: two comments from Dr. Harold Kerr, which were taken from an article in Public Health written in 1910, and the remarks of a Rochdale clergyman in 1908. The latter ‘well-meaning gentleman’, attempted to explain to a mothers’ meeting how to nurture infants. He was told by the mothers, ‘to go and play at marbles’. It seems that the clergyman’s comments were thought demeaning by the mothers and their own experience superior.

Dr. Kerr’s comments were even more derogatory when referring to the influence of grandmothers, and also the nature of some of the foods offered to infants by working-class parents. Dr. Kerr referred to grandmothers as ‘infanticide experts’ and implied that the higher the number of babies a woman lost, the more esteem she had and the more confidently she would then pass on her advice. Moving on to the feeding of an infant, Dr. Kerr pointed to some of the ‘grosser outrages upon the infantile digestive organs’ such as offering a three-month old infant pickled onions, or attempting to calm the baby with ‘a weelk soaked in gin’. These were probably extreme examples of incorrect feeding. However, other examples were mentioned in medical officers’ reports later in 1938 including an illustration offered by Dr. Catto MO for Newport Borough in Monmouthshire. He claimed that some mothers introduced alcohol to infants’ diets. The evidence suggests that middle-class medical professionals believed that one of the habits
of the working-class was to offer weaning children a sample of everything the parents had
to eat and drink.

Dr. Catto produced a booklet for the Maternity and Child Welfare Committee in 1938
called Hints on the Management of Children from 1 to 5 Years. The booklet contained
advice for parents on the correct way to care for young children. After explaining that
infants needed to learn slowly to digest solid foods, he suggested introducing the infant to
‘bread-pap’ smoothly mixed with milk for one month before moving on to ‘plain bread
and milk’ for a further month. He gave the following warning to parents.

Do not give your child a taste for alcohol by giving him ‘sips’ of beer, stout or
gin...as a ‘treat’, they are most injurious to children, and should never be given
without the doctor’s consent.

Additionally, Dr. Catto warned parents against frightening their children with ‘foolish
tales of ‘bogies’’, threatening to fetch the doctor, ‘boxing’ their ears or putting them in
the dark. Furthermore, Dr. Catto advised parents that a child should have at least
twelve hours sleep each night, since lack of sleep led to ‘...nervous diseases and brain
troubles, and later on, ‘dullness’ at school’. The language and terminology used by Dr. Catto in the booklet: ‘bogies’, ‘boxing’ the
ears, and ‘brain troubles’, was aimed at working-class parents particularly mothers. Dr.
Catto’s view of the social class of the mothers to whom the booklet was directed
influenced his choice of language. It can be argued that his tone implied an assumption
that mothers in working-class districts needed to be told how to care for children. The
language used by Dr. Catto marginalised the natural intelligence and capabilities of
mothers in working-class districts. The above example substantiates the argument
proposed by Dyhouse and mentioned earlier in this section, that there was a devaluation of working-class motherhood by the medical profession.

The Perpetuation of a Myth

The concept of carelessness and ignorance was associated with the way mothers in working-class districts brought up their children. It can be suggested that the narrow perspective of the medical professionals perpetuated the myth of maternal ignorance long after the initial reference to the idea had surfaced at the turn of the twentieth century. The ‘bad habits’ referred to by the lady superintendent in 1911 included ‘old superstitions’ passed down through the centuries, which she was determined to ‘root out of the minds of the present generation of mothers’ in Newport.¹³⁴

One of these anxieties involved the mothers’ fear to weigh infants regularly believing the action would bring bad luck to the infant. In 1909, out of 392 babies that had attended the school for mothers at Lyne Road Mission, only forty-seven babies were weighed during the year. The MO stated that ‘the old superstition of ill luck in this matter of weighing dies hard’.¹³⁵ Evidence found in the later reports of the Maternity and Child Welfare Centres discussed in the following chapter, reveals that the superstition continued to some extent well into the twentieth century in South Wales.

The use of flannelette for baby clothing was also condemned and mothers were encouraged to use plain flannel as a substitute ‘in view of recent investigations with regard to burning fatalities’.¹³⁶ Additionally, ‘abominable and pernicious inventions’ such as dummy teats, ‘go-carts’ and long tube bottles to feed infants were severely criticised.¹³⁷ These items were identified by medical officers as being urban evils and breeders of germs, particularly the dummy teats and the long tube bottles. Rarely was the
medical rationale of decisions taken by medical officers explained fully to mothers. A medical professional’s skill was unquestionable and expert, whereas a mother’s natural skill was unrecognised.

It can be argued that opinions concerning the skills of mothers in working-class districts were based on extremes not generalities. Furthermore, since many mothers did not attend the ‘schools for mothers’ or the later infant welfare centres, conclusions were based on a limited sample of mothers. The evidence suggests that perceptions of working-class motherhood were misleading and accusatory in nature. Explanations were founded on the underlying principle that mothers in working-class districts were ignorant. Therefore, it can be argued that this underlying principle was one of the reasons for the conflict and resentment that was often present between mothers and the medical and welfare providers.

A parallel can be identified in the situation apparent between medical men and midwives prior to the passing of the Midwives Act in 1902. There is no firm evidence to suggest that the majority of untrained, bona fide midwives were one of the causes of infant mortality. Similarly it can be argued that evidence is lacking to substantiate claims that mothers in working-class districts were ignorant, careless and neglectful of their duties in respect of motherhood. As Dr. Lane-Claypon argued in 1920,

...the ignorance and carelessness are surely mainly due to the impossible conditions under which so many of these poor mothers have to live. 138

Dr. Lane-Claypon claimed that it was the ignorance of the ‘well-to-do’ concerning the situation faced by a mother and her family when forced to live in insanitary surroundings.

139 Given the evidence, it can be suggested that conflict between mothers in working-class
districts and middle-class medical and welfare providers could have discouraged many women from attending the early schools for mothers. Comments concerning attendance at the later infant welfare centres will be analysed in the following chapter to assess the extent to which this conflict remained.

**The Scope of the Schools for Mothers**

The way in which information was passed to the mother in schools and Baby Welcome’s has been partially covered in previous sections of this chapter. In general, these schools set out to instruct mothers in matters of hygiene and infant care through formal classes and informal meetings. Tea and biscuits were usually provided free of charge to the mothers making an effort to attend. At the Lyne Road Mission in Newport a ‘cutting-out’ class was started where mothers were shown how to cut up old clothes to make garments for their babies and children. 140 The stress on thrift and self-help, which were Victorian ideals, was an attempt to teach middle-class practises to mothers in working-class districts who attended these early schools. Advice concerning the health of infants was also imparted to anxious mothers. However, treatment of ailments was not deemed to be within the scope of a school for mothers.

If a ‘school’ undertakes the treatment of sickness it will very probably ultimately be drawn away from its main purpose. 141 Lewis suggests that the attitude of the medical profession would ‘undoubtedly have prevented such a move’ towards the treatment of sickness, citing the *Lancet*’s condemnation of the Chelsea Baby Club as a threat to the general practitioner. 142 The lack of treatment for ailing babies was a weakness in the system. The fear that the offer of medical treatment would impinge on the work undertaken by general practitioners shaped
and moulded the early informative and educational role of the schools. Furthermore, the
needs of mothers in working-class districts in particular were not met fully. A mother was
referred to a doctor when her infant or child needed medical attention. However, a
doctor’s fee was out of reach for many mothers, especially during periods of
unemployment, strikes and general poverty. In 1911, the Women’s Labour League clinic,
gave advice and medical treatment when necessary, stating that

...the hope of the clinic is to show in this poor district that a higher standard of
health might be reached if medical aid were to be freely at the command of
parents for the many and mysterious ailments of childhood. 143

The Newport school and the majority of other centres in England and Wales, continued to
resist the call to treat infants, emphasising that the main aim was to educate the mothers.
Advice on infant feeding continually impressed on the mother the need to protect infant
life. Mothers were encouraged to breast-feed and when difficulties could not be
overcome, milk was provided. At the Newport school, mothers and expectant mothers
found to be needy were given one quart, or four pints, of milk daily until the husband was
able to provide the milk, on condition that the mother suckled her infant. 144

During 1909, the school issued a total of 954 quarts of milk to mothers in need. Forty-two
mothers received a total of 856 quarts during 1910, and for the year 1911, sixty-six
mothers benefited from a total of 1,197 quarts of milk. Out of the latter sixty-six mothers,
two were expectant and ten mothers had twins. Five babies died from the seventy-four
births recorded at the school, which was 6.7 per cent.

The infant mortality rate for the whole of Newport Borough for the year 1911 stood at
113.0. 145 This was lower than the rest of Monmouthshire, which was 149.0 for that year.
The infant mortality rate for England and Wales was 130.0. Although Newport Borough's infant mortality rate was favourable to the rest of Monmouthshire and England and Wales, the Lyne Road school for mothers was situated in a poor district of Newport where many large families lived. A list of some of the particulars of the sixty-six mothers provided with milk for the benefit of themselves and their infants appeared in the 1911 report. The details offer an indication of the nature of the problems faced by the women as mothers.

It was stated that all sixty-six mothers were 'weak' and 'in need of nourishment' when allocated the milk supply. One mother gave birth to her seventh child, although only two out of the seven had survived. Her husband was an unemployed general labourer. Out of fourteen children born to another mother, thirteen were still living. This family was fortunate with the father in continuous employment as a 'horse driver'. However, his wages were described as being low with twenty-five shillings a week to pay rent, buy fuel and food for the whole family.

Another mother gave birth to a set of twins, which increased the number of her children to four. Her husband was reported as being in casual employment. However, the medical officer remarked that he was 'given to drink', which suggests that this was one of the reasons that the mother was classed as 'needy'. One sad case portrayed a wife deserted by her husband. She had given birth to her fourth child although only two had survived. The above four cases were selected from the sixty-four mothers mentioned in the report. Many of the mothers had at least three children with the highest number reported to be thirteen from fourteen pregnancies.
The medical officer attending the mothers pointed out that many men and women had ‘sunk into poverty and unemployment’. He did not believe their predicament was due to weak characters. He claimed that ‘personal physical defects’ made the strain and stress of working and providing for others too severe. Schools for mothers could do little to remedy poverty. However, part of the aim of the schools was to provide information on nutrition for mothers as well as babies. By providing nourishment in the form of milk and in some cases, dinners for the needy mothers, it was believed that these same mothers would be indirectly informed of the nutritional value of certain foods.

Nevertheless, schools for mothers and the wide variety of similar clubs and groups throughout the country followed no set pattern in this respect. The North Islington Centre chose to initiate a scheme for overworked mothers to have a holiday and sometimes provided sausages and chocolate biscuits to encourage mothers to attend the weekly sessions. Other centres held baby shows and offered prizes for breast-fed babies while some loaned baby equipment, such as perambulators to ease the cost of infant care.

The Newport school provided dinners for ‘necessitous’ mothers, although in 1911, only two mothers were given the meals: one mother for a period of nine weeks and one for six days. In both cases there were wide variations in the time scale. Furthermore, it can be argued that the effect would have been short-lived especially if the home situation of the mother remained constant and had not improved.

Overall, the evidence suggests that the schools for mothers were gathering places where women could meet to exchange experiences and gain valuable advice on their health, nutrition and the care of the infant. Nevertheless, the way in which information was imparted to the mothers and the condescending attitude of some of the middle-class
provider was criticised. As Lewis states, the centres, as with the later infant welfare centres did meet women's need to share their problems. However, the help offered to mothers was limited. 152

**Concluding Comments**

The concept of the 'ignorance and fecklessness' of mothers 153 perpetuated the myth that mothers in working-class districts in particular, were the main cause of infant mortality. The education of girls in elementary schools and mothers in centres such as 'Baby Welcomes' and 'Schools for Mothers' attempted to rectify what was perceived as maternal ignorance. Middle-class practises were taught to girls through the school curriculum and to women in working-class districts at the early Schools and Welcomes. Furthermore, girls were being prepared for their exclusive future role as wife and mother. Evidence found in the annual reports of the Maternity and Child Welfare Committee in Monmouthshire suggests that conflict materialised at times. The conflict was due to the perception of the middle-class welfare providers concerning mothers in working-class districts and the mothers themselves, particularly over the question of infant care. A communication gap was evident between providers and users of welfare services, which discouraged many mothers from attending the early centres. Conflict was fixed in the frame of reference employed by both providers and users, or consumers, of welfare facilities such as schools for mothers. Differing social perspectives can be identified between the medical profession, voluntary workers and mothers as they interact with each other. Dr. Newman’s notion that the ignorance and fecklessness of mothers was the main cause of infant mortality denied recognition of the problems facing mothers when rearing
infants in insanitary conditions over which the mother had little or no control. A further major weakness in Dr. Newman’s theory was that his generalisations ignored the hard evidence of the wide variation in infant mortality rates between and within urban and rural districts. These variations imply that other influences besides the ignorance of the mother were present.

It was a simple solution for the state to reduce all probable reasons for infant mortality to one fundamental cause: maternal ignorance. The remedy lay, it was believed, in the education of the mother. The project appealed to philanthropic and religious organisations and their belief in self-help and thrift. With the assistance of volunteers the main responsibility for educating mothers was placed into their hands with the least monetary assistance from the government. Officers in institutions established to educate mothers were not able to meet the mothers’ needs. For needy mothers and their infants, many of the advantages of attending and receiving help was short-lived when they were forced to continue to live in poverty.

Chapter Two : Notes


2 Ibid. p.6.


6 Ibid. p.2.


10 For further details and an informative Table, see the *47th Annual Report of the Local Government Board* (1917-1918) Cd 9169 p. iv and p. v.


19 Ibid. p.21.


22 Ibid. pp.35-38.


24 Ibid. p.74.


See also Rural, Mining and Manufacturing Counties Infant Mortality Rates for 1908 Appendix 111, Table 1, p.133.

27 Ibid. p.83.

28 Ibid. p.84.

29 Part of Dr. S. W. Wheaton’s report to the Local Government Board in 1908 on the sanitary conditions in Maesteg urban district, is reproduced in the 39th Annual Report of the Local Government Board (1908) Cd 5263 pp.87-88.

30 Ibid. Evidence of Dr. A. Duncan p.86.

31 Ibid. Evidence of Dr. S. W. Wheaton p.87.

32 Ibid. p.87.


36 Ibid. pp.21-23.


41 Ibid. p.26.

42 Ibid. p.40. A list of twelve influences affecting infant mortality was given in the report. The list was not printed in order of importance and many of the points overlapped. It was agreed that one of the main influences affecting infant mortality rates was the ignorance and fecklessness of mothers.


44 Ibid. pp. xxxvi, xxxvii.
47 Ibid. p.50.
48 Ibid. p.76.
49 The Free Press of Monmouthshire 6 August 1909.
50 Ibid. The Monmouthshire County Council report and the extract from Mrs. Dore’s evidence was published in the Free Press. Refer also to Table 1 in the 39th Annual Report of the Local Government Board (1909-1910) Cd 5263, for statistics on Monmouthshire.
51 Monmouthshire County Council (MCC) Midwives Act 1902 Register of Midwives Practising in the County of Monmouthshire 1914 County Record Office, Cwmbran, Gwent. C. Misc. R. 25.
52 Ibid.
54 Ibid. p. 235.
55 Ibid. p. 236.
56 Ibid. p. 236.
57 Ibid. 10 May 1902.
58 The training period was extended to six months in 1916. Refer to Chapter One.
59 MCC, Annual Report of the County Medical Officer for 1914 p.47.
60 See the MCC Annual Report for 1913 and Annual Report for 1914 for statistics concerning the infant mortality rates for 1909 to 1914 inclusive.
61 MCC Annual Report for 1913 p.17.
62 MCC Annual Report for 1914 p.47.
63 MCC, Register of Midwives for 1914 pp.22-23.
Medical Officer (MO), *Annual Report for Tredegar, 1914*
Table IV. County Record Office, Cwmbran. A. 350. R2. 1.

MCC, *Register of Midwives 1914* pp.22-23.

MO, *Annual Report for Ebbw Vale 1914*
Table IV. County Record Office, Cwmbran. A. 350. R2. 1.

MCC, *Register of Midwives 1914* pp.22-23.


Ibid. Table IV.

MCC, County Medical Officer (CMO), (1914) *A Resume upon Infant Mortality and the Notification of Births Act, 1907*.


Cited by the MO for Abertillery Urban District Council
*Annual Report for Abertillery 1909* p.36.


Ibid. p.71.

Ibid. pp.70-72.


MCC, Report to the Maternity and Child Welfare Committee (MCWC)
*Annual Report for 1919* p.32.

Ibid. p.27.
The Board of Education believed that the use of a live infant instead of a doll would appeal to the motherly instinct of older girls.

MCC, MCWC, Annual Report for 1920 p.47.

Interview by Jan King with Mrs. B. at Blaenavon, November 1988.

Interview by Jan King with Mrs. S. at Blaenavon, November 1988.


Ibid. p.92.


Nanterderry Hostel for Unmarried Mothers Annual Report for 1919 p.48. For further information on the administration and work of the Hostel during period covered by this thesis, refer to the individual yearly reports from 1919 to 1938. The name of the Hostel became ‘Nanterderry House’ and the reports can be found under that name in the County Record Office, Cwmbran, Gwent.

Lewis, J., (1980) p.95. The questionnaire was conducted by Mother and Child Journal in 1931.

MO for Newport Borough, Annual Report for 1907 p.5.

Ibid. p.4.


NBC Infantile Health Central Committee Annual Report for 1909

See Lewis, J. (1980) pp.96-100 for more information concerning schools for mothers in other parts of the country. In 1910 St. Pancras’ school for mothers had 130 women attending its classes each week, and 300 visiting for advice.


Ibid. p.100.
Ibid. p.61.

NBC, Infantile Health Committee Annual Report for 1909

Ibid. Annual Report for 1911


Ibid. p.261.


Ibid. Cited on p.262.


Ibid. p.3.

Ibid. p.7.

Ibid. p.6.

NBC, Infantile Health Committee Annual Report for 1911

Ibid. Annual Report for 1909

Ibid. Annual Report for 1911

Ibid.


Ibid. p.186.

NBC, Infantile Health Committee Annual Report for 1909

For the establishment of the Chelsea Baby Club which was aimed at middle-class mothers, the Club’s aims and objectives, see Lewis, J., (1980) p.102. The *Lancet* editorial referred to by Lewis was dated 28 July 1928.


Ibid. *Annual Report for 1911*.


Ibid.


CHAPTER THREE

THE INFANT WELFARE MOVEMENT

Introduction

The preceding chapter examined the notion of the ‘ignorance and fecklessness’ of mothers, which appeared in the 39th Annual Report of the Local Government Board in 1910 as being one of the main causes of high infant mortality rates. Altogether twelve influences were listed in the report as influencing infant mortality rates. However, it was agreed that many of the influences overlapped including urban and rural conditions, poverty and social conditions, domestic and municipal sanitation and housing. Also overlapping were the influences stated as the age of the woman at marriage, size of the family, the proportion of male to female births, the proportion of legitimate to illegitimate births and the number of stillbirths. Furthermore, it was agreed that the employment of married women outside the home was a suggested influence that did not apply to all areas of the country. Therefore, the ignorance and fecklessness of mothers became accepted as being one of the main causes of infant deaths. 1

The concept of maternal ignorance was the prime instigator of attempts to educate girls to become good wives and mothers through domestic science and mother-craft classes in elementary schools. Mothers were given classes in baby-care, personal and domestic hygiene at ‘Babies’ Welcomes’ and ‘Schools for Mothers’. Placing the blame on mothers rather than identifying and treating the causes of maternal ill-health and death denied the recognition of social, environmental and economic conditions affecting mothers, which in turn perpetuated maternal morbidity and mortality. This chapter probes further into the
attitude of middle-class medical professionals toward mothers in working-class districts. The importance of the Notification of Births Acts in the development of the infant welfare movement, the introduction and training of new health officials at the local level and the reaction of working-class mothers to these new officials. Additionally, the extent of the influence of both health visitors and midwives on mothers will be assessed, using relevant documentation from medical officers in Monmouthshire for the local perspective. Social and environmental conditions prevalent in Monmouthshire prior to the introduction of a countywide scheme for infant welfare centres will be discussed. Finally, the implementation of the scheme will be examined in detail in preparation for the following chapter, which will analyse documentation relating to Maternal and Infant Welfare Centres in Monmouthshire from 1919 to 1938. Continuity and change in attitudes towards working-class mothers will be assessed.

**The Notification of Births' Acts**

...there is hardly a country, however primitive, that is not stirred by the need for improving the condition of its children. 

Schools for mothers concentrated on the education of mothers concerning the upbringing and care of infants. However, it was recognised that medical advice was needed in addition to the classes offered at the schools in an attempt to reduce the infant mortality rate prevalent in the country as a whole. The need for preventive work was a significant stimulus in the development of the infant welfare movement. One of the main difficulties faced by the early proponents of infant welfare was the lack of information available on the exact number and location of births. Subsequently, in 1907 the first Notification of Births Act was passed by Parliament. Lord Robert Cecil introduced it as a Private Bill.
However, the Act was an adoptive one, which did not require the compulsory notification of all births by the local authorities. At the beginning of 1915, eighty per cent of the population of England and Wales complied with the Act. Following the Notification of Births (Extension) Act later in 1915 the remaining twenty per cent were required to adhere to the compulsory notification of births.  

Generally, discrepancies were evident between the number of births notified and those registered. An example of this can be seen in Monmouthshire County Council’s (MCC) Public Health Committee report for 1916. The adoption of the Act required the parent or any person present at the birth to notify within thirty-six hours, the occurrence of a birth after the twenty-eighth week of pregnancy. Notification had to be sent to the county medical officer (CMO). In Monmouthshire during 1916 a total of 8,977 births were officially notified to the CMO. However, it was pointed out that 307 births had not been notified which brought the grand total of births for 1916 to 9,284 and not 8,977. It was stated that the discrepancy was due to the necessity to notify only live births to Registrars.  

The CMO queried the discrepancy, pointing out that considering 307 birth details had not been sent to him, the number of actual stillbirths remained hidden. Attempts were made to reduce the differences. In order to prevent any ‘leakage’ of notifications of births the CMO made certain arrangements with the Registrar-General. He requested that the Superintendent Registrars of the districts within the county notified him every six weeks concerning the number of births registered with them that had not been notified to the Registrar-General.  

Nevertheless, the problems continued for some time. In 1919, the CMO found that health visitors had discovered forty-four births that were not officially notified. He sternly remarked,
...it is obvious that some Sub-Registrars are not doing their duty by the Council. In 1930, the number of live births registered during the year was 6,342. The CMO stated that 98.28 per cent of the births had been notified in compliance with the Notification of Births Acts 1907 and 1915. Out of the remainder, 99 births were ‘discovered’: 83 by District Registrars and 16 through the process of health visitors visiting homes. No one had officially notified the remaining .16 per cent of the total births registered to the CMO in attendance at births. However, the CMO stated that the overall notifications for that year were ‘the best proportion of notifications ever obtained in the County’. The year 1931 appeared to show the highest percentage of unnotified births at 2.79 per cent of all registered births. The period between 1931 and 1934 continued to register fluctuations. However, there was no further mention of discrepancies following 1934, which suggests that finally the problematic situation had been resolved. In 1917 the Local Government Board had recognised that in many districts there were births that escaped notification, and strongly urged local authorities to bring to the attention of midwives and doctors their duty in this matter.

The importance of securing complete notification is that the births which are unnotified are in many cases those most likely to need visiting. Furthermore, it was stated that an investigation by health visitors into births remaining unregistered would lead to the identification of uncertified midwifery practice and unsatisfactory sanitary conditions in the homes. This comment reveals that the health visitor’s role involved other duties in addition to visiting mothers to advise on the care of the infant. The health visitor was expected to report to medical officers the misdemeanours of birth attendants contravening the rules of
the Central Midwives Board (CMB). Furthermore, she was required to report defects in sanitation within the homes. These two extensions of the main duties of the health visitor would have involved them in a certain amount of inquisitiveness, which could have been interpreted as prying by mothers. The Notification of Births Act and the extension of the Act were highly significant to the development of infant welfare work, as pointed out by Dr. Lane-Claypon.

The notification of births forms the nucleus around which centres the great mass of infant welfare work. 13 An important duty related to the implementation of the Acts was the introduction of home visits to new mothers. Local authorities responsible for public welfare appointed health visitors to carry out home visitation following the termination of the midwife's duty. However, as Lewis pointed out, home visits had been in operation prior to the official introduction of visitation by employed health visitors. The work originated from the earlier 'lady health missioners', whose philanthropic ideas combined with their religious and social beliefs, led to voluntary visits to the homes of poor mothers to distribute soap and disinfectants. It was firmly believed that the perceived anti-social habits of the working-class poor could be reformed by direct contact with their betters. 14 The difference, following the implementation of the Acts, was that home visiting was brought under the auspices of officialdom instead of voluntary practice. This meant that the new style of health visitor required training to ensure that she would reflect the social values and educational perspectives of state legislation.
The Qualities and Qualifications Required of Health Visitors

In 1909, the Local Government Board issued an order prescribing the qualifications required for health visitors in London. Later, in 1916, a memorandum issued by the Board's medical officer indicated that the given qualifications would 'most likely...fit a woman to undertake this work elsewhere'. The selection criteria stipulated that a health visitor must be one of the following; a medical woman, a nurse with three years training, a certified midwife, or a nurse with six months training plus a certificate from the Royal Sanitary Institute or other approved body. A woman employed by a local authority and with proven competency in similar duties to those required for the post could also apply to become a health visitor. The points mentioned by the Local Government Board as qualifying a woman for the position of health visitor were recognised as not being specifically designed for the actual work.

The lack of guidelines for specific qualifications required led to varied interpretations by local medical officers of the main quality desired for a health visitor's position. Some considered a priority to be training in nursing, some emphasised midwifery qualifications, and others favoured training in sanitary inspection as an essential requirement.

There were special qualities needed for the post of health visitor, which were difficult to obtain through the various training pathways for the position. Dr. Lane-Claypon highlighted the inefficiencies of the variety of qualifications listed for the role of health visitor, pointing out that

No one of these trainings can therefore be regarded as adequate without further special training.
The main aspects omitted from any form of training according to Dr. Lane-Claypon, was firstly infant hygiene, and secondly a knowledge of general social conditions. With reference to the first point, midwifery training involved the general care and feeding of infants up to weaning. However, a health visitor needed to offer advice extending to the nutrition of the infant up to the age of five years. Furthermore, in addition to the general care of a newborn infant, the health visitor was expected to be knowledgeable concerning issues affecting the development of an infant. These issues included sleeping arrangements for the day and night, the amount of fresh air an infant should need, ventilation of the rooms occupied by the infant, suitable clothing, the condition of the bowels and skin as well as the general cleanliness and bathing procedures the infant needed. Offering mothers the invitation to attend an infant welfare centre was also one of the responsibilities of the position. A health visitor required the quality of tact and a reassuring manner, particularly when it was noticed that the infant was not progressing in a satisfactory manner.

With regard to the second point made by Dr. Lane-Claypon, health visitors needed to be aware of the general social, economic and environmental conditions prevalent in the area within which they were appointed to work. Industrial and rural districts presented specific advantages and disadvantages to both mother and infant. For instance, in a mining district new mothers would generally have the help of female members of their extended family: mother, grandmother, sisters and also female neighbours and friends living nearby. A new mother in an isolated rural district might not have such support close at hand. However, in the mining districts many mothers were disadvantaged by the extra burden of work involved in being miners' wives. General housework was made more difficult
with the need for bathing, generally inside the houses before the pithead baths were supplied. This entailed multiple journeys for the wives, regardless of pregnancies, carrying heavy buckets of hot water to fill the tin baths used by coal-mining husbands at the end of each shift. Work clothes, stiff with dirt had to be washed regularly, and there was a constant battle against coal dust inside the homes.

Families in working-class districts often took in lodgers to supplement their incomes, which meant additional work for women. In the industrial districts in particular, rooms were often sub-let. The habit of sub-letting created overcrowding in districts where the housing situation was already a cause for concern. Furthermore, the privacy factor was considerably restricted for new mothers in sub-let accommodation. An examination of the medical officers reports for Blaenavon, a coal, iron and later, steel-producing community, in conjunction with newspaper reports and oral testimony, provide an insight into the difficulties faced by wives and mothers in a heavily populated industrial district. Reports constantly mentioned the practice of sub-letting available rooms and revealed that the housing situation in Blaenavon improved only marginally in the 1920s and 1930s. The continuing problem prompted the local newspaper to claim, as late as 1938 that Blaenavon was out of touch with the ‘outer world’ and portrayed some of the worst cases of overcrowding in the district. 17

It is evident that a specific set of circumstances would have presented themselves to the health visitor in different areas of the country. Within many counties, industrial and rural districts existed side by side, as was the case in the county of Monmouthshire. Therefore, Dr. Lane-Claypon’s claim that a health visitor needed to know about conditions that affected the lives of those she visited was justified. In addition to conditions within the
domestic sphere of motherhood, it was necessary for the health visitor to be aware of the prevailing economic atmosphere of the district within which she was to be employed. This would enable her to assess family stress, financial problems and availability of expendable income. Dr. Lane-Claypon’s concluding remark reflected her ideas.

The visitor is dealing with the complexities of human life, and the more she is able to enter into the varied conditions of the life of those among whom she visits, the greater will be the value of her specialised work. 18

**Numbers of Health Visitors**

In 1915, the Local Government Board advised that one health visitor should be appointed for every 500 births. 19 By 1934 this advice had been amended to suggest that one per 250-280 births was more efficient. 20 Monmouthshire’s CMO, while acknowledging the standard lay down by the Board, recognised that in Monmouthshire this rule was impossible to observe. The ratio operating in Monmouthshire in 1916 was one full time health visitor for every 850 births. 21 This gave the number of health visitors in Monmouthshire as eleven to cover the total 9,284 births in the county that year. With the number of first visits to infants reported as being 9,128 and 24,648 subsequent visits by the health visitors, the total number of 33,776 visits paid to homes 22 was a remarkable achievement. In 1919, the number of health visitors had risen to twenty-four full time and one part-time visitor, who was engaged in Maternity and Child Welfare work. Seven of the twenty-four health visitors were restricted to school inspections due to a lack of specific qualifications. The remaining seventeen involved in home visitation came just in line with the 400-500 births each required by the Board. A total of 8,487 births in the county in 1919 gave a ratio of 500 to one visitor. 23
The number of health visitors in Monmouthshire gradually increased until 1938 saw thirty-nine on the staff, making a total of 58,148 visits to homes during the year. Nevertheless, there were occasions when the number of visits faced criticism. In a report on the inspection of Monmouthshire County Maternity and Child Welfare Services, compiled by an Inspectress of the Ministry of Health in 1932, it was pointed out that the number of visits made to children between the ages of one and five years was not sufficient. However, first visitations were deemed adequate. Attempting to justify the position, the CMO claimed that since health visitors had to spend a large proportion of their time in infant centres, home visitations subsequently suffered. The only remedy was to increase the number of health visitors and this was not deemed feasible due to ‘financial stringency’. Therefore, financial limitations on local authority budgets meant that welfare services often needed to be restricted and in this way the health of both mother and infant was at risk. A paradoxical situation was created.

The Work of a Health Visitor in Monmouthshire

The responsibilities of a health visitor encompassed all aspects of infant care, usually from ten days after birth to the age of five years. Defective sanitary conditions found in homes were reported to the district medical officers. The pivotal thrust of the role of the health visitor was the education of the mother in practical mother craft, domestic hygiene and the successful rearing of her children. The language used by the CMO when mentioning the work of the health visitors in Monmouthshire reveals the esteem with which he regarded the process of visitation.

Home visitation is necessarily the chief method of inspection of mothers...
The choice of the word ‘inspection’ signifies an examination of the mother’s home and habits in relation to the welfare of the infant. The characteristics of a health visitor did require a certain amount of inquisitiveness and this had to be evenly tempered with tolerance and tactfulness. Gaining the confidence of working-class mothers was believed to be a step toward visits to Maternity and Child Welfare Centres. The CMO observed that in 1925,

...the prejudice against the invasion of the home by ‘strangers’ is now a negligible factor, and a bond of sympathy and confidence has been established between the mother and the Health Visitor, which has yielded and will continue to yield, a powerful influence in the welfare of the mother and child. 27

The inference that prejudices by mothers had disappeared implied that it was noticeable in earlier years. The CMO’s remarks may have been premature. In 1927, he was forced to comment on the ‘very arduous’ nature of the health visitor’s work and the ‘many disappointments including rebuffs’ that she encountered while undertaking her responsibilities. 28 An examination of the Maternity and Child Welfare Committee’s Annual Reports from 1924 to 1938 reveal that the number of ‘fruitless’ visits paid to the homes of mothers rose considerably. There were 109 registered in 1924 out of a total of 64,266 visits. 29 A higher figure of 3,846 out of 58,148 visits was recorded in 1938. 30 [See Table 13] The CMO was unable to offer an explanation for the number of visits culminating in a lack of response from mothers. In 1931 some of the ‘fruitless’ visits were attributed to the mother being away from home at the time of the expected visit. 31
Table 13

<table>
<thead>
<tr>
<th>Year</th>
<th>‘Fruitless’</th>
<th>Total Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1924</td>
<td>109</td>
<td>64,266</td>
</tr>
<tr>
<td>1925</td>
<td>590</td>
<td>61,644</td>
</tr>
<tr>
<td>1926</td>
<td>416</td>
<td>58,000</td>
</tr>
<tr>
<td>1927</td>
<td>775</td>
<td>42,548</td>
</tr>
<tr>
<td>1928</td>
<td>1047</td>
<td>36,475</td>
</tr>
<tr>
<td>1929</td>
<td>1122</td>
<td>47,178</td>
</tr>
<tr>
<td>1930</td>
<td>1133</td>
<td>46,145</td>
</tr>
<tr>
<td>1931</td>
<td>940</td>
<td>45,595</td>
</tr>
<tr>
<td>1932</td>
<td>907</td>
<td>47,020</td>
</tr>
<tr>
<td>1933</td>
<td>1078</td>
<td>54,434</td>
</tr>
<tr>
<td>1934</td>
<td>1502</td>
<td>55,531</td>
</tr>
<tr>
<td>1935</td>
<td>2487</td>
<td>52,284</td>
</tr>
<tr>
<td>1936</td>
<td>3917</td>
<td>56,148</td>
</tr>
<tr>
<td>1937</td>
<td>4221</td>
<td>62,262</td>
</tr>
<tr>
<td>1938</td>
<td>3846</td>
<td>58,148</td>
</tr>
</tbody>
</table>

Sources: MCC, Maternity and Child Welfare Committee Reports 1924-1938 inclusive

However, other reasons could have prevailed, such as the mother refusing to answer the door or refusing entry to the health visitor so that she was unable to carry out her duties. The various reasons are undoubtedly difficult to determine. Nevertheless, the actual rise in the number of ‘fruitless’ visits from 1924 to 1938 in Monmouthshire show that mothers in Monmouthshire were not keen on home visitations. A number of possible scenarios can be forwarded for discussion. Some mothers might not have accepted the process of home visitation and looked on it as an intrusion imposed by officialdom. Other mothers might have been indifferent and disinterested in the attention of a health visitor. Some might have viewed the role of health visitor as an additional official contact they did not feel they needed.
The Uniform as a Vehicle of Social Control

Health visitors were employed by and answerable to local authorities. Evidence suggests that the regulation uniform, which was a required to be worn by health visitors and other officials was used as a form of social control for erring mothers. An example of this is revealed through reading Dr. T.W. Wade's remarks in 1919. Dr. Wade was the assistant medical officer for Monmouthshire and attended the Caerleon and Rumney Maternal and Child Welfare Centres. His comment concerned the visitation process and the ability of health visitors to report suspected child neglect. Claims of neglect were followed up by visits from inspectors employed by the National Society for the Prevention of Cruelty to Children. These officers also wore official uniforms.

For the type of wilfully neglectful mother, nothing but fear has the least effect, and the salutary effect of a visit by an official in uniform is the most effective way of converting a mother who is wilfully or negligently neglectful of a child's health into a woman anxious, for her own safety, to see her child thrive. 32

In this way, the uniform was a visual symbol of authority used in a process of social control over mothers. The health visitor was the middle person between the mother and the medical profession, a link between the private and the public world. She was the vehicle with which middle-class practises and ideas concerning the 'correct' way to bring up children in order to save the nation were brought into working-class homes.

Contemporary Criticism Concerning Health Visitors

Dr. J. M. Kerr, an obstetrician in Glasgow, recognised the differing levels of acceptance by mothers, of both midwives and health visitors. In 1933, Dr Kerr raised the question of the effectiveness of health visitors visiting expectant mothers, particularly primiparaes, in
their own homes. Agreeing with the Departmental Committee’s Report on The Training and Employment of Midwives and the proposal that midwives should undergo a special post-examination course in antenatal work, Dr. Kerr suggested that the midwife should perform the duties of health visitor during her patients’ pregnancy and puerperium period. This, he said, would maintain constancy of care. To bring in the health visitor, he claimed, would complicate the situation, could lead to friction and was often ‘resented by the patient’. Furthermore, it would have the effect of ‘lowering the authority of the midwife’. Evidence presented in the Report on Maternal Mortality in Wales undertaken by the Ministry of Health in 1937, seems to justify Dr. Kerr’s comments and concerns. It was claimed that home visiting to the expectant mothers ‘was not done adequately or systematically’ by health visitors. The published statistics in tabular format in the report shows that the percentage of first visits to expectant mothers in Monmouthshire was very low. (See Table 14)

**Table 14**

**Visits Paid to Expectant Mothers in Wales by Health Visitors: 1934**

<table>
<thead>
<tr>
<th>Administrative Area</th>
<th>No. of Births Notified</th>
<th>No. of first visits to Expectant Mothers</th>
<th>No. of first visits to Expectant Mothers as a percentage of Notified Births</th>
<th>Average No. of visits paid to these Expectant Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glamorgan</td>
<td>12,759</td>
<td>3,879</td>
<td>30.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Monmouth</td>
<td>5,850</td>
<td>298</td>
<td>5.1</td>
<td>2.6</td>
</tr>
<tr>
<td>Boroughs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiff</td>
<td>3,632</td>
<td>120</td>
<td>3.3</td>
<td>1.5</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>1,095</td>
<td>514</td>
<td>46.9</td>
<td>1.8</td>
</tr>
<tr>
<td>Newport</td>
<td>1,607</td>
<td>542</td>
<td>33.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Swansea</td>
<td>2,701</td>
<td>333</td>
<td>12.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Wales</td>
<td>40,709</td>
<td>12,096</td>
<td>29.7</td>
<td>3.1</td>
</tr>
</tbody>
</table>

In support of contemporary criticism due to the evidence found in the medical officer of health reports in Monmouthshire and the memories of mothers interviewed, it can be suggested that home visits to mothers by health visitors were unnecessary. The extension of the state into public health matters including maternity and child welfare, meant that money was spent on training new officials to undertake the work. However, midwives could have adequately and successfully accomplished part of the health visitor's responsibilities.

As a result, health visitors might have had more time to spend in the worthwhile field of infant and child welfare at Centres and School Clinics. With a minimum of additional training, midwives might have held a more influential position with regard to reducing infant mortality in the first month of life. It can be suggested that funds linked to infant welfare services were misdirected. The process of home visitation was not always accepted by the mother. Furthermore, health visitors were the servants of local authorities, whereas midwives were initially the servants of the mothers. For this reason midwives were more readily invited into the home of the mother. The chosen midwife was generally the person to whom the mother approached for advice during the first ten days following the birth of the infant. Family and female friends provided another avenue for advice. If the midwife's responsibilities could have been extended, information concerning antenatal issues, including the importance of adequate nutrition to the health of the mother and the unborn child could have been shared with the mother. Additionally, post-natal matters relating to both mother and infant could have been discussed. This would be in addition to advice on infant feeding in the first ten days, which did come under the remit of the midwife's duties.
The Influence of Midwives on Mothers

Oral testimony collected in Monmouthshire, Glamorgan and Pembrokeshire in Wales and some English counties provide evidence to substantiate the claim that the influence of midwives and female relatives was stronger than that of health visitors, at least in the capacity of home visitations. The midwife’s attention and advice was remembered more sharply than contact with the health visitor in the home. Furthermore, out of fifty women interviewed all mentioned the support at birth, following birth, or both from female relatives and friends. It is significant that not one of the fifty interviewees mentioned remembering a health visitor coming to their homes after a birth. This does not imply that the mothers questioned did not receive a visit from a health visitor. The experience of the interviewees reveal that the influence of a health visitor’s visit to the home was negligible in comparison to the impact of the midwife during the birth and in the first few months of the infant’s life. The advice of female relatives and friends was also influential at that time. The majority of interviewees chose the midwife through the recommendations of relatives and friends. The midwife was generally known and respected in the neighbourhood. By choosing her midwife the expectant mother made a conscious decision to invite the midwife into her home. The mother, on the other hand, did not choose her health visitor and did not invite her to visit her home.

Paradoxically, the health visitor was given the title of ‘visitor’ by the state. Occasionally, the mother did not have the option to choose her midwife. It is with estranged contacts such as these that friction might materialise between mother and midwife, or female relatives and midwife. This sense of estrangement might provide another clue for the
reason many health visitors faced rebuffs from mothers and ‘fruitless’ visits were recorded in CMOs’ reports.

Mrs. Pethybridge was a health visitor in Plymouth. Her oral testimony based on her experiences in England in the 1920s highlight similar problems to the ones identified in the Welsh county of Monmouthshire. Mrs. Pethybridge realised her visits to mothers offered certain restrictions for her,

...the trouble was you see, you went in on the tenth day. It was considered an urgent visit then... feeding wasn’t going too well... but there were so many of them, I had 800 under 5 and I couldn’t really follow up those young babies as you would like to. 36

In contrast, when Miss Pethybridge acted as midwife, district nurse and health visitor in a small country area in Hertfordshire, she confirmed that undertaking all three positions ‘...was ideal. You were known, you see’. 37

A Woman’s Choice

The comments of the women interviewed for this study, all of whom had babies in the 1920s and 1930s, serve as illustrations of the continuation of the belief that it was a mothers’ right to choose her birth attendant. Additionally, the women’s comments lead to the suggestion that a midwife’s influence on the mother was stronger than the influence of a health visitor. Dolly, from Newport in Monmouthshire would only allow her mother to deliver her babies. Other women in the neighbourhood called on Dolly’s mother to attend them in their confinements. Although Dolly’s mother was not a trained midwife, her combined experience attending births was widely accepted by women who knew her in Pill, the dock area of Newport. 38 Elizabeth also experienced little difficulty when her
mother delivered her three children in Newport. Margaret of Liswerry did not have a trained midwife at the birth of her first child. Her mother and aunt attended to her needs successfully. The women’s mothers were not trained midwives. They were women who were mothers and who were known for their experience delivering infants. The women whose birth attendants were their mothers or another female relative, were not familiar with the term *bona fide* midwife. When asked, they did not know whether their untrained birth attendants were registered with the local authority. In Chapter One it was mentioned that uncertified midwives were banned from practice in 1910, unless under the supervision of a medical practitioner. The 1926 Midwives Act strengthened this clause. It became illegal for an untrained woman to act as midwife except in an emergency. The testimonies collected from the women suggest that in each of the above cases, no trained midwife or doctor were engaged to attend the births. Therefore, the advent of labour and imminent birth constituted an ‘emergency’. It was not uncommon for this situation to occur in Monmouthshire in the 1920s and 1930s.

In contrast, Mrs. R-M of St. Helen’s in Lancashire and Mrs. M. of Cardiff chose well-known trained midwives to attend them. Mrs. M chose a midwife on the recommendation of her aunt who had told her that there was ‘a good midwife down the road’. Her aunt went with her to book the services of the midwife. Mrs. M’s mother and aunt helped with the housework and general care of the baby following the birth. As with the previous examples, the assistance offered by relatives and neighbours illustrates the support network in place in working-class districts. The majority of interviewees were working-class women with similar stories of a support network of relatives. Mrs. R-M. was the only interviewee financially able to pay for private help after the birth. Mrs. T. of
Gosport was visiting relatives in rural Chepstow when she went into labour. In this instance, Mrs. T. did not have a choice of midwives. Her relative called for the only local midwife in the rural district who was also a ‘good friend of the family’. Mrs. T’s baby was found to be in a breach position. The midwife, adhering to the rules of the CMB, called a doctor to attend the birth. Two doctors successfully delivered Mrs. T. with the midwife in attendance. She remained under her relative’s care until she felt strong enough to return to Gosport. 43 Mrs. J. and Mrs. B. lived in the rural districts of Saundersfoot and Tenby in Pembrokeshire, West Wales. Both had the additional help of relatives at the birth and to assist in the care of the home afterwards. Mrs. J’s midwife was the local district nurse. 44 Mrs. B. engaged an elderly midwife. 45 The choice of midwives was more limited in rural than in urban districts, as shown through Mrs. T’s experience in rural Chepstow. Often rural midwives would continue to work as birth attendants well into the sixties. Without their commitment, many rural districts, particularly if isolated, would have been without a midwife and too much strain would have been placed on the local medical practitioner.

Some mother-midwife relationships were not free of friction. When Phyllis, of Newport, had her first, and she decided, her last baby, the local midwife, Phyllis’s mother and a neighbour were present. Phyllis suffered a long, hard labour but the midwife refused to call a doctor, saying that it was not necessary. The prolonged labour weakened Phyllis to the point that forced her mother to send for the doctor much to the aggression of the midwife, who became, as Phyllis remembered, ‘very nasty’. 46 There was a lack of communication and empathy between the midwife, Phyllis and her female relatives that made the whole experience of birth traumatic to Phyllis. Ada, from Ebbw Vale, was
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concerned that since she had ‘suffered great poverty’ in the years preceding the birth of her first child in 1935, that she might have a difficult time during confinement, and so chose one of the local midwives recommended to her by friends. Ada was relieved that her baby was delivered normally, although, she added, ‘without much mercy’ shown by the midwife. 47

The memories of the women interviewed established the extent to which the family support network operated within working-class communities at the time of, and following birth. Additionally, details concerning the midwife’s status in working-class districts, her attitude towards mothers in those districts and the nature of the attention and advice she gave to the mother remained firmly fixed in the memories shared by interviewees. This is in sharp contrast to the lack of reference to the visits paid to homes by health visitors when the midwives’ duties were concluded. Some of the mothers interviewed remembered attending infant welfare centres with their baby, where they came into contact with a health visitor for the first time. However, from the oral evidence collected it seems that the influence of the midwife was felt most strongly in every case.

Recalling the response of the interviewees, midwives who were chosen by the mothers might have been more influential in securing the better health and vitality of both mothers and infants. It is possible to suggest that restricted midwifery training did not allow for the development of the profession in this way. In retrospect, the comment of the CMO for Monmouthshire in 1926 referring to health visitors gaining information through general conversation, which consequently led to an ‘absence of friction in their work’, 48 might have been subjective. This subjective ‘view from above’ revealed the perceptions of a middle-class medical man with regard to the working-class mothers in his county and the
perceived educational role of the health visitor as a vehicle to teach middle-class ideals and practises. The subjective comments of the CMO reflected continuity in attitudinal behaviour, which was representative of most medical men of the time. The issue of infant mortality and infant health was addressed by initially placing the blame on the ignorance of mothers. However, it can be suggested that the educative force of infant welfare legislation did not ultimately mean that control emanated solely from the middle-class officials, such as medical men and women health visitors. Mothers did retain some autonomy as the evidence of the rising number of ‘fruitless’ visits of health visitors and oral testimony suggests.

In the following sections of this chapter an analysis of attendance figures at Maternity and Child Welfare Centres and the later Antenatal Clinics in Monmouthshire will be presented, in conjunction with the comments of medical officers. The evidence consolidates the argument that mothers resisted measures of medical and social intervention into the private realm of motherhood. Firstly, a brief outline of the work of infant welfare centres nationally serves to set the framework for a case study of the establishment of such centres in Monmouthshire.

The Infant Welfare Centres

The idea of Centres where mothers could take their infants and receive advice on matters pertaining to health and infant feeding originated in France in the late nineteenth century. Concern regarding a low birth rate coupled with a high infant mortality rate, urged action directed towards infant welfare which culminated in the establishment of consultation clinics and infant milk depots. In 1890, Professor Herrgott founded L'Oeuvre de la Maternite in Nancy, where infants of four weeks of age were examined and mothers
given a small payment if the infant was in good health. The year 1892 saw the establishment of Professor Budin's *Consultation des Nourrissons* at the Charite Hospital in Paris for mothers and infants. Then in 1894 Dr. Leon Dufour pioneered the *Goutte de Lait* or milk depots, to provide an alternative treated milk for infants unable to be breast-fed. The Centres in France differed from the later Centres in Britain where the responsibility of health visitors included visits to mothers' homes. The early experiments in infant welfare in France did not incorporate home visitation into the schemes. Although there was encouragement in Britain for an extension of the infant welfare scheme, some opposition was evident.

**Opposition to the Scheme**

The encouragement of extended infant welfare schemes in Britain raised some opposition concerning the influence infant welfare Centres had on infant mortality figures. One critic was Dr. Leonard Findlay, a physician at the Royal Hospital for Sick Children in Glasgow. In a paper discussing the causes of infant mortality presented to the Medical Research Committee in 1916, he noted the expense entailed in the establishment of infant welfare centres and milk depots in England and Scotland. He doubted the influence these Centres had in reducing infant mortality rates. He stated that the reasons for infant deaths were too complex to be affected by proposed schemes for welfare centres. To justify his conclusions Dr. Findlay outlined the position in towns where schemes had been adopted, including Liverpool, Bradford, Poplar and Glasgow. In Liverpool, a milk depot was established in 1901 of which the medical officer of health enthusiastically expounded its positive effects in his 1914 report. However, Dr. Findlay claimed that according to the figures in the report, the Depot did not become popular for a number of years after its
inauguration. The death rate, generally found to begin its decline in Britain around 1900 was unaffected by the introduction of the measure. Dr. Findlay pointed to a similar situation in Glasgow where a Depot was opened in 1904. Again the death rate showed no acceleration of fall following the introduction of the scheme. Furthermore, when the Depot was abandoned in 1910, the death rate continued to reduce. 53

An Infant Clinique was opened in Bradford in 1912 and although Dr. Findlay conceded that ‘the infantile death rate for that year shows a marked fall’, he did not associate the decline with the infant centre. Rather, Dr. Findlay claimed, the lower rate reflected an overall recorded low rate for the whole country in that year. He cited a comment printed in the Glasgow Herald concerning the infant welfare scheme in Poplar.

It is remarkable and disappointing that in Poplar the death rate (infantile) has continued to rise, and has gone up from 83 to 117 per thousand ever since the inauguration of the baby-saving campaign. 54

Dr. Findlay observed that Poplar’s lady health visitor admitted that the increase had occurred despite the amount of money and energy that had been put into the scheme by various organisations. Finally, Dr. Findlay concluded that it was hardly justified to ascribe such general results to the adoption of such a scheme in any individual town. 55

Accepting that each city, town, borough and county experienced differing infant mortality rates, it is difficult to assess the influence of infant welfare centres on infant mortality figures. Furthermore, the infant welfare movement as a whole was complex prior to the Notification of Births (Extension) Act of 1915. There were various voluntary organisations in existence. The problem was compounded when co-operation between these organisations and local authorities implementing the
Act was not consolidated. In some counties, a health visitor employed by the County Council attended a Centre provided by a local sanitary authority or a voluntary organisation. Cheshire and Durham County Councils subscribed to voluntary infant centres in the respective districts. However, the Councils did not control the centres. Other more forward-looking County Councils organised its own system of Centres. These counties included Hertfordshire, Denbighshire and Monmouthshire. 56

**Differences in the Scheme's Implementation**

Differences between some large towns, boroughs and counties with regard to welfare work and the nature and number of Centres established can be identified in a Local Government Board report in 1917. 57 Selected examples using Merthyr Tydfil, Newport and Swansea Boroughs and the county of Monmouthshire will be briefly examined to identify a pattern in the system of infant welfare provision in various places.

**Merthyr Tydfil**

In Merthyr Tydfil, with a population of 80,990, a birth count of 1,948 and an infant mortality rate of 109 in 1916, there were five municipal health visitors. Four of these gave half their time to school clinic work. Two Infant Welfare Centres covered the whole of the borough. 58

**Newport Borough**

Newport Borough in Monmouthshire returned similar statistics to Merthyr Tydfil. The population was 83,691 with 2,008 births and an infant mortality rate of 103. The Borough had five health visitors and five Infant Welfare Centres organised by Newport Borough Council in conjunction with the Newport Infantile Health Central Committee. Voluntary workers assisted in the running of these Centres. 59
**Swansea Borough**

Swansea Borough, with an infant mortality rate of 106, had one municipal Centre and one voluntary scheme run by the Swansea Mothers' and Babies' Welcome. A lady medical officer and a Superintendent led the weekly consultations at the latter. 60

**Monmouthshire**

At the time of the publication of the Local Government Board’s report in 1917, MCC had established the comparatively high figure of twenty-one Infant Welfare Centres 61 within the county under the central authority of the Public Health Committee of Monmouthshire County Council. The whole of the work was under the supervision of the CMO.

Using the brief examples above, it is evident that a confused web of infant welfare providers existed throughout England and Wales in 1917. Monmouthshire was relatively advanced with its maternity and child welfare provision. Overall, there were no set patterns to the number of Centres, appointment of municipal health visitors, or the number of Centres that were controlled by local authorities or voluntary organisations. General tasks and duties tended to be covered in all Centres. In Monmouthshire local committees were formed to report to the CMO on the work of each Centre. Through the detailed reports of medical officers in charge of individual Centres, the extent to which the establishment of the countywide scheme improved the health of mothers and infants in Monmouthshire can be assessed. Firstly, an outline of the reasons such a scheme was introduced in Monmouthshire is necessary for an understanding of the aims and objectives of the scheme.
Reasons for the Establishment of Maternity and Child Welfare Centres in Monmouthshire

The Public Health Committee adopted a scheme for the whole of the administrative county of Monmouthshire in July 1916. The proposed scheme was accepted by the County Council in August and in October 1916 it received approval from the Local Government Board. At the County Council meeting in November of that year, it was unanimously decided that implementation of the scheme should be started immediately. The decision illustrates the commitment of MCC to improve the health of mothers and infants in the county. The CMO strongly believed there was a need for such a scheme. Evidence of his initiative was illustrated in the amount of research he conducted prior to the Council’s acceptance of the scheme.

The CMO was aware that contradictory medical opinion prevailed at the time concerning the effectiveness of welfare centres and referred to the ‘misapprehensions held in certain quarters as to the necessity for this special work’. He analysed vital statistics from both country and county returns, together with reports submitted to the Local Government Board by Sir Arthur Newsholme, the Chief Medical Officer of the Board, in order to justify the need for a scheme throughout the county of Monmouthshire. The CMO presented Monmouthshire County Council with an analysis of the four years from 1911 to 1914 for England and Wales, then he placed the situation in Monmouthshire within this framework.

England and Wales

In England and Wales during the period studied by Monmouthshire’s CMO 2,036,466 deaths were registered. Out of this total 575,078 or 28.2 per cent occurred in the first five
years of life. Nine per cent of the mortality in infancy was attributed to infectious diseases. Diarrhoeal diseases described as 'a disease of urban life' claimed 18.4 per cent and was the most fatal of the infectious diseases occurring in the first year after birth. A total of 304,334 or 52.9 per cent of infants and children of five years and under died from measles, whooping cough, diarrhoeal diseases, tuberculosis, bronchitis and pneumonia. The death rate in England and Wales from all causes at five years and under was 164, with the Northern Counties returning the highest rate. However, the CMO noted that Wales and Monmouthshire were the next highest. Therefore, after discussing England and Wales, the CMO turned his attention to the statistics for Monmouthshire and used the same four-year period 1911-1914 to justify his final conclusions.

The Situation in Monmouthshire

It was found that fifty per cent of the urban districts in Monmouthshire, returned a higher rate than average for England and Wales among the deaths of children under five years of age. A list was provided for the council in order of gravity. [See Table 15]

Table 15

<table>
<thead>
<tr>
<th>Urban District</th>
<th>Death Rate per Thousand Births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blaenavon</td>
<td>217</td>
</tr>
<tr>
<td>Tredegar</td>
<td>211</td>
</tr>
<tr>
<td>Ebbw Vale</td>
<td>200</td>
</tr>
<tr>
<td>Bedwellty</td>
<td>196</td>
</tr>
<tr>
<td>Abertillery</td>
<td>187</td>
</tr>
<tr>
<td>Abercarn</td>
<td>186</td>
</tr>
<tr>
<td>Llanfrechfa Upper</td>
<td>180</td>
</tr>
<tr>
<td>Pontypool</td>
<td>175</td>
</tr>
<tr>
<td>Mynyddisilwn</td>
<td>168</td>
</tr>
<tr>
<td>Risca</td>
<td>167</td>
</tr>
<tr>
<td>Abersychan</td>
<td>169</td>
</tr>
<tr>
<td>Nantyglo / Blaina</td>
<td>156</td>
</tr>
<tr>
<td>Llantarnam</td>
<td>153</td>
</tr>
<tr>
<td>Abergavenny</td>
<td>150</td>
</tr>
<tr>
<td>Bedwas / Machen</td>
<td>149</td>
</tr>
<tr>
<td>Usk</td>
<td>136</td>
</tr>
<tr>
<td>Panteg</td>
<td>132</td>
</tr>
<tr>
<td>Caerleon</td>
<td>129</td>
</tr>
<tr>
<td>Monmouth</td>
<td>114</td>
</tr>
<tr>
<td>Chepstow</td>
<td>90</td>
</tr>
</tbody>
</table>

In the table above, the urban districts with the highest rates were heavily industrialised areas. The lower urban rates were from districts with less of a concentration of industry and some element of rural habitat. In the following section an analysis of reports submitted by DMOs in 1913 and 1914, together with reports in local newspapers such as the Free Press of Monmouthshire and the South Wales Argus, substantiates evidence produced by the CMO. The collected evidence further explains the child mortality rates displayed in the table above and the CMO’s commitment to provide a comprehensive maternal and infant welfare system in Monmouthshire.

**Conditions in the Urban Districts**

As shown in the previous section, the heavily industrialised areas expressed the highest infant mortality rate. Evidence found in the reports of the DMOs and the CMO further identified the inadequate housing and sanitation prevalent in those districts. A selection of urban districts in Monmouthshire returning high infant mortality rates were chosen as an example of the need for a system of infant welfare support in the county. Some of the evidence uncovered the poor housing conditions facing many of the workers and their families. It should be remembered that the housing stock in the industrial valleys of Monmouthshire was the workplace of the urban midwives. Therefore, an indication of the working conditions faced by the midwives in the districts mentioned can be gleaned from the reports.

**Nantyglo and Blaina**

Nantyglo and Blaina’s infant mortality rate for 1913 was 106.6. The District Medical Officer (DMO) advocated that due to the relatively high infant mortality rate, there was need for a district nurse and the formation of Infant Care Committees. He suggested that
'proper nursing and feeding' would reduce the infant death rate and followed with the comment that there were 'too many bottle-fed babies, and too many are taken out of doors at night'. The DMO’s comments indicate that he discouraged certain practises in the working-class districts. It follows that he would have encouraged other child-care methods. These ‘proper nursing and feeding’ methods were practises popular with the middle-class. Many of the county’s DMOs recognised the urgent need for some form of welfare work in the County and voiced their opinion in a similar manner.

Panteg

In Panteg, the infant mortality rate was higher in 1913, at 98, than in 1912 returning 80 as the rate for that year. However, it was noted that the district had a lower rate of deaths under five years of age than the County as a whole. The low rate was attributed to ‘education and improved sanitation’.

The DMO commented that

It is hoped to raise the standard of conduct and moral responsibility by the movement known as ‘National Health work’.

An interesting comparison of the incidence of infant mortality among different employment categories concerning family breadwinners was included in the DMO’s report. Lower rates were shown among some poorly-paid workers, such as postmen with a rate of 85, Army soldiers at 95 and farm labourers at 97, than among the iron and steel workers at 151 and coal-miners with a rate of 162. The DMO did not mention the source of the information on which he based his report. However, he concluded that infant mortality was ‘largely a question of heredity or parentage’. In Panteg, the majority of workers were employed in iron and steel production with some in coal mining in
neighbouring districts. An attempt had been made to ‘enforce cleanliness and fresh air
and the danger of flies’ through the distribution of leaflets and the combined work of the
sanitary inspector, district nurse and midwives. 67 The belief in the influence of education
to improve the situation of the working-class was continually present in the report and
through the remarks of the DMO for Panteg. Furthermore, his conclusion mirrored
contemporary Social Darwinism and eugenicist beliefs.

Tredegar

In 1913, the DMO for Tredegar revealed that one-fifth of the infants in his district died of
diarrhoea and enteritis. A further one-fifth died from bronchitis and pneumonia and two-
fifths died from congenital debility. 68 The infant mortality rate for 1915 stood at 125.
Nevertheless, the DMO pointed out that the Midwives Act was ‘very satisfactorily
administered’ in his district. 69 Therefore, the blame for infant deaths was not placed on
the birth attendant. Other factors influencing infant deaths were prevalent in the district.
The social and sanitary conditions of the district were revealed in the report. The
industries supplying the work for the men in the district were coal, iron and steel. These
were employment categories that claimed to produce higher infant mortality statistics for
families associated with these industries. The Poor Law relief was said to be ‘very great’
in the district. There were also many crowded lodging houses, which were needed to take
the overflow of people unable to acquire housing. 70 Overall, there was a marked scarcity
of housing for the population, which was estimated to be 24,500 in 1914. Only sixty-nine
new houses were erected that year and the DMO stated that the low figure ‘proves that
private enterprise does not by any means cope with the needs of the locality’. He
continued to say that until satisfactory accommodation was provided for everyone in the
chief accountant to the above Ebbw Vale Company, provided an up-to-date report for the
Urban District Council in 1912. He began by claiming that Building Clubs,

...not only illustrates the generosity of the Company and the enterprise of their
workmen, but affords an interesting example of what thrift and enterprise might
accomplish in other districts. 79

The total number of Building Clubs formed in Ebbw Vale was twenty; nine of them had
completed the work they set out to accomplish, leaving eleven in operation in 1912. A
total of 320 houses had been built, more were in the process of erection, and an additional
246 were planned. A standard style was adopted, which was generous compared to the
details revealed concerning the older properties in the DMO’s report. The new houses
contained a living room, kitchen, scullery and pantry, with three bedrooms above, most
also had a bathroom. Employees of the Ebbw Vale Steel, Iron and Coal Company paid
not less than three shillings a week into the Club plus the rent for the property, which
ranged from five to seven shillings a week. Eventually the employee through his
contribution owned the house. 80 The rents for these new, spacious and well-ventilated
houses contrast sharply with the rentals of some of the older style hovels mentioned in the
same report. For example, in Beaufort Rise there were two cellar dwellings beneath the
Welsh Wesleyan Chapel that had no ventilation and were cold and damp. One dwelling
consisted of a kitchen and two bedrooms occupied by two young men, one elderly
woman and her nineteen-year-old granddaughter. There was a ‘complete absence of
natural lighting and ventilation’. The second dwelling was the same except that it had one
small window, which was covered by a piece of canvas. The dwellings were rented out at
twelve shillings and eight pence a month each. 81 The landlord was receiving twenty-five
shillings and four pence per month for the same number of rooms that the cheapest Building Club house returned for rent.

Nevertheless, regardless of the additional benefits to some workers’ families in relation to new houses, many children in Ebbw Vale suffered ill health. In 1914 out of the 451 deaths for the whole district, 232 deaths were children under five years of age. In June of that year, twelve of the twenty-six deaths recorded for the month were infants under twelve months old and fifty per cent of these occurred in the first two weeks after birth. The number prompted the DMO to comment that the instruction of the mother relating to the ways in which she could secure the health of her infant, both before and after birth by ‘maintaining a healthy condition in themselves and their surroundings’ was urgently required.

His comment serves as an example of the contemporary belief that educating the mother in infant care and domestic hygiene would lead to a decline in infant mortality rates. The DMO, in keeping with other medical officers put the onus of blame for infant mortality figures squarely on the shoulders of the mothers and gave sanction to the proposal that working-class mothers were ignorant. However, the DMO’s report revealed that it was not only the insanitary and overcrowded conditions of domestic housing that impinged on and threatened the health of mothers and infants. Other public buildings situated close to homes gave cause for concern.

**Additional Concerns**

**Slaughterhouses**

Two ‘Special Reports’, one on the public slaughter house in Tredegar and one on private ‘gut-scraping’ premises in a residential street in Tredegar bear witness to the possible
health hazards. The District Council had received complaints that the slaughterhouse was a public nuisance. On inspection it was found that ‘...external drains were choked with blood and cow-dung’. In the interests of public health and due to the close proximity of dwelling houses it was decided that the slaughterhouse should be relocated to purpose-built premises. The ‘gut-scraping’ trade was undertaken at the rear of a building in Lower Salisbury Street and was in a row of domestic houses. The DMO together with the CMO visited the building concerned. The DMO complained to the Urban District Council that both men ‘had to beat as hasty a retreat as possible’ due to the offensive ‘stench’ emanating from the process. There was no dissent of opinion and both MOs agreed that gut scraping could not be carried out in premises so unsuitable. Furthermore, it was pointed out that ‘the stench emitted is a nuisance to the health of the inhabitants in the immediate neighbourhood’. Finally, it was decided that the Urban District Council should consult their legal advisor with a view to prosecution. 84

The Fly Vector Argument

As with housing and water supply details mentioned previously in this chapter, reports on slaughter houses, piggeries, cow-sheds and dairies often revealed conditions that would have attracted flies. The close proximity of these properties to houses where the inhabitants often had to struggle with structural defects and poor sanitation, exasperated attempts made by mothers to protect infants from conditions in which flies thrived. A report in the local newspaper the Free Press of Monmouthshire in 1915, referred to research conducted by a health publication called Good Health that argued
Thousands and tens of thousands of children die every summer (due to) the ignorance of their parents with regard to the terrible mischief that the common housefly is capable of doing.  

Research undertaken in the 1890s informed the medical profession of the fly vector danger in transmitting disease. Dr. J.T.C. Nash, the MO for Southend-on-Sea, was an early proponent of the theory that flies were the vehicles in epidemic diarrhoea. He presented a paper at a conference on infant mortality in 1901 to illustrate his work. Dr. Nash’s remarks are relevant to the dangerous position faced by mothers and infants living near to slaughterhouses, piggeries, cowsheds and dairies in Monmouthshire. Dr. Nash deduced that after visiting refuse, midden heaps, cow-dung and foetid matter from slaughterhouses, flies would then carry infection into the home.

A great deal of continuous research was conducted in the early twentieth century to determine the causes of infantile diarrhoea in particular. Later in 1922, Hugh Ashby and Charles Roberts, researchers and writers concerning diseases in childhood, firmly concluded that the common housefly was the usual means by which infection was carried.

However, it was as late as 1945 that the theory of the fly as a vehicle for the transmission of disease was finally confirmed. Nevertheless, the notion that flies transmitted diseases fatal to infants fuelled one of the main schools of thought on the causes of infant mortality. The argument was that mothers were dirty, lazy and ignorant concerning the preparation and storage of infant food. It was believed that breast-feeding was the best and most pure form of infant sustenance. The need to educate the mother was the dominant feature of the introduction of infant welfare centres.
Other causes of infant mortality, such as insanitary surroundings outside the home, which attracted flies, was often overlooked by local authorities. The state of the environment outside the homes was not classed as a primary cause for concern. Local authorities took action when they were forced to do so through the repeated complaints of the residents affected by the particular nuisance, or by an outbreak of some infectious disease.

Prevention of health problems in this way was slow to materialise. The improvement of the environment, as with the building of sufficient sanitary housing was protracted, which in turn perpetuated the high infant and maternal mortality rates for the period covered in this study.

The Spread of Disease

Overcrowding contributed to insanitary conditions within houses and this situation created the ideal environment for the spread of disease. A vivid illustration of this point was presented in the evidence given by the MO for Tredegar. In 1914, he was called on to investigated notifications of scarlet fever in the district. At Meredith's House, which was a cellar-dwelling situated under the King's Arms Inn, he found five children infected with scarlet fever. The body of a three-year-old girl, who had died five days previously, lay on the kitchen table. It was discovered that when the fever first broke out, the whole family of husband, wife and nine children ranging from thirteen years down to eleven months were sleeping in a 'lean-to' bedroom in which there were three beds. The average height of the sloping ceiling was six feet. The dwelling was badly-lit with no through ventilation and very overcrowded with no means to separate the sexes. Five of the children were still suffering from the disease, which had killed their three-year-old sister. In an adjoining cottage, three children and two men slept in one bedroom. One of the children was
infected with the disease. The mother and father slept downstairs. With the nature of
the overcrowding, there was no effective way in which cases could be isolated in order to
control the spread of the disease to other members of the family or neighbours.

Reflecting on the scarlet fever and measles epidemic, the MO concluded

I am of the opinion that the incidence of the disease could have been lessened,
and, perhaps, life saved, had there been no overcrowding and better housing and
nursing facilities. 91

The evidence suggests that housing conditions in the urban districts of Monmouthshire
created more problems than infant welfare centres could address. As Sir Arthur
Newsholme, Chief Medical Officer for the Local Government Board stated in 1913,
infant mortality was

...highest among the most densely populated and poorest wards in any given town,
and in the poorest and most crowded parts of a given ward. 92

Three years earlier the Local Government Board pointed out the need for the local
authorities in ‘compactly populated districts’ to improve and maintain efficient refuse
collections, install water-flushing closets and pave streets and yards. It was recognised
that some of the measures would be expensive. However, the Board declared that the
measures would be more economical than the sickness and ‘impaired efficiency of the
population’ which were alternatives. The Board concluded that sanitary authorities could
not justify neglect in undertaking these essential tasks. 93

As shown with the example of Blaenavon Urban District Council, the Local Government
Board was capable of issuing ultimatums to defaulting bodies. The administrative
counties of Durham, Northumberland, Staffordshire, West Riding of Yorkshire and
Lancashire in England; Glamorgan, Carmarthen and Monmouthshire in Wales were highlighted as specific counties in England and Wales, which should attend to such matters due to their excessive infant mortality rates. Given the evidence uncovered by DMOs in some urban districts of Monmouthshire from 1913 to 1915, it can be claimed that there were no substantial improvements in the environment or in the living conditions of the urban population. The Maternity and Child Welfare Centres in Monmouthshire were introduced into these districts, which were so graphically portrayed through the CMO and the DMOs' reports.

**The Administration of the Maternity and Child Welfare Centres in Monmouthshire**

The County Council appointed a Public Health Committee to act as the central authority for maternity and child welfare throughout the county. It was decided that the Committee would select, appoint, pay and discharge, both full-time and part-time medical officers and health visitors engaged in the scheme. Additionally, at each Maternity and Child Welfare Centre a local committee would function to supervise the work of the centre in its area and co-ordinate the involvement of voluntary agencies with the county schemes. The membership structure of the local committees was designed to include medical representatives, local residents and women with a special interest in infant welfare. The intention was that some members could contribute medical knowledge. The remainder of the members would be socially and environmentally aware residents of the locality within which the Centre served and sensitive to the problems faced by mothers and infants in the area.

For each local committee the Honorary Secretary of the Monmouthshire Nursing Association would act as *ex-officio* member. The work undertaken by the Centres would
be supervised and controlled by the CMO and he was required to submit bi-annual and annual reports to the Public Health Committee. 95 The combination of a central authority and local committees acted to maintain co-operation and continual contact with every Centre. Evidence suggests that the implementation of the scheme had been carefully planned to ensure that the maximum information on maternal and infant health throughout the county was collected.

A total of twenty-one Centres were established in various buildings, usually Domestic Arts Centres attached to schools. There were no purpose-built structures in the early years of the scheme. When Domestic Arts Centres were not available other places were utilised, such as the Wesleyan Chapel at Pontnewynydd, the Council Offices at Blaina, a school clinic at Newport, the Soldiers’ and Sailors’ Wives Club at Sebastopol and the Nurses’ Home in Tredegar. 96 The Centres opened for one day a week for a two-hour session. The overall area covered by each Centre was large and involved a long walk or a bus journey for the mothers wanting to attend. Comments concerning difficulties experienced by some mothers’ were found in Centres’ reports and expressed in the oral testimony of Monmouthshire mothers. The evidence will be examined at the relevant point in the following chapter.

At each Centre there was a medical officer and a health visitor in attendance. The health visitor supervised the sessions and was expected to be present at consultations with the medical officer to take note of the advice offered to the mothers concerning their infants. When conducting home visitations the health visitor was expected to ensure that the advice was carried out. The medical officer was the only official responsible for medical advice given to the mothers. Volunteer helpers were an essential part of the smooth
operation of the Centres. They attended to the daily running of the Centres, filling out and maintaining registers and record cards and weighing infants. It was also hoped that volunteers would play a vital role in the dissemination of information to mothers regarding the location and work of the Centres. The volunteers' role included encouraging mothers to attend.

A comment by the CMO concerning an additional role that he expected of voluntary helpers covertly reveals his attitude to working-class mothers who did not attend the Centres. The CMO stated that volunteers would occasionally be asked to pay visits to homes and pointed out that they would be able to follow up cases, which included seeing mothers who had ceased to attend Centres and ‘...lapsed into indolence and neglect’. He suggested that health visitors and volunteers taking an active interest in the children would be ‘a valuable asset in counteracting and diminishing carelessness’ on the part of mothers. Home visitations were an integral part of welfare work. It can be suggested that visitations were often used as a means to investigate the home situation and habits of mothers’ who did not attend Centres with their children.

The CMO’s comments reveal that he believed these mothers to be indolent and neglectful in their duty. A mother attending a Centre was looked on favourably since she was seen to be following the advice of the middle-class medical professionals. The latter group was promoting middle-class motherhood and childcare practises to mothers attending Centres, regardless of their social class. The eloquent gentleman’s choice of words when reflecting on the deeds of health visitors’ involved with home visitations paints a picture of guardian angels. In addition to their ‘other good work’ the CMO claimed that health visitors in the county had
rescued several young mothers from the perils of intemperance, many an illegitimate child...from an untimely death,...many a family from the vicious and disease-pervading atmosphere of hovels, and many a child from the brutality of inhuman parents and guardians.  

In conclusion it can be argued that the Maternity and Child Welfare Centres were expected to put right all the 'evils' found in working-class urban life as perceived by middle-class officials connected with welfare work.  

The Aims and Objectives of the Centres

It was intended that the same Centre should be used by the mother for both ante-natal and post-natal care, the latter of which involved the infant’s health and feeding habits more than the mother’s medical condition. The aim was to introduce antenatal work to foster healthier motherhood. Postnatal efforts would focus on preventive methods 'instituted to save the infant victims of badly-housed, diseased or indifferent motherhood'. The objectives of the ante-natal work carried out at the Centres were intended to save infant life, prevent the chronic diseases of childhood and reduce unnecessary suffering on the part of the mother during pregnancy. The objectives, it was claimed, would ensure a healthy mother who would be able to breast-feed her infant. Failure to meet these objectives, it was stated, would mean any one or more of the following; death of the mother, death of the infant, chronic invalidity or debility of the mother, poor development and impaired health of the infant due to deprivation of the mother’s milk.  

The main function related to the antenatal perspective was to offer advice to expectant mothers. The topics on which advice was offered included hygiene during pregnancy, the preparation of the birth, and minor ailments such as constipation, varicose veins and
dental caries. Antenatal examinations were also expected to identify more serious conditions of pregnancy, including albiminuria and toxaemic developments, cardiac or pulmonary disease. When conditions were discovered that could lead to complications during the birth, the mother was to be referred to an obstetrician in Cardiff. It was hoped that antenatal care would lead to a reduction in infant mortality rates including stillbirths, a reduction in the number of miscarriages and a longer period of breast-feeding.\textsuperscript{101} The objectives were noble, expressing sympathetic awareness of the trials of pregnancy and childbirth. However, it can be argued that the prime motivation was an improvement in the health of infants. Antenatal clinics, as separate entities to infant welfare centres did not operate in Monmouthshire as a whole until 1930. Therefore, it can be argued that the health of mothers came secondary to the health of infants when initiating the antenatal scheme into the infant welfare Centres. The provision of facilities specifically for antenatal care in the 1930s, attendance at these clinics and the impact of such care on the health of expectant women and nursing mothers will be evaluated in Chapter Six.

Recognition of the need for antenatal care in 1916 did very little to stem the number of maternal deaths, particularly in Monmouthshire. Proper facilities and adequate attention to antenatal issues did not materialise until 1930 when maternal mortality rates in Monmouthshire far exceeded those of England and Wales. Post-natal work was primarily concerned with the medical supervision of infants and young children up to the age of five. Supervision was a key word. The CMO categorically stated that it was not intended that the Centres would attempt to replace the work of the private practitioner.\textsuperscript{102} Dr. Lane-Claypon noted that when the infant welfare movement was first started, treatment of medical conditions at the Centres was not contemplated. However, as the
Centres became more established some of the mothers, infants or children would occasionally need some kind of treatment. Objections to treatment being offered at Centres came early in the movement from two main areas: hospitals and general practitioners. The hospitals objected strongly to the possibility of overlapping responsibilities. It was claimed that more adequate facilities were available at hospitals than at Centres for treatment of illnesses. A possible exception allowed by hospital authorities was for Centres to offer treatment for minor ailments.

Local practitioners voiced dissent due to the concern that Centres would take patients away from their practice, since advice and treatment given at the Centres would be free. Doctors argued that cases needing treatment should be referred to local doctors. When a patient was too poor to pay the doctor's fee, the patient should be referred to the nearest hospital. Objections to the offer of treatment at Centres were also raised due to the infrequent nature of the opening of the Centres. It was argued that the mother might keep her sick infant away from the doctor when the infant most needed help if she waited until the scheduled day came around to visit the Centre's medical officer. A delay in treatment could mean the ailment developing from a minor to a major condition.

The counter-argument was that while medical treatment would not be given to cases needing hospital treatment, minor ailments could be adequately dealt with at the Centres. It was suggested that many local practitioners might not feel a minor ailment worthy of attention. It was finally decided that minor treatment only would be undertaken at Centres. Remedies offered to the mothers and infants would include mild laxatives, lotions, powders and a simple cough syrup. It was agreed that mothers and infants in need of continued medical attention would be referred to private practitioners or hospitals.
Additionally, the Local Government Board reported that medical officers had found that bad teeth caused a great deal of ill health in mothers. The MOs believed that the health of infants could be affected when the mothers’ teeth were bad. The Board was concerned enough to pay a grant towards the employment of a dentist in addition to providing equipment and maintenance for authorities wanting to set up a dental clinic. The aim was to ensure that the mothers’ dental problems could be treated promptly. 105 Lane-Claypon stated that dental care was ‘one of the most valuable branches of the work at a centre’. 106 Dentistry provision for expectant women and mothers who attended Centres in Monmouthshire will be discussed in a later chapter. An assessment will be made of the extent to which dental treatment was available to mothers. Additionally, the response and reaction of mothers to this service will also be analysed.

The Main Objective

The Local Government Board set out the provisions of the Maternity and Child Welfare Act in Circular (M & C.W. 4). It was sent to all county councils in August 1918. Local authorities were given extended powers to act in matters concerning maternity and child welfare, which included the health of expectant and nursing mothers. The Board claimed that the importance of maternity and child welfare work did not need to be emphasised: conserving infant lives and infant health was paramount. 107 There appeared to be recognition of the need to care for the mother’s health. However, the focus was centred on the sustenance of the unborn infant and its survival following birth. It can be argued that the expectant mother was viewed as a receptacle for the growth of a new human life: the mother’s health was secondary. In the same way it can be argued that emphasis on ways to improve the health of the nursing mother was initially
fuelled by concerns regarding high infant mortality rates and poor infant health. To substantiate the argument the following chapter looks at the establishment and work of the Centres in Monmouthshire. The main objective of the Centres in Monmouthshire, according to the CMO was ‘to secure medical supervision and advice for the infants with special reference to the nutritional disturbances caused by dietetic errors’. Breast-feeding was believed to be the superior mode of infant feeding and was encouraged particularly during the first six to nine months after birth. It was declared to be the chief object of the consultation with the mother. The care of infants was a primary motivation for the establishment of the Centres. Throughout the following chapter special emphasis will be placed on the comments of the medical officers in charge of the Centres in Monmouthshire, particularly with reference to breast-feeding. Attitudes towards mothers, both expectant and nursing, will be evaluated and discussed.

**Chapter Three : Notes**


3 Ibid. pp.9-10.


5 Monmouthshire County Council (MCC), Public Health Department, Annual Report for 1916 p.2.

6 Ibid. p.3.

7 MCC, Maternity and Child Welfare Committee (MCWC) Annual Report for 1919 p.3 Subsequent Annual Reports show the number of births unnotified, which were revealed by the health visitors visiting the homes of mothers (see below). 1930 showed the lowest recorded percentage of unnotified births overall (.16). 1931, with 2.79 per cent was the highest for the years covered below.
Subsequent Annual Reports show the number of births unnotified, which were revealed by the health visitors visiting the homes of mothers (see below). 1930 showed the lowest recorded percentage of unnotified births overall (1.6). 1931, with 2.79 per cent was the highest for the years covered below.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Unnotified Births</th>
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<tbody>
<tr>
<td>1920</td>
<td>58 (p.3.)</td>
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<tr>
<td>1921</td>
<td>77 (p.1.)</td>
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<tr>
<td>1922</td>
<td>75 (p.1.)</td>
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<tr>
<td>1923</td>
<td>9 (p.1.)</td>
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<tr>
<td>1924</td>
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<td>1927</td>
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<td>1929</td>
<td>10 (p.1.)</td>
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<tr>
<td>1930</td>
<td>16 (p.1.)</td>
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<tr>
<td>1931</td>
<td>16 (p.1.)</td>
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</table>


In 1934, 1.01 per cent of registered births were found to be unnotified under the Notification of Births Acts *Annual Report for 1934* p.1.


12 Ibid. p.vi.


See also pp.101-109 for a discussion on the inadequacies of various types of training.

17 The practice of sub-letting rooms in houses produced continual overcrowding. One three-bedroom house was sub-let to two families containing thirteen people. See the Report of the DMO for Blaenavon, 1908.

A tenant sub-let one room to a male lodger leaving his wife and five children cramped into one ‘filthy’ room. Free Press of Monmouthshire 2 Sept. 1910.

Mrs. G. M. of Cwmbran (formerly Blaenavon), remembers the persistent sub-letting of any available rooms in houses in the 1920s. No empty rooms were ‘kept for best’, unused rooms were let to a lodger or another family. Interview by Jan King with Mrs. G. M., Cwmbran, December 1988.


See also the Sanitary Inspector’s Report in Blaenavon Urban District Council Minutes 30 June 1909. Consecutive medical officer reports and Council Minutes reveal that the housing situation only marginally improved in the 1920s and 1930s. In 1938, the Free Press reported that Blaenavon was not in touch with the ‘outer world’ and many houses were still needed ‘to relieve the worst cases of overcrowding’ Free Press of Monmouthshire 30 December 1938.

See also the South Wales Weekly Argus 12 March 1938. This edition published a report concerning a house occupied by thirteen people. The youngest was an infant born two weeks previously. The thirteen occupants slept in two bedrooms. The house had been officially closed thirty years earlier.

The 1935-1940 Overcrowding Surveys carried out by Blaenavon Urban District Council, reveal that situations existed in some parts of Blaenavon that were reminiscent of mid-nineteenth century housing conditions. See Blaenavon Urban District Council Overcrowding Surveys A.410.A.C.27., .28, .29, and .30. County Record Office, Cwmbran, Gwent.


18 Lane-Claypon, J. E. (1920) p.25.

19 Local Government Board (1917) Report on the Provision...Public Health Authorities...Voluntary Agencies... Cd 8085 p.vii.


22 Ibid. p.4.


24 Ibid. *Annual Report for 1938* pp.4-5.


27 Ibid. p.4.


34 Ibid. p.316.


37 Ibid. p.27.

38 With all interviewees mentioned in this thesis, full names and addresses have been withheld for confidentiality. Interviews were conducted in three ways.

- Personal contact in the interviewees home.
- Initial contact with the Warden of a Residential Home in which case the name of the Home is also given.
Through written correspondence with the interviewee. Dolly L. was interviewed by Jan King at the Blaen-y-Pant Residential Home, Malpas, Newport on 6th February 1993. Dolly was born, and continued to reside in Pill, the dockland area of Newport, until taking up residency at the Home.

Elizabeth L. of Newport, born in 1896, interviewed by Jan King at Blaen-y-Pant Residential Home on 6th February 1993.

Margaret of Liswerry Newport. (No surname given) Interviewed by Jan King at the Bettws Residential Home, Newport, on 8th October 1994.

Mrs M. Of Cardiff, born in 1910. Interviewed by Jan King at Pant-y-Celyn Residential Home, Malpas, Newport, on 14th December 1994.

Mrs. R-M., originally of St. Helen’s in Lancashire. Interviewed by Jan King at Pant-y-Celyn Residential Home, on 14th December 1994.

Mrs. T., originally from Gosport, born in 1913. Her first and only child was born in 1938. Interviewed by Jan King at Pant-y-Celyn on 14th December 1994.

Mrs. J., of Saundersfoot, Pembrokeshire, born in 1905. Interviewed by Jan King in Mrs. J’s home at Saundersfoot, 6th February 1993.

Mrs. B. of Tenby, Pembrokeshire. Interviewed by Jan King at Mrs. J’s home in Saundersfoot, 6th February 1993.

Phyllis of Newport. (No surname given) Her baby was born in 1939. Interviewed by Jan King at the Bettws residential Home, 8th October 1994.

Mrs. Ada C., of Ebbw Vale. Correspondence received from Ada, 2nd February 1993, following a request by the author, for information on childbirth in the 1930s. The request was sent to local newspapers including the South Wales Argus, Free Press and Western Mail in January 1993.

MCC, MCWC, Annual Report for 1926  p.4.


Medical Research Committee, (1910) The Mortalities of Birth, Infancy and Childhood Special Series No. 10.

53 Ibid. p.37.

54 Ibid. Cited on p.38.

55 Ibid. p.38.


57 Ibid. Pages 223 to 239 cover counties and county districts in Wales and Monmouthshire. Preceding pages cover many of the County Boroughs in England, Wales and Monmouthshire.

58 Ibid. pp.85-86.


60 Ibid. p.87, 1916 statistics.

61 Ibid. p.236.

62 MCC, Public Health Department, *Annual Report for 1916* p.11

63 Ibid. p.11.

64 Ibid. p.17.


A report was initially submitted to the CMO from the DMO for Nantyglo and Blaina.


67 Ibid. p.20.

68 Ibid. p.20. Report submitted from the DMO of Tredegar.


70 Ibid. p.3.

71 Ibid. p.4.


73 Ibid. p.95. Letter from the Local Government Board dated 17th December 1913, to the Clerk of MCC
74 South Wales Argus 31 July 1913.

75 Ebbw Vale Urban District Council, Report to the County Medical Officer of Health for Monmouthshire for 1912 p.540.

76 Ibid. p.541.

77 Ibid. pp.543-556.

78 Ibid. p.537.

79 Ibid. p537. Comments of Mr. Brundett.

80 Ibid. p.538. Pages 537 to 540 offer a comprehensive explanation of the establishment and work of the various Building Clubs in Ebbw Vale from 1899 to 1912.

81 Ibid. p.549.


83 Ibid. p.4.


85 Free Press of Monmouthshire 6 August 1915.


87 Ibid.p.45.


89 Ibid. p.50 and see note 99 on p.241.

90 Tredegar Urban District Council, Medical Officer of Health Report for 1914 pp.6-7.

91 Ibid. p.7.


94 Ibid. p.77.

95 MCC, Public Health Department, *Annual Report of the County Medical Officer for 1916* p.11-12.

96 Ibid. Taken from the list of Centres on pp13-14.

97 Ibid. p.16.

98 Ibid. Dr. Rocyn Jones’ comments p.16.

99 Ibid. p.18.

100 Ibid. p.14.

101 Ibid. p.15.

102 Ibid. p.16.

103 Lane-Claypon, J. E. (1920) pp.69-71.


105 Ibid. p.xi.

106 Lane-Claypon, J. (1920) p.44.


CHAPTER FOUR

THE MATERNITY AND CHILD WELFARE CENTRES

IN MONMOUTHSHIRE: 1919-1938

Introduction

The Maternity and Child Welfare Act of 1918 consolidated and formalised the
establishment of a maternal and infant welfare system which had been in its embryonic
form with the early ‘Schools for Mothers’ and the ‘Babies’ Welcomes’. Funds were made
available to local authorities for a range of activities connected with Maternity and Child
Welfare Centres (Centres) including the provision of milk and food for mothers and
infants. Maternal, infant and child welfare came entirely under the control of the state.
The system formulated under the Act remained essentially intact until the National Health
Service superseded it in 1948.1 Monmouthshire, as documentation has revealed in the
previous chapter, instituted a countywide scheme of Centres before the 1918 Act
statutorily required local authorities to comply with the legislation. The work of the
Centres in Monmouthshire involved a vast range of activities including keeping and
maintaining records, weighing infants, and holding consultations with expectant and
nursing mothers. Medical Officers at the Centres advised mothers on health and hygiene
matters, infant feeding and weaning methods and provided simple drugs for minor
ailments. The Centres also offered cheap infant foods and sometimes free milk and
dinners for needy mothers. Home visitations and dental facilities for mothers and children
were part of the service. Social occasions such as Baby Shows were often planned to
enable mothers to have a break from the arduous task of childbearing and child rearing. It
is evident that there was a commitment to a supportive maternity and infant welfare scheme for mothers and infants within Monmouthshire. Dyhouse, Lewis and Davin promote the thesis that it was easier and cheaper to arrange some classes for mothers than to expand welfare services. Davin states that

The focus on mothers provided an easy way out. It was cheaper to blame them and to organise a few classes than to expand social and medical services. 

Dwork suggests an alternative thesis: maternal and child welfare schemes were not cheap and easy ways to shift the blame for high infant mortality rates onto mothers. Dwork's argument is more appropriate in relation to Monmouthshire. The evidence in Monmouthshire suggests that the establishment of Centres and the work involved in them, were not cheap and easy remedies. Classes for mothers were a small part of the services offered and there is evidence of an expansion of both social and medical services.

However, middle-class practises concerning child rearing were continually promoted through the Centres in working-class districts. Some medical officers were highly critical of mothers, particularly if they did not attend the Centres. A paradoxical situation materialised through a mixture of strict middle-class idealism concerning motherhood and childcare, and an empathetic and sympathetic approach to mothers in abject poverty. The reports of the medical officers in charge of the Centres bear witness to this claim. Some medical officers' attitudes towards mothers were condescending and often harsh, particularly when directed at mothers who did not attend Centres. It is not intended to correlate critical comments with low attendance figures at specific Centres. Nevertheless,
some of the medical officers showing a more sympathetic approach towards the mothers in their district did have a high attendance figure at the Centre in their charge. Reasons for not attending Centres were numerous and varied between districts within Monmouthshire according to the individual social and economic position of the mother within that district. Furthermore, it can be argued that mothers retained freedom of choice by consciously making a decision to attend or stay away from Centres. The Centres were in operation to offer advice and information on a wide spectrum of issues. All mothers were invited to attend the operative word being ‘invited’, by midwives, health visitors, local doctors and volunteer helpers attached to Centres. Yet many mothers chose to stay away from Centres.

Recent research conducted by Lewis suggests that even though mothers were portrayed, and generally accepted as being ‘victims’ of male medical men and policy makers, it is not correct to view mothers as passive recipients or victims of change. Expanding on Lewis’s argument, the evidence in Monmouthshire reveals that female medical officers were initially in control of many of the Centres in Monmouthshire. These women were middle-class officials initially accountable to the CMO, which was Dr. Rocyn Jones for the whole of the period studied. It could be suggested that the female medical officers might have mirrored the middle-class perspective on motherhood issues in a similar vein to the CMO and their male colleagues, the DMOs. At Centres attended by female medical officers, health visitors and volunteers the sources for assistance and advice would have been these women. Subsequently, if the question of mothers’ as ‘victims’ were purely gender-specific, mothers would have more readily accepted the perspective of motherhood promoted by the female rather than male medical officers.
However, the issue is more complex and involves different class perspectives of motherhood. It can be argued that two sets of values, middle-class and working-class, were in conflict rather than one set of values, middle-class, and specifically male middle-class, being imposed on and suppressing traditional working-class ideas concerning infant care. One specific example of this hypothesis will be illustrated in the current chapter using medical officers' attitudes towards methods of infant feeding. However, additional illustrations will be drawn from the evidence collected over the nineteen-year period covered in this chapter. Many mothers in working-class districts rejected and resisted the values and ideals promoted in Centres and chose to stay away regardless of the gender of the medical officer in charge. A mother could ask for advice by attending a Centre, by inviting a health visitor into her home, or by asking female relatives and friends. The final choice remained with the mother. Evidence in Monmouthshire suggests that generally, when mothers asked for advice in Centres, the guidance was well accepted and followed. However, the control of motherhood and childcare issues did not rest solely with middle-class medical professionals.

In the previous chapter the establishment, administration, aims and objectives and the general work of the Maternity and Child Welfare Centres were catalogued. This offered background information and a framework within which to assess the value of the work in relation to the health of both mothers and infants. This chapter will examine in depth the scope of the work at Centres in Monmouthshire from 1919 to 1938. Particular reference will be made to the attitude of middle-class officials toward mothers in working-class districts attending and staying away from Centres. Additionally, advice given to mothers concerning methods of feeding infants will be examined. Finally, the ailments of the
mothers and infants attending the Centres will be identified in order to assess their general health. The year 1919 will be analysed first, being the year following the Maternity and Child Welfare Act of 1918 and two years into the scheme in Monmouthshire when the existence of the Centres would have been recognised by most mothers. Following the 1919 case study, an examination of the period 1920 to 1938 will be used to assess patterns of change and continuity in attitudes, attendance at centres, infant feeding and common ailments. Patterns of change and continuity will assist in establishing the overall influence of Maternity and Child Welfare Centres on infant mortality rates and the health of both mothers and infants in Monmouthshire.

The previous chapter revealed the social and environmental conditions prevalent in the county during the period immediately prior to the introduction of the Centres. When examining the years 1919 to 1938, social, environmental and economic conditions filter through the reports submitted by the medical officers in charge of the Centres. Economic situations continually affected the well being of mothers and infants. At certain times during the period covered, Monmouthshire suffered severe industrial depression. Both the overt and covert evidence contained in the MOs' reports reveal the ways in which Centres throughout the county attempted to cope with the difficulties faced by mothers and infants as a result of economic and social problems.

**THE CENTRES IN MONMOUTHSHIRE IN 1919**

By the end of 1919 there were thirty-eight Centres in Monmouthshire. Normally, Centres were opened one day a week for a two-hour session except for the Centres at Ebbw Vale, Fleur-de-Lis, Abertillery, Newbridge, and Trethomas where four-hour sessions were held. At each Centre a medical officer, a health visitor and volunteer
helpers were in attendance. Reports were made by the MOs in charge and presented to the CMO. The reports of the individual MOs varied in detail and length. However, all reveal evidence concerning attitudes, attendance, infant feeding, ailments suffered by both mother and infant and details of the free food supplied by each Centre. The attitude of the MO in charge of a Centre was important to the success of that Centre, both for interprofessional relationships and to ensure that the mothers felt welcomed and not criticised when they attended. Positive and negative attitudes towards mothers are identifiable in the reports submitted to the CMO. Additionally, some comments suggest a strained relationship between MOs and midwives in certain districts. The majority of MOs in Monmouthshire displayed an element of empathy and were sympathetic to the problems facing mothers attending Centres. However, some were decidedly caustic in their comments on issues such as attendance at Centres; weighing, clothing and feeding infants; and the cause of some of the ailments suffered by mothers and infants. This section will analyse the comments of medical officers at a variety of Centres in Monmouthshire to distinguish similar and contrasting attitudes towards mothers in working-class districts.

**Attending the Centres**

Many mothers had to travel long distances since each Centre covered a wide area. Dr. Bevan, DMO for Nantyglo and Blaina urban district noted that some mothers travelled to his Centre from the adjoining county of Breconshire. Dr. Mary Howie, Assistant Medical Officer (AMO) for Monmouthshire mentioned that one mother brought her baby to the Centre in Pontymoile from Usk, a distance of around nine miles each way, before the opening of a Centre in that town. The baby weighed just three pounds and was her
only living child out of five births. The mother believed that bringing the infant to the Centre offered her ‘...the faint hope that the child might live’. Through regular attendance and by the mother following advice, the baby did survive. In her report, Dr. Howie said that she was pleased that finally the baby had reached the average weight for its age. 9 Dr. Mary Scott (AMO) was responsible for six Centres in Monmouthshire. Her report also contains reference to the long distances many mothers had to cover. 10 In contrast, Dr. Laura Pugh (AMO) pointed out that her Centres in Blackwood and Oakdale were central for most mothers and yet attendance was poor. 11 In Blackwood there were 139 infants on the register with an average attendance at each session of eleven infants. In Oakdale the average attendance was only nine. 12 Dr. Pugh reported that the mothers had complained that the Centres were very cold for the babies in winter. 13 Her report reflected Dr. Scott’s general remarks that many Centres were

...insufficiently heated and draughty, have no proper water supply, and few can be called comfortable. 14

The reports reveal that when a mother made an effort to attend in the colder months of the year, she usually had to wait in a cold room and then undress her infant to be examined and weighed. Furthermore, the consistency of the remarks concerning the structural inadequacies of the Centres for mothers and infants offers an insight into one of the reasons for poor attendance.

**Weighing the Infant**

The ritual of weighing the infant unclothed was an integral part of the infant welfare system in order to check on development and growth. However, it was also a means to investigate into the general cleanliness of the mother and the suitability of the infant’s
clothing. Dr. Scott found that the majority of the infants at her six Centres were ‘both insufficiently and improperly clothed’. As a result she advocated additional sessions to be held so that mothers could learn how to make suitable baby clothes. 15 Dr. Scott’s Centres covered some of the older, mainly coal-mining districts of Monmouthshire where housing was far from adequate. In contrast, Dr. Pugh, whose Centres at Oakdale and Blackwood were situated in a ‘comparatively new area’, noted that the majority of infants brought in to be weighed were well clothed with ‘signs of being brought up in clean and tidy homes’. 16 It seems that the task of weighing infants provided more information for the staff at Centres than the actual record of weight.

**Contrasting Views**

Mothers were constantly encouraged to attend Centres and yet if they did so on cold, wet days they were often criticised. Noting that attendance figures were lower on these days, Dr. Howie stated that mothers should keep infants indoors on such days,

...as there would be much less of the Bronchial Catarrh, which is so prevalent, if the babies were more protected from the cold and wet. 17

Dr. Howie openly blamed mothers for bronchial conditions in infants. She said that babies were kept as ‘hot-house plants’ by a large fire ‘with no ventilation in the room, muffled up in clothes’ then kept at an open door or taken out in ‘driving rain and bitter wind’. 18 Generally, Dr. Howie regarded the mothers who attended her Centres as ‘careful, good, industrious, thrifty’ mothers. 19 However, Dr. Howie made a point of saying that many of these mothers were ‘woefully ignorant where a baby is concerned’. 20 Her comments suggest she viewed a mother’s appearance at the Centre to be of primary importance. Attitudes towards mothers attending and mothers staying away from Centres
contrasted sharply. Dr. Howie believed it was difficult to persuade ‘the really careless, shiftless, neglectful’ mother to attend and claimed that it was the infants of these mothers who most needed the help Centres could offer. Dr. T. W. Wade was one of the medical men responsible for some Centres. He was the AMO at Newport, Rogerstone, Caerleon and Rumney Centres and was more critical of mothers staying away than Dr. Howie. Ignorance of the existence of the Centres, he claimed, could not be cited as a reason since all mothers were invited to attend by health visitors. He insisted that mothers who did not attend were ‘responsible for our infant mortality figures’. Dr Wade claimed that the main reason was indifference towards the well being of the infant, which in turn bred neglect and disease. Expanding on his ‘indifference’ theory, he explained that the indifference could be due to the mother’s natural constitution

...or may be implanted by vice and drunkenness, which have supplanted the natural maternal instincts of protection and care of her young. 22

**Dr. Wade - Firm Control Needed**

It can be argued that Dr. Wade advocated firm control through closer ‘supervision’ of mothers in their own homes, more frequent health visiting and an ‘insistence’ that infants were taken to the nearest Centre. Dr. Wade strongly supported the role of the ‘official in uniform’ to coerce the mother to conform to middle-class child rearing practises. Dr. Wade seemed more tolerant towards mothers who were ‘constitutionally too weak to attend to her children through ill health or disease’. He called for an extension of the ‘home-help’ system to be used for these mothers, which would not be confined to ‘lying-in’ women. He also requested the establishment of a convalescent home for sick mothers.

24 However, as Dr. Howie pointed out, when mothers needed treatment in hospital, many
found it difficult or impossible to find someone to look after their home and children while they were away for any length of time. She claimed that mothers often remained untreated for that reason. Poor general health for women persisted. It was a significant part of many women’s daily lives and was perpetuated by the lack of facilities available to substantially reduce their suffering.

A remedy put forward by Dr. Wade for treating ‘delicate and malnourished’ infants was unrealistic given the economic situation prevalent in some districts of Monmouthshire in 1919, which suffered from rail strikes particularly affecting the industrial centres. Dr. Wade called for ‘observation wards’ in hospitals where infants suffering from malnutrition could be properly fed. Additionally, he claimed, the plan would afford ‘an excellent opportunity for experimental and research work into the causation, prevention and treatment of malnutrition’. Dr. Wade’s ‘experiments’ were planned to take place in controlled surroundings. Therefore, regular nutrition would offer short-term benefits to the infant while in the hospital. A scheme to alleviate distress, malnutrition and poor health in the wider community was needed.

Dr. Smith - Awareness of Difficulties

In direct contrast to Dr. Wade’s comments concerning mothers in his area, Dr. T. Baillie Smith, DMO for Abertillery seemed to be fully aware of the difficulties faced by the mothers in the coal-mining districts of Abertillery, Cwmtillery, Six Bells and Llanhilleth. The reports he sent to the CMO regarding the work of his Centre in Abertillery were highly detailed. His commitment to maternal and infant welfare was illustrated through his forcefully-stated opinions. In Abertillery urban district in 1919 there were 1,037 births recorded and out of these, 104 infants died before reaching their first birthday.
Smith looked at the overall advantage that a comprehensive system of maternity and infant welfare could offer women, rather than criticise mothers for not attending Centres. He noted the dual benefits of the system for mothers and their children. Mothers, infants and children could be helped when the mothers attended Centres. Additionally, home visits by health visitors had 'a considerable bearing on child life' since advice on the care of sick and ailing children could be given in their own homes. 28 The emphasis was not on the supervision of the mother in her home, which was in contrast to the idea of Dr. Wade. The overall attitude of Dr. Smith towards mothers reflected his concern for their welfare and that of their infants. At no time did he criticise mothers for not attending Centres, or devalue their actions in caring for infants. On the contrary, he was critical of the existing welfare system and believed that more could be done to alleviate distress and poor health. He claimed that additional money needed to be spent on welfare work because

…it is a weakness in existing legislation that we are spending a lot of money to meet results which are the accumulation of a set of preventable circumstances. 29

Dr. Smith was anxious concerning the health of mothers who needed medical treatment and seemed to be too weak to respond to such treatment. It was clear to him that surgical treatment was required in many cases. Furthermore, he advocated that ‘regardless of expense’ some mothers should be sent to seaside or country convalescent homes to have a complete rest. He conceded that many mothers were ‘not only worried to death but also worked out’. 30 In 1919 sixteen MOs were in attendance at the thirty-eight Centres operating in Monmouthshire. Dr. Smith was the only MO, apart from Dr. Laura Pugh, who mentioned over-work of the mother as being one of the reasons for her absence from a Centre. 31 Both Dr. Smith and Dr. Pugh emphasised the difficulties encountered by
mothers at that time and the effect on their health of poor conditions and overwork in the home. Dr. Smith pointed out that while workers were agitating for shorter hours and more employment, the situation faced by mothers at home was rarely addressed.

How is the mother of a large family to obtain shorter hours and more rest?  

It could be assumed that Dr. Smith’s observations reveal an alternative, forward-thinking approach to the role of the housewife, rather than the generally accepted patriarchal view dominant among contemporary middle-class men. However, closer examination of his comments reveal that while there is some evidence to suggest the former assumption, it is not sufficient to give weight to a change in generally-held middle-class views.

After all, housework, most of it at least, is essentially a woman’s work...  

Nevertheless, Dr. Smith did make some relevant suggestions to the CMO to help alleviate the workload of housewives. Pit-head baths, he claimed, would considerably reduce the work of the mother by making it unnecessary for her to prepare baths for the men-folk of the household, returning home from the coal mines. In this way, pit-head baths would lead to a reduction in the heavy nature of housework for mothers in coal-mining districts. Dirty work-clothes could be kept out of the house for longer periods lightening household labour further. Dr. Smith also believed that a tailor should be employed at the pits to do ‘necessary rough repairs’ to work-clothes. He finally concluded his report by saying that his ideas were not the ‘dreams of an idealist’. Rather, he said, his ideas were ‘suggestive means to meet the varied deficiencies of our present system’. The evidence contained in Dr. Smith’s report reveals that he was more concerned with the welfare of mothers and infants than the actual attendance figures at his Centres.
Inter-Professional Conflict

Apart from reasons given by some of the medical officers mentioned above for non-attendance by mothers, other suggestions imply inter-professional conflict between MOs and midwives in their respective districts. While Dr. Mary Scott praised the co-operation of local doctors and midwives in many districts, Dr. ET.H. Davies, MO for Tredegar, spoke of the midwives in his district as being unhelpful.

...the maternity nurses (midwives) are not recommending, as they should, the mothers to bring their babies to the Centre. Dr. H.N. Taylor, MO for Ebbw Vale was also critical of local midwives and blamed them for the lack of interest in the Ebbw Vale Centre amongst expectant and parturient mothers. In 1919 there were only eight expectant mothers attending the Centre and twenty-six nursing mothers on the register. The attitude of Dr. Davies and Dr. Taylor towards midwives in their districts should not be attributed to a lack of qualified birth attendants. In Ebbw Vale there were fourteen unqualified compared to seven qualified midwives. However, in Tredegar the balance was opposite with seven unqualified midwives to twelve qualified ones.

The suggestion of an element of tension and conflict between some MOs and midwives can be further reinforced through the observations of Dr. H.S. Mason, MO for Pontypool, when he called for an extra antenatal clinic. He claimed that not only could advice be given to mothers concerning their health during pregnancy, they could also be advised on the choice of midwife. The correct choice of birth attendant, he believed, would mean that the infant would be cared for properly instead of Centres ‘having to undo a great deal, as is the case now’.
Out of the separate reports from the thirty-eight Centres in Monmouthshire, health visitors were spoken of highly and their work praised. As shown in the previous chapter, health officials were uniformed officials directly working for local authorities. Qualified midwives still did not enjoy the same status as health visitors seventeen years after the passing of the first Midwives Act in 1902. Medical Officers’ reports reveal evidence of conflict between MOs and midwives in 1919 regardless of the midwives’ qualifications.

**Perception of Appearance**

One final comment concerning the lack of attendance by expectant mothers at Centres is worth pursuing since it is linked to the role of the midwife and can be substantiated by oral testimony. Dr. R.V.De A. Redwood, MO for Rhymney, was concerned that expectant mothers were not attending his Centre at Rhymney although he claimed that they were ‘urged’ to attend by health visitors and midwives. Dr. Redwood only had two expectant mothers on the Centre’s register and attributed the non-attendance of other mothers to a ‘dislike of publicity’. The birth and death statistics listed in the annual report of the CMO shows there were 305 births in Rhymney that year. Therefore, two expectant mothers paying one visit each to the Centre does suggest that the overall majority of mothers expecting babies that year did not want to attend.

Oral testimony conducted for the purpose of this thesis presents an interesting insight into the feelings of expectant mothers. One line of questioning pursued the way women felt about their appearance while pregnant in the 1920s and 1930s. A second avenue of questioning attempted to reveal whether, as young girls, they knew when their own mothers were expecting a baby. Women were interviewed who lived in the Welsh industrial valleys as children and also when expecting babies. Out of the answers received
a pattern emerged which reveals aspects of traditional working-class life in the industrial valleys.

Mrs. H. revealed that her mother always concealed her enlarged stomach with loose dresses and aprons. A baby appeared in her mother’s arms following a visit from the midwife, which led the young Mrs. H. to believe that the midwife brought the baby in her black bag. She was not corrected by her mother. 45 Mrs. M. thought that her mother was ‘just getting fat, you know’. She remembered that her attention was only drawn to her mother’s widening girth when her mother had difficulty cutting the bread! 46 Many of the women interviewed confirmed that in parts of Wales, particularly the Welsh industrial valleys, it was common practice to support a loaf of bread on one hip while cutting slices from the loaf rather than using a bread-board on the table. In an advanced state of pregnancy this habit became awkward for Mrs. M’s mother. Audrey J. also remained unaware of her mother’s pregnancy. She arrived home from school one day to be greeted by her Aunt who said, ‘There’s a special visitor in the other room’. 47

Sissy’s Memories

Sissy’s experiences differed from the other women to some extent. Although she does not remember her mother being pregnant ‘so that you could notice’, Sissy did have an abrupt introduction to childbirth when she was twelve years old in 1926, which Sissy called ‘shocking and frightening’. Her mother had sent her to help the local midwife in Pill for the first time. The midwife paid a small sum to Sissy’s mother for allowing her to help. However, Sissy had not been told what the midwife’s work entailed. Sissy said she would always remember the first time she attended the birth of a baby with that midwife. Sissy admitted that she did not know how or why a baby appeared. Neither was she given any
Sissy shuddered as she recounted the day she witnessed the birth of a baby for the first time. It had been dead inside the unfortunate woman for a while. She vividly remembered the woman straddling a bucket and what looked like ‘a black skinned rabbit just hanging there’. Sissy’s duty was to hold the woman’s legs for the midwife to have her own hands free to deliver the dead infant. Regardless of her traumatic introduction into the birthing process, Sissy had four children of her own. She remembered that when she was pregnant she used to ‘hide’ under ‘big coats’ when she went outside; ‘you felt ashamed...everyone would know what you had been up to’. She recalled her father’s disapproval of her ‘showing’ one day when she went to visit him. He showed his disapproval by refusing to speak to her until she ‘covered herself up’. Sissy’s final words are relevant to the observations of Dr. Redwood in 1919; ‘Everything was so secretive’. Given the evidence, it seems that many mothers did not want to display their condition outside their own homes regardless of the encouragement from midwives and health visitors. Within the family circle secrecy surrounding pregnancy and birth was prevalent, which could have minimised the efforts of medical men and women in their aims to improve maternal and infant health. Finally, traditional working-class habits and mores were ignored and viewed as being inconsequential by some middle-class medical professionals. However, the traditional patterns of behaviour were of significant importance to mothers. The arrogance of refusing to accept the feelings of expectant mothers provides some evidence of the gap between the perception of pregnancy and birth held by the different classes. The middle-class medical professionals’ ideas of pregnancy and birth focused on the medical condition.
Attitudes towards mothers in working-class districts varied from one medical officer to another, regardless of the gender of the medical officer. In general, mothers who attended the Centres were classed as 'good' mothers and those staying away were classified as ignorant, lazy and in Dr. Wade’s eyes, these mothers endangered infant lives.

The average number of mothers attending each session for the thirty-eight Centres in 1919 was 24.95. Out of 8,487 live births throughout Monmouthshire 5,431 new infants were brought to the Centres by their mothers. 49 The evidence reveals that many expectant mothers and mothers with infants did chose to stay away from Centres. However, reasons varied and it is not possible to distinguish one over-riding cause of non-attendance. Nevertheless, the interviews conducted revealed that working-class mores were strong and did have an influential effect on the behaviour of expectant women.

**Advice on Infant Feeding**

Central to the ideology of motherhood was the notion that the mother’s care of the infant’s well being in the first year of life in particular, led to a healthy and well-trained child. Ideas promoted through infant care manuals and literature available for mothers at Maternity and Child Welfare Centres were founded on the concerns of government and medical officials when the poor physique and health of men during recruitment campaigns for the Boer War were made public. As Lewis mentions

> The unfit army recruits who sparked the inquiry into national deterioration had once been infants. 50

The massive loss of lives during the First World War further emphasised the need for an urgent programme to save infant lives. The perception of the government regarding the survival of the nation shaped policies pertaining to maternity, infant and child welfare.
Advice filtered down to mothers through the middle-class medical men and women controlling Centres. One of the targeted areas where it was thought that advice was necessary was infant feeding. Breast-feeding was believed to offer the infant the best start in life. Dr. Newman’s research into infant mortality in 1906 covered many sources and different countries. The results of the research revealed that higher infant mortality rates occurred among artificially fed compared to breast-fed infants. The belief that breast-milk was the ultimate food for infants cemented the notion that alternatives were ‘artificial’. It was stated that artificial alternatives were to be used only when the mother was unable to suckle her infant through an insufficiency in the quantity or quality of breast-milk, or through disease. It was believed that bottle-fed infants were fifteen times more likely to die within the first year of their lives than those being breast-fed. Therefore, the promotion of breast-feeding became one of the priorities of every Centre.

Infant-Care Manuals

A proliferation of infant care manuals appeared on the market around the same time as the establishment of Centres and enjoyed a hey-day of popularity. The majority of the manuals were aimed initially for middle-class mothers who often employed nurses to tend to their infants’ needs. An example of a targeted middle-class readership was demonstrated through the nature of the advice offered to ‘mothers and nurses’ by Dr. Bernard Miles, physician at the Royal Waterloo Hospital for Children and Women in London. He firmly advocating that breast-feeding was the ‘ideal’ and that it was ‘the duty of every healthy mother to feed her child’. He continued with his advice by pointing out that many doctors were ‘confronted with the growing desire among society mothers’ to bottle-feed their babies from birth. These mothers, he suggested, should be reasoned with,
however if they persisted, another method of feeding should be arranged. Dr. Miles' comments imply that 'society mothers' were allowed to decide on the method to be used to feed their infant without undue disapproval. This was in sharp contrast to the attitude towards mothers in working-class districts who did not want to breast-feed their infants. Staff at Centres attended by mothers in working-class districts insisted on breast-feeding by the mothers and did not give in easily to the use of 'artificial' methods. Midwives and health visitors were instructed to advise mothers on natural feeding as opposed to bottle-feeding which was classed as 'artificial'.

Mothers were encouraged to attend Centres as soon as possible after the birth of an infant. It was believed that the earlier a mother visited a Centre with her infant, 'the greater likelihood there is of the mother being able to continue to feed her infant'. One of the most influential writers on infant care was Dr. Frederick Truby King whose scientific approach to infant feeding protected breast-feeding rather than bottle-feeding, in a strict regime which denounced feeds on demand. This regimented middle-class approach became the standard advice offered to mothers at the Centres. The strict pattern with set times during the day for feeding and no night feeding, was meant to inculcate 'good habits' in the growing child.

This is the proper state of things and tends to make a healthy and contented child...

Evidence that these middle-class ideals were passed on to mothers in the working-class districts of Monmouthshire can be illustrated through the comments of Dr. Mary Howie, AMO, and other medical officers in Monmouthshire. Dr. Howie strongly advocated
regular feeding patterns instead of demand feeding. However, she experienced some problems imposing her views onto mothers at her Centres:

…it is difficult to convince mothers that babies can be taught regular habits from earliest infancy, and if trained in childhood, helps to keep them in good health all their lives. 58

Therefore, given that it was probable that some mothers in working-class districts could not read or could not afford to buy baby-care manuals, the midwife, health visitor and the medical officers at the Centres ensured that middle-class ideas concerning the feeding of infants were promoted. However, there is evidence to suggest that mothers in working-class districts often rejected and resisted advice choosing their own method of feeding to suit their needs and examples will be highlighted later in the chapter.

Breast-Feeding Percentages: 1916-1919

Generally, in 1919 the Monmouthshire Centres mirrored the accepted middle-class views on breast-feeding. Throughout Monmouthshire it was found that 78.6 per cent of all babies visited by health visitors were breast-fed, although the percentage was lower than that recorded in 1916, 1917 and 1918, which was 81.2, 84.1 and 81.7 per cent respectively. 59 The percentages were correlated using information received from health visitors visiting homes around ten days after births. Percentages shown in reports from Centres referred to the infants attending those Centres only. Therefore, since every infant born in Monmouthshire was not taken to a Centre by the mother, a complete picture of breast-feeding percentages cannot be illustrated in each district. However, patterns do emerge over the nineteen-year period covered in this chapter and will be discussed later.
In all the Monmouthshire Centres breast-feeding was given primary importance. As Dr. Mary Scott noted, ‘everything possible is done to encourage breast-feeding’. Dr. Scott’s Centres were at Aberbargoed, Beaufort, Crosskeys, Fleur-de-Lis, New Tredegar and Trethomas, which were all urban districts with a high concentration of industry. With the exception of Crosskeys over fifty per cent of the infants attending each Centre were entirely breast-fed. In Crosskeys the percentage was 47.6 for breast-fed infants, 18.6 per cent for mixed feeding, which was both breast- and artificially-fed and 33.8 per cent wholly artificially fed. In the industrial districts cow’s milk was often difficult to obtain and was of an ‘uncertain quality’. The alternative food for infants was dried milk. Dr. Howie did not find the same problem with the fresh milk in Usk. The district was mainly rural and good quality milk was easily available. Nevertheless, in Usk few infants attending the Centre were artificially fed since the mothers preferred to breast-feed. The availability of cow’s milk did not necessarily mean that the mother would discontinue breast-feeding. There were dissimilarities between districts. In areas where the purity of cow’s milk was questionable, some Centres returned higher breast-feeding figures than others. Crosskeys has already been mentioned. Another example was found in two adjoining areas, Oakdale and Blackwood. In the Oakdale Centre more than half the infants were breast-fed, whereas in Blackwood, out of 113 infants under twelve months of age, forty-six were entirely breast-fed. Dr. Laura Pugh was moved to comment that ‘too many babies are artificially fed’. Dr. Drapes, MO for Chepstow urban district, also found this to be the case at his Chepstow Centre, and believed that mothers attended in order to obtain infant food cheaply. The healthy breast-fed baby, he said, was not taken to the Centre on a regular basis.
This was a common complaint among the medical officers at the Centres. Dr. Scott remarked that whereas at her Centres the majority was breast-fed, mothers tended to stay away when weaning was mentioned. She attributed this to a combination of factors: the mother found it cheaper to continue with the breast, she found it ‘too much trouble to wean’ and she believed that the continuation of breast-feeding prevented pregnancy. The result was that often, mothers would object to the instructions given at the Centres and would cease to attend. Clearly, no set pattern was evident for the method of feeding for infants attending the Centres in 1919. In some districts there appeared to be a majority of breast-fed infants, while other districts returned a higher number of infants fed artificially. The common factor was the attitude of the medical officers to the way in which an infant should be fed: on the breast. Finally, the argument that mothers attended solely for cheap infant food is not generally substantiated, since there were more Centres with a higher proportion of breast-fed infants than there were infants fed artificially.

**The Ailments of Mothers and Infants Attending the Centres**

The extent to which the existence of Centres influenced a reduction in infant mortality rates in Monmouthshire is arguable. Medical officers firmly believed that the advice and minor treatment offered at Centres was beneficial to infant health. However, there is evidence that a great deal of concern was felt regarding the general health of expectant mothers. Throughout 1919 calls for antenatal clinics were voiced by all MOs in charge of operating Centres. Dr. Howie pointed out that due to the number of infants attending the Centres adequate attention could not be given to expectant mothers. The MOs in Monmouthshire believed that the number of abortions and premature births would lessen with adequate attention paid to expectant mothers in separate antenatal clinics.
However, it was to be a long wait: separate antenatal facilities were not established outside hospitals in Monmouthshire until 1930.

For all mothers, nursing and expectant, attending the Centres in 1919 the most common ailments on which advice was offered were anaemia, constipation and dental carries. Dr. Scott found that many nursing mothers coming to her Centres had a good supply of breast-milk. However, the quality of the breast milk was poor, which led to the danger that the infant could become under-nourished. 70 When nursing mothers had difficulty producing sufficient high quality breast-milk, the Centres were able to provide Glaxo dried milk for the mothers. The product was claimed to improve the richness of the breast-milk. In 1919, mothers attending Centres purchased 50,988 pounds of Glaxo and 958 pounds were given free to ‘necessitous’ mothers. 71

Before being awarded free milk the mother had to satisfy the medical officer that she was a needy case. At some of the Centres these mothers were also awarded free dinners. Mothers who did not attend Centres were not entitled to buy the cheap products on sale at the Centres or have the benefit of free food. Therefore, it can be argued that the policy in practise at the Centres was discriminating in character and contradicted the objectives of maternity and child welfare schemes. The objectives were aimed at improving the general health of both mothers and children to secure a reduction in infant mortality rates. The 958 pounds of Glaxo given free to needy mothers in Monmouthshire was provided only for those mothers who were able to attend. Many more stayed away for numerous reasons.

The amount of free food distributed to mothers in any one year cannot be taken as an accurate indication of the extent of poverty in a given area that year. It can serve as a
guideline to suggest the minimum level of poverty that might have existed. However, fluctuations in the actual amount of free food distributed over the years covered by this chapter point to periods of severe economic depression. In conjunction with comments made by medical officers concerning the condition of mothers and infants attending the Centres, it is possible to assess the extent to which periods of extended unemployment or low wages affected the health of mothers and infants.

Some government and medical officials voiced disapproval when free dinners for mothers were planned at some Centres. It was argued that the measures would be beneficial in the short-term only. It was claimed that many mothers were too lazy or ignorant to cook when they could afford to buy food, which perpetuated the 'fecklessness' myth. Dr. Lane-Claypon warned that the system of free dinners could 'degenerate into mere charity' unless individual cases were carefully investigated.

While benefits to mothers and particularly expectant mothers were questionable prior to the establishment of the separate antenatal clinics, MOs were quick to advocate that improvements in infant health were directly due to the work undertaken at the Centres. Dr. Mason proudly asserted that his Centre in Pontypool ‘undoubtedly exerted a beneficial influence on infantile health in the district’. However, the infant mortality rate for Pontypool urban district stood at 106.1 in 1919, a rise from 89.2 in 1918. The rate was considerably higher than the average for Monmouthshire in 1919 (88.0) and England and Wales (89.0). The rate for the county of Monmouthshire that year was lower than the national average.

Out of the years covered in this chapter, there was one additional year, 1926, returning a fractionally lower infant mortality rate in Monmouthshire compared to England and
The benefit of the Centres on infant mortality rates remained questionable. Nevertheless, the Centres provided mothers with a place to meet, receive advice and simple treatment for common infant ailments such as chest and intestinal disorders and teething difficulties. During consultations with MOs serious conditions could be identified which might not have been noticed if the infant had not been taken to the Centre. Referral to the local doctor or the hospital followed the identification of the problem, ensuring that the infant would be treated for the condition. Dr. Mason noted that the chief ailments dealt with at his Pontypool Centre were errors of feeding, teething problems and bronchitis. However, on dealing with these ailments, Dr. Mason stated that other problems requiring treatment had been identified such as hernias, cleft-palate, 'tongue-tie' and the need for circumcision. Dr. Prosser (Monmouth Borough), Dr. Redwood (Rhymney) and Dr. Smith (Abertillery), emphasised the advantages of the cheap food available at the Centres for infants, particularly during the rail strikes in 1919. Dr. Smith pointed out that the availability of such food, including the free nourishment given to poor mothers, helped to keep the baby up to the standard that would otherwise have had a very rough journey indeed.

Abertillery was mainly a coal-mining community, which according to Dr. Smith’s reports suffered severe hardships. In the Abertillery and Llanhilleth districts it can be suggested that many of the mothers did attend for cheap or free food. Out of the 958 pounds of Glaxo distributed free to mothers in Monmouthshire, 231 pounds was given out at Abertillery. Together with the 80 pounds distributed in Llanhilleth this accounted for almost one-third of the county’s supply. In addition, free Cow and Gate dried milk for
infant feeding totalling 17 pounds in Abertillery and 82 pounds in Llanhilleth accounted for over half of the county’s total amount of free infant food. With only one expectant mother on the register at Abertillery and five at Llanhilleth, it seems that mothers were attending for the benefit of their infants. The average number of infants at each session in Abertillery was 50.2 and at Llanhilleth 43.8. Abertillery had the highest attendance figure recorded at any of the Centres in Monmouthshire. The average for the whole county was 24.95.

As mentioned earlier, the chief ailments of infants treated at Centres were chest complaints and intestinal disorders. The former included conditions such as bronchitis, bronchial catarrh, colds, influenza and pneumonia. The latter complaint would have required additional treatment from the local doctor or the hospital according to severity. Common intestinal disorders included constipation, enteritis, gastro-enteritis and diarrhoea. However, an element of contradiction can be identified in the advice given by some MOs. Mothers were continually advised to leave infants outside for long periods to ensure an adequate amount of fresh air. This advice was a reflection of the predominant philosophy in many infant care manuals of the period. Nevertheless, mothers were blamed when they followed the advice and the infant developed chest troubles. Some severe disorders such as rickets and anaemia were attributed to late weaning. However, ‘injudicious’ feeding of infants was claimed to be the cause of most of the intestinal disorders found in infants. It is possible to suggest that the contradictory and often confusing nature of the advice offered to mothers concerning the feeding and care of infants led to some mothers rejecting the potential benefits Centres had to offer. Furthermore, mothers who were unable to attend regularly for
various reasons including lack of transport were labelled lazy and ignorant by many MOs. Evidence suggests that these mothers faced discrimination. They were denied the chance to obtain cheap or free food for themselves and their offspring. Finally, regardless of the remarks of many MOs at the Centres in Monmouthshire in 1919 referring to an improvement in infant mortality rates and general infant health, it must be remembered that many mothers did not attend Centres with their infants. Given the evidence, it can be argued that the Centres alone did not have a significant positive effect on the general health of infants and mothers throughout Monmouthshire in 1919. Furthermore, the attitude of MOs towards mothers remained unsympathetic. Predominant middle-class practises concerning child-care were persuasively promoted at Centres. The home visitation process conducted by health visitors introduced the same practises to mothers not attending Centres.

**Change and Continuity: 1919-1938**

One of the most dramatic changes appearing between 1920 and 1938 was in the attitude of the MOs in Monmouthshire towards mothers. The altered perspective can be illustrated through the observations made by MOs in their annual reports to the CMO. In 1919 many of the MOs referred in some way to the laziness or the ignorance of mothers. Many mothers were verbally attacked for lack of attendance at Centres, feeding infants artificially and for the perceived poor quality of their childcare practises. However, during the 1920s a subtle change can be detected, which was occasionally punctuated with derogatory remarks. Dr. Steel, MO for Abergavenny persisted in denouncing mothers believing that their ignorance was 'almost unfathomable' and led to the infant being 'fed and nursed into sickness'. His comments reveal his support of the scientific
approach to infant health, which advocated regimented patterns of feeding, sleeping, fresh air, less clothing and more frequent bathing. The medical profession as a whole blamed deformities due to rickets on ‘faulty feeding and too little fresh air and sunshine’. In the 1920s and 1930s the economic environment facing mothers meant that many were forced to struggle against adverse conditions, which resulted in the Centres MOs’ realising that poor infant health was not solely due to the ignorance of the mothers.

The efforts of the medical officers aimed at encouraging and maintaining breast-feeding in the difficult times of the 1920s and 1930s will be analysed in the following sections. In retrospect the concerns of the medical officers can be related to the latest research to be conducted into infant feeding in 1998. The research reveals that Britain has one of the lowest breast-feeding rates in Europe. Two-thirds of babies are breast-fed at birth compared to almost 100 per cent in Scandinavian countries. Furthermore, the poorer the mother the less likely she is to breast-feed her baby. It has been found that 50 per cent of low income mothers in Britain breast-feed their babies at birth compared to 90 per cent of high income mothers. The apparent need for a promotional campaign to encourage mothers in the late 1990s to breast-feed babies, stands as testimony to the continuing importance placed on breast-milk as the best food for babies. The remaining sections contained in this chapter concerning breast-feeding will uncover evidence related to the 1920s and 1930s. It is not within the scope of this study to expand on the evidence presented in this chapter and offer a full comparison to be made with current research. However, this study offers the chance for such a comparison to be made and will add to the debate on the effect of low incomes and poor nutrition on the ability of the mother to breast-feed.
**Continuing Deprivation**

Dr. Smith of Abertillery was a champion promoter of the need to protect the health of expectant and nursing mothers in order to secure the welfare of the infant. He was sensitively aware of the effects of economic deprivation in his community and constantly criticised the government for the empty rhetoric and false economy of the maternity and child welfare policies. His main criticism was that the focus on infant welfare centres and school medical schemes were misdirected. He claimed that little was done concerning the feeding and nourishment of expectant and nursing mothers who were the first to suffer in times of hardship. 87

One of the effects of insufficient nourishment was an inability to breast-feed or to sustain breast-feeding. Dr. Scott found that in four of her six Centres breast-feeding decreased in 1921. In Beaufort, Fleur-de-Lis, Crosskeys and Trethomas distress was ‘very acute’, which led Dr. Scott to claim that there was ‘little doubt’ that the decrease in breast-feeding was one of the results of the prolonged coal dispute. She continued that few mothers could obtain sufficient food for themselves and consequently could not satisfy their infants. Furthermore, babies born in the last few months of the stoppage were under the average weight of healthy new-born infants. Dr. Scott was concerned enough to comment that she could not remember seeing so many babies weighing four to five pounds at their first visit. 88

The majority of districts in Monmouthshire suffered from the economic distress in 1921. The Nantyglo and Blaina urban district MO claimed that with most of the men in the area out of work it was ‘...about the worst (district) in the South Wales coalfield’. 89 Many districts distributed free foods and dinners to mothers and in some Centres volunteers
gave out clothing and other items to needy families. The quantity of cheap infant food purchased at the Centres was reported to be higher than any year since the beginning of the scheme in 1915. The total value of all products given free to mothers for themselves and their infants totalled 3,652 pounds sterling compared to 537 pounds sterling in 1920. The 'huge increase' was directly attributed to the coal stoppage which lasted three months. However, the effects of the distress prolonged both maternal and infant suffering.

Free dinners were provided at fourteen of the Centres in Monmouthshire. The CMO warned health visitors that only mothers who attended Centres regularly and could not afford to pay current prices could benefit from cheap or free foods and dinners. A policy of exclusion continued to be in existence regardless of the recognition of endemic poverty. Although the CMO seemed pleased to report 'a continued low Infantile Mortality rate' in Monmouthshire, evidence reveals that the rate had increased from 87.9 in 1920 to 91.5 in 1921 and was higher than the rate for England and Wales, which stood at 83.0 in 1921.

**The Situation in Blaenavon**

Blaenavon was one of the towns in Blaenavon urban district that had experienced a boost in industrial production during the war years. A post-war return to normality coincided with the general industrial depression of the 1920s and plunged Blaenavon into despair. The cost of living soared to one hundred and seventy-six per cent above pre-war figures by 1922 and the situation became desperate throughout the Eastern Valley. In 1921 the unemployed marched in protest against the suffering and poor quality of life in the valley. In September of that year at a meeting in Pontypool Town Hall, the unemployed were encouraged to form committees in Blaenavon, Abersychan, Pontnewynydd, Cwmbran...
and other distressed towns to keep in touch with each other and to form a united front of protest. One speaker, Mr. Jenkins, urged the people ‘...to put up a strong and determined fight’, since children ‘were dying like flies because they could not be fed’. These were strong words uttered with conviction and prompted by a gathering of more than a thousand of the unemployed from Crumlin, Six Bells and Abertillery who had marched to Pontypool the day before. They protested loudly about the lack of work, high prices for food and rent and the amount of relief paid to unemployed families by the Board of Guardians. In November 1921 a deputation of Blaenavon’s two thousand unemployed, which amounted to almost half of the wage-earning population of the district marched to Abergavenny to present their case for a rise in the maximum relief of two pounds to the Board of Guardians. The effort was to no avail and dejected, the men returned to Blaenavon. In many cases it would have been impossible for anyone claiming relief or living on a low wage to pay rent and buy sufficient staple foods for the nourishment of the whole family. The two pounds relief was the maximum amount received by a family regardless of the number of children. Large families suffered considerable hardship as a result. The coal-miner’s wage before deductions was one pound eighteen shillings and eight pence after six days work in the mines. The maximum family relief juxtapositioned with the wage of a miner confirms the generally low wages of a coal-miner in the 1920s in Monmouthshire. The destitution was felt by families with or without a wage and the effects were noted as being ‘very terrible indeed especially among children’.

[See Table 16 below for examples of the cost of some staple goods in 1921]
### Table 16
Price List for Selected Foods and Other Goods
Eastern Valley of Monmouthshire: 1921

<table>
<thead>
<tr>
<th>Item</th>
<th>Price Range</th>
<th>Item</th>
<th>Price Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potatoes per cwt bag</td>
<td>9s. to 11s. 9d.</td>
<td>Un-iced Cakes per lb.</td>
<td>1s. 4d.</td>
</tr>
<tr>
<td>Bread per 4lb. loaf</td>
<td>9d. to 1s. 0d.</td>
<td>Salmon per tin</td>
<td>6d. to 8d.</td>
</tr>
<tr>
<td>Butter per lb.</td>
<td>2s. to 3s. 6d.</td>
<td>Men’s Boots</td>
<td>from 13s.6d. per pair</td>
</tr>
<tr>
<td>Margarine per lb.</td>
<td>11d. to 1s.</td>
<td>Boys nailed Boots</td>
<td>from 6s. 11d. per pair</td>
</tr>
<tr>
<td>Sugar per lb.</td>
<td>7d. to 8d.</td>
<td>Ladies Shoes</td>
<td>from 8s. 11d. per pair</td>
</tr>
<tr>
<td>Bacon per lb.</td>
<td>1s. 6d. to 3s.</td>
<td>Girls Boots</td>
<td>from 7s. 0d. per pair</td>
</tr>
<tr>
<td>Cheese per lb.</td>
<td>1s. 6d.</td>
<td>Bedroom Suites</td>
<td>from 13. 13s. 0d.</td>
</tr>
<tr>
<td>Tomatoes 3lb. tin</td>
<td>7d. to 10d.</td>
<td>Box Mattress</td>
<td>90s. to 157s. 6d.</td>
</tr>
<tr>
<td>Tinned fruit per tin</td>
<td>1s. to 1s.6d.</td>
<td>Martell Brandy</td>
<td>23s. per bottle</td>
</tr>
<tr>
<td>Condensed milk tin</td>
<td>8d. for skimmed</td>
<td>Candles 3lb packets</td>
<td>1s.5d. to 2s.3d.</td>
</tr>
<tr>
<td>Condensed milk tin</td>
<td>11d. for full cream</td>
<td>Soap per bar</td>
<td>7d. to 8d.</td>
</tr>
</tbody>
</table>

Sources: Free Press of Monmouthshire various editions
February 25th to November 25th 1921.

Free foods and dinners were given to mothers at the Blaenavon Centre in 1921 in an effort to ease the situation. However, while the infant mortality rate for England and Wales stood at 83 and for Monmouthshire 91.5 in 1921, in Blaenavon the rate was 101. Out of the thirty-three infants dying in Blaenavon twelve deaths happened in the first week following birth, three between the first and second week and two between the third and fourth weeks after birth, which meant that fifty per cent of infant deaths occurred in the first month of life. At the Blaenavon Centre 262 new infants were registered in 1921. With a total of 326 births that year it appears that not every infant was taken to the Centre. Furthermore, the infants most at risk including those under one week would
not have been taken for their first visit to the Centre until four to six weeks after birth.
The evidence suggests that the Centre at Blaenavon, which was typical of all the Centres in Monmouthshire did not have an effect on infant mortality rates in the first month of life during the 1920s.

Poverty and destitution drove the working-class women of the valleys to join their husbands on protest marches in support of their cause. Soon women’s voices were heard in the 1920s proclaiming loudly for the rights of mothers. Various women’s political societies thrived and demanded among other things, adequate maternity and infant welfare schemes and decent housing in an attempt to stem infant mortality and maternal ill-health.

What did hard-faced men know of maternity and child welfare? 104 This was one of the protests that became typical of the women’s Labour movement in the valleys. It was felt that infant welfare centres did not attack the cause of the problems existing for mothers in the 1920s: inadequate housing and poor nourishment. Furthermore, it was believed that until the situation improved infant and maternal mortality rates would not decline. Predictably, in 1922 infant mortality rates rose again in Blaenavon to 118.88. The rate for England and Wales was 77.0. 105 More than fifty-two per cent of the infant deaths in Blaenavon occurred within the first month of life. Dr. Martin, MO for Blaenavon, remarked that a high figure seemed to occur year after year ‘even though good work is done at the infant welfare clinic’. 106 The average infant mortality rate for Blaenavon for twelve years was 118.99 and was claimed to be a marked ‘wastage of infant life’. 107 The sanitary inspector made a thorough inspection of twenty-nine houses in which infants had died. He found that twenty-two of the houses were
overcrowded and in an insanitary condition, which led the MO to conclude that infant mortality was linked to poor housing conditions. 108

The infant mortality rate for Blaenavon dropped slightly in 1923 to 111.11. However, the rate for England and Wales showed a corresponding decrease from 77 in 1922 to 69 in 1923. 109 The MO blamed the continuing infant mortality scandal on the conditions that mothers were forced to live in and argued that they could not be expected to give birth to healthy babies until facilities improved. 110 The ‘good work’ the MO said was conducted at his Blaenavon Centre was cancelled out due to poor housing conditions. The first council houses to be built in Blaenavon were on the Elgam Estate in 1922. Nevertheless, the sanitary inspector claimed that at least two hundred and fifty more were needed to ‘relieve the vast amount of overcrowding’ in Blaenavon. 111 Furthermore, prospective tenants had to apply to the district council for housing and many families found that they had a long wait to be re-housed. Mrs. Elsie B. remained on the list for twenty-one years. 112 Many families fortunate to be granted the new houses soon faced problems paying the rent and rates during periods of unemployment and low wages. Evidence contained in letters from tenants to Blaenavon Urban District Council in the 1920s confirm that improved housing conditions alone did not necessarily lead to an improvement in the health of the tenants. 113

**The Situation in Other Towns in the Eastern Valley**

Throughout the 1920s economic circumstances fluctuated. Generally, in the industrial districts Centres recorded a decline in breast-feeding and MOs reported that this was mainly due to the inability of mothers to sustain a good supply of breast-milk, rather than the ignorance or laziness of the mother to continue to breast-feed. Dr. H. Ellis, AMO at
the Centre in Cwm, found that less than fifty per cent of the infants registered were
breast-fed. 114 It was the same at other Centres. In 1925, cases of rickets increased with
thirty reported in Abertillery district compared to twenty-three cases in 1924. Dr. Smith
commented that it was to be expected considering ‘...the hardship suffered by the people
of this valley... it is surprising many more cases were not met with’. 115 Dr. Smith
observed that prevention was ‘no mystery’. It was important, he said, that the expectant
mother’s health was closely guarded. He claimed that the situation would improve with
nourishing food, a rich supply of breast-milk, fresh air, sunlight and good housing
conditions. 116

As revealed through the reports of the MOs adequate supplies of food and good housing
conditions were not available to most mothers in the working-class districts of
Monmouthshire in the 1920s. Care of the expectant mother came second to the care of the
infant in maternity and infant welfare schemes in the 1920s. The CMO claimed that one
of the first principles of maternity and infant welfare was the encouragement of breast-
feeding. 117 Nevertheless, he was aware that antenatal care was important for the ultimate
health of the infant and the ability of the mother to breast-feed. Antenatal advice was
offered to any expectant mother attending the Centres, although no specific examinations
were conducted and no separate facilities existed in the 1920s. The CMO noted that many
mothers attending the Centres with infants complained that they had not felt well since
their confinement and believed that these mothers would have enjoyed better health if
they had taken advantage of the advice offered at Centres in the early months of their
pregnancies. He pointed out that possible abnormal deliveries could be recognised and
preparations taken to reduce the risk to both mother and infant. However, he dismally admitted defeat when he stated that

It is of little use advising mothers to make arrangements for complicated labour, or informing them that their homes are unsuitable for the confinement, if the necessary hospital accommodation cannot be offered. 118

The Experience of the Depression in 1926

In 1926 industrial disputes ravaged the country and continued for most of the year. Dr. Scott found that many of the mothers attending the Centres came for the cheap food, which was available for them to buy. During the height of the disputes attendance figures rose and there was a higher percentage of breast-fed babies. 119 Dr. Winifred Austin, AMO at the Pontypool Centre, also found that the average attendance at each session had risen from 19.8 in 1925 to 34.27 in 1926 and called it an ‘abnormal year’. Mothers at the Pontypool Centre were supplied with daily dinners for a twelve week period from July 14th to September 4th: a total of 3,983 meals were prepared and provided free. Whereas many Centres had shown a decrease in breast-feeding, the Pontypool Centre’s percentage increased from 55.27 in 1925 to 57 per cent in 1926, which prompted Dr. Austin to view the supply of nourishing dinners in a different light.

Whether this can be regarded as cause and effect it is difficult to say especially in view of the abnormal attendance as compared with other years. 120

The evidence suggests that nourishment of the mother improved her capacity to breast-feed. Dr. Austin’s sentiments were reinforced by many of the MOs in 1926. Dr. Gordon, AMO for Caldicot Centre reported that the Centre had enjoyed an increase in infant attendance from 120 in 1925 to 136 in 1926. Additionally, it was claimed that breast-
feeding had increased due to the extra nourishment supplied by the ‘Save the Children Fund’ during the industrial crisis. Dr. Smith of Abertillery again voiced his concern about the health of the mothers which had ‘depreciated considerably’ owing to the prolonged period of dispute. As a result he found that breast-milk failed or was poor in quality. However, he reported that the free milk supplied to mothers did help them to

...overcome a crisis which otherwise would have proved disastrous, not only to their own health but to that of their offspring.

The Centres at Abertillery and Llanhilleth, as with Pontypool, provided free dinners to mothers. However, the Risca Centre was not financially able to supply the dinners. Breast-feeding at this Centre fell to an all-time low and according to Dr. Roberts, the MO in charge of the Centre, this was ‘chiefly due to lack of nourishing food for mothers during the strike’.

Significantly, many of the urban Centres found that the poor economic conditions increased attendance at Centres. Nursing mothers suffered from debility and anaemia, the flow of breast-milk became unsatisfactory and the quality was poor. Voluntary organisations such as the ‘Save the Children Fund’ donated grants of money, boots, runner beans, fresh milk, dried milk and dinners to mothers to alleviate distress.

Nevertheless, the CMO declared that ‘extreme privation amongst infants was avoided’ and the county returned the lowest infant mortality rate on record with 69.2 compared to the national rate of 70. However, close examination of the district rates reveal that eight urban and three rural districts returned higher rates than England and Wales, with the addition of Abersychan showing the same rate and Monmouth fractionally below at 69. Furthermore, the rate for England and Wales was correspondingly the lowest rate
recorded for many years. Finally, whereas the rate continued to decline nationally in 1927 and 1928, 69 and 65 respectively before experiencing a rise to 74 in 1929, the infant mortality rate for Monmouthshire saw a significant rise to 87.3 in 1927. It remained above the national rate in 1928 returning 72.29. 127

Therefore, caution must be exercised when dealing with the county rate. The CMO’s comments relating to Monmouthshire as a county, did not accurately reflect the vast amount of deprivation, particularly in the industrial communities. There were wide variations between different districts within the county. The individual reports of the district MOs attending Centres in the coal-mining valleys continued to reveal the extent to which poverty affected the health of mothers in those districts.

**Continuing Problems**

Problems for mothers continued. In 1927 Dr. Scott declared that the amount of free food given out at the Centres was higher than it had ever been due to the economic situation in the valleys which were

> ...passing through a time of poverty which has been unequalled since the inauguration of the Maternity and Child Welfare Scheme. 128

At the Centres in Nantyglo and Blaina, Dr. M.M. Proudfoot, MO for the district found a ‘serious decrease’ in breast-feeding. He claimed that the decrease was mainly due to the inability of mothers to obtain sufficient nourishment, which led to poor general health. The majority of the mothers had been given free milk in an attempt to increase the quantity and quality of breast-milk. However, the mothers had still found it impossible to continue with breast-feeding. 129 Similar stories came from other Centres in Monmouthshire. Dr. Gordon, MO at the Caldicot Centre, found that in addition to the
'poor physique' of nursing mothers in general, mothers who were weaning infants were too poor to feed them properly. He claimed that the mothers would give infants 'sloppy' food rather than 'more solid bone-forming foods'. This method of weaning, he said, could lead to problems such as rickets. Dr. Gordon did not label mothers as ignorant for giving weaning infants incorrect nourishment. On the contrary, his remarks reveal that he acknowledged that the root of the problem was poverty.

The CMO confirmed that unemployment in colliery districts had continued since the stoppages in 1926 and had reached its peak towards the end of 1927. However, he also pointed out that little evidence of malnutrition amongst infants attending Centres was detected according to Dr. Pearse, the Assistant Medical Officer of Health for the Ministry of Health, when he paid a 'visit of inspection' to the county. Dr. Pearse did not mention the health of the mothers. The evidence suggests that the Ministry's main priority continued to place the focus on the infant before the health of the mother. Visits to Centres alone would not have revealed the reality of the state of health of all the mothers and infants in the county.

Volunteer groups continued to be active in 1927 to supplement the work of the Centres. The 'Save the Children Fund' provided extra nourishment, gifts of clothing, grants to Centres for additional equipment for antenatal purposes and instigated an 'adoption' programme. The programme entailed adopting a responsibility towards the welfare of certain infants from poor families and included a weekly payment to parents towards the maintenance of the infant. The Coalfields Distress Fund gave help to expectant and nursing mothers in the form of grants for extra nourishment and the provision of sterile maternity packs in preparation for the birth of the baby. The British Red Cross Society,
chapels and churches also donated gifts of clothing to families in need, and some religious organisations held ‘sewing parties’ to make garments from old clothing to give to families. The work of volunteers and volunteer organisations cannot be underestimated. The contributions from volunteers, which were freely given, helped to alleviate a great deal of stress, suffering and discomfort. Nevertheless, regardless of the additional help from these sources and the continued work conducted through Centres, the infant mortality rates in eighteen of the twenty-one urban districts and four out of the six rural districts in Monmouthshire returned a significantly higher rate than in 1926. (See Table 17)

<table>
<thead>
<tr>
<th>DISTRICT</th>
<th>1927</th>
<th>1926</th>
<th>DISTRICT</th>
<th>1927</th>
<th>1926</th>
</tr>
</thead>
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<tr>
<td>Blaenavon</td>
<td>132.9</td>
<td>59.6</td>
<td>Abersychan</td>
<td>73.3</td>
<td>66.3</td>
</tr>
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<td>84.5</td>
<td>Abergavenny</td>
<td>62.9</td>
<td>40.0</td>
</tr>
<tr>
<td>Rhymney</td>
<td>109.7</td>
<td>76.3</td>
<td>Pontypool</td>
<td>57.1</td>
<td>66.3</td>
</tr>
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<td>Mynyddislwyn</td>
<td>107.3</td>
<td>69.1</td>
<td>Caerleon</td>
<td>55.5</td>
<td>27.8</td>
</tr>
<tr>
<td>Risca</td>
<td>103.5</td>
<td>45.8</td>
<td>Llantarnam</td>
<td>50.4</td>
<td>51.7</td>
</tr>
<tr>
<td>Nantyglo and Blaina</td>
<td>102.5</td>
<td>54.3</td>
<td>Usk</td>
<td>47.6</td>
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<td>Bedwas and Machen</td>
<td>95.7</td>
<td>67.0</td>
<td>Chepstow</td>
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<td>10.7</td>
</tr>
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<td>83.0</td>
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<td>73.6</td>
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<td>Monmouth</td>
<td>81.1</td>
<td>69.0</td>
<td>Monmouth</td>
<td>26.1</td>
<td>23.7</td>
</tr>
<tr>
<td>Llanfrechfa Upper</td>
<td>78.6</td>
<td>76.1</td>
<td>Abergavenny</td>
<td>23.1</td>
<td>25.0</td>
</tr>
</tbody>
</table>

It can be argued that infants born in 1927 suffered from the poor health of mothers due to the prolonged period of inadequate nutrition prior to pregnancy and while pregnant. An analysis of the 1927 statistics reveal that in the districts with the six highest rates, which were Blaenavon, Bedwellty, Rhymney, Mynyddislwyn, Risca, and Nantyglo-Blaina, more infants died in the first three months after birth than in the three to twelve month period. 134

The health visitor paid the first visit to the home on the tenth day following birth, or shortly after the tenth day, and recorded the method of feeding that the mother adopted. In 1926 it was reported that in the whole of Monmouthshire 86.2 per cent of all babies born were breast-fed. 135 In 1927 it was found that the percentage had dropped to 84.7, 136 which does suggest that mothers were having difficulty maintaining good quality breast milk in the poor economic environment of the time.

Additional evidence can be used to suggest that the general state of health was low in the industrial districts of Monmouthshire: in the spring of 1927 smallpox gripped the Eastern Valley. 137 Incidences of infectious cases were hidden in houses since many families were afraid to report the illness and risk the wage-earner, if fortunate to be in employment, being compelled to remain at home to avoid cross-infection. 138 In Blaenavon the MO reported that housing conditions had not generally improved. Sewage was discharged untreated into streams and the water supply was heavily polluted with animal matter. 139

Among these conditions Blaenavon mothers were trying to cope with low incomes, high food prices and often, a number of children under the age of five. Continuity of the prevailing poor conditions was the reality of many women’s lives in the working-class industrial valleys of Monmouthshire. The difficult conditions depleted their physical
strength and the ability to successfully lactate. Although some Centres, such as the ones in Panteg and Pontymoile reported a rise in breast-feeding percentages, it was pointed out that in these areas the majority of men worked for the steelworks or the railway. These areas did not experience the effects of the industrial depression as harshly as the coal-mining areas. Some of the latter districts, using Blackwood, Oakdale, Crumlin and Abertillery as examples, produced evidence to support the extent of the problems. Dr. Whitaker, AMO for Monmouthshire, stated that there was a marked diminution in the general physical condition of both mothers and children, particularly for mothers. Thirty-three per cent of the expectant mothers visiting Centres in Blackwood, Crumlin, Oakdale, Rogerstone and Usk were found to require extra nourishment. In addition, twenty per cent of the nursing mothers and ten per cent of children were found to have nutritional deficiencies. These figures, as mentioned previously, were relating to the mothers attending Centres and not to the full quota of mothers in the districts. It can be argued that the percentage overall would have been considerably higher. In the Abertillery district, one colliery in Aberbeeg had been forced to close down permanently, three collieries had been idle for over four years and another colliery employed less than half its pre-war cohort of men. Dr. Smith continued to report that the birth weights of new born infants were less than normal. Dr. Smith believed that the prolonged period of unemployment was reflected most keenly on children between two and five years of age and on the young nursing mother. Examples of Dr. Smith’s empathy and sympathetic attitude toward mothers have been illustrated earlier in this chapter. The following comment from Dr. Smith highlights his continuing concern for the mothers in his district.
Mental anxiety to make ends meet owing to insufficient income and consequent lack of well-balanced dietary has told its tale on the general physique and condition and the nervous system of the mothers.  

The Centres in Dr. Smith's charge at Abertillery and Llanhilleth returned two of the highest average attendance at each session in almost every year from 1919 to 1938, with Abercarn Centre overtaking the highest average number per session in the late 1930s. In 1928 the Abertillery Centre had an average attendance at each session of 90.58, which was the highest in the county. In 1925 the CMO claimed that the chief element of success for any Centre seemed to be the 'personality' of the medical officer in charge. He continued to say that it was essential for a medical officer to have patience and the skill to listen to the mother in order to separate essential facts from irrelevant information.

The doctor who will conscientiously undertake this duty soon gains the confidence of the mothers, and their recommendation of the Centre to their friends.

Dr. Smith's reports reveal that he supported the mothers in his district and fought for the right of all mothers and infants to have the welfare care they needed. Therefore, the high attendance figures at Dr. Smith's Centres might have been a reflection of his general attitude toward mothers. Given the high attendance figures, it can also be suggested that mothers responded readily to help and advice when offered in a manner that did not belittle or demean their skills as mothers.

Dr. Smith was a source of support to the mothers in the districts that he covered and was aware of the problems they faced each day. It seems probable that attitudes towards mothers were changing. However, the following section will illustrate that prejudice
remained in some areas, which served to prolong the image of the mother in working-class districts as generally ignorant and lazy.

**A Return to the Myth of the Ignorance of Mothers in Working-Class Districts**

A brief return to the idea that mothers in working-class districts were ignorant and lazy was revealed in Monmouthshire in 1928 when Blaenavon mothers were sharply criticised by Blaenavon’s MO, Dr. Reynolds. The domestic and economic circumstances that mothers in Blaenavon and other coal-mining districts had to cope with has been vividly illustrated in previous sections of this chapter. In 1928 the same mothers were dealt a psychological blow when Dr. Reynolds proclaimed Blaenavon mothers to be ignorant. He claimed that ignorance in feeding infants was a key factor in the high infant mortality rates experienced in the valleys. He said that there were no cases of children under five suffering from lack of food although many suffered from an unsuitable diet. Members of Blaenavon Urban District Council rallied in support of the mothers and accused the MO of indiscretion in stigmatising Blaenavon mothers. When challenged, Dr Reynolds denied he had used the word ‘lazy’ in connection with the mothers. However, Councillor Dash produced a cutting from a North Country newspaper claiming Blaenavon mothers were ‘ignorant and lazy’. 147 He wanted to know how a North Country newspaper managed to print such an article about Blaenavon mothers. An argument developed between the Councillors and Dr. Reynolds. Councillor Dash pointed out that men, women and children were starving in the town ‘by a slow and cruel process’. 148

The CMO stepped in to the furore to record that through information gathered one hundred and fifty ‘sub-normal’ children had been detected in Blaenavon: the sub-normality was caused by starvation. However, the Reverend Morris of Blaenavon
disagreed with the CMO, and said that he knew of no cases of starvation. Dr. Reynolds, agreeing with the Reverend Morris, remained adamant that in attending the Centre in Blaenavon he had found no cases of under-nourishment. He maintained his claim that general ignorance existed among mothers with regard to feeding infants and offered two examples to substantiate his remarks. One example involved the case of a mother feeding her child on condensed milk for fourteen months. In another case, a mother tried to feed her infant with hard rusks, which were impossible for the infant to digest. 149

As shown previously, MOs condemned the practice of artificial feeding particularly using condensed milk, which was believed to be unhealthy, insanitary and dangerous. The main criticism was in the use of polluted water to dilute the milk and the habit of leaving condensed milk tins uncovered, which attracted flies and in mining communities, also coal-dust. 150 Dr. Reynolds was a firm believer that breast-feeding was the best for every infant. In 1928 he found that 46.5 per cent of Blaenavon's infants were breast-fed compared to 53.5 per cent who were artificially fed. 151 Reasons for artificial feeding such as lactating difficulties through the poor nutritional state of the mother, which was revealed in the evidence contained in the Centres' reports throughout Monmouthshire was overlooked by Dr. Reynolds.

The condition of the mother when giving birth was also a factor affecting the health of the infant. The evidence suggests that the poor general health of expectant and nursing mothers were due to poverty. When poverty is endemic the struggle for survival becomes more acute. Money to pay for the basic necessities in life such as shelter and sustenance is limited compounding inadequate, insanitary conditions and under-nourishment., Prolonged lack of essential vitamins and minerals weakens an expectant mother's
physical constitution and places her in a vulnerable position at the time of and following the birth. This situation also affects the infant's chances of survival. The Centres could not control the level of poverty in the areas in which they operated. Therefore, they could only be of limited assistance to mothers and infants and offer cheap or free milk and dinners as a short-term remedy.

While pleased that the Monmouthshire infant mortality rate had decreased in 1929 to 67.7 from 72.29 in 1928, the CMO realised that certain problems existed that had not been addressed. He revealed that almost half the number of infant deaths occurred in the first four weeks after birth, and stated that measures in place to reduce infant mortality rates, such as the infant welfare Centres, affected the one- to twelve-month infant only. He continued,

It cannot be suggested that any organised form of health work will improve this figure. 152

Separate antenatal facilities for expectant mothers were planned to become operational in 1930 throughout Monmouthshire in an attempt to target the health of the mother during pregnancy. An additional objective was to detect circumstances, which might lead to difficult deliveries. The CMO hoped that the introduction of antenatal and confinement facilities would ‘free mothers from the anxieties of unsatisfactory home conditions’ and subsequently lead to a reduction in infant deaths in the first month of life. 153 It seemed that the CMO recognised that infant mortality rates might be improved through preventive work in antenatal clinics. Nevertheless, the typical middle-class attitude toward mothers in working-class districts, which was common in the preceding and early
years of the introduction of infant welfare Centres was noticeable in his following comment in 1930.

Despite the results which have already been attained, there is still plenty of work to be done to combat the ignorance, apathy and carelessness of some mothers, which continue to rob the cradle and the nursery. \(^{154}\)

The evidence contained in the reports from the Centres suggests that the attitude of many of the medical officers in Monmouthshire did undergo a change. Medical men and women became more tolerant and recognised the hardships faced by mothers, particularly those in industrial communities. However, some retained their prejudices and continued to blame mothers for infant deaths, which served to perpetuate the myth that mothers in working-class districts were ignorant and lazy.

**Centres in the 1930s**

During the 1930s, reports from MOs at Centres throughout Monmouthshire continued to reveal that the health of mothers suffered more than infants, particularly for those mothers residing in the highly industrialised districts. In 1929, Centres in coalfield communities reported high percentages of mothers suffering from debility and malnutrition. However, although the weight of most new-born infants remained lower than average, the infants were generally healthy. \(^{155}\) All Centres in industrialised districts continued to show the same pattern during the early 1930s. In the agricultural districts, although some difficulties were reported with regard to lactational problems it was generally found that both infants and mothers were fit and little or no malnutrition was present. \(^{156}\)

Furthermore, districts with low unemployment tended to show an increase in the number of breast-fed infants. \(^{157}\) Attendance figures reveal that the popularity of the Centres was
increasing. In 1930, the CMO claimed that 67.7 per cent of all infants born in that year were taken to the Centres by their mothers. The average attendance at each session was 36.8. By 1935 it was 41.04 and in 1938 the attendance average had reached 45.22 with 4,179 new infants registered in 1938 out of 4,944 of the total births in the county. The attendance details reveal that in the 1930s, mothers were more inclined to take their infants to Centres and receive minor treatment for themselves and their infants, ask for advice and buy cheap food than they were previously. Subsequently, a more rounded picture of the health of both mother and infant can be established. The following section will discuss the general health of mothers and infants, the ailments they suffered and infant feeding methods practised in the 1930s. The latter point became an issue with a different perspective to that overtly apparent in earlier years.

**General Health**

The most common ailments suffered by infants were bronchial problems and intestinal disorders. Cases of anaemia in infants decreased from 197 cases in 1919 to 84 cases in 1930. Bronchial and intestinal disorders continued to be main ailments that were treated at Centres throughout the 1930s. These common complaints were easier to treat than the type of ailments impinging on the well being of mothers. For mothers, health disorders such as tiredness, debility, malnutrition and anaemia, needed a nutritious diet for improvement of the condition. Due to the impoverished circumstances faced by a large number of families in the industrial districts, many mothers could not afford to buy the required foods to improve their general state of health. In 1931 the parents of every child attending the Aberbargoed Centre were ‘on dole, parish relief or short-time pay’. As a result mothers were found to be ‘suffering from some degree of anaemia’. Breast-
feeding at the Centre had also fallen from 46 per cent in 1930 to 41 per cent in 1931. 166

The New Tredegar Centre reported that at least half of their mothers were suffering from malnutrition and anaemia, although infants seemed ‘healthier...than previously’. 167 In 1932, Dr. Gordon, AMO for Monmouthshire, reported that due to the irregular nature of the work at the docks in Newport and the high unemployment in the area, breast-feeding was low in Newport since mothers were unable to lactate sufficiently. 168 Dr. Redwood, MO for Rhymney also found a considerable amount of under-nourishment in mothers. 169 Nevertheless, he added that in general the younger the mother, the more fit and healthy they tended to be. It was the older mother with large families that experienced the poorest health. 170 In Pontypool 24.5 per cent of mothers attending the Centre in 1932 were found to be in poor health. The figure rose to 32 per cent in 1933 prompting Dr. Evelyn Owen, AMO, to state that there was a general deterioration in the condition of the mothers. 171 At the same time, expansion in infant welfare services was restricted due to a lack of resources and limited funding by the government. Voluntary agencies had been experiencing financial difficulties since 1931. Funds were low and consequently less help was able to be given to needy mothers. 172 In 1933 the Maternity and Child Welfare Committee again curtailed the amount of funding to Centres, which meant that the quantity of free milk and food available to mothers and infants was limited and only distributed on strict medical grounds. 173 In addition, the discrimination policy prevalent in the operation of Centres continued with mothers excluded from the benefits of cheaper infant foods when they did not attend Centres on a regular basis. Many MOs, given the economic distress and limited resources available in the industrial districts, expected mothers to experience difficulties in continuing with breast-feeding.
However, a major concern appearing in numerous reports from 1934 onwards, seemed to be that young, healthy, well-nourished, first-time mothers, attended Centres for their initial visit three to four weeks following delivery and would say that their infant was already weaned. 174 Dr. MacQuillan at the Pengam Centre, noted that the etiology of the general decline in breast-feeding was difficult to define. He offered four reasons for the apparent decrease among first-time mothers or primiparaes. His conclusions followed research into cases at his Centre where 374 infants and 160 nursing mothers were registered, which was the highest number of nursing mothers attending the county’s Centres. 175

Firstly, Dr. MacQuillan found that when the infant was ‘cross’ for several days following the birth, a new mother was more likely to turn to bottle-feeding rather than persevere with the breast. A crying baby, he said, was justification enough for the young mother to bottle-feed. Secondly, the well-intended, though misguided advice given to the new mother by female relatives and friends sufficiently influenced them to resort to bottle-feeding as a more convenient method. Thirdly, Dr. MacQuillan believed some midwives were to blame for not insisting that breast-feeding was essential to the health of the infant. He claimed that many mothers were advised not to breast-feed by their midwives regardless of whether they were capable or not. When mothers gave this answer as a reason for not beginning or discontinuing breast-feeding, Dr. MacQuillan invariably advised a return to breast-feeding. This suggests that midwives and medical officers at Centres gave conflicting advice to mothers. The fourth reason offered reflects a change in society in general, which might have played an influential role when it came to a
mother’s choice of feeding methods. Additionally, it was argued that the ‘era of canned foods entering into the realms of infant feeding’ had an impact on the mother’s choice.

**Media Influence on Infant Feeding**

Dr. Drapes, MO for Chepstow, mirrored Dr. MacQuillan’s concerns regarding the fall in the popularity of breast-feeding. Dr. Drapes aimed to strive towards a return to the ‘normal’ conditions of infant feeding, which he believed to be breast-feeding. However, Dr. Drapes claimed that this would involve efforts to counteract and check

...the subtle propaganda of commercial interests which, however discreet and apparently scientific in individual pronouncements, undoubtedly have the cummulative effect of undermining many a mother’s faith in the need for breast-feeding and in her ability to achieve it.

Dr. Drapes went further to state that it was the ‘continuous suggestion in print and picture’ that was ‘robbing many babies of their heritage’. In 1934 less than half of the Centres in Monmouthshire returned higher than fifty per cent of the infants continuing breast-feeding: sixteen out of forty-three Centres. In the county of Monmouthshire percentages continued to decrease. In 1934, fractionally over eighty per cent of infants were breast-fed and in 1938 the percentage stood at seventy-two for the whole county.

Therefore, the statistics represent a definite decline in popularity for breast-feeding. The poor lactational ability of the mother, which was one of the reasons for a decline in this method of feeding infants has been analysed in this study. Another reason, not overtly apparent through MOs remarks in earlier years, was revealed through the comments of Dr. MacQuillan and Dr. Drapes. The influence of the media rather than the mother’s ignorance or laziness was being attacked in the Centres’ reports for the first time.
When scrutinising some advertisements found in a 1916 baby-care manual and a journal published in 1933, certain observations can be made to substantiate the anxiety of both medical officers. Advertisements for 'Robinson's Groats' and 'Robinson's Barley' were cleverly positioned on one page of a manual in 1916 aimed at mothers. [See Appendix 3]

At a time when concern regarding high infant mortality rates was continually voiced by government officials and medical practitioners, the Robinson's advertisements chose 'Save the Babies!' as the main eye-catching heading. The motto was used in both advertisements, which duplicated the intended message to the mothers: using Robinson's products would ensure the survival of their infants. The first advertisement targeted expectant mothers and insisted that by taking 'Gruel' made with milk and 'Robinson's Groats' for breakfast and supper 'assistance in nursing their babies when born' would be assured. The second advertisement positioned directly below the first, displayed the main motto and added a personalised message to mothers. The message reflected the ideology of the period, which was 'breast is best'. However, the beginnings of the commercialisation of infant feeding and skilful marketing strategies aimed at increasing profits was evident in the wording of the message. The message, aimed directly at its audience began 'TO MOTHERS'. It continued

Try and nurse your babies yourselves. If not able to do so, try the next best thing supplied by Nature -...BARLEY WATER...

The advertisement clearly aimed to divest the mother of blame if she decided not to breast-feed her infant. Regardless of the type of milk chosen, whether fresh, dried or condensed, the Company scientifically claimed that stomach upsets would be prevented,
implying that the infant would be contented and satisfied. A contented baby seemed to be one of the major aims of mothers attending the consultations in the infant Centres. The advertisement for ‘Benger’s Food’ in the same publication similarly used familiarity to persuade mothers to buy the product. Furthermore, the use of statements from medical journals such as the Lancet and the British Medical Journal worked to substantiate the claims of the Company. The advertisement claimed that the Lancet described the product as ‘Mr. Benger’s admirable preparation’. The use of the prefix ‘Mr.’ aimed to promote a respectability of presence and a personalisation of the Company rather than just a product name. A friendlier image was produced, which acted to put the mother at ease prior to reading the information contained in the advertisement. Firstly, nursing mothers were addressed with assurance that ‘Benger’s Food’ would increase breast milk production. However, the assurance is brief compared to the section ‘For Infants’. This part of the advertisement is a mixture of medical and scientific rhetoric entwined with the everyday language most commonly used by mothers. The patronising tone of the advertisement is meant to be understood by all mothers regardless of educational standards. The medical term ‘malnutrition’ is explained in the same sentence with the commonly expressed term, ‘outgrowing their strength’. Finally, it is claimed that the product is made from ‘fresh new milk’ which is easy to digest ‘by the most delicate and weakly child’, which further served to reassure the mother that she would be making the right decision choosing the product for her baby.

Later in 1933, an advertisement for ‘Glaxo’ maintained a claim to medical knowledge through ‘research on infant foods and infant feeding problems’. The ‘Glaxo’ advertisement used a border of plump, contented cherubs to visually promote its product.
The catchy phrase ‘Builds Bonnie Babies’ was used together with the prefix ‘Sunshine’ added to the brand name of the product to make ‘Sunshine Glaxo’. This was intended to impart the image of natural, radiant health for any infant fed with the product. 184

[See Appendix 4]

The 'subtle propaganda' mentioned by Dr. Drapes in 1934 was evident much earlier in 1916 as illustrated through the two advertisements. The media continued to impress images of infant contentment throughout the 1930s. It can be argued that this type of advertising language and symbolism worked to encourage mothers to abandon breast-feeding without a guilty conscience.

When Dr. J. J. O'Reilly, MO for Chepstow, took over the running of the Chepstow Centre in 1935 he continued to attempt to increase breast-feeding statistics and strongly supported Dr. Drapes’ earlier criticism of media influence on mothers. He forcefully accused advertisers of portraying the nursing mother as the victim with the infant sapping her strength instead of illustrating the benefits breast-feeding could bring to mother and infant.

...it is typical of the effect produced by the activities of the advertisers that the relation of a mother and her suckling infant appears to suggest, not a kind of symbiosis benefiting both, so much as a variant of the vampire theme, the mother of course being the exsanguinated victim. 185

By 1938, Dr. O'Reilly admitted defeat and stated that in spite of attempts to encourage mothers to breast-feed percentages at the Chepstow Centre had decreased further.

Keeping to his firm anti-advertising stance, he commented that ‘Breast-milk, having no cash value, has no press agent’. 186 Dr. O'Reilly justified his continued support of breast-
feeding by quoting in his report to the CMO points made by three medical sources and
the result of research undertaken at the Birmingham Children’s Hospital. The three
medical authorities were in agreement that more infants died in their first year if they
were artificially fed than if they were breast-fed. The section in Dr. O’Reilly’s report
taken from a lecture on ‘Infantile Diarrhoea’ was printed in the *Lancet* and based on a
study of five hundred consecutive cases in the Birmingham Children’s Hospital. It was
found that out of the children who were breast-fed compared to artificially fed, the
‘mortality rate in the latter group was more than three times greater than in the former’. Dr. O’Reilly concluded that mothers could not be blamed for refusing to breast-feed their
infants and choosing to use an artificial source of food. He believed that the blame should
be placed firmly on the advertisers and stated that ‘mass suggestion’ was the ‘greatest
cause’ of failure to breast-feed. He continued to point out that the working-class mother
was

...exposed to the full battery of a modern publicity campaign operated with the
utmost skill to produce maximum profit for the manufacturer.

Furthermore, he believed that the ‘exploitation of the innocents’ should be checked by
law. Nevertheless, Dr. O’Reilly saw the potential of the advertisers techniques. He called
for Centres to be more innovative in their design of leaflets and literature which was
aimed at nursing mothers to explain the benefits of breast-feeding. The leaflets found in
Centres, he said, were too practical and uninspiring. He thought the use of modern
advertising tricks could be promoted to produce leaflets that would be more interesting
and appealing to mothers. Therefore, although Dr. O’Reilly criticised advertisers he
could recognise the benefits to infants and the possibility of increasing breast-feeding numbers at the Centres with the use of the same techniques he claimed to despise.

**The Centres in 1938**

Through the evidence supplied in the reports of the MOs at Centres in Monmouthshire in 1916, breast-feeding was the method chosen for 81.2 per cent of infants born that year. In 1926, the year of the coal stoppage, the percentage rose briefly to 86.2, which was the highest recorded for the period covered in this study. There was a gradual decline until in 1938 the percentage stood at 72.0. Individual Centres reported percentages which fluctuated according to the choice made by mothers, which was usually influenced by problems in lactating ability due to the poor health of the mother during the severe economic depression in the South Wales valley communities. Voluntary agencies, such as the 'Save the Children Fund', the Coalfields Distress Fund, the British Red Cross Society, churches and chapels contributed money, fresh milk, food supplies, boots and clothing to families in need in the 1920s and 1930s. Without the help of these volunteer groups, everyday life for mothers and infants might have been more severe. The most common ailments that infants were found to be suffering from when taken to Centres by their mothers were bronchial and intestinal disorders, although in periods of severe distress, rickets became more noticeable in the coal-mining communities. By 1938, there appeared to be few cases of malnutrition among infants under one year of age and infants were generally healthy. However, the health of mothers repeatedly exhibited deterioration. Debility, malnutrition, general tiredness and anaemia, which all led to lactational problems, continued to affect the well being of mothers, particularly in working-class districts. Furthermore, the effect of the mother’s health on the new-born
infant was devastating. Whereas the overall infant mortality rate in Monmouthshire declined from 97.6 in 1918,\textsuperscript{195} to 55.0 in 1938,\textsuperscript{196} in all except three years, 1919, 1926 and 1929, the rate remained higher than England and Wales, which in 1938 stood at 5.0.\textsuperscript{197} In 1931 the CMO for Monmouthshire noted that a large proportion of infant deaths occurred in the first months of infant life. The CMO observed that
\begin{quote}
Death at this period in life is often due to the ill-health of the mother during pregnancy and to difficulties during confinement.\textsuperscript{198}
\end{quote}
It is significant that the CMO chose to use the same comment in his report for 1932, 1933, 1934 and 1935.\textsuperscript{199} In 1938 neo-natal mortality was ‘still very noticeable’ with 149 of the 275 infant deaths, or 54.1 per cent happening in the first four weeks of life. Although the overall infant mortality rate for Monmouthshire had reduced considerably over the thirty-year period, the CMO noted that the neo-natal rate had remained practically the same.\textsuperscript{200} In an effort to target the expectant mother, separate antenatal clinics were opened in Monmouthshire in 1930. The effects of these separate clinics will be discussed in detail in the following chapters.
Nursing mothers attending the Centres in 1938 were still found to be suffering from an inability to sustain breast-milk flow for their infants. Consequently, many Centres reported a drop in the percentage of infants that were wholly breast-fed.\textsuperscript{201} The only Centres showing fifty per cent or more infants fed entirely by breast were Trehomas (52.4\textsuperscript{\textdegree}), Caldicot (53.0\textsuperscript{\textdegree}), Blaina (52.0\textsuperscript{\textdegree}) and Usk (50.0\textsuperscript{\textdegree}) with Ebbw Vale having the highest percentage at 67.0.\textsuperscript{202} At the Risca Centre, Dr. Roberts was disheartened to report that breast-feeding was very low, with just over a quarter of the infants attending being breast-fed and 57 per cent wholly bottle-fed. Dr. Roberts complained that in an article
that had appeared in the British Medical Journal it was inferred that MOs at Centres were to blame for low breast-feeding statistics. Dr. Roberts argued that the insinuation was ‘hardly reasonable’ and stated that neither family doctors nor midwives bothered to give advice to mothers on breast-feeding, which led to the majority of mothers choosing to bottle-feed before making their first visit to Centres.

However, Dr. Roberts conceded that the bottle-fed babies had thrived as well as the breast-fed ones and that ‘summer diarrhoea’ was ‘almost unknown’. She reported that ninety-eight per cent of the breast-fed babies were in a satisfactory condition compared to eighty-eight per cent of the babies who were both breast- and bottle-fed. The wholly bottle-fed babies were as equally satisfactory, ninety-eight per cent, as the wholly breast-fed babies. She concluded her argument by stating that except for psychological reasons, arguments were lacking to persuade mothers to persevere with breast-feeding. 203

Dr. Smith of Abertillery, had noticed in earlier years, that young, first-time mothers were most eager to give up breast-feeding. In 1938, he reinforced his opinion by mentioning that the young mothers too readily accepted advice from other mothers who had bottle-fed. He remained firm in his belief that breast-feeding was the best method of nutrition for the infant in the early months of life. 204 Dr. Smith found that the majority of nursing mothers attending his Centres at Abertillery and Llanhilleth lacked adequate nutrition particularly in relation to fresh milk and vegetables, which he claimed cost too much for the working-class family. 205 Other Centres also reported that mothers seemed to be below the normal nutritional requirements needed for general good health. In Pontypool Dr. Owen reported that twenty per cent of the nursing mothers displayed signs of general debility. 206 Dr. O’Riordan found 12.5 per cent below average at Newbridge 207 and 18.6
per cent at Pontymoile. The cumulative evidence appears to reveal that the long period of unstable economic conditions in the industrial districts of South Wales led to the deterioration of the health of mothers in working-class districts. This in turn affected the mothers' ability to breast-feed and the chance of survival for their infants in the first four weeks of life.

It has been shown that attendance figures increased from 1919 to 1938 and breast-feeding percentages decreased. Additionally, evidence was presented which revealed that many medical men and women in charge of the Centres around 1920 blamed mothers for infant deaths and ill-health. The comments of the majority of MOs show that they remained firm in their belief that breast-milk was the best form of nutrition for the young infant. However, a change in attitude towards mothers was detected. This change materialised through the realisation that mothers were not to blame for lactational deficiencies. Mothers were heavily criticised for being 'ignorant' and 'lazy' by MOs when the Centres first opened, for not attending, for choosing to bottle-feed and for the poor quality of infant care that, as middle-class medical practitioners, they perceived mothers in working-class districts gave to their infants. The work of health visitors attached to Centres included home visitations. Health visitors reported to the MOs at Centres and to the CMO. Through health visitors' reports the reality of home conditions were uncovered. Together with the observations made by the MOs following consultations with mothers at the Centres the stigma of ignorance lessened. Occasionally, stigmatisation perpetuated the myth that mothers in working-class districts were lazy and ignorant, as illustrated through newspaper reports which labelled Blaenavon mothers as incompetent.
Nevertheless, there was also evidence of support for the mothers from middle-class officials. The evidence contained in the forty-two reports from the Centres in Monmouthshire in 1938 reveal that there was a change in attitude. Not one of the reports criticise the mothers. Dr. Jones, MO for the Pengam Centre praised the mothers for their ‘noteworthy achievement in the face of economic pressure’. Mothers, he said, eagerly followed the progress of the infants, frequently asked for advice, followed the advice ‘intelligently’ and all the children were ‘well-turned-out’. It can be argued that blame was removed from the mother to other influencing agents within her environment such as economic and social conditions affecting her health and well being. Some medical officers also mentioned the impact of the media as being at fault.

Finally, the Centres helped mothers in a hidden way, which had not been envisaged with the implementation of the scheme. Medical officers, regardless of gender and preconceived ideas of maternal care were brought face to face with the problems of a county where the industrial districts, particularly the coal-mining areas, posed severe economic difficulties for the mothers. The effect the prolonged depression had on the health of the mothers was uncovered through the consultation and visitation process of the scheme. In part, this helped to alter the opinions and the attitude of the middle-class care providers towards the mothers in working-class districts in the county. A concluding comment from Dr. Rocyn Jones, the CMO for Monmouthshire will serve to underscore the main focus of this chapter and lead neatly into the central theme of the following chapter, which is maternal mortality.
Deaths (neo-natal) are largely due to conditions of the mother and to difficulties during confinement, and the problem is closely associated with that of maternal mortality. 210

Chapter Four Notes


7 Monmouthshire County Council (M.C.C.), Maternity and Child Welfare Committee (MCWC), Annual Report for 1919 p.9.

8 Ibid. Comments of Dr. T. W. Bevan, Medical Officer (MO) for Blaina and Nantyglo, p.26.

9 Ibid. Comments of Dr. M. Howie, Assistant Medical Officer (AMO) for Monmouthshire, Pontymoile Centre, p.15.

10 Ibid. Dr. M. Scott, (AMO), p.18.

11 Ibid. Dr. L. Pugh, (AMO), p.22.

12 Ibid. Taken from the list ‘Details of Attendances at Centres’.

13 Ibid. p.22.

14 Ibid. Dr. M. Scott, (AMO), p.20.

15 Ibid. p.20.

16 Ibid. Dr. L. Pugh, (AMO), p.21 and p.23.
18 Ibid. p.16.
19 Ibid. p.17.
20 Ibid. p.17.
21 Ibid. p.17.
23 Ibid. p.24.
24 Ibid. p.25.
25 Ibid. Dr. M. Howie, p.18.
26 Ibid. Dr. T. W. Wade, p.25.
27 Ibid. Taken from a Table submitted by Dr. T. B. Smith, MO for Abertillery urban district, p.36.
28 Ibid. Comments of Dr. T. B. Smith, p.39.
29 Ibid. p.42.
30 Ibid. p.41.
31 Ibid. Dr. L. Pugh, p.21.
32 Ibid. Dr. T. B. Smith, p.41.
33 Ibid. p.41.
34 Ibid. p.41.
35 Ibid. p.43.
36 Ibid. Dr. M. Scott, p.18.
37 Ibid. Dr. E. T. H. Davies, MO for Tredegar, p.25.
38 Ibid. Dr. H. N. Taylor, MO for Ebbw Vale, p.33.
39 Ibid. ‘Details of Attendances at Centres’.
These figures are taken from the M.C.C. *Midwives Register for 1914*. The numbers would have varied insignificantly by 1919, however the percentage of unqualified to qualified midwives continued to decrease throughout the 1920s and 1930s - see earlier chapters.

41 MCC., MCWC, *Annual Report for 1919*  
Dr. H. S. Mason, MO for Pontypool, p.29.

42 Ibid. ‘Details of Attendances at Centres’.

43 Ibid. Dr. R. V. de A. Redwood, MO for Rhymney Centre, p.32.

44 Ibid. p.31.


47 Audrey J. of Tenby in South West Wales. Interview by Jan King at Audrey’s mother’s home in Saundersfoot, 6 February 1993.

48 Sissy, no surname was given, born in Newport in 1914. Interview by Jan King at Bettws Residential Home, 8 October 1994.

49 MCC., MCWC, *Annual Report for 1919*  
Figures taken from ‘Table of Vital Statistics’ and ‘Details of Attendances at Centres’.


See pages 221 to 256 ‘Infant Feeding and Management’ and pages 285 to 315 for additional information on alternative methods of feeding infants.

p.51.

53 Myers, B., (1916) *The Care of Children from Babyhood to Adolescence*  
p.19.

54 Ibid. p.20.

55 MCC., MCWC, *Annual Report for 1919*  
p.15.

56 Dr. Frederick Truby King initially promoted his theories in New Zealand
then became influential in Britain in the inter-war years.

57 Myers, B., (1916) p.15.


61 Ibid. p.18.

62 Ibid. p.19.

63 Ibid. Dr. M. Howie, p.15.

64 Ibid. Dr. L. Pugh, p.21.

65 Ibid. Dr. T. I. Drapes, p.27.

66 Ibid. Dr. M. Scott, p.20.

67 Ibid. p.29.

68 Ibid. Dr. M. Howie, p.15.

69 Ibid. The medical officers making specific comments were - Dr. Howie, p.15., Dr. Scott, p.20., Dr. Martin, p.28., Dr. Mason, p.29., Dr. Redwood, p.32., and Dr. Smith, p.40.

70 Ibid. p.19.

71 Ibid. p.43.


73 Ibid. p.55.

74 MCC., MCWC, *Annual Report for 1919* Dr. H. S. Mason, p.29.

75 Ibid. p.7.

76 Ibid. p.8.

77 MCC., MCWC, see individual Annual Reports for the years 1919 to 1938. Also refer to Appendix 1 for a comparison of infant mortality rates.
MCC., MCWC, Annual Report for 1919 Dr. Mason, p.29.

Ibid. Dr. Prosser, p.30., Dr. Redwood, p.32. and Dr. Smith, p.40.

Ibid. See p.40 for Abertillery and Llanhilleth and p.43 for Monmouthshire.

Ibid. Figures taken from ‘Details of Attendances at Centres’.

The list of ailments are long and vary in severity from mild ‘snuffles’ to serious defects. Lists can usually be found on pages 12 and 13 of each of the Annual Reports from 1919 to 1938.

MCC., MCWC, Annual Report for 1920 Dr. W. D. Steel, MO for Abergavenny, p.28.

MCC., MCWC, Annual Report for 1925 p.52.


Babyworld News ‘Breastfeeding Boost’ 22 May 1999 http://www.babyworld.co.uk

Ibid. Annual Report for 1920 p.34.


Ibid. p.34.

Ibid. p.34.

Ibid. p.34.


Blaenavon Urban District Council Minutes for 1922 20 February 1922.

Free Press of Monmouthshire 23 September 1921.

Ibid.

Ibid. 22 September 1921.

Ibid. 25 November 1921.

Ibid. A letter from the Blaenavon Rate Payers Association pointed out that an increase in relief payments would put an added burden on the rate payers.
The letter claimed that relief ‘compared favourably’ to the miners’ wage of £1.18s. 8d. before deductions, and that ‘some families were getting more than those in work and living next door to them’. This would have happened in some cases. However, Census returns reveal that some families whose head of household was a miner, often had one, two or three sons working in the mine with him, therefore multiple wages would have been going into some of the miners’ households.

99 Ibid. 9 December 1921.

100 MCC., MCWC, Annual Report for 1921 Dr. G. H. Martin, MO for Blaenavon, p.32.

101 Ibid. ‘Vital Statistics Table’.

102 Ibid. ‘Details of Attendances at Centres’.

103 Ibid.

104 Spokeswoman at the Women’s Labour Conference at Newbridge. This comment reflected the typical issues discussed by other women’s political societies within the Eastern and Western Valleys of Monmouthshire.

Free Press of Monmouthshire 20 September 1921.

105 MCC., MCWC, Annual Report for 1922 ‘Vital Statistics Table’.


107 Ibid.

108 Ibid.

109 Ibid. 26 May 1924. Also see MCC., MCWC, Annual Report for 1923.

110 Free Press of Monmouthshire 26 May 1924.

111 Ibid. 25 May 1923.

112 Interview by Jan King with Mrs. E. B., resident of Blaenavon, November 1988. Mrs. B. was living in Llanover Road when her husband applied for council house accommodation. Mrs. B. gave birth to six of her eight children in the house at Llanover Road. It was very damp and had a cellar which flooded in wet weather due to water draining from a field at the back of Ebenezer Chapel Cemetery. Mrs. B. said that the atmosphere was unhealthy for the children. Her eldest daughter contracted tuberculosis, and Dr. James, the family’s general practitioner, told Mrs. B. abruptly, that they would have to move or the other children
would suffer the same fate. The ill-health of the children, however, did not accelerate the allocation of a council house for the family.

Blaenavon Urban District Council suggested rents, exclusive of rates, to be set between 6s. 8d. and 8s. 1d. However, the Housing Committee in Cardiff stated that the amounts were too low to recommend to the Ministry of Health, and proposed initial rents of 8s and 9s. 6d. exclusive of rates. See Letter Book of Blaenavon Urban District Council 30 September 1921 A. 410. G. C. 000634 County Record Office, Cwmbran, Gwent.

A letter from Mr. Herbert Witchell of 41, Elgam Avenue, to Councillor G. I. Thomas of Blaenavon Urban District Council, explains the predicament many council tenants found themselves in: unable to pay the rent if they bought food or their families. Ibid. 28 January 1924.


Ibid. Annual Report for 1925 Dr. Smith, Abertillery, p.34.

Ibid. p.34.

Ibid. Annual Report for 1924 Dr. Rocyn Jones, County Medical Officer, (CMO) p.46.


Ibid. Annual Report for 1926 Dr M. Scott’s general remarks, p.18.

Ibid. Dr. W Austin, AMO for Pontypool Centre, p.18.

Ibid. Dr. M. Gordon, AMO for the Caldicot Centre, p.24.

Ibid. Dr. Smith, Abertillery Centre, p.28.

Ibid. Dr. A. C. Roberts, AMO for the Risca Centre, p.25.

Ibid. CMO, pp.35 - 36.

Ibid. p.37.

Ibid. ‘Vital Statistics Table’.

129 Ibid. Dr. M. M. Proudfoot, AMO, p.24.
130 Ibid. Dr. M. Gordon, p.25.
131 Ibid. CMO, p.49.
132 Ibid.
133 Ibid.
134 Ibid. ‘Vital Statistics Table’

**Infant Deaths: 1927**

<table>
<thead>
<tr>
<th>District</th>
<th>First three months</th>
<th>Three to twelve months</th>
<th>Total under one year</th>
</tr>
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<tr>
<td>Blaenavon</td>
<td>13</td>
<td>11</td>
<td>24</td>
</tr>
<tr>
<td>Bedwellty</td>
<td>51</td>
<td>34</td>
<td>85</td>
</tr>
<tr>
<td>Rhymney</td>
<td>14</td>
<td>9</td>
<td>23</td>
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<tr>
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<td>25</td>
<td>10</td>
<td>35</td>
</tr>
<tr>
<td>Risca</td>
<td>16</td>
<td>12</td>
<td>28</td>
</tr>
<tr>
<td>Nantyglo and Blaina</td>
<td>14</td>
<td>11</td>
<td>25</td>
</tr>
</tbody>
</table>

137 Free Press of Monmouthshire Various editions from February to April 1927.
138 Ibid. 26 May 1927.
139 Ibid. Dr. Reynolds report for Blaenavon printed in the same edition.
141 Ibid. Dr. P. R. Whitaker, AMO, p.29.
142 Ibid. Dr. Smith, p.37.
143 Ibid. p.37.
144 Ibid. Taken from the ‘Details of Attendances at Centres’ found in each of the Annual Reports from 1919 to 1938. The lists are printed on un-numbered pages in each report, but can usually be found between pages 12 to 20.
Ibid. Annual Report for 1928 'Details of Attendances at Centres'.


Free Press of Monmouthshire 2 November 1928.

Ibid.

Ibid.


Medical Officer of Health Report for 1928.


Ibid. p.12.


Ibid. Annual Report for 1930 At the Caerleon Centre, only mothers whose husbands were agricultural labourers working irregularly had lactational difficulties, p.36.

Ibid. Annual Report for 1932 The Caerleon Centre again returned an increase in breast-feeding from 43.4 per cent in 1931 to 50 per cent in 1932. There was little unemployment in the district. In Malpas, there was also a high percentage of infants breast-fed, 62.3, and little unemployment, p.30.

Ibid. Annual Report for 1930 CMO, p.64.

Ibid. 'Details of Attendances at Centres'.

Ibid. Annual Report for 1935 'Details of Attendances at Centres'

Ibid. Annual Report for 1938 'Details of Attendances at Centres'.

Ibid. 'Vital Statistics Table'.

Ibid. Annual Report for 1919 Taken from the list 'Most Common Ailments on which Advice is Given at Centres'.

Ibid. Annual Report for 1930 Taken from the list 'Most Common Ailments
on which Advice is Given at Centres'.

165 See individual Annual Reports for the years 1931 to 1938.


169 Ibid. Annual Report for 1932 Dr. Redwood at the Rhymney Centre, p.51.

170 Ibid. Annual Report for 1933 Dr. Redwood, p.28.

171 Ibid. Annual Report for 1933 Dr. Owen at the Pontypool Centre, p.32.


174 Ibid. Annual Report for 1934 Dr. MacQuillan, Pengam Centre, p.34. Dr. Drapes, Chepstow Centre, p.39.

Annual Report for 1935 Dr. Gordon noted that at the Rumney Centre, breast-feeding dropped from 54 to 25 per cent, and also mentioned that young mothers attending for the first time had already started bottle-feeding, p.30. Dr O’Riordan gave the same reasons as Dr Gordon, although in the case of the Newbridge Centre, breast-feeding had increased from 40 to 43 per cent. Artificially fed infant numbers also increased, p.30. Dr. Dewar, AMO for Blackwood, stated that some mothers ‘make no attempt at breast-feeding’, p.36.

175 Ibid. Annual Report for 1934 Figures taken from ‘Details of Attendances at Centres’.

176 Ibid. Dr. MacQuillan, Pengam Centre, p.34.

177 Ibid. Dr. Drapes, Chepstow Centre, p.39.

178 Ibid.

179 Ibid. See the individual reports of the Centres in the 1934 Annual Report.

180 Breast-feeding percentages for Monmouthshire.

1934 = 80.09 Annual Report for 1934 p.5.

1935 = 77.60 Annual Report for 1935 p.5.
1936 = 76.10 Annual Report for 1936 p.5.
1937 = 74.70 Annual Report for 1937 p.5.
1938 = 72.00 Annual Report for 1938 p.5.

181 Myers, B., (1916) p.177.
182 Ibid.
183 Ibid. p.176.
184 Punch No. 4798 Vol. CLXXIV. 14 June 1933 p.xxii.
185 MCC., MCWC, Annual Report for 1935 Dr. O'Reilly, MO for Chepstow, p.41.
186 Ibid. Annual Report for 1938 Dr. O'Reilly, p.41.
187 Ibid. p.41. The sources referred to by Dr. O'Reilly were:
   Paterson, D., and Forest Smith J., Modern Methods of Feeding in Infancy and Childhood
   Smith and Byers, The Specialities in General Practice
   Parson and Barling, Diseases of Infancy and Childhood
188 MCC., MCWC, Annual Report for 1938 p.41, which was taken from the Lancet 29 April 1939.
189 Ibid. p.42.
190 Ibid. p.42.
192 Ibid. Annual Report for 1926 p.5.
194 Ibid. See the individual reports from the Centres in the 1938 Annual Report, pp.21 to 42.
195 Ibid. Annual Report for 1918
196 Ibid. Annual Report for 1938
197 Ibid.
Eleven of the Centres reported a significant decrease and thirteen Centres reported an increase in breast-feeding. The remaining eighteen Centres did not elaborate on the percentage, however many medical officers voiced disappointment to find that mothers were turning more to artificial feeding than persevering with breast-feeding.


Ibid. Dr. Annie C. Roberts, Risca Centre, p.30.

Ibid. Dr. Smith, Abertillery Centre, p.38.

Ibid. p.39.

Ibid. Dr. Owen, Pontypool Centre, p.25.

Ibid. Dr. O’Riordan, Newbridge Centre, p.26.

Ibid. Pontymoile Centre, p.27.

Ibid. Dr. Jones, Pengam Centre, p.36.

Ibid. Dr. Rocyn Jones, CMO, p.10.
CHAPTER FIVE

MATERNAL MORTALITY

Introduction

The Maternity and Child Welfare Centres (Centres) established following the Notification of Births Act 1915 and the Maternity and Child Welfare Act of 1918 offered help to mothers in numerous ways, as illustrated in the previous chapter. The evidence found in Monmouthshire substantiates the claim that the popularity of Centres increased between 1919 and 1938 regardless of the predominantly middle-class practises generated through the aims of the Centres' work. However, as Lewis points out, the services offered to mothers were extremely limited. ¹ Centres did offer advice to expectant women in addition to nursing mothers. However, medical officers, some of whom had to cope with a large attendance at each brief two-hour sessions gave priority to infants and nursing mothers. Separate antenatal clinics were needed for expectant mothers. Consultations at these clinics would help to identify specific problems, which could lead to complications before, during or following birth. Separate antenatal clinics were not freely available in Monmouthshire until 1930. In 1924 there were only eight antenatal clinics in Wales; local authorities controlled seven and a voluntary association operated one. ² By 1934 there were eighty-seven local authority clinics and none controlled by the voluntary sector. Forty-three of these clinics were situated in the county of Glamorgan and a further twenty-three were in Monmouthshire. ³ Expectant women in other Welsh counties were poorly represented.
The previous chapter revealed that Centres in Monmouthshire were not able to exert an influence on reducing the number of infant deaths in the first four weeks of life. It can be suggested that the education of the mother might have played a part in the reduction of infant mortality rates for one to twelve-month-old infants. However, education alone could not provide a remedy for the high number of maternal deaths from pregnancy and childbirth which occurred nationally each year. The advent of the First World War in conjunction with a decreasing birth rate brought the focus of government and medical officials to the maternal problem. This chapter will firstly identify the extent of maternal mortality associated with pregnancy and childbirth nationally. Secondly, some of the problems related to classification of maternal deaths will be discussed. Thirdly, Wales with particular reference to Monmouthshire will be examined concerning the incidence and causes of maternal deaths. This section will include examples of the problems related to pregnancy and childbirth, mainly using the reports of the CMO and the MOs at the Centres in Monmouthshire. The position and role of the general practitioners and midwives will also be discussed in relation to maternal mortality and morbidity. Chapter Six will extend the current chapter’s focus to present a detailed analysis of the antenatal clinics’ work in Monmouthshire and conclude with the findings of the 1937 Report on Maternal Mortality in Wales.

**The Extent of the Problem Nationally**

Before 1880 the number of maternal deaths in hospitals was horrific. According to Loudon, the number of maternal deaths sometimes reached as high as ‘400 per 10,000 births, or about ten times the rate in home deliveries’. Following the introduction of antisepsis and asepsis in midwifery practice, a transformation occurred in hospital
deliveries. Out of 2,060 women who were delivered at the Rotunda Hospital in Dublin in 1907-1908 only three died from puerperal sepsis. Similarly, in London’s York Road Lying-in Hospital, over a period of sixteen years from the beginning of the twentieth century 8,373 deliveries were undertaken without a single death from the infection. The amazing improvements led the medical profession to confidently claim that maternal deaths were ‘preventable but not prevented’. It can be suggested that the transformation in hospital deliveries also offers an indication of one cause of animosity, which medical men often directed towards qualified and unqualified female midwives attending home births following the Midwives Act of 1902.

In 1915, Sir Arthur Newsholme presented a report to the Local Government Board [LGB] on maternal mortality in relation to childbearing. It was a supplement to three earlier reports on infant and child welfare, which had been submitted to the LGB. In the report Newsholme stated that:

Over 800 mothers die each year in England and Wales, as a result of childbearing, whose lives would be saved if the experience of the rest of England and Wales were as favourable as that of London.

However, even though maternal mortality rates had decreased substantially in Lying-in Hospitals in London, Newsholme admitted that the ‘recorded experience’ of puerperal fever was as ‘unfavourable’ as that in the provinces. Eradication of puerperal fever, he claimed, would save a further 1,100 mothers’ lives annually in England and Wales. Newsholme found that Welsh counties returned the highest maternal mortality rates in the country, with one mother dying to every 179 births. The main causes of death for mothers’ nation-wide were puerperal fever, haemorrhage and convulsions. These causes, Newsholme stated, were preventable. Furthermore, the
excessive mortality of mothers in childbearing led to a high number of stillbirths and infant deaths in the first four weeks following birth. In the four-year period 1911 to 1914, the total number of deaths assigned to complications of pregnancy and childbirth in England and Wales was 14,045, which corresponded to a rate of four per thousand births. Out of this total 4,951 or over one third were attributed to puerperal fever. Significantly, Newsholme noted that many more deaths had occurred which were not 'directly traceable' to childbirth, although the state of pregnancy contributed to some conditions leading to the death of the mother.

It can be argued that maternal mortality statistics were not exaggerated. Many registered causes of death concealed contributory factors associated with childbearing. Between 1897 and 1906 in England and Wales, one mother died for every 228 births. By 1914 the figure had risen to one in every 253 births. Maternal mortality rates did not correspondingly decline with the general decrease in infant mortality rates. The registered causes of mothers' deaths, such as heart disease, pneumonia and tuberculosis were often associated with childbirth. However, many deaths were not classed as due to pregnancy and childbirth. In 1913 'accidents of pregnancy' including abortion, haemorrhage, uncontrollable vomiting and ectopic gestation accounted for 377 deaths. Puerperal conditions resulted in 3,115 deaths with puerperal fever causing 1,108 of the total. Furthermore, the Registrar-General found that some practitioners returned obscure causes of death such as inflammatory conditions of the abdomen or pelvic region, which on investigation were found to be due to puerperal conditions. Deaths from puerperal causes were clearly understated. Therefore, before continuing with this investigation into maternal mortality and morbidity it is necessary to elaborate more fully on the nature of puerperal conditions affecting mothers.
Puerperal Conditions

Puerperal fever became a notifiable disease in 1899 and figures related to the number of cases and deaths as a result of the condition were available from 1911. The generic term 'puerperal fever' covered a long list of conditions, which might have been suffered by the mother. The list included 'milk fever', post-abortion sepsis, puerperal inflammation of the uterus and post-partum pyaemia. The generic term did not include puerperal scarletina or septicaemia except in connection with childbirth. The puerperal prefix covered all conditions returned in connection with abortion, miscarriage, childbirth, labour and post-natal problems. Puerperal fever was reclassified in 1926 as puerperal pyrexia. Puerperal sepsis was the name given to the clinical conditions resulting from the infection of a wound in the birth canal. The term puerperal pyrexia denoted a rise of temperature above 100.4 degrees F from any cause within three weeks of labour or miscarriage and seemed to include every case of puerperal sepsis. Local medical officers were required to notify each case in which fever occurred and was maintained at 100.4 degrees F for twenty-four hours at any time during the twenty-one day period stated. When the patient was diagnosed as suffering from puerperal sepsis the case had to be notified immediately as puerperal fever.

The most virulent cause of puerperal infection was the organism haemolytic streptococcus and was found to be responsible for the majority of the cases of puerperal sepsis. It was present in over seventy-five per cent of all fatal cases. A small percentage of pregnant women were carriers of the organism. However, the common forms of transmission were the hands, breath and appliances of the birth attendant. Three important points were known concerning the development of puerperal sepsis by the mid twentieth century. Firstly, sepsis was more common with
the first rather than subsequent confinements. Secondly, the condition was directly related to injury of the birth canal and the degree of infection was proportionate to the extent of trauma that was experienced by the mother. Thirdly, there was a definite correlation with instrumental interference. Nevertheless, some medical practitioners in the early twentieth century did not seem to practise preventive measures. Lewis states that the danger of droplet infection was known as early as 1900. However, it was not until the results of later research were published in the 1930s that the Ministry of Health stressed the use of masks and gloves. Little attention was paid to the importance of masks and gloves in practise or in medical texts before 1930. As late as 1938 the BMI referred to the delay in using face-masks as ‘astonishing’.

Maternal Deaths Under-recorded

Loudon suggests that deaths from post-partum sepsis and septic abortion tended to be under-recorded. He claims that doctors would hesitate to classify a death as being due to puerperal fever as this would imply the birth attendant’s negligence. An example of such reticence can be found in the 1920 report of the CMO for Monmouthshire. It is to be regretted that there is reason to support that some medical practitioners are averse to the definite notification of cases of this disease, lest some midwife or old gamp might have proceedings taken against her.

Therefore, an accurate indication as to how many mothers suffered from puerperal conditions, particularly before the 1930s and exactly how many mothers died from puerperal sepsis is extremely difficult to assess. Nevertheless, official figures contained in medical officer of health reports can be utilised. It should be remembered that many cases and deaths were not recorded as
being directly related to pregnancy and childbirth. The only positive assumption is
that the figures were not exaggerated. As Newsholme pointed out in 1915, many of
the less severe septic conditions associated with childbirth were not notified ‘in most
areas’, which gave reason to assume that the notification of ‘more septic conditions’
were ‘not infrequently neglected’. 18 It followed, Newsholme suggested, that deaths
from puerperal fever were understated. 19 Furthermore, there were often more deaths
from puerperal infection than there were cases notified.

In Monmouthshire in 1922, when fourteen women died from puerperal sepsis only
eleven cases of infection were notified. 20 The same happened in 1928, 21 1929, 22
1930, 23 1931, 24 1932 25 and 1935. 26 The evidence shows that the situation continued
throughout the 1920s and 1930s. The CMO admitted that it was difficult to assess the
reasons for the discrepancies and stated that an investigation into maternal deaths
would begin in 1929. 27

A national investigation into maternal mortality had started in 1928 on the instructions
of the Ministry of Health. A Departmental Committee was appointed and local
authorities were urged to conduct their own enquiries into the causes of puerperal
deaths in their districts. The Scottish Departmental Committee on Puerperal Morbidity
and Mortality recommended the investigation. The recommendation was based on the
results of research into maternal deaths in Aberdeen from 1918 to 1927, which was
conducted by Professor Matthew Hay, MO for Aberdeen. The published report of the
Aberdeen Inquiry highlighted the results that could be gained from similar inquiries
nation-wide. 28 The following section offers an insight into the reasons behind the
investigation into maternal deaths in Aberdeen and the results of that inquiry.
The Aberdeen Inquiry

An investigation into 252 maternal deaths was conducted in Aberdeen from 1918 to 1927. Both home and hospital births were assessed to enable a comparison to be made. The registration entries for all deaths attributed to pregnancy and childbirth had to be supplied for the investigation. When a maternal death occurred, the midwife and doctor were asked questions concerning the home conditions, pre-natal health of the mother, her previous obstetric history and the actual confinement. If the death occurred in the practice of a midwife, she was ‘interrogated’ by the Department of Public Health. Additional information was collected from the health visitor when necessary. At the beginning of the inquiry it was found that in Aberdeen only fatal cases of infection were notified. The number of deaths being roughly equal to the number of cases notified substantiated this finding. However, as the inquiry progressed a change was apparent and cases began to number around three times more than the number of deaths. Non-certification of cases was also quite common in England and Wales, as shown in the previous section with the example of Monmouthshire.

The Aberdeen Inquiry revealed that a correlation did not exist between environmental conditions and maternal mortality. The reason given was that the death rate in confinements in one-roomed houses was less than half that recorded for houses with four or more rooms. However, two main conclusions were noticeable. Firstly, the health of the mother was a crucial factor in determining safe delivery. Secondly, it was apparent that a higher mortality rate was present in institutions than in the community. In relation to the health of the mother, it was found that 31.8 per cent of the women whose pregnancy terminated fatally were in an unsatisfactory condition
prior to pregnancy. Aberdeen’s antenatal clinic records revealed that around eighty per cent of the women attending the clinic were found to be in good health during pregnancy. Deaths occurred in forty per cent of the women stated as having ‘good’ health. Overall, the death rate for women attending antenatal clinics proved to be half the rate of those who chose not to attend, 3.8 to 7.4 respectively. This confirmed the belief of the Ministry of Health that antenatal care was vital, particularly for primiparae mentioned in the report as facing the greatest risk. 

**Doctors Delivering in Hospitals**

With reference to higher institutional rates, the investigation revealed that in outdoor practices when a midwife was in attendance the rate was 2.3 per 1,000 deliveries, and for doctors the rate was 6.9 per thousand. In indoor institutional practices the rate for midwives was 5.6 and for doctors the much higher rate of 14.9 was reported. Furthermore, it was found that the forceps rate was 5.8 per cent among midwives’ cases and out of the total number of these births, 445, there were no resulting deaths of the mother. The report concluded that as far as the midwife was concerned the use of forceps had no prejudicial effect.

However, some criticism was aimed at this conclusion since no account had been taken of the extent of morbidity, trauma or recovery with permanent disabilities. It was suggested that it could be argued that in midwives cases, dilatation was normally complete before a doctor was called to intervene. It was claimed that the improper use of forceps ‘with the object of accelerating delivery’ was responsible for ‘trauma with ensuing sepsis in the practice of doctors’. In the report, blame for the improper use of forceps was placed on doctors. The criticism of this decision was that little or no
account had been taken of the pressure that was often placed on doctors by the patient and her relatives to use forceps to shorten an arduous delivery. 33

Mr. T.W. Eden, Consulting Obstetric Physician to Charing Cross Hospital in London pointed out that the comparison between midwives and doctors cases may be unfair, since midwives conducted normal labours and doctors attended abnormal cases. Therefore, the latter type were difficult cases and were more likely to develop sepsis. Mentioning the overall higher rate in institutions, Mr. Eden commentated that this could have been due to three major outbreaks of infection in 1922, 1924, and 1928. He continued that if the outbreaks could have been prevented, a 'notable reduction' of the maternal mortality rate from sepsis in Aberdeen would have been the result. Nevertheless, the higher institutional rates were appalling. Deaths from haemorrhage were found to be more than double that in the city. Additionally, deaths from albuminuria and convulsions were two and a half times higher and sepsis three times higher. No explanations concerning the reasons for the higher figures were offered. 34

In conclusion, the report recognised the need for improvements in institutions, particularly in the control of droplet infection in overcrowded wards. There were two main suggestions made in the report. Firstly, the report advised the extension and improvement of antenatal care and secondly, the development of a new midwifery organisation. It was proposed that midwives would attend normal deliveries while doctors provided antenatal care and dealt with difficult obstetric cases. 35

The Aberdeen Inquiry revealed details concerning maternal deaths, which confirmed general government and medical opinion. However, medical practitioners raised some criticism when the Ministry of Health decided to undertake similar inquiries. Throughout 1929, evidence contained in the BMJ highlights the trend towards the
medicalisation of childbirth and the classification of pregnancy as a medical condition.

**General Practice for Doctors, Domestic Practice for Midwives**

The decision to undertake an in-depth investigation into maternal mortality met with some obstacles from general practitioners and led to discussions concerning the role of the doctor in midwifery cases. Dr. R.L. Kitching, a general practitioner, pointed out that doctors had been informed that investigations into maternal mortality were directed towards an improvement of maternity services nation-wide. However, doctors had not been enlightened as to the type of information the Committee on Maternal Mortality and Morbidity hoped to obtain. Furthermore, he claimed that general practitioners had not been asked if they were willing to co-operate in the investigation and raised 'grave objections' to the Committee's scheme. Dr. Kitching's concerns reflected the uncertainty some doctors felt in relation to the practice of midwifery.

During a conference on the future of maternity services, held jointly by the Section of Obstetrics and Gynaecology of the Royal Society of Medicine and the Maternity and Child Welfare Group of the Society of Medical Officers of Health, Dr. Munro Kerr of Glasgow noted that in most medical schools adequate instruction in obstetrics was offered to undergraduates. Nevertheless, he argued that on graduating and working as a general practitioner, the doctor would still be inexperienced for the attendance of difficult labour cases. Lady Barrett responded by pointing out that training was hardly adequate when even in the best medical schools only three months were entirely devoted to obstetrics or six months to midwifery and gynaecology. Midwives were trained wholly in midwifery. Dr. Kerr believed that many general practitioners did not want to engage in general midwifery work due to the difficulties surrounding
domestic practice. He claimed that it was often too problematic to obtain ‘surgical cleanliness’ in unhygienic surroundings or to acquire adequate assistance when an operation was needed. Furthermore, Dr. Kerr said that midwifery practice ‘disturbed the routine’ of general practice, which might lead to temptation for the doctor to procure a speedy delivery. Finally, he noted that the general practitioner’s opportunity to practise obstetrics had been severely limited, since sixty to seventy per cent of cases had passed into the remit of the midwife. Dr. Kerr was offering an average percentage; the actual percentage varied from town to town, county borough to county borough and county to county.

In 1917 midwives in the Welsh county borough of Merthyr Tydfil attended ninety-eight per cent of all births; in Cardiff the percentage stood at sixty-four; in Swansea it was seventy-eight per cent and Newport’s percentage was lower at fifty-two. The counties in Wales returned large variations in the percentage of midwives attending births, ranging from a low percentage of sixteen in Cardiganshire to above average percentages in Breconshire at 94 and Monmouthshire with 95 per cent. In Monmouthshire in 1916, 155 births were attended by unregistered midwives without a doctor and a further 137 births with a doctor in attendance. The CMO admitted knowing that thirty-one unregistered midwives were practising in the county. While the situation was not condoned, rural areas in particular found it difficult to secure an adequate number of trained midwives.

Throughout the 1930s, Monmouthshire midwives submitted notifications of ninety-nine per cent of all births in the county. In 1930 midwives in Monmouthshire notified 6,523 births and medical practitioners notified forty births. In 1933, births notified by doctors and parents totalled only twenty-seven. The remainder 99.5 per cent of the
total births was attributed to midwives. The 1937 report for Monmouthshire gave
the same percentage to midwives. However, the number of births notified by doctors
and parents had fallen to twenty-one. The evidence suggests that midwives in
Monmouthshire were attending more births than general practitioners. Therefore, the
statistics furnished in the above reports confirms Dr. Kerr’s suggestion that general
practitioners lacked the opportunity to attend births and gain relevant experience in
problems associated to both normal and abnormal births.

A Preventable Condition

The general underlying belief of many medical professionals was that puerperal sepsis
was preventable. Some called for more maternity beds in hospitals, others believed a
more efficient maternity service with additional training for doctors and midwives
would help. Dr. C.M. Craig, a general practitioner in Kendal, argued that puerperal
sepsis was not always preventable. He offered examples of six cases of infection and
three cases where infection did not develop, to prove his point. He claimed that the
varied reasons given for the development of puerperal infection did not hold true and
proposed an alternative suggestion resulting from his observations of the cases he had
attended during his ten years in private practice. Dr. Craig firmly believed septic
tonsils, bad teeth and bowel problems were the root cause of the development of
puerperal infection. Additionally, dental problems led to improper nutrition in an
indirect way. With defective teeth, foods that should have been eaten were often
avoided due to the difficulties of chewing caused by bad or missing teeth. Inadequate
mastication of food also led to indigestion and bowel complaints. Dental hygiene, he
claimed, was essential for the general health of the expectant mother. However, since
women would not attend their local doctor for problems related to their teeth, general practitioners were not in the position to identify women at risk in this way.

In Monmouthshire a scheme for the dental treatment of mothers was inaugurated on the first of September in the year 1920. The Senior School Dentist, Mr. C.J.H. Riches, was engaged for one half-day a week to attend to the dental needs of expectant and nursing mothers at the Newport School Clinic. In the last quarter of 1920 five mothers were treated. The evidence contained in the Centre’s reports suggests that the scheme was a success in the identification and treatment of dental caries in nursing and expectant mothers. In 1930 the number of mothers treated amounted to 572. A total of 2,868 permanent teeth were extracted. Advice was given on dental hygiene and the treatment available included the extraction of defective teeth; dentures were not provided.

The evidence suggests that the scheme helped mothers who attended Centres to have bad teeth removed. However chewing difficulties would have remained if the mother could not afford to purchase dentures. The general practitioners’ involvement in dental treatment was limited to the indirect symptoms such as digestive disorders. Nevertheless, the majority of women postponed seeking advice and treatment from doctors for complaints, which they accepted as being a normal part of their ‘lot’ in life. Dr. Craig’s conclusions were based on his own observations and not on any empirical study of the relationship of dental caries to the general health of the expectant mother.

In contemporary documentation concerning maternal mortality and maternal health there appears to be a disregard of the dental problem. Dame Janet Campbell confirmed that it was the antenatal clinics that had given an insight into the general
health of mothers. She pointed out that conditions such as indigestion, constipation and dental caries were accepted as a matter of course and usually left unattended until the situation was detected at the clinic. It can be suggested that at least prior to the implementation of nation-wide antenatal clinics, many local general practitioners had limited knowledge of women's health concerns and the extent to which general poor health contributed to an unsuccessful pregnancy and labour. An interest in midwifery practice would need to be present for a doctor to take notice of the well being of mothers.

**The Conclusions of the Interim Report**

The diversity of opinion evident among the medical profession in the early 1920s concerning the establishment of a national maternity service seemed to come to a head and reach a general agreement by 1930. The *Interim Report of the Departmental Committee on Maternal Mortality and Morbidity* stated that after due consideration, the suggestion of confining maternity work to a selected panel of practitioners with particular experience in obstetrics was discrimination. The suggestion would be both unwise and impracticable as a generally applied system. It was believed that all general practitioners should be free to practise or abstain from maternity work.

Furthermore, the Committee recognised that particularly in remote country districts, the local doctor was the only person available to attend to difficult cases. The aim should be to increase the general standard of knowledge in midwifery among both doctors and midwives, rather than encouraging the formation of a select team of obstetrical practitioners.

The role and responsibilities of the general practitioner in the new scheme was set out clearly by the Committee. Once accepting responsibility for the expectant mother
whom had 'booked' his services, the doctor would be responsible for both mother and child from the date of such a booking until the end of the puerperium. This was defined as covering a period of four weeks from the date of delivery. It was stressed that the patient should at all times be free to choose the doctor or midwife of her choice. However, the chosen doctor's responsibility once he had accepted the case was to attend to all antenatal examinations that were necessary, including the general early examination and the special checks in late pregnancy. The doctor would then be in a position to report to the local authorities on a number of issues concerning his patient. These issues included reporting additional medical and dental treatment a patient might need. An assessment could be made on each case. A midwife could deliver impending births regarded as normal at home. Pregnancies showing signs of abnormalities would require hospital confinement or specialised treatment.

Additionally, the doctor would be responsible for post-natal care and would conduct a complete examination of the physical and general health of the mother. The post-natal examination would assist the identification of problems directly associated with childbearing, whether minor, such as infection of the teeth or tonsils, or major such as heart or lung defects. The whole objective was based on the principle that the person responsible for antenatal care should be responsible for offering the mother continuity of care throughout her pregnancy. This included attendance during labour, confinement and puerperium.

The Committee hoped that antenatal clinics, as opposed to antenatal care under the auspices of the general practitioner, would continue to play an important role in educating the mothers and midwives. The Committee recognised that the general practitioner was under a 'serious handicap' yet often worked on obstetric cases
including complications and accidents of labour. Therefore, the Committee concluded that there was a need for a higher standard of knowledge and skill on the part of the doctor.

It was found that in nearly one-third of the doctors' cases ending in maternal death through 'errors of judgement', the most common mistake was the premature application of forceps. The second highest category involved the comparative rarity with which doctors gave saline solutions when needed during ante- and post-partum haemorrhages. The third highest reason seemed to stem from the absence of full details taken at the time of birth. To ensure more knowledgeable domiciliary practice in midwifery for doctors, one of the principal recommendations was the education of the medical student in obstetrics.

The Committee referred to the earlier view of the Royal Society of Medicine in 1919, which stated that 'the practical instruction leaves much to be desired, and in some respects merits emphatic condemnation'. It was the Committee's belief that a general reduction in maternal mortality would be realised through the tightening of all links in the obstetric chain. This would come about gradually through the improved training of both medical students and midwives. The proposed national maternity scheme intended to place general practitioners in the foreground of antenatal care and ensure continuity of care for mothers. Co-operation between the doctor and the midwife was essential and specialist advice and hospital accommodation should be available for all complicated cases. One of the main criticism's of the Committee was that maternity services were 'not yielding their potential value' and were 'not proving a solution to maternal mortality'.
Fees Payable to Doctors

The payment of fees to doctors called out to attend confinements by midwives had proved to be a problem area and was also investigated by the same Committee. The Committee submitted the opinion that the 'meagre practical experience' obtained through the under-graduate training period, aggravated the difficulties faced by the general practitioner when undertaking maternity cases. Problems were accentuated through adverse economic conditions and the payment of fees. With the proposed new national maternity service, the Committee recognised that the number of normal cases in which the doctor would be involved could be small, further restricting the development of his knowledge of normal deliveries. However, the Committee continued, the disadvantage would be outweighed by the overall advantages the scheme had to offer. Furthermore, the doctor's experience and expenses would be made up by his private patients and with the requests from midwives to attend confinements displaying slight abnormalities. Nevertheless, it was noted that a doctor conducting good antenatal work should not be in danger of a diminishing income due to a lessening of the number of mothers requiring attendance at home confinements. The regard for the general practitioners' income suggests that the Committee believed that antenatal care would improve the general health of mothers and lead to fewer complications during birth. The method of payment for a doctor's services was recognised as needing a review. Instead of a set fee for 'special services' an inclusive fee for each case accepted by the doctor under the new scheme was suggested. It was agreed that the medical profession would have to be consulted on the issue. Under Section 14 of the Midwives Act 1918, the local supervising authorities were responsible for the payment of fees to general practitioners called in to confinements
by midwives in cases of emergency. The authorities then had the power to recover the whole or part of the fees from the husband.

**Conflict in Monmouthshire**

The supervising authority for Monmouthshire was the County Council. In 1922 fees were paid in 195 cases involving payment of 338 pounds fourteen shillings and sixpence. The total amount recovered was 46 pounds eight shillings and sixpence. The majority of the money had to be paid by the County Council. The CMO noted that since Monmouthshire was chiefly an industrial area the fees paid out to doctors should be small. Most of the collieries and other heavy industries in the county had introduced a ‘poundage system of medical aid’. This covered ordinary medical attendance on dependants of insured workers and special medical attendance during pregnancy and confinement of women dependants. Workers paid a weekly contribution out of their wages into the scheme.

However, there is evidence that conflict existed between MCC and some of the operators of the schemes in place in the county, particularly the ones in Ebbw Vale and Sirhowy. The CMO complained that there was ‘an attempt being made to throw upon the County Council the ordinary midwifery service of these areas’ and that a ‘firm stand’ was being taken ‘to remedy this unfair and unreasonable practice’. The situation was not resolved. In the intervening years between 1922 and 1935, the number of cases requiring fees to be paid by MCC varied from 160 in 1929, to the highest figure of 225 cases recorded in 1930. Each of the cases were investigated in the home where the confinement took place before the Council authorised payment and decided on the amount to be recovered from the husband. The amount repaid each year varied considerably. The lowest amount recovered was in 1934. With 202 cases
accounting for 362 pounds and seven shillings, the Council was only able to recover just over ten pounds. In the same year, the Council was forced to face court action concerning the non-payment of fees to doctors called out by midwives to attend confinements.

Four doctors whose fees for attendance had been disallowed took proceedings against MCC. The Council was successful in the County Court. However following appeal, the High Court reversed the decision much to the dismay of the Council. The appellants were Dr. A.P. Brown, Dr. K.S. Thom, Dr. A.J. Partridge and Dr. D.J. Buckley, general practitioners in Monmouthshire. The Ministry of Health had established the scale of fees payable by local authorities. Guidelines provided signposts for reasons to exclude payment of fees to doctors by the local authorities. A number of main points were established. Fees would not be payable to doctors when the doctor had agreed to attend following consultation with the patient, or on behalf of ‘a club, medical institute or other association of which the patient or her husband is a member’. Also, no fees would be paid if the doctor had received a payment from the patient or her representative. Finally, the doctor would not be paid by the County Council if any service was given after the tenth day of the first attendance, except under special circumstances. MCC would not pay the doctors’ fees as it was claimed that they had agreed to attend under arrangements with the patient or on behalf of a ‘club’. The County Council had disallowed the fees on the grounds that the doctors had agreed to attend under these conditions. Although the County Court ruled in favour of the Council, the doctors appealed against the decision and eventually won the case. The example in Monmouthshire illustrates the complex nature of statutory provisions surrounding attendance at confinements which was bound by the rules of
the Central Midwives Board, the Midwives Act of 1902 and the revised Act of 1918, particularly Section 14. The example offered bears witness to the conflict that could surround the payment of fees to doctors attending births.

Comments and observations contained in the report of the case highlight the involvement of the state in the process of childbirth. Lord Hanworth stated that the keynote principle of the Midwives' Acts was that in the interest of the state the mother was treated in an emergency. Prompt attention would ensure that the mother and her child would not suffer disabilities 'which may arise from some difficulty at the time of parturition or afterwards'. However, it can be argued that monetary reward payable to birth attendants did play a part in the choice between a doctor and a midwife that wives in working-class districts in particular had to make. At a Maternal and Child Welfare Conference in 1929, Dr. Fairbairn pointed out that it was 'regrettable' that mothers who could barely afford a doctor were more likely to engage the unqualified attendants because they were cheaper. He believed that puerperal morbidity 'would remain more rife than it should be' until the untrained midwives were 'wiped out'.

The court case in 1935 and the reports of MOs, highlights one of the problems faced by many families in the industrial districts of Monmouthshire; the potential inability to pay for adequate care during confinements. When a medical club was in existence, the husband would have needed to be employed and able to pay his contributions for his dependant wife to benefit. Furthermore, it can be suggested that difficulties encountered by general practitioners to recover fees from the Council might have led to some animosity on the part of the doctors called out to such cases. The High Court case ended in favour of the appellants, which meant that the County Council were
obliged to pay the fees of the doctors involved. The CMO stated that it would entail ‘a considerable increase in future payments’. From 1935 to the end of this study in 1938, there were no further mention of the number of cases where fees were payable to doctors although the amounts were still included in the reports. In 1935, fees for medical attendance rose to 833 pounds and nine shillings with only 58 pounds recovered from husbands. The same pattern was revealed in 1936 with 625 pounds in fees and 80 pounds recovered. However, without additional details it is not possible to identify whether the increase was due to the CMO’s prediction or to an actual increase in the number of cases requiring attendance. The recommendation of an inclusive fee to doctors called out to confinements, which had been made by the Departmental Committee in 1930 seemed a suitable arrangement. This suggestion was not implemented for a considerable time.

Doctors and Continuity of Care

As mentioned earlier in the chapter, the involvement of the general practitioner in both ante- and post-natal care was clearly laid out in the Committee’s report and effectively extended the remit of the practitioner in the care of the mother through pregnancy to the puerperium. It was hoped that not only would the maternal mortality rate decline, the incidence of chronic ill health from morbid conditions would diminish. Nevertheless, it would be incorrect to imply that arguments relating to the role of the general practitioner in midwifery cases had ceased. One example will suffice which will also mirror previous aspects pointed out by medical professionals in relation to doctors and midwifery practice.

Dr. J. Lishman of Milford in Surrey, responded to statements made by Professor F. Murray in February 1936 concerning the need for the maternity service of the future
to depend on 'general practitioner obstetricians'.  

Dr. Lishman emphatically pointed out that there was 'a large and growing body' of medical opinion that believed the general practitioner had no place in the maternity schemes of the future. A maternity service comprising salaried midwives for home births and 'obstetric officers of consultant standing' for antenatal and postnatal clinics and the care of abnormal labours would be more satisfactory. Dr. Lishman agreed that it was advisable that continuity of care existed throughout the pre- to postnatal period. However, he disagreed with Professor Murray on the matter of the conduct of the actual labour. The following points were put forward by Dr. Lishman to support his argument. Firstly, it would be impossible for a doctor in an average practice to devote his time efficiently to maternity cases and undertake his other duties. 'He cannot have time for both - it is time which is the most important factor'. The temptation to speed up labour would be present, which would lead to further complications. Secondly, Dr. Lishman pointed out that the general practitioner was open to infection due to the nature of his work in the wider sense. Therefore, the general practitioner was unwittingly a potential source of infection to the parturient woman. Thirdly, Dr. Lishman stated that a doctor could rarely attend more than one hundred cases a year, which meant that he could not build up sufficient experience to deal with the more difficult and obscure obstetric cases. Finally, private midwifery was poorly paid and satisfaction could not compensate for the great deal of time and trouble that maternity cases required. Dr. Lishman rested his case by concluding that 'it would be better for all concerned to abandon this miserable arrangement'. The arguments presented by Dr. Lishman, in addition to reflecting many points mentioned in earlier discussions, honestly put across the feelings of a doctor caught up in the crossfire of inter-professionalism.
Criticism had often been directed toward birth attendants, both doctors and midwives, from medical professionals removed from the world of general practice. This particular point was emphasised by Dr. T. E. Hinks, general practitioner in the country districts of Herefordshire and Radnorshire with thirty years experience in rural midwifery. He sharply criticised the ‘aspersions on the general practitioner’ which ‘were made by men high in the profession who spoke from statistics, without a first-hand knowledge of the facts’. Continuing, Dr. Hinks said that instead of blaming the general practitioner for ‘excessive’ maternal mortality, energies should be directed into the establishment of maternity beds in hospitals, which would lessen the risks of complicated cases of labour and decrease ‘the subsequent morbidity of mothers’. However, the role of the general practitioner in maternity cases was decided. The fully qualified midwife would attend normal home births and call for assistance from a doctor in cases of emergencies or abnormalities. Policy-makers presented their plans and formulated legislation that affected all women and everyone associated with the process of childbirth. It can be argued that the emphasis was placed on bureaucracy and the medicalisation of childbirth rather than the practical implementation of the national scheme.

The Position of the Midwife

The national maternity service envisaged by the Committee confirmed the position of the doctor and consultant in the birth process. Doctors would conduct antenatal and postnatal work. Consultants would be responsible for all cases of severe abnormalities referred by the doctor in attendance during the pregnancy, labour and puerperium. Hospital beds would be provided for cases that required institutional care and
ancillary services would be arranged, including transport facilities, for mothers in need. Finally, suitably qualified and registered midwives would be appointed to attend normal home deliveries. The emphasis, except for the suggestion that ancillary services should be developed, was placed firmly in the medical arena. The slight consideration shown for the comfort of the mother was fuelled by out-dated perceptions of the stereotypical birth attendant, the ‘gamp’. It was believed that a trained midwife, with or without a doctor present at a home birth, would add to the ‘safety and comfort’ of the mother. Furthermore, the employment of trained midwives would,

...eliminate the employment of ignorant and untrained ‘handywomen’, a problem of pressing importance which has proved difficult to deal with by restrictive and penal measures. 77

Once engaged to attend a birth, the midwife’s duties involved a range of responsibilities from the ante- to the postnatal period. 78 The Committee recognised that the midwife would be called on to undertake a more responsible role than had previously been expected. In agreement with the conclusions of the earlier Report of the Departmental Committee on the Training and Employment of Midwives, certain points were emphasised. These included the provision of post-graduate courses for midwives; suitable arrangements for relief, holidays and sick leave and a limitation on the annual number of cases a midwife should attend. In addition, the Committee recommended that an age limit of sixty should be introduced. 79
The Older Midwife

Depending on the structure of some counties, the mainly rural areas depended heavily on older midwives. Monmouthshire was part rural with most of its population concentrated in the industrial valleys. However, there were still a number of midwives practising who were over the age of sixty in 1936. In 1911 sixty-seven midwives on Monmouthshire’s Midwives Roll were over the age of sixty. The number rose to 111 in 1914 and then began a slow decline until the figure had dropped to thirty-five in 1929. The number remained stationary for a few years before lowering to 30 by 1936.

Following the Midwives Act of 1936, which introduced salaries and age limitation for practising midwives among the other considerations, MCC discussed their position and the difficulties that could be encountered following the implementation of the Act in the county. The Council noted that there could be difficulties in fixing the age limit. However, the CMO pointed out that people dealing with midwives recognised that after sixty years of age

...they were not always equal to their hard exacting work. The night work and long distances which some have to travel to their patients make the work very trying for these elderly women.

This was often the case in Monmouthshire where the heavily populated industrial districts were situated in deep valleys. When a midwife was called to attend a woman in labour at an isolated hill-farm, for example, the bicycle she would normally use for transport in the valley would be of limited use to her on steep and stony mountain paths. Mrs. S. of Blaina remembers the time she was in labour with her first child. Her husband met the midwife at the bottom of the lane in the early hours of a cold winter’s
morning. He led the way to their cottage with the help of a storm lantern after the
midwife had dismounted and left her bicycle propped against the hedges in the lane. 83

However, the main discussion concerning age as far as the implementation of the Act
was concerned, was the question of whether to fix the retirement age at sixty or sixty-
five for midwives and other officers such as health visitors. The situation tended to
resolve itself since practising midwives had to apply for a salaried post and most of
the elderly midwives retired voluntarily or were not be re-appointed. The Act allowed
local authorities grants to pay compensation to those who had to retire. A complete
restructuring of the profession of midwife resulted from the passing of the new
Midwives Act of 1936. The main purpose of the Act was to improve the standard of
domiciliary midwifery in England and Wales by establishing an efficient service of
salaried midwives under the control of the local authorities. Subsequently, the Act
raised the status of the midwives’ profession by providing adequate regular salaries
and more secure future prospects for those wishing to enter the new service.

Unqualified persons were prohibited from practising. The Act also provided for the
salaried midwives to attend courses to keep their skills up-to-date with medical
developments in the field of midwifery. The BMJ noted that when the scheme had
become fully operational,

...every expectant mother, whatever her financial position, will be able to
obtain the services of a qualified midwife for her confinement, and if she
engages a doctor, a midwife will be available for the maternity nursing'. 84

The British Medical Association [BMA] stated that they were appreciative of the need
to improve the status, training and financial position of the midwife. However, they
were convinced that this was a small part in the process of the development of an
efficient maternity scheme. The initial consideration was the need of the mother during the period of maternity. The language used by the BMA reflected the composition of the Association with phrases such as ‘medical needs of mothers’ and the ‘medical requirements of a woman’.

Nevertheless, the four points laid out by the BMA as essential to the new service illustrates a recognition of the personal and practical needs of mothers as opposed to purely medical. The points addressed as a mother’s right were that she should have the choice of a doctor and midwife, and be provided with help in the home, a supply of sterile dressings and transport to hospital when needed. Additional research undertaken by the BMA led to the conclusion that normal births and births with slight complications were safer conducted in the confines of the mothers’ homes. The Association found that establishing antenatal clinics, providing maternity beds and encouraging women to accept these provisions had not led to a decrease in maternal mortality. Unfortunately, it had been ‘accompanied by an appreciable increase’. The Association pointed out that where there was a collection of maternity cases in hospitals, there was an increased risk of puerperal infection. Given the evidence, it can be suggested that the BMA supported home births and consequently the role of midwives and general practitioners, rather than the hospitalisation of childbirth unless complications were apparent.

**Monmouthshire and the 1936 Midwives act**

The original stimulus for the revised Midwives Act was to improve the standard of midwifery practice, which in conjunction with extended antenatal and postnatal care would help to reduce maternal mortality and morbidity. In Monmouthshire the supervising authority was the County Council and the County’s scheme under Section
1 of the Midwives Act of 1936 came into force on the first day of October 1937. The Act provided for a domiciliary midwifery service in the rural areas through the Monmouthshire Nursing Association (MNA), and in the urban areas through salaried midwives employed by the County Council. There were 229 midwives on the Roll at the passing of the Act and 141 were practising midwives. The latter figure comprised sixty-three County midwives, six peripatetic midwives also employed by the County Council, twenty-two MNA midwives, seventeen midwives practising in hospitals and other public institutions and thirty-three who practised independently. The Council paid the MNA an annual payment of 1,397 pounds for the period 1938 to 1939, which rose to 1,582 pounds for 1944 to 1945. The peripatetic midwives were there to assist in relief work when midwives were on holiday, away in cases of sickness and suspension and to help at weekends. The hours of work were regulated to allow midwives to have adequate breaks and also time to attend regular refresher courses. Each midwife was required to commence work at nine each working morning unless there was an emergency in her district. She was allowed one half-day a week and one weekend in three as off-duty breaks. These considerations were luxuries for midwives. Finally, salaries were paid in accordance to the qualifications they had acquired. The Act had suggested that midwives' salaries should be in keeping with those received by health visitors.

However, Dr. Rocyn Jones, CMO for Monmouthshire, noted that the arguments against this seemed stronger than in favour since the health visitor was highly qualified. He said that the midwife in most cases, only held a CMB Certificate and often had a low standard of education. Nevertheless, he continued, eventually the payment of a reasonably high salary would 'raise the standard of midwifery as
nothing else will’. The agreed salary was set at 150 pounds a year rising by ten pound increments to a maximum of 200 pounds a year. A uniform allowance, transport expenses, equipment, dressings, disinfectants and drugs were to be provided in addition to the salary. Although the Act did not stipulate it, the Council decided to include new ‘Labour Bags and Nursing Bags’ in the free supplies to midwives following reports by the Inspectresses of Midwives on the ‘unclean condition’ of the bags in use by the midwives in Monmouthshire. It was claimed that a supply of new bags would help to prevent infection and reduce the incidence of maternal mortality and neo-natal mortality. The idea, said the Council, ‘was a provision well worthwhile’. This illustrates that MCC was willing to provide their new salaried midwives with equipment, which would aid the efficiency of their work. Nevertheless, the following section will show that a policy of exclusion existed in the selection criteria for the appointment of midwives following the 1936 Act.

At the start of the scheme in Monmouthshire, the majority of the midwives appointed were absorbed from those already practising in the County when the Act came into force. To ensure a higher calibre of midwife it was decided that only general trained nurses also possessing the CMB Certificate would be employed. Appointments would be restricted to women under thirty-five years of age. The policy of Monmouthshire County Council was in keeping with the guidelines set down in government legislation. Overall, it can be argued that the guidelines promoted discrimination. General practitioners, mainly men, undertaking to practise midwifery were not subjected to the same regulations as a woman midwife.

Among the criteria set down by the Council for the appointment of midwives to substantiate the above argument, was the decision that the midwives’ homes would be
inspected and appointment made only where conditions proved to be satisfactory.

Midwives’ private homes were subject to inspection at any time following appointment, with or without notice. Furthermore, no ‘shop-keeping’ or ‘keeping of lodgers’ was allowed. The evidence points to a continued intrusion into the private lives of midwives by the state. The medical examination of midwives prior to appointment paid particular attention to the condition of the nose, throat, gums and teeth. The latter point was introduced due to cases of puerperal fever in Monmouthshire arising from pyorrhoea or septic throat conditions of the midwife in attendance at the puerperium. However, no similar criteria were set down for doctors intending to practise midwifery within their general practice.

The adoption of the salaried scheme for midwives in Monmouthshire was expected to ensure an increase of the services offered by the midwife. In addition, it would enable her to keep in close contact with all expected births in her district whether the actual birth was to take place at home or in hospital. The midwife was also expected to cover post-natal work, educate the mother on the advantages of antenatal care and infant welfare, and accompany the mother to both antenatal clinics and Centres. The Council stated that a new era in midwifery had arrived and each local authority should embark on the ‘adventure’ thoroughly so that ‘...ultimately the right type of midwife culturally and professionally, may be forthcoming’. The female midwife had gained the status she deserved. However, it had taken thirty-four years from the passing of the first Midwives Act in 1902 to achieve recognition. The position of the midwife who had previously worked independently and was appointed by the Council under the terms of the Act had improved greatly. She was assured of a regular income and holiday leave. Her working hours were regulated and refresher courses were available.
A uniform, telephone, travelling expenses and equipment was provided, as was the safeguard of a retirement pension. The new service, the Council declared, would 'do much to lighten the burden of women during pregnancy and confinement'. Finally, the Council stated that they hoped that with the implementation of the scheme '...the damage to the health of the expectant mothers will become negligible and that the incidence of stillbirths will show a rapid decline'. 94 However, the evidence contained in the reports of the Centres and the antenatal clinics from 1930 to 1938 reveal that the increase in status for the midwife came too late to have an affect on reducing maternal mortality and morbidity in Monmouthshire.

**The Incidence of Maternal Mortality in Monmouthshire**

In Monmouthshire in 1921 the total number of maternal deaths amounted to forty-two with twenty-nine of the deaths attributed to 'other causes'. 95 In 1938 the figure stood at thirty-eight and out of these, twenty-five were from causes other than puerperal infection. 96 Therefore, the seventeen-year period hardly revealed any improvement in the incidence of maternal mortality in the County. Furthermore, 'other causes' were returned in the majority of cases. Dr. Janet Campbell, Senior Medical Officer for Maternity and Child Welfare, provided information to the Ministry of Health for a report on maternal mortality.

The report revealed that Monmouthshire was tenth highest in order in the whole country for deaths from accidents and diseases of pregnancy and childbirth. For the period 1919-1922 the puerperal fever death rate for England and Wales was 1.57, while for Monmouthshire, it stood favourably at 1.51. However, the death rate from other causes gave a different result. In England and Wales the rate was 2.54;
Monmouthshire returned a rate of 3.65. The measures suggested to lessen the incidence of maternal mortality included extending antenatal care, supplying maternity beds for all women needing them and providing efficient care for mothers in their own homes from trained midwives. Since the first point will be analysed in depth in the following chapter it is sufficient here to mention a comment made by Monmouthshire's CMO. He noted that during 1923, while a large number of expectant women attended Centres with their other children,

...it was found difficult to convince quite a number of them that antenatal supervision was essential or even desirable. Prior to 1930, antenatal clinics were few in Monmouthshire. The three in existence were supplemented by an additional eleven in November 1929 in preparation for a county-wide scheme of antenatal care in 1930. Before the opening of separate antenatal clinics, expectant women had to attend the Centres which gave priority to infants, although health visitors did pay visits to expectant mothers in their own homes. A total of 584 visits were conducted in 1929, which included 319 new visits and 265 re-visits. The following section will look at the hospital facilities available in Wales and Monmouthshire for women with complications during pregnancy and birth. The final section will examine the role of the midwife and the attitude of the medical profession toward her in connection to maternal mortality. This section will compliment the previous section on the general position of the midwife in the community.

**Hospital Facilities for Mothers in Wales and Monmouthshire**

Hospital accommodation throughout Wales was found to be inadequate particularly for non-septic cases. In Glamorgan, fourteen out of the twenty-four local authorities
had made arrangements for hospital beds for non-septic cases. As late as 1932, Carmarthenshire and Cardiganshire County Councils had no suitable maternity facilities. Flint County Council was able to use the maternity home opened in the area in 1924. However, there were only ten beds available, which hardly covered demand. Merionethshire, Breconshire, Radnorshire, Anglesey, Caernarvonshire and Denbighshire County Councils had made similar arrangements to that of Monmouthshire County Council, with the referral of complicated antenatal and labour cases to near-by general hospitals. Therefore, the evidence suggests that in Wales, expectant women and women in labour who were in danger of developing complications did not have adequate facilities to meet their needs and allow for their safe delivery.

Dr. Dilys Jones confirmed that the highest maternal mortality rates were consistently found to come from the Welsh counties. The excessive mortality in some of the counties could be attributed, she said, to the ‘inaccessibility of skilled help in pregnancy and confinement, or at any rate to the delay which must often of necessity arise before such help can be procured’. Dr. Jones was referring to the geographical nature of Wales with its sparsely populated rural districts and densely populated industrial areas, both of which were hilly or mountainous in parts making access problematic for midwives and doctors. Dr. Jones admitted that it was difficult for financial and geographical reasons for some of the rural counties in Wales to make suitable arrangements for the services of a consultant obstetrician. Nevertheless, she pointed out, more could be done with regard to non-emergency cases. Dr. Jones concluded
The number of beds available for non-septic maternity cases in the Welsh Counties generally is most inadequate.\textsuperscript{104}

In Monmouthshire, MCC realised that the hospital facilities for maternity cases including the availability of beds were very poor. The MO noted that the county was 'very much handicapped' by the lack of a maternity hospital.\textsuperscript{105} Some of the more urgent cases had to be sent to the adjoining county borough of Cardiff for their confinements.\textsuperscript{106} Difficult cases were referred to Dr. Strachan, Consultant Obstetric Surgeon at the Cardiff Royal Infirmary.\textsuperscript{107} A country mansion called the 'Coldra', had been offered to the Council for a maternity home by Sir John Beynon in 1925 and was to be named 'Lydia Beynon' after his wife.\textsuperscript{108} It was a generous gift for the mothers of Monmouthshire. The CMO stated that the 'preservation of life, and particularly maternal life' should take precedence above other considerations in the County.\textsuperscript{109} However, the Home still remained unopened in 1938 due to financial difficulties faced by the Council in equipping the facility for maternity cases.\textsuperscript{110}

It can be argued that maternal welfare suffered to some extent from the economic environment, which faced MCC in the 1920s and 1930s. The lack of attention paid by central government to the provision of maternity hospitals for the care of women with complicated pregnancies and births compounded the problem. The responsibility fell heavily on the local authorities. Some maternity beds in Monmouthshire were made available at the Tredegar Nursing Home, although places were strictly limited and were used for mothers whose home conditions were thought to be unsuitable for their confinement.\textsuperscript{111} There were only seven beds available at Tredegar in 1930 and twelve women were sent there for their confinements that year. During the year, a further twelve beds were available in the County for ten more women. The total number of
maternity beds available was nineteen for the whole county. Twenty-two women were able to take advantage of the service out of the 6,342 confinements that took place in Monmouthshire in 1930. Therefore, the percentage of mothers who were able to benefit was very small. Expectant mothers could have benefited from adequate antenatal care. However, the evidence in the reports of medical officers attending Centres suggests that antenatal facilities were limited prior to 1930.

**Some Comments Concerning Antenatal Care in Monmouthshire**

Dr. Annie Roberts, AMO, reported that at the Aberbargoed Centre the only examination carried out on pregnant women was urine testing. When measurements were needed the expectant mother was sent to the Centre at Pengam where Dr. Mary Scott, AMO, held a separate clinic for the purpose of antenatal examinations. Any pregnancies displaying abnormal symptoms were referred directly to Dr. Strachan at Cardiff. One woman attending Dr. Robert’s Centre had three previous difficult labours, which had each resulted in the death of an infant. As a precaution, Dr. Robert’s referred the mother to Dr. Strachan for examination after which he arranged for her to be admitted for the confinement.

Further examples of referrals to Dr. Strachan can be found in reports throughout the 1920s and 1930s. The referrals were mainly for medical conditions detected through the analysis of the urine such as albuminuria in the later months of pregnancy, a condition that could lead to a toxaemic condition in the mother. In 1928, Dr. Strachan examined ten mothers and nine of the mothers were subsequently admitted to Cardiff Hospital due to detected abnormalities. A further nine were admitted to Tredegar Nursing Home due to poor home conditions. The total number of maternal deaths in 1928 was thirty-seven with fifteen attributed to puerperal fever and twenty-
two associated to other causes related to childbirth. The CMO was forced to admit that the maternal mortality rate was the highest recorded ‘for many years’. The number of referrals to Dr. Strachan increased during the 1930s as a result of the extension of antenatal facilities and more expectant women attending the new clinics. In 1938, Dr. Strachan saw 105 cases out of which seventy women were admitted to the Cardiff Hospital.

The suggestion of the Ministry of Health relating to the plan that adequate arrangements should be available for the institutional treatment of all complicated midwifery cases was not followed through by the state release of money to provide new or additional maternity beds in existing hospitals. The burden of care on the local supervising authorities was heavy. In Monmouthshire the CMO emphasised this point when he remarked that the extension and improvement of the maternity services in the county were proceeding steadily ‘...as far as economic conditions permit’. The attempt to draw a positive picture was illustrated through his following remark. He stated that the maternal mortality rate, although high, had not increased since antenatal clinics were opened in Monmouthshire. The reference to the lack of an increase hid the reality that there was no decrease in the figure. The brief endeavour to appear positive could not be upheld when the CMO had to reply to requests for extra sessions to be held at the clinics. Additional sessions were ‘impossible’ without more staff, which he admitted the County were in no position to finance. He attempted to justify the Council’s policy to cut down the expenditure on maternity and child welfare by referring to the ‘financial stringency’ caused through lack of funds. This was the reason behind the delayed opening of ‘Lydia Beynon’ maternity hospital, ‘which would have given many a poor mother a fighting chance to pull through a
difficult confinement’. There are numerous references to the Save the Children Fund helping to equip the antenatal clinics in Monmouthshire through gifts of money and equipment, which stands testimony to the difficulties faced by the Council to fulfil its role of responsibility to the mothers and infants under its care.

Dr. Janet Campbell observed that an adequate number of hospital beds for maternity cases would enable local authorities to encourage general practitioners to refer all complicated midwifery cases requiring treatment to hospital. The cases referred would include problems occurring during labour, such as haemorrhage. Dr. Campbell pointed out that a busy doctor could not deal with such cases adequately in the working-class home. Furthermore, she continued,

...a recognition that all operative treatment should take place in hospital as a routine practice would save life and would greatly reduce morbidity. 

Dr. Campbell believed that it would be possible to discharge the mother into the care of the midwife for supervision and nursing when the patient and the home conditions proved to be satisfactory. Finally Dr. Campbell pointed out that by paying a suitable fee to a doctor called to attend a labour by the midwife, he would be more inclined to transfer the patient to hospital in cases of need, when his time and effort had been adequately remunerated.

The Role of the Midwife in Monmouthshire

This section will concentrate on the role of the midwife as birth attendant in the 1920s and 1930s, her duties under the rules of the Central Midwives Board and the attitude of the medical profession towards her work in relation to maternal mortality and morbidity. The midwife’s work became increasingly linked to antenatal care.
However, it is not the intention of this section to develop that particular aspect as it will be part of the final chapter concerning antenatal provision.

The status of the midwife gradually improved in the 1920s and 1930s through the revision of the first Midwives Act of 1902 and the subsequent Act of 1918. One of the provisions of the first Act that remained in place was the rule that midwives were instructed to summon a medical practitioner in cases of abnormalities in labour. Normal deliveries were left to the midwives when the patient had not previously booked the attendance of a doctor. Conflict occasionally surfaced among the medical profession when it was evident that registered untrained midwives were attending births. However, the comments of both county and district MOs in Monmouthshire reveal that attitudes towards midwives in the county did undergo considerable change over the period covered in this study.

Firstly, some comments from medical practitioners prior to the 1936 Midwives Act will be discussed in relation to the midwife. Secondly, the reasons for and frequency of calls from midwives to doctors in Monmouthshire will be identified. Finally, an assessment will be made of the extent of continuity and change in the attitude of the medical profession towards the midwives’ role and responsibilities as birth attendants in relation to the relatively high maternal mortality rate in Monmouthshire.

When reading the comments of the CMO in Monmouthshire, it can be argued that he placed emphasis on the need to increase the training period for midwives to ensure a more educated class of midwife. Education was regarded more highly than experience gained practically. When the Ministry of Health stated that the provision of adequate care by midwives for mothers in their own homes would reduce maternal mortality rates, the CMO agreed and claimed that the situation in Monmouthshire was gradually
becoming more effective ‘as the standard of midwifery training becomes higher’. He pointed out that in 1911 there were 168 untrained and registered midwives practising in the county. By 1923, the number had been reduced to fifty-five. Furthermore, the number of illiterate midwives for the same period had reduced from sixty-six to fourteen. Nevertheless, he noted that there was ‘a distinct menace in certain districts’ meaning that midwives without proper training were still attending births.

The CMO’s response illustrates his disapproval of practical experience without statutory training. The proposal of the Central Midwives Board to increase the training period for prospective midwives to twelve months from 1926 prompted him to remark that he hoped a ‘big advance’ would follow the new rules. He believed that antenatal work was closely bound to midwifery. However, he stated that he had found that the midwives in Monmouthshire did not approach the subject in a methodical manner. Few had knowledge of the examinations that should be undertaken during the antenatal period. Furthermore, he was disappointed to discover that the midwives rarely recommended that expectant mothers visited a doctor or advised them to attend the Centres.

In contrast, Dr. Mary Scott, AMO for the county, supported the midwives in the New Tredegar district and reported that they kept in touch and visited the Centre regularly. Nevertheless, the CMO’s observations reveal a slight animosity towards the midwives under his supervision and his comments concerning training, places his perception of education as synonymous with a better class of female midwife more in keeping with his own social class. Three years after the implementation of the additional training period for midwives, the CMO happily stated that ‘...a better educated type of woman is taking up the work’.
Reasons for Calling for Aid

Under the rules of the Central Midwives Board midwives were required to send for assistance from a doctor in cases of abnormalities during confinements. The number of calls for aid in 1919 in Monmouthshire amounted to 843. \(^{127}\) In 1921 the figure had risen to 1,884 \(^{128}\) and in 1938 the summons for aid numbered 1,945. \(^{129}\) Therefore, throughout the period of this study four-number figures were consistent. However, the number of births decreased in Monmouthshire as it did in Britain as a whole. In Monmouthshire there were 8,487 births in 1919. There was an increase in 1920 to 10,779, then the number gradually decreased to 4,944 by 1938. \(^{130}\) Therefore, it can be argued that the increase in calls for assistance did not relate to an increase in births attended.

The main reasons a midwife sent for help were prolonged and difficult labour, ruptured perineum, and the unsatisfactory condition of the mother or the infant. Other reasons included abnormal presentation, retained placenta, high temperature, anti- and post-partum haemorrhage, uterine inertia, threatened abortion, premature birth, stillbirth and eclampsia. The highest number shown for the latter condition was twelve in 1920. \(^{131}\) However, signs that eclampsia was developing would normally show prior to the commencement of labour and the patient would have been treated by a doctor or referred to hospital.

The number of cases where medical aid was required due to puerperal fever was exceptionally low. There were two cases in 1923, \(^{132}\) one in both 1924 and 1925 \(^{133}\) and three in 1926. \(^{134}\) There were no other cases of puerperal fever given as a reason for calling for medical aid. Nevertheless, it cannot be ignored that a high temperature would have necessitated a summon from the midwife for aid and subsequently, these
call-outs might have turned into notifications of puerperal fever by the doctor. Therefore, it is not possible to suggest that incidences of puerperal fever were less in births attended by midwives in Monmouthshire, than in births where doctors were in attendance or when a birth took place in hospital.

Midwives were obliged to inform the local authorities if they were a source of infection resulting from a personal illness such as a sore throat or attending a patient who had developed a puerperal infection. In 1923 fourteen midwives sent in notification that they were liable to be a source of infection and there were eleven notifications of midwives laying out a dead body. Since there were thirty-eight maternal deaths that year, seven of which were notified by midwives, it is possible that midwives were responsible for laying-out mothers who had died in their homes following childbirth. In 1938, sixteen of the thirty-eight maternal deaths were notified by midwives and sixteen bodies were laid out by midwives, which seems to substantiate the above suggestion. In the same year, a total of forty-four notifications went to the local authorities from midwives who were liable to be sources of infection. Since this figure exceeded the total number of deaths, the cases of puerperal fever and the number of puerperal fever deaths, it can be argued that midwives were sufficiently aware of their responsibilities to ensure notification of any personal illness and infection which might affect the mother.

However, a comment made by the CMO when discussing arrangements for the implementation of the new Midwives Act of 1936, suggests another more probable reason for such notifications. The chief Inspectress of Midwives in Monmouthshire in 1936 was Dr. Mary Scott. She supervised three women Inspectresses for the whole of the County who were trained in general nursing and midwifery. In addition to the
Inspectresses calls, the AMOs also paid visits to midwives in their areas. Conferences were held fortnightly in County Hall to discuss any difficulties that might have arisen out of the visits. Decisions were also made concerning action to be taken against defaulting midwives. The CMO claimed that the system had enabled the County's midwifery nursing to reach a high standard, '...the old 'gamps' have been cleared out' and only eight women remained registered while unqualified. It seems that the inspection and close supervision of the midwives in the County ensured that the rules and regulations of the Central Midwives Board were strictly maintained. As a result the untrained found it increasingly difficult to practice.

Reports reveal that the number of conditions requiring aid from a doctor was consistently higher for prolonged and difficult labour, ruptured perineum and the unsatisfactory condition of the mother, in that order, from 1919 to 1938. Fluctuations in the number of call-outs from midwives for these conditions were evident over the period studied. An analysis of the reasons for sending for medical aid in the mid-1920s and early 1930s suggests the impact on mothers' of years of hardship. Cases of stillbirth, deformity in the child and premature labour also increased. However, the main reason for medical assistance that showed an increase was the unsatisfactory condition of the mother. Given the evidence, it can be argued that the general health of expectant and nursing mothers was adversely affected by the endemic poverty within Monmouthshire during periods of economic stress. It is probable that when the health of the mother was poor at the time of confinement, both mother and infant suffered more problems than at times when the economic climate was stable. The following chapter will examine the general health of expectant and nursing mothers with reference to the antenatal reports from antenatal clinics in Monmouthshire.
To return to the role of the midwife, the CMB required a midwife to fill in a form each time medical help was summoned. The midwife retained the original form; one copy was sent to the doctor and one copy to the local supervising authority. The information requested on the form included the midwife’s name, the reason for the request, the name and address of the patient, and the doctor’s details. It would not have been possible for illiterate midwives to complete the compact form. The growth in the administrative duties of the midwife in addition to her practical responsibilities assisted in eliminating the practice of unqualified and illiterate midwives. A glance through some of the forms kept by midwife Elizabeth Mullins who worked in the Corsham district of Wiltshire, confirms that in the majority of the cases, help was requested for a prolonged and difficult labour or the unsatisfactory condition of the mother. 142 [See Appendix 5] Mrs. Mullins completed her general nursing training at a hospital in Marlborough in 1923 before taking midwifery in a Swindon Maternity Home in 1924 and passing the CMB Certificate. Later she worked in a Cardiff hospital as a midwife. She was accomplished in nursing and midwifery skills. Many midwives held only the CMB Certificate.

The latter point caused occasional conflict in rural districts particularly before the 1936 Midwives Act was fully operational. In 1932, Dr. Dilys Jones stated that one CMO in Wales had pointed out that it was often the case that midwives were employed as district nurse-midwives in rural areas where there were problems obtaining medical supervision quickly for difficult confinements. These midwives, the CMO claimed, were often too young and had too little practical experience immediately after gaining their CMB Certificate. In agreement, Dr. Jones said that the twelve months training given to pupil-midwives who had no general nurse-training
was not adequate for a midwife who found herself practising in a remote country district. She advised that midwives should be sent on post-graduate courses at residential institutions to improve their training. However, she claimed that only one County Council in Wales had started such a scheme for a short period. 143

Included in Dr. Jones' conclusions on maternal mortality in Wales was the recommendation that all midwives attend post-certificate courses in training institutions. However, she found that in Wales there were no local authorities who assisted their midwives to attend such courses. 144 The need for extended training for midwives in the form of 'refresher courses' was introduced into the 1936 Midwives Act, under Section 7. Discussing this requirement MCC seemed undecided at first on the scope and duration of the courses. Three opinions were put to the Council. One suggestion was a course every five years for a period of two months. The second suggestion was five-yearly for one month. The Training School's idea was that the course should be shorter and more frequent to ensure all midwives were kept up-to-date on developments, which would not be possible if the courses were too far apart. The Council adopted the latter suggestion and it was decided that courses would take place every three years for duration of two weeks. Thirty salaried midwives and fifteen independent midwives would be given the opportunity to attend each year. The Inspectresses of Midwives were to be consulted to help to identify the weaknesses of individual midwives. This particular responsibility further illustrates the role of the Inspectresses as investigators into the quality of care offered by midwives under their jurisdiction. The discussions and final conclusions of the County Council reveal that although they recognised that residential requirements could not be provided for some years, the County Council agreed to subsidise accommodation and travelling expenses
for midwives at a rate of three pounds a week. Furthermore, the Council noted that the independent midwife would lose a portion of her income while attending a course. Therefore, it was decided that she should be compensated for this loss by paying her five pounds for the time she was on the course. 145 The evidence reveals that MCC were aiming to implement the new Act as efficiently as possible to ensure that expectant mothers had the best help available in an attempt to reduce the high maternal mortality rate prevalent in the county. The emphasis had shifted from infant to maternal mortality. The position of the midwife, who had previously worked independently and was appointed by the Council under the new Act found her position altered for the better. Her hours of work were regulated, she was ensured a regular income, holiday leave, a uniform, telephone, travelling expenses, equipment, refresher courses and on retirement, a pension. As the training periods increased through the revisions of the Midwives’ Acts attitudes towards midwives changed in relation to the additional training they received. Registered and unqualified midwives found it more difficult to remain in practice due to the regulations the CMB imposed on midwives and the investigative role of the Inspectresses of Midwives.

Furthermore, the unqualified midwife retained the stigma of the stereotypical ‘gamp’ throughout the period of this study. Many of the midwives appointed under the new Act had been absorbed from those already practising in the County. However, it was decided that all new appointments would be general nurses who also held the CMB Certificate. Voluntary retirements were accepted from elderly midwives ensuring that the new quota of practising midwives would be actively able to undertake their duties. The responsibilities of the midwife also increased with the implementation of the
1936 Midwives Act and the improvement in her status. More attention would be paid to the midwife’s involvement in antenatal work than previously and refresher courses would ensure she would be able to conduct the necessary examinations and observations needed to detect abnormalities in pregnancy. However, the midwife’s role was also an educational one since she was required to keep a check on the domestic condition of the mother’s home, encourage her to attend the antenatal clinic, and following the birth of the infant, persuade the mother to take her child to the Centre. In this way it can be argued that the midwife perpetuated the middle-class practises of the welfare providers. Furthermore, it can be suggested that out of the new officials appointed under various Acts including health visitors and Inspectresses of Midwives, it was the role of the midwife that faced the greatest change and challenge. The National Maternity Service envisaged by the Ministry of Health in the 1920s to combat the rising maternal mortality in the country was criticised by many and supported by just as many in the medical profession.

The essential services provided for all expectant women included the services of a qualified midwife; a doctor to carry out antenatal and postnatal examinations; a consultant when needed during pregnancy, labour and puerperium; and the provision of hospital beds for difficult cases. MCC attempted to implement the requirements as laid down in the recommendations of the Ministry. However, their difficulties providing sufficient hospital accommodation can be followed through the reports of the CMO and stands testament to the problems faced by the local authority to provide adequate welfare provision in times of economic depression in the County. Furthermore, without the help of volunteers and charity groups such as the Save the Children Fund and the National Birthday Trust, among others, it is arguable whether
Monmouthshire would have been able to offer the services that they operated. Except for the medical officers in charge, the staff at the Centres' consisted of volunteers who undertook the administrative and many of the practical tasks such as keeping record cards and weighing the infants. As the CMO pointed out, progress could only proceed as fast as money would allow. The Departmental Committee's conclusion following the investigation into maternal mortality was that approximately half of all maternal deaths could be prevented. It did not help the situation if the facilities were not available to aid the prevention of those deaths. Dr. Dilyss Jones, enquiring into the incidence of maternal mortality in Wales came to the following conclusion.

The improvement in the standard of the midwifery service, as indicated by the replacement of untrained by trained midwives, does not appear to be generally reflected in the maternal mortality figures. 146 This can be confirmed in Monmouthshire where in 1923, out of 245 practising midwives 55 were untrained and 42 were over the age of sixty, the number of maternal deaths totalled 38. Thirteen years later in 1936, with 225 midwives, 30 over the age of sixty and only seven untrained, the number of maternal deaths still stood at thirty-five. Furthermore, in 1938, the number rose to thirty-eight, which was the highest figure recorded since 1929. The figure was the equivalent to a rate of 7.6 per thousand live births, which was considerably higher than the 3.08 rate for England and Wales in the same year. 147 Dr. Jones stated that even where maternity services were provided, she found that mothers did not take adequate advantage of the facilities. Emphasis needed to be placed on the education of the mother on these points. 148
However, while conducting an analysis of the high number of maternal deaths in Monmouthshire in 1938 it was found that attendance at the antenatal clinics in the county had increased and that 62.5 per cent of mothers received at least one examination prior to her confinement. Therefore, the answer to the high maternal mortality rate in Monmouthshire in 1938 cannot be attributed to non-attendance at the antenatal clinics. Given the other evidence shown in the CMO’s reports, neither can the high rate be attributed to the lack of qualified midwives attending confinements. The final chapter will look more closely at the reports of medical officers conducting the examinations at antenatal clinics in Monmouthshire. Details contained in the reports will aid an assessment of the general health of expectant and nursing mothers in Monmouthshire and an evaluation of the reasons for the high number of maternal deaths during the 1920s and 1930s.

Chapter Five: Notes

3 Ibid. p. 28.
5 Ibid. p. 9.
6 Ibid. p.10.
8 Ibid. pp.8-9.
This was a midwifery text for the use of students preparing for final examinations. It was first published in 1917. Sir Comyns Berkeley was a renowned obstetrician and physician who was also the Chairman of the Central Midwives Board and an examiner in midwifery and the diseases of women.


MCC., MCWC *Annual Report for 1922* p. 5.

MCC., MCWC *Annual Report for 1928* 14 cases and 15 deaths from puerperal infection, p. 6. Total maternal deaths = 37, p. 8.


MCC., MCWC *Annual Report for 1930* 13 cases and 14 deaths, p. 6. Total maternal deaths = 34, p. 13.

25 MCC., MCWC Annual Report for 1932
6 cases and 8 deaths, p. 6. Total maternal deaths = 33, p. 12.

26 MCC., MCWC Annual Report for 1935
11 cases and 13 deaths, p. 6. Total maternal deaths = 36, p. 11.

27 MCC., MCWC Annual Report for 1928
In 1928, puerperal fever cases amounted to forty per cent of all maternal deaths, p.7.


29 BMJ 20 July 1929, p. 81.
Mr. T. W. Eden, Consulting Obstetric Physician to Charing Cross Hospital, London, commenting on the method of inquiry at Aberdeen.

30 Ibid. p. 82.

31 Ibid. 19 January 1929, p. 115.

32 Ibid. 20 July 1929, p. 82.
Mr. Eden criticised the Aberdeen Inquiry for sectioning women's health into two categories only: 'good' and 'unsatisfactory'.

33 Ibid. 19 January 1929, p. 115.

34 Ibid. 20 July 1929, pp.82-84.


36 Ibid. 5 January 1929, pp.41-42.

37 Ibid. 23 March 1929, p.552.

38 Ibid. p.554.

39 Ibid. p.552.


41 Ibid. p.87.

42 Ibid. p.86.

43 Ibid. p.225.

44 Ibid. p.224.


49 BMJ., 8 June 1929, Dr. C. M. Craig, Kendal, pp.1057-1058.

50 Ibid. p.1058.

51 MCC, MCWC Annual Report for 1920 p.48.


54 Ibid. Introduction by Dame Janet Campbell, pxvi.


56 Ibid. pp.94-97.


58 Ibid. p.110.

59 Ibid. pp.94-95.

60 Ibid. p.95.

61 MCC, MCWC Annual Report for 1922 p.43.

62 Ibid. p.43.

63 MCC., MCWC Annual Report for 1929 p.61.

64 MCC., MCWC Annual Report for 1930 p.61.


66 Ibid. p.48.

68 Ibid. p.229.

69 BMJ., 13 July 1929, Dr. J. S. Fairbairn, p.58.

70 MCC., MCWC Annual Report for 1934 p.48.

71 MCC., MCWC Annual Report for 1935 p.50.

72 MCC., MCWC Annual Report for 1936 p.50.

73 BMJ., 22 February 1936, Professor F. Murray, p.375.

74 Ibid. 29 February 1936, Dr. Lishman, pp.446-447.

75 Ibid. 24 August 1929, Dr. Hincks, p.346.

76 Ibid. p.347.


78 Ibid. p.93. The midwife was expected to inform the local administrative body, arrange antenatal examinations and supervise the pregnancy. When abnormalities were suspected or discovered she should refer the patient to the doctor. When attending a home birth the midwife was bound by the rules of the Central Midwives Board and was to send for a doctor when necessary. Furthermore, following the birth the midwife should offer adequate nursing care and encourage the mother to seek post-natal attention to which she was entitled.

79 Ibid. p.93.

80 MCC., MCWC Annual Reports for each year from 1919 to 1936.

81 MCC., Midwives Act 1936 [C.Misc.R.0059] County Record Office, Cwmbran, Gwent.

82 Ibid. p.6.

83 Mrs. S. of Blaina, interviewed by Jan King at Blaina Institute, Nov 1990.

84 BMJ., 28 March 1936 p.655. For further discussions on the Midwives Bill see various issues of the BMJ including 9 May, 23 May, 30 May 1936, and issues in June 1936.

85 Ibid. 28 March 1936, ‘The BMA and Maternity Services’, p.656.

86 MCC., MCWC Annual Report for 1937 p.46.
345

87 MCC., Midwives Act 1936 p.6.

88 Ibid. p.7.

89 Ibid. p.21.

90 MCC., MCWC Annual Report for 1937 p.46.

91 MCC., Midwives Act 1936 p.8.

92 Ibid. p.8.

93 Ibid. p.18.

94 MCC., MCWC Annual Report for 1937 p.47.

95 MCC., MCWC Annual Report for 1921 p.7.

96 MCC., MCWC Annual Report for 1938 p.10.

97 MCC., MCWC. Cited in the Annual Report for 1923 p.46.

98 Ibid. p.46.


100 Ibid. p.6.

101 Ibid. p.6.

102 Ibid. Dr. Dilys Jones, p.72.

103 Ibid. p.76.

104 Ibid. p.75.

105 MCC., MCWC Annual Report for 1923 p.47.

106 MCC., MCWC Annual Report for 1924 p.47.


110 MCC., MCWC Annual Report for 1938 p.50.

112 Ibid. p.62.

113 Ibid. Vital Statistics Table

114 MCC., MCWC Annual Report for 1928, see p.27 for an example at the Aberbargoed Centre.

115 Ibid. See p.30 for an example at the Risca Centre.

116 Ibid. p.48.

117 Ibid. p.8.


120 Ibid. p.65.


123 MCC., MCWC Annual Report for 1923 p.47.


126 MCC., MCWC Annual Report for 1929 p.47.

127 MCC., MCWC Annual Report for 1919 p.45.

128 MCC., MCWC Annual Report for 1921 p.38.

129 MCC., MCWC Annual Report for 1938 p.45.

130 MCC., MCWC Annual Reports each year from 1919 to 1938, Vital Statistics Tables.

131 MCC., MCWC Annual Report for 1920 p.45.

132 MCC., MCWC Annual Report for 1923 p.42.


MCC., MCWC Annual Report for 1923 p.42.

Ibid. p.7.

Ibid. p.42.

MCC., MCWC Annual Report for 1938 See p.10 for total maternal deaths. For information on midwives relating to notifications of maternal deaths and midwives laying out dead bodies, see p.45.

Ibid. p.45.

MCC., Midwives Act 1936 p.11.

Ibid. Annual Reports for each year from 1919 to 1938. Page numbers vary with each Annual Report. However, reasons for calling for medical aid can be found between p.38 and p.57 of each report.

Mrs. Elizabeth Mullins, retired midwife. Letter and midwives forms received from Mrs. Mullins following a request for information, from the author, in the Midwives Chronicle, 1994.

Mrs. Mullins undertook her general nursing training at a Marlborough hospital before training for midwifery at Swindon Maternity Home in 1924. From 1925 to 1928 she worked in a maternity home in Wiltshire and then became the midwife for the Corsham district, where she was ‘sent all over the county’. Between 1947 and 1953, when she retired, Mrs. Mullins was responsible for fourteen villages in the Salisbury area where she worked as District Nurse Midwife, and for the first time had a car supplied.


Dr. D. Jones, [1932] Maternal Mortality in Wales p.84.

MCC., Midwives Act 1936 pp.10-11.

Dr. D. Jones, [1932] ‘Maternal Mortality in Wales’ p.79.


MCC., MCWC Annual Report for 1938 p.10.
CHAPTER SIX

ANTENATAL CARE

Introduction

The preceding chapter dealt with maternal mortality, the incidence rate, some causes of death and puerperal infection. The county of Monmouthshire was highlighted to illustrate the maternal mortality prevalent in that county in comparison to other parts of the country, and to reveal the steps taken by the CMO in an attempt to remedy the situation. The roles of general practitioners and midwives were also discussed in relation to maternal mortality and morbidity. This chapter will continue to look into the issue of maternal health and welfare through an examination of antenatal care and the facilities set up to implement such attention. Drawing on the evidence found in Monmouthshire, the effectiveness of antenatal clinics to reduce maternal mortality and improve the general health of expectant mothers will be assessed. The evidence provides a valuable local dimension to the national struggle for the improvement of maternal health in the 1930s. Firstly, arguments surrounding the need for separate antenatal clinics will be addressed, including the effect of publicity concerning maternal deaths and the dangers of childbirth. Secondly, facilities in Monmouthshire and the care offered to expectant mothers through the Maternity and Child Welfare Centres and the later antenatal clinics will be outlined. Thirdly, the work of the antenatal clinics will be evaluated to assess the effectiveness of antenatal care on the expectant mother’s health and her ability to have a relatively safe birth with less risk to herself and the infant. Throughout this chapter attention will be paid
to details concerning the general health of expectant mothers', including the ailments they suffered, the number of, and the suggested reasons for both stillbirths and abortions.

THE OPINIONS OF THE MEDICAL PROFESSION

Speaking at the Annual Maternity and Child Welfare Conference held in London in the July of 1929, Mr. Arthur Greenwood, Minister of Health, was keen to emphasise his support of antenatal care and extolled its value in reducing maternal mortality in the country. He stated that he hoped to strengthen the part of the health service relating to maternal and infant welfare,

...to improve the status and opportunities of the midwife, and to ensure that, as far as humanly possible, the terrors of confinement were removed from the mother. ¹

All medical professionals, some of whom voiced their opinions strongly, did not reciprocate Mr. Greenwood’s belief in the results of quality antenatal care. Mr. E. Holland, an obstetrician, criticised antenatal clinics and claimed that the country had ‘gone mad’ on antenatal work ‘which had been given an exaggerated importance’. ² He insisted that more women died from lack of attention during the birth than in the antenatal period. Furthermore, he claimed that most antenatal work was ‘utterly irresponsible’ since the doctor or person in charge was rarely the one who was ultimately responsible for the mother during her labour. ³

Sir Henry Simpson, an obstetric surgeon, was of the opinion that where antenatal facilities existed it was the duty of the mother to attend. However, he continued, too often the mother would not go, or if she did avail herself of the opportunity, she would not follow the suggestions put to her by the medical officer in charge. To substantiate his comment Sir Henry cited a case where a primipara who had not attended any antenatal
sessions at the local clinic engaged a midwife. The midwife called to see her patient the week before the baby was due and found the woman suffering from swollen ankles and a headache. She immediately asked her to visit the doctor at the clinic, where a urine test proved there was a high albumin content. She was then strongly advised to go to the hospital for treatment. However, instead of carrying out the instructions, she went home to her husband and mother and took no further action on the advice. Later, she had two eclamptic fits and died. Sir Henry blamed the ‘wait and see’ tradition of ‘working-class’ families. His comment ignored the right of women to make choices in situations affecting themselves, regardless of the outcome of that choice.

Sir Henry suggested that someone should be made responsible for the attendance of expectant women at antenatal clinics since no authority had a responsibility of care at the time. He put forward the idea that payment of the cash maternity benefit from the Ministry of Health could be dependant on proof of adequate antenatal visitation by the woman claiming the money. The general practitioner, midwife or medical officer in charge at the relevant clinic could then sign a ‘certificate of observation’, to prove that the woman had attended the sessions. The comments of Sir Henry compounds the concept of extended state and medical involvement in the natural process of childbirth and further attempts to disassociate women from freedom of choice.

Perceptions of Pregnancy

In answer to Sir Henry, an anonymous writer signing only ‘PW’ sent an alternative viewpoint to the BMJ. The letter concerned the perception of the medical profession to the apathy of some women towards attendance at clinics. It was suggested that women did not understand the ‘mysterious’ and ‘repellent’ name of ‘antenatal clinic’. The writer claimed
that many women hearing the word 'ante', related it in their minds to 'anti' and believed it to be some form of birth control. The 'ante' prefix was suggestive of limitation of families. Many people, the writer said, imagined birth control to be abortion, which provided them with a strong reason to stay away. He concluded that if the Latin term was dropped and the 'common tongue' employed instead, the aims of the clinics would be more clearly understood and attendance may consequently improve. The use of language has been highlighted in previous chapters and will be highlighted again later in the current chapter. It can be suggested that the point made by 'PW' revealed the contrast between middle-class and working-class perceptions of pregnancy, childbirth and related issues. The language normally used by medical practitioners to label and describe medical conditions related to pregnancy created a communication barrier between the medical world and the mothers they were hoping to help. This situation led to some mothers misunderstanding the course of action they were advised to adopt. Examples can be found in Monmouthshire concerning the routine examination of expectant mothers. Dr. P.R. Whitaker AMO for the Oakdale, Blackwood and Usk Centres complained that the mothers in those areas did not visit the Centres as often as they should for routine examinations. In Oakdale he found it difficult to communicate to the mothers the importance of urinary checks in particular, and said

They are often very slack over this point and fail to comply with instructions.

At the Usk Centre, which was situated in an agricultural district, Dr. Whitaker came up against opposition from expectant mothers who preferred to stay away. With only three new cases attending during 1929, Dr. Whitaker stated that antenatal work in the district was 'still very much behind' other districts in Monmouthshire. He noted that
...local farm folk are very slow to fall in with any 'change' and consider visits before confinement rather unnecessary. 

Sociologist Peter Worsley claims that '...common patterns of behaviour emerge amongst people in common-life situations...'. Throughout the period covered by this study, common patterns of behaviour were noticeable among the people living in the rural and urban working-class districts of Monmouthshire. Reference was made in previous chapters to traditional patterns and mores. In agreement with Worsley it can be suggested that in Usk, the traditional attitude of the women living in rural working-class districts was that pregnancy and childbirth was a natural process. Therefore, interference during the pregnancy by doctors was not an easily accepted concept.

Many expectant mothers did not wish to be seen in a pregnant condition. Sissy, of Newport in Monmouthshire, remembered that each time she was pregnant, she would only go outside with 'a big coat to cover me bump'. She felt that 'people would know what you'd bin up to'. Sissy’s first two babies were born in the late 1930s. Her third child was born in 1942 during an air raid and delivered by the midwife in candle-light. By the time Sissy’s fourth child was born, women’s attitudes to being seen pregnant had changed: Sissy ‘felt proud to be pregnant’. However her father had retained his traditional pre-war attitude. He would not let Sissy come inside his house and was angry with her for ‘parading’ the streets in her condition without her coat.

The comments of both Dr. Whitaker and Sissy substantiate the claim that the perception of pregnancy was different between the middle-class medical professionals and mothers in working-class districts. Whereas Dr. Whitaker’s observations related mainly to the medical condition of the expectant mother, Sissy was more conscious of the social and
moral traditions prevalent amongst the people living in working-class districts. These common patterns of behaviour, together with practical considerations such as the long distance to travel to a clinic, often led to an expectant mother deciding to stay away from the Centre and antenatal clinic in the 1920s and 1930s.

Sir Henry Simpson noted the attitude of the general public towards childbirth in 1929 in his address concerning maternal mortality. He pointed out that the general attitude was that childbirth was the ‘natural occupation of women’ and that the process was natural and normal. This led to the belief that the best obstetrics was nature and the only help that a woman required was the company of another woman who had ‘gone through’ it. Sir Henry strongly believed that to apply this attitude to a primipara could almost be called ‘criminally negligent’. He concluded by stating that the public ‘must be taught otherwise’.

The education of the general public in medical matters associated to pregnancy and childbirth rather than educating only mothers and young women was his main focus. Nevertheless, his attitude, the comments he made highlighting education, and his emphasis on the medicalisation of childbirth, were typical of the approach of the medical profession at that time.

**Conflicting Opinions**

Dr. Fairbairn chairing the Annual Conference on Maternal Mortality in 1929 mentioned the effect of publicity concerning maternal deaths and the dangers of childbirth. He pointed out that the mental attitude of mothers had been affected by published reports of high maternal mortality rates. The CMO for Monmouthshire also made an observation in the same year on the situation. He said that one of the chief causes of the falling birth rate was that ‘young women of today are inclined to be afraid of the risks of motherhood’.
He continued in his usual manner to express his belief that women 'must be taught' that antenatal care diminished the dangers considerably. He concluded that there was 'a definite place in the community for antenatal clinics', and that in the Monmouthshire clinics, mothers could be certain of receiving 'sympathy, understanding and consideration', as it was the duty of the doctor and the health visitor to 'lighten her lot'. 13 The evidence suggests that Dr. Fairbairn and Monmouthshire's CMO held different opinions as to the result such publicity had on women. The view of the CMO reflects the commonly held belief of the medical profession that women needed to be educated in the advantages of pre-natal care. However, his comments also reveal compassion toward women and an understanding of the fears of the expectant mother. In contrast Dr. Fairbairn followed his initial observation with the comment that mothers

...shrank from what it [birth] might involve in the way of pain and suffering, and demanded anaesthetics and a quick termination of labour. 14

He stated that pressure from relatives, the father or the mother about to give birth was difficult to resist in a domiciliary case. A similar situation in a hospital environment was easier to handle. 15 Dr. Fairbairn did not show the same compassion to mothers, as did the CMO. He was more concerned about the pressures that could be put on the doctor during labour.

Professor Strachan, Professor of Obstetrics and Gynaecology, addressed this problem at the University of Wales, in a speech delivered to the South Wales and Monmouthshire Branch of the British Medical Association later in 1937. The time lapse between the two similar comments suggests that some obstetricians' attitudes had not altered. Professor Strachan pointed out that in domiciliary cases most labours were normal although some
progressed slowly due to weak pains. In these cases there were no dangers to the mother or
the infant, particularly when the membranes were intact. The only danger came from the
'unwise interference on the part of the attendant'. He continued that the main problem was
in convincing the patient and relatives that this was the case. On account of pressure, the
practitioner could be 'put off his judgement' and may be 'pressed to interfere too soon,
often with disastrous results'. He concluded by mirroring Dr. Fairbairn's comment. He
stated that with the absence of relatives, hospital treatment offered better results. 16
Professor Strachan's comments suggest that he was a supporter of the hospitalisation of
women in childbirth and the exclusion of relatives at the birth, which would have the
effect of isolating the mother in an alien and clinical environment. To Professor Strachan,
the process of pregnancy and childbirth was enshrined in the medical world of male
obstetric specialists as his closing remarks confirm. He strongly believed that obstetric
practice should be 'confined to a class of medical men' known to be expert at the work. 17

A Right to Know

The evidence contained in the primary sources used for the previous section, reveal that
conflicting attitudes and opinions existed among the medical profession regarding
antenatal work and the effect of publicity concerning maternal mortality rates on women.
It can be suggested that as far as the latter point is concerned, emphasis on maternal deaths
rather than the number of births not ending in a maternal fatality could have had an
adverse effect on the mental attitude of women to childbirth, particularly the young,
childbearing women. In Monmouthshire, according to official statistics the year returning
the highest number of maternal deaths out of the period covered in this study was
1929. The total maternal deaths amounted to forty-eight out of the 6,419 births that year.
Therefore, 6,371 births did not end in the death of the mother. However, debilitating illnesses and diseases associated with childbirth, in other words, maternal morbidity was a factor in the psychological perception of the process of childbearing to women confronted by adverse reports. The British Medical Association [BMA], made the comment that in the case of maternal mortality,

...the publicity which it is receiving today is tending to terrify child-bearing women and is in itself a cause of increased mortality.

Maternal mortality and morbidity were mentioned by Leonard Colebrook of the Queen Charlotte’s Hospital in London, concerning the prevention of puerperal sepsis. In an article written for the *BMJ* he stated that there were around 18,000 fatal or serious illnesses each year in England and Wales associated with childbirth. He pointed out that this would have ‘a very disquieting effect’ on any group of women hearing about it. Personal knowledge was not necessary for the information to leave a deep impression. He proposed that the public should be told of the dangers of throat- and nose-carried streptococci, which could result in maternal mortality and morbidity through puerperal infection. He said that the means to accomplish this was to ‘keep our propaganda sane’. He posed the following question to sceptics.

Why should they not be told of this just as they are told of the danger from tuberculosis sputum or contaminated milk or road accidents?

Continuing to voice his opinion, he admitted that the suggestion of propaganda would arouse opposition in some quarters on the grounds that knowledge of unseen dangers would inevitably filter through to expectant mothers and ‘frighten the more timorous of them’. However, he argued that women were hardy enough to recognise the message and
take ‘intelligent precautions’. Nevertheless, information focusing on the positive results of births was not forthcoming through government or medical reports. The emphasis remained strongly fixed on the dangers of inadequate birth attendants and the lack of attention to antenatal care by expectant mothers. The remedy to effect a reduction in the maternal mortality rate remained constant; medical examinations at an antenatal clinic or by the local doctor.

**The Perceived Need for Antenatal Care**

The movement in favour of antenatal care arose from the desire to reduce the number of stillbirths and abortions. In 1915, legislation requiring the notification of stillbirths consolidated the idea of the preventive care of the expectant mother. It was generally agreed that systematic antenatal observation furnished important data as to the probable course of both pregnancy and labour. The main conditions that may be foreseen through examinations during pregnancy were abnormalities in the urine, disproportion between the pelvis and the infant, and abnormal presentation. Additionally, enquiries could be made into the obstetric history of the mother and her general hygiene could be monitored. The Local Government Board stated

> Antenatal care is the application of preventive medicine to pregnancy in the common interest of both mother and infant.

The Board stressed that antenatal care could save infant lives, prevent chronic diseases in childhood and reduce the unnecessary suffering of mothers. It can be suggested that the main functions of antenatal clinics as set out by the Board, were to provide both an educational role and a method of surveillance. The educational aspect covered the advice offered to the mother concerning the ‘special hygiene of her condition’ in order to prepare
her practically and physically for the birth. Additionally, mothers were to be kept under surveillance in a medical and social sense. Medically, the 'minor disabilities' of pregnancy including 'dyspepsia, constipation, varicose veins and defective teeth' could be recognised and treated, saving 'unnecessary suffering' to the mother. More serious conditions such as albuminuria, cardiac or pulmonary disease could be detected and suitable steps taken to treat them. Socially, the mother's home conditions, general personal and practical hygiene were noted and reported through the 'sympathetic home-visiting by a trained visitor'.

Substantiation of the claim that antenatal clinics worked, in part, as a form of social control in a similar way to the earlier Schools for Mothers and the Maternity and Child Welfare Centres can be found in an extract from a report by Dr. Janet Lane-Claypon. The report was the result of an investigation into the antenatal care facilities that were available prior to the establishment of separate clinics. Dr. Lane-Claypon visited various hospitals in the London area. She found that at St. Thomas's Hospital, antenatal work was well-organised and included visits made to the homes of expectant mothers by the hospital almoners' visitors and voluntary agencies. The visitors advised the mothers on suitable clothing for the expected infants and general home conditions, then reported to the almoner. It was pointed out that the home visits led to

...much improvement in the general cleanliness of the homes, and to better preparation for the infant.

Evidence suggests that the Local Government Board supported the social control of mothers through the visitation process. It was promoted that the antenatal clinics supplemented by home visitation would ensure that there would be a reduction in the
number of miscarriages and stillbirths, a 'happier home' and safer future confinements. Furthermore, it was believed that there would be additional benefits, such as

...more intelligent preparation for confinement, increased interest in the post-natal care of the infant, a marked increase and longer duration of breast feeding...  

The function of antenatal clinics covered a wider area than the 'application of preventive medicine', which the Local Government Board allocated to them in 1915. Furthermore, the closing comment of the Board on the organisation of antenatal work reveals that monetary considerations were taken into account when regarding the benefits of antenatal care. It was acknowledged that maternity benefit under the National Insurance Act meant that many mothers could have better care at home. However, it was pointed out that if insured mothers or the wives of insured workers attended antenatal clinics in the early stages of pregnancy, there would be a probable reduction in illness during pregnancy and the 'sickness claims of pregnant occupied women' would be 'greatly reduced'.  

Ten years after the passing of the Maternity and Child Welfare Act, which established the Centres where expectant mothers could receive a limited amount of antenatal care, the maternal mortality rate had not experienced the reduction that had been envisaged. An article in the BMJ noted the emphatically expressed opinion of the BMA concerning antenatal clinics,

...apart from their educational work, there is nothing essential done at antenatal clinics that should not be done equally well either at the woman’s own house or at the doctor’s consulting room.  

The BMJ stated that part of the problem was due to the lack of antenatal training that midwives received. The BMJ also directed criticism toward doctors who showed a general
lack of interest in antenatal work. However, it was claimed that ‘these unfortunate conditions’ were in the process of being overcome. The BMJ continued to briefly relate the six principles on which antenatal care should be based according to the Committee on Maternal Mortality. The Committee was in the process of drafting a memorandum for the guidance of local authorities. The first four points were essentially medical preventive measures, such as the prevention of difficulties during labour, detection and treatment of toxaemia, venereal disease and infections. The fifth point involved co-operation between the care-givers and receivers. The final point highlighted the educational value of the antenatal clinics. The BMJ admitted that there was general agreement on the need for the six principles. However, regret was voiced at the apparent ‘absence of emphasis on attention to the health of body and mind in the expectant mother’. 29 Relief of the many minor ailments that expectant mothers encountered was a vital part of the pre-maternity care. The BMJ pointed out that the frequency with which minor disorders such as varicose veins and digestive problems occurred, illustrated the fundamental role minor ailments played in the disabilities arising out of childbearing. It was suggested that by explaining to expectant women that ‘their little troubles and discomforts’ would receive attention in the form of treatment or reassurance, the advantages of pre-maternity care would be impressed on women. 30 The basic need for the antenatal care of the mother was not in dispute. Nevertheless, evidence suggests that there was conflict and disagreement among the medical profession and government officials. The disputed issues included the method of implementing pre-maternity facilities, the nature of propaganda techniques, and the quality of the work of antenatal clinics. In order to assess the effect of antenatal work prior to the introduction of separate clinics
specifically for the attention of the expectant mother, it is necessary to examine the reports
of the medical officers at the Centres. The chief ailments suffered by expectant mothers
visiting the Centres to ask for advice is difficult to assess, since the ailments of all mothers
requesting attention were listed.

Through the evidence contained in the medical officers’ reports, the middle-class
perception of the way a woman should conduct herself during pregnancy becomes
apparent. Additionally, it is possible to indicate the way in which a mother from a
working-class district related to her expectant condition. MCC implemented a
comprehensive network of Centres in the county and offered expectant mothers the benefit
of limited antenatal attention. Therefore, the following section will analyse the reports
returned to the CMO concerning the general health of the mothers examined by medical
officers in charge of those Centres.

**Antenatal Care at the Maternity and Child Welfare Centres in Monmouthshire**

This section deals with the antenatal attention available to expectant mothers visiting the
Maternity and Child Welfare Centres in Monmouthshire from 1919 to 1929. In the
November of 1929, the County Council was able to implement a scheme for separate
antenatal clinics. Through the reports of the medical officers in charge of the Centres, it is
possible to detect the extent of support for, or apathy towards, antenatal examinations
being undertaken at the Centres in Monmouthshire. Furthermore, covert evidence
contained in the reports together with the record of attendance made by expectant mothers
reveals the attitudes towards pregnancy of both the middle-class care-givers and the
mothers in working-class districts of the county.
In 1919, the CMO mentioned that although there had been a ‘distinct advance’ in antenatal care in the county, it would be impossible to improve further until satisfactory premises ‘planned for the purpose’ were erected. The majority of Centres in the county were conducted in churches, chapels or Domestic Arts Centres linked to schools. A scheme for the provision of twenty-four buildings in different parts of the county had received approval from the Maternity and Child Welfare Committee. However, due to the ‘state of the building trade’ the CMO noted that it would be some considerable time before plans could become operational.

The lack of proper facilities for the monitoring of expectant mothers caused some problems. The reports of all the medical officers at the Centres from 1919 to 1929 contained comments referring to the lack of specific accommodation for the adequate examination of expectant mothers attending the Centres for that purpose. Dr. Mary Howie, AMO, said of the facilities at Ynyssdu Centre in 1919, that more could be done ‘given suitable accommodation and equipment’. She pointed out that it was difficult to carry out antenatal work in a satisfactory manner. Dr. Mary Scott substantiated Dr. Howie’s remarks by saying that in general, new premises were needed with constant hot water supplies and facilities for proper sterilisation, since work could not be conducted ‘with any degree of safety to the patient’. The comments of most of the medical officers contained similar remarks in 1919 and the intervening years up to 1929. Dr. Winifred Austin, AMO, was in charge of seven Centres in the county. She noted that in only one of her Centres she had a couch suitable to use for the examination of expectant women. Privacy was an added problem since sessions were held in one room. When expectant mothers did attend for the specific purpose of gaining advice and help for problems associated to pregnancy,
they were met with a room full of other mothers with their infants and children. It is probable that the lack of privacy was one of the reasons for the comparatively low attendance figures prior to the introduction of separate antenatal clinics. However, apart from the lack of facilities, other reasons were put forward by medical officers for the apparent apathy of expectant women to attend the Centres for antenatal examinations. The comments reveal certain attitudes and perceptions towards pregnancy of both medical officers and expectant women.

**Some Reasons for Absence**

Dr. R.V. de A. Redwood, MO for Rhymney found that it was difficult to persuade expectant mothers to attend his Centre and attributed their reticence to a ‘dislike of publicity’. 35 This was one reason that was mentioned in an interview with Newport-born Sissy and was discussed in Chapter Four. Two years after Dr. Redwood had made the comment, Dr. E.M. Griffith, MO for Abercarn, observed that expectant mothers in Abercarn were ‘loth to shew themselves in a crowd of mothers’. 36 Traditional social mores prevalent in working-class districts surrounding the appearance of a pregnant woman in public did seem to have an effect on expectant mothers. Many preferred to stay indoors or near to the family home where they were known and were relatively comfortable with their enlarging condition. Mrs. G. of Saundersfoot in South West Wales spoke of staying indoors as soon as she started to show signs of being pregnant for the same reasons as Sissy. Mrs. G. said that since she did not want to be seen outside her home, she did not have any ‘check-ups’ at clinics while pregnant. 37 Comments made by Dr. Mary Scott in 1920 serve to offer two other reasons women might not have attended Centres. The comments also substantiate the above statement
concerning the preference of expectant mothers to remain close to familiar surroundings.

Speaking of the general decline in attendance numbers at one of her Centres in 1920, Dr. Scott pointed out that she took over the work of that particular Centre in the autumn of that year after there had already been two other changes of MOs in 1920. She firmly believed that ‘...frequent changes are subversive to any progressive scheme of work’, adding that at other Centres in her care where no change had occurred, there had been significant increase in attendance. \(^{38}\) Dr. Scott’s comment suggests that some medical officers might not have regarded the work at Centres important enough to give commitment.

Alternatively, it can be suggested that there were an inadequate number of medical officers to undertake the work in a sufficiently committed way to familiarise themselves with the specific problems of that area. Dr. Scott’s second observation on the apparent indifference of the mothers to attend pointed directly to the long distances some had to walk before reaching a designated Centre.

Many of the mothers had to cover miles on foot often with a small baby and perhaps a toddler. \(^{39}\) Mrs. D. of Rogerstone, revealed that to attend an antenatal clinic, she travelled four miles each way on public transport, which she found very uncomfortable, ‘my feet and legs were very swollen’. Her antenatal clinic in Newport was on the top floor of a three-storey building. Consequently, she had to climb thirty steps to reach the waiting room. A doctor and a nurse were in attendance. The doctor gave her a date for the confinement and ‘a ticket for free orange juice and powdered milk, very acceptable...’.

However, Mrs. D. complained that he did not offer her any treatment for the sickness and her swollen feet, which were the reasons for her decision to attend. She did not go back to the clinic. \(^{40}\) Mrs. D’s experience came in 1933 when there were more special clinics for
expectant mothers. Her experience suggests that some of the problems referred to in the 1920s continued into the 1930s regardless of extra facilities.

None of the ten women interviewed at Blaen-y-Pant in Bettws attended antenatal clinics although four of the women remembered attending their local doctor's surgery on a regular basis while pregnant. Only one of the seven women interviewed at Pant-y-Celyn in Bettws, Mrs. M. attended an antenatal clinic at a church hall in Cardiff when she was expecting her first child in 1933. Mrs. M. went to the clinic regularly and was weighed each time. She claimed that she did not need any treatment because she was healthy during her pregnancies. However, some women still did not know antenatal clinics existed when the service was extended in the 1930s. Mrs. C. of Ebbw Vale said,

I knew of no ante natal clinic here in this area, but had an occasional examination by the nurse who was a midwife living in this area.

Out of a total of fifty interviews conducted and letters received from women concerning their pregnancies in the 1920s and 1930s, only two attended special antenatal clinics. Furthermore, while addressing a meeting of the Sunshine Coast Welsh Society in Australia consisting of many elderly women who had given birth in Wales prior to emigrating to Australia, information was requested concerning antenatal clinics in Wales in the 1920s and 1930s. The answer was unanimous, not one woman remembered attending Centres or clinics for the specific purpose of antenatal examinations. There seemed to be a general lack of knowledge that antenatal care was undertaken at Centres, and separate antenatal clinics existed in the 1930s.
The Call for More Publicity

Dr. Steel, MO for Abergavenny was one of the medical officers to point out the need for wider publicity concerning the antenatal facilities available to women in an attempt to attract more expectant mothers to attend. The CMO also believed that there had been a problem in the past with insufficient knowledge concerning the number and distribution of women who were pregnant. However, he felt that the situation was changing due to the additional visits made to the homes of mothers by health visitors. Nevertheless, the information passed to mothers by health visitors was not acted on in many cases. Some medical officers believed that more co-operation from midwives was needed including a programme of propaganda organised to inform mothers of the facilities. Dr. Steel pointed out that mothers were not aware that antenatal advice and attention was part of the work of the Centres.

Dr. Ellis, MO at the Centre in Cwm, Ebbw Vale, expressed his disappointment that there had been no increase in antenatal attendance. He stated that in his opinion mothers were unaware of the importance of antenatal supervision. He claimed that if the circumstances were more generally appreciated by the public ‘labour would be robbed of its difficulties and dangers’. The stress on antenatal care as the fore-runner to a successful labour in the context implied by Dr. Ellis was a change from the attitude many medical men held at the start of this study. Previously, it was believed that the untrained female midwife posed the most danger to women in labour.

Dr. Werden, AMO at the Centre voiced his opinion on the need for propaganda in Aberbargoed. Dr Werden reflected Dr.Ellis’s view with his concerns regarding the lack of
attendance by expectant mothers. He said, the 'conviction grows' for some form of propaganda.

Many women seem still quite content to go to the term and be confined without any medical supervision whatever. 50

Dr. Werden continued to say that in his experience, when expectant mothers were told that they should provide a specimen of urine periodically for testing 'they expressed surprise' and were 'apt to neglect' to carry out instructions. 51 Dr. Werden did not mention whether an explanation was offered to the mothers so that they would understand the need for such tests.

Three years later, Dr. Gladys Russell, AMO at the Centres in Caldicot, Blackwood, Oakdale and Risca, observed that 'prejudices against examinations are being overcome gradually'. 52 In conjunction with the comments of Dr. Werden, the evidence indicates that expectant mothers were uncertain as to the nature of the intimate examinations that took place under the guise of antenatal work. Furthermore, this could have played a part in keeping some pregnant women away from Centres, particularly those women expecting their first child. Women might not have been familiar with the work conducted in those Centres when they had not attended with other children. Dr. Russell found that,

The best attenders are those mothers who happen to be bringing an older child also, and these are seen right up to term. 53

It is probable that when a mother attended a Centre for the sake of her child and became pregnant during that time, she was more likely to accept the antenatal care offered to her than to attend of her own accord in the period before antenatal clinics became divorced
from Child Welfare Centres. Dr. Russell believed that once mothers had received pre-
maternity care this way, they would return voluntarily in a subsequent pregnancy. 54

Nevertheless, Dr. Russell’s comments concerning the need to seek advice early in
pregnancy, reveals an attitude that can be detected among other medical officers at the
time in Monmouthshire. The comments often reflect the medical emphasis placed on the
pregnant condition of the mother.

The language used by Dr. Russell seemed to detach the mother from her condition and
dehumanise her. Dr. Russell stated that early observation would mean that the expectant
mother’s general condition could be ‘overhauled’. She could be given advice and ‘general
rules’ for the rest of the pregnancy and a ‘warning to report any suspicious symptoms’. 55

Furthermore, without an explanation of the reasons for certain symptoms to be reported
and the nature of those symptoms, it could be suggested that the medical emphasis might
have perpetuated fear, misunderstanding and uncertainty in the mother about her
condition, rather than putting her at ease.

Dr. Griffith labelled expectant mothers as ‘patients’, which also illustrated the medical
emphasis that was placed on pregnancy. He felt that expectant mothers had ‘not yet got
into the habit of coming to the clinic’. 56 His comment reflected his attitude towards
mothers in working-class districts. He believed that it was the duty of women to present
themselves for medical examinations while pregnant. It can be argued that both Dr.
Russell and Dr. Griffith tended to focus on the medical aspect of pregnancy, which
excluded the feelings and anxieties of the expectant mother.
**A Weight of Responsibility**

The psychological weight of responsibility on expectant mothers was increasing as desired patterns of behaviour were laid down by the middle-class care-givers. There was a fundamental difference between the way mothers in working-class districts and middle-class medical professionals viewed pregnancy and childbirth. A further example of the weight of responsibility placed on expectant mothers can be seen through the remarks of Dr. Martin, MO for Blaenafon. Expressing hope that antenatal clinics would soon be established throughout the county, he declared that there was little doubt that such clinics ...would have a good effect in instructing young expectant mothers as to the proper means of maintaining their own health during the expectant period, and in that manner would do much to lessen abortion and premature births...  

Dr. Mason, MO for Pontypool, voiced a similar opinion concerning the work of separate clinics. He suggested that antenatal facilities were needed to detect abnormalities and also to aid the improvement of the mothers’ health. Additionally, advice could be offered to an expectant mother that would help her to choose a midwife. The overall assistance would ensure that the expected child ‘would be catered for on the proper lines from the start...’.  

Information on correct nutrition during pregnancy was offered to any expectant mother attending the sessions at the Centres. However, other medical officers besides Dr. Martin and Dr. Mason viewed the improved nutrition of the mother as a means to reduce infant mortality and decrease the number of ‘badly nourished children’.  

Dr. Davies, AMO at the Abertysswg Centre, believed that poor nutrition was discovered too late. The majority of the reports sent to the CMO by medical officers in charge of the Centres mentioned that antenatal care would lessen the cases of abortion and stillbirths in
the county. Few mentioned the direct benefit the expectant mother could gain through additional care during her pregnancy. As stated earlier, advice was given to mothers concerning nutrition while pregnant. However, the type of food suggested was often too expensive for some mothers, especially in times of severe economic depression in the county. This situation added to the weight of responsibility placed on mothers by medical officers.

Mrs. L., now living in Worcester, explained that her mother attended a local ‘Health Clinic’ when she was pregnant in 1931. She told her daughter that very little was done except ‘to feel her abdomen’. She was advised to eat special foods such as fresh fruit, vegetables and plenty of red meat, fresh milk and cheese. However, she found that apart from the vegetables, which were grown in the garden, there was little chance that she could afford to buy the fruit or enough meat. Mrs. L’s father was a coal-miner working a three-day week at that time, and money was very short. When born, the baby was underweight and undernourished. Although the baby survived the trauma of birth, rickets later developed and poor health remained into adult-hood. 60

Many of the women interviewed mentioned that it was difficult to afford or obtain some of the foods recommended to them by health visitors or midwives. However, the majority of the interviewees’ husbands grew vegetables in the garden and had a good supply of potatoes, carrots and some green leafy vegetables. Mrs. R-M was one of the mothers who did not attend an antenatal clinic. She visited the doctor for the first time when she was three months pregnant in 1936, and then attended every month. The doctor told her ‘You must build yourself up’, so she chose to have porridge for breakfast every morning and a hot meal in the evening. Mrs. R-M.’s husband had a good position in the Royal Air Force
securing a good income. She mentioned that she was more fortunate than many expectant women were at that time. 61

Most of the women interviewed thought that when they had a reasonable amount of food to eat, they had a ‘good’ diet. Generally, there seemed to be little knowledge about the type of food that they should eat for health reasons. The women would use whatever could be grown in the garden to supplement the food they could afford to buy. A number of the women interviewed were able to take advantage of the practise of growing vegetables and fruit, which was prevalent in working-class districts. Mrs. J. was fortunate in Saundersfoot to have chickens, pigs and a few cows on some adjoining land in addition to fruit and vegetables in the garden. She baked her own bread, made fruit pies and jams and made butter out of the milk from the cows. Mrs. J. mentioned that many of the miners in Saundersfoot, which used to be mainly rural with a few coalmines, had some land and kept a few cows and pigs. There was also a barter system among the neighbours where one would exchange pork for beef or eggs for butter: no money would change hands. 62 Mrs. J. and her neighbours in rural Pembrokeshire seemed to have plenty of good fresh food at a time when industrial districts in Wales were suffering from the depression in trade. In the industrial district of Blaenafon, a barter system operated within which neighbours exchanged tea for lard, or butter for eggs 63 as in Saundersfoot. Mrs. J’s friend, Mrs. B., confirmed Mrs. J’s story. Mrs. B’s husband was a gardener, so they had abundant supplies of fresh fruit and vegetables. Her step-mother also kept pigs. Mrs. B. did not attend an antenatal clinic, although she did see the local midwife occasionally before the birth of her baby. The midwife advised her to eat oranges. She could not afford to buy them and can remember feeling guilty even though she had plenty of other fresh fruit from the garden. 64
The impression of authority, which emanated from an official in uniform, was a powerful force.

In the industrial valleys land was not plentiful. Nevertheless, many of the husbands had an allotment where extra vegetables were grown, as the responses of the women interviewed confirm. It is probable that many women had an adequate supply of fresh vegetables from allotments during the 1920s and 1930s, particularly when money was in short supply. Nutrition and its effect on expectant women and their infants will be addressed later in this chapter when analysing the work of the separate antenatal clinics from 1930.

The Centres’ part in antenatal care was extremely limited. Women were generally unaware of the antenatal facilities available unless they attended a Centre with their other child or children while pregnant. They would then be given advice on the ‘general care of health, diet, exercise and bodily function’. Urine tests were conducted at the Centres. However, there were very few Centres equipped with the basic needs to undertake intimate examinations. Little treatment was offered to expectant mothers except to give them ‘a simple tonic’ when needed. Any other medicine or treatment that mothers required meant a referral to the local doctor. Nevertheless, the majority of the medical officers were in agreement that separate antenatal clinics were necessary to reduce the abortion and stillbirth rate in the county. Furthermore, every medical officer in Monmouthshire made some remark concerning antenatal care in 1919 and 1920.

An interesting observation can be made on reading the statements of the MOs. Comments began to become repetitive. The most common statement was that little or no antenatal work was undertaken due to lack of equipment and accommodation. The more the statement was in evidence, the less mention there was of the need for antenatal work at
Centres or separate clinics. Dr. Ellis of the Cwm Centre seemed disillusioned enough to comment that it was

...doubtful whether many of the parents would avail themselves of such facilities even if they were in existence. 67

Many mothers stayed away from the Centres due to practical reasons such as the distance they had to travel. Others were bound by traditional mores, which had been impressed on them by earlier generations. This often led to a feeling of shame at their pregnant appearance and a dislike of unfamiliar surroundings. Dr. Ellis pointed out that the only reason expectant women attended was to apply for free milk during their pregnancy, 68 which reinforces the suggestion that Dr. Ellis was disillusioned.

The evidence emanating from the reports reveal that medical officers attending the Centres from 1919 to 1929 in Monmouthshire were aware of the need for antenatal care. However, they were unable to attend to those needs through the lack of adequate facilities. Consequently, they were not enthusiastic about their role in pre-maternity. The emphasis in Centres remained firmly fixed on the well-being of the infant and child. Therefore, it can be argued that the antenatal care offered to expectant women at the Centres was limited and inadequate and could not have effected a positive response in the improvement of the health of expectant women. Furthermore, in 1921 when antenatal care was available in Centres, the number of women dying in childbirth amounted to forty-two. In 1929, when separate antenatal clinics were introduced into the county in the November of that year, the figure was even higher at forty-eight. 69 These figures stand testimony to the lack of effect the Centres had on maternal health. Nevertheless, attendance figures do show that over the period 1919 to 1928, expectant mothers were slowly overcoming their reticence
and were beginning to ask for help. In 1919 there were 258 expectant mothers on the registers of Maternity and Child Welfare Centres in Monmouthshire. Some Centres had no expectant mothers while other Centres had a high figure, such as Newbridge with forty-three. In 1928 the CMO stated that he was pleased to note that antenatal supervision seemed that it was becoming more popular. There were 884 expectant mothers attending the Centres in that year.

The Perceived Need for Separate Clinics

For antenatal attention from 1919 to 1929, women could attend the Centres, the local doctor’s surgery or see their midwife if they felt the need. The previous section revealed that many women did not bother with pre-maternity care at all, preferring to wait until labour started to call the midwife. At the beginning of 1929, three clinics had been equipped and were operating as antenatal clinics. By November 1929 eleven more clinics had been added to the list. For the year 1929 the number of expectant mothers on the register for the county was 1,241, a further increase on the 1928 figure. The CMO noted that the increase could not be attributed to the opening of the new clinics since there had only been two sessions for those clinics during the year. Therefore, the rise in attendance figures stand as confirmation of the argument presented earlier concerning the changing attitude of mothers to pregnancy.

The CMO declared the increase to be due to the ‘wisdom’ of antenatal care becoming more apparent to expectant mothers in the county. He stressed the benefits to women on seeking ‘skilled advice’ at the earliest possible moment. Through his remarks it is possible to identify the importance the CMO placed on educating the mother in antenatal issues. However, it is also possible to detect a different attitude towards expectant mothers
than some of the medical officers at the Centres seemed to portray in the previous section. The CMO believed that the expectant mother would experience feelings of contentment when her case was in the hands of a doctor specialised in the subject. She would feel secure that he would be able to use his specialised knowledge for the benefit of herself and her child. Secondly, the CMO pointed out that many minor ailments would be treated adding to the mothers ‘bodily comfort’ in pregnancy and would save her unnecessary suffering. Thirdly, he noted that danger symptoms could be detected and steps taken to ensure a safe confinement. Finally, the CMO repeated his belief that the falling birth rate was the result of the fears of young women. He said that antenatal clinics could become places where young women were ‘taught’ that pregnancy was a time of well-being and then helped to achieve that goal. The CMO’s focus on the educational role of the clinics was firm. However, the CMO’s comments also revealed an interest in the well-being of the expectant mother, which was a feature often missing from the reports of the medical officers attending the Centres.

The organisation and staffing of the antenatal clinics had met with previous criticism, as pointed out in the articles published in the BMJ in 1929. The chief problem seemed to be that pre-maternity work would be divorced from midwifery practice and placed in clinics, which would be conducted by medical officers with little or no experience in obstetrics. The BMJ stated that the Memorandum of the Committee on Maternal Mortality failed to address the problem ‘except for some praiseworthy suggestions as to co-operation between clinic officers, doctors, midwives and hospitals’. It was also suggested that continuity of care was needed throughout the early pregnancy to the post-natal period.
It is in institutions and in private practices where there is continued observation of and responsibility for the woman throughout child-bearing that good results are apparent. 77

The limitations of the antenatal clinics become clear through the final words of the Memorandum. It was stated that ‘...treatment of abnormal conditions is not the work of an antenatal clinic’. Any cases requiring treatment would need to be referred to the family doctor, a consulting clinic or a hospital. 78 It can be argued that given these specifications, the separation of antenatal care from midwifery practice would have led to a splintering of responsibilities. Co-operation between all parties engaged in the process would be required for the system to work efficiently. Furthermore, expectant mothers would see one person at the clinic and engage a different person for a midwife. Then they might see the family doctor if treatment was needed for more than a minor complaint, and when there were complications that the doctor could not handle, the mother would need to see yet another person at a different location. It can be argued that the introduction of separate antenatal facilities led to an increase in the number of people involved in the private function of child-birth. This was in contrast to the time when the only contacts might have been the familiar local midwife with a family doctor when difficulties were experienced during the labour.

The extension of medical interference into the sphere of womanhood had not reduced the maternal mortality rate in comparison to the falling birth rate and infant mortality rate. The Departmental Committee on Maternal Mortality and Morbidity stated that the issue of maternal mortality involved the ‘survival of the nation’. The Committee continued that attempts to safeguard confinement for the purpose of a safe delivery for both the mother
and the infant, often failed due to 'a four-fold evil'. The four points referred to were the high maternal mortality rate, the subsequent invalidity of the mother if she survived the birth, the relatively large number of stillbirths and the excessive early mortality or later morbidity of infants.

Sir Arthur Greenwood, Minister of Health, showed apparent consternation when he mentioned that the loss of a mother to her husband and children was devastating. However, his real concern was with the deterrent effect such tragedies had on the effect of the birth rate. He pointed out that the loss of mothers mainly occurred among young women who were at the height of their reproductive years. Furthermore, a mother was a 'supreme physical contribution to the country' as the 'upbringer and trainer of a family'. He concluded that knowledge of disasters would produce 'a fear of maternity in both mother and father'.

The evidence suggests that the survival of the nation was a key concern of the Minister of Health and the Committee. Antenatal care was believed to be the answer. The Committee was convinced that systematic observation during the pre-maternity period would furnish the details required to accurately assess the probable course of pregnancy and labour. With accurate details, it was believed that the successful delivery of both mother and infant should be the result. The research undertaken by the Committee prompted the opinion that 'a certain amount of inefficient work' had been undertaken 'under the guise of 'antenatal care". The Committee had found evidence of neglect in diagnosis and treatment of abnormal conditions. In the latter case, the Committee suggested that the neglect was mainly the result of the lack of adequate facilities to treat the expectant mother.
Earlier evidence revealed that there were severe inadequacies in Monmouthshire related to antenatal facilities prior to 1930. However, when an expectant mother did attend a Centre and was found to have some abnormal condition, she was finally referred to an obstetric surgeon in Cardiff. Nevertheless, this meant travelling to the adjoining county since no obstetric service existed in Monmouthshire. By 1930 there were 900 antenatal clinics in England and Wales. However, the Committee was ‘strongly of the opinion’ that the medical practitioner responsible for the confinement should carry out antenatal care. 81 This opinion was mirrored by many in the medical profession. The provisions required for an efficient maternity scheme to prevent maternal mortality included the service of a qualified midwife; a doctor to carry out ante-and post-natal examinations; a consultant when necessary; more hospital beds and certain ancillary services. Co-operation was vital for the overall provision of care to function smoothly. The following sections will examine the way in which Monmouthshire County Council implemented a county-wide antenatal scheme and the extent to which the scheme was successful in effecting a reduction in maternal mortality rates in the county.

**ANTENATAL CLINICS IN MONMOUTHSHIRE: 1930 TO 1939**

The Maternity and Child Welfare Committee’s report for the year 1930 offered a full account of the first year’s working of the sixteen antenatal clinics introduced into Monmouthshire. The number of expectant women attending the clinics in the first year as new cases was 1,047. The attendance figures show that most of the women attended for one session. The average attendance at the clinics throughout the county was only 9.9 per session. 82 The majority of clinics opened for one day each month. However, there were no set patterns for the times of opening or the length of the sessions. The clinic with the
highest number of new cases in 1930 was Crumlin with 142, followed by Blaina, 129 and New Tredegar with 101 new cases. The lowest number returned came from Abergavenny where seven expectant mothers attended and only one made a second visit during the year.  

Dr. Mary Scott, AMO, mentioned that the Abergavenny clinic was the only centre where attendance was disappointing in the whole of the county.

The clinics were kept apart from the child welfare sessions at the Centres. Female medical officers attended the sessions. They were chosen for their specialist qualifications for the work, which corresponded with the recommendations of the Departmental Committee. The women officers were Drs Mary Scott, Mary Gordon and Philomene Whitaker and were Assistant Medical Officers of the county council. The three women had gained experience attending the Maternity and Child Welfare Centres. Dr. Mary Scott was chosen to be chiefly responsible for the work of the clinics.

Dr. Scott noted that attendance at the clinics gradually increased during the first year, with approximately fifty per cent attending 'simply for advice and attention', and some attending solely to take advantage of the free milk offered to expectant women.

The First Clinic Visit

When an expectant mother attended for the first time, the same systematic recording and examination of her condition was conducted at all the clinics. Firstly, the mother was questioned concerning previous pregnancies, if any, and her past health problems and the information was recorded. Secondly, the mother’s general physical condition was examined, urine tests were taken and she was weighed. Specific points related to pregnancy were investigated such as pelvic capacity in relation to the unborn infant. Finally, she was advised to attend the sessions every month. During the last month, and
intervening months if necessary, a further examination was made with a view to ascertaining if a safe delivery was able to take place. In the event of any abnormal conditions appearing during the pregnancy, or when it was felt that the mother would have a difficult birth, she was referred to Cardiff to see an obstetric specialist. Evidently, there was a considerable improvement in the nature of the attention an expectant mother could receive in Monmouthshire from 1930 compared to the period 1919 to 1929. However it is arguable whether the additional facilities aided an improvement in the health of mothers in the county. Expectant mothers continuing to attend the Centres did not have the same attention paid to their condition. This situation remained throughout the period covered in this study. When an expectant mother attended a Centre she was advised to go to the nearest antenatal clinic. However, the choice was hers and she remained in control of the decision to attend a separate clinic or to stay away.

The Role of the Health Visitors and Midwives

One method used by local authorities to keep in touch with expectant women in the county was the visitation process. A health visitor would visit the mother in her own home following information received from the midwife, the Centres or the new clinics. In 1919, the number of visits paid by health visitors to the homes of expectant mothers totalled 376. The number peaked in 1925 at 1,020, then gradually decreased to 584 in 1929. In 1930, the new cases seen by health visitors numbered 331 with an additional 341 re-visits made. This did not constitute a large increase, although the CMO preferred to place a positive emphasis on the number of visits by claiming that the visits were increasing every year. Nevertheless, referring to some of the problems in the first year of the full operation of the clinics, Dr. Scott said that one of the 'greatest difficulties' was persuading
patients that it was essential to attend the clinic for examination around the thirty-sixth week of pregnancy. One of the health visitor's tasks was to encourage the expectant mother to attend up to the end of her pregnancy. However, Dr. Scott's concluding remark suggests a possible reason for the number of visits to expectant mothers' homes failing to increase. She pointed out that 'unfortunately the Health Visitors have not the time to spend in this work ...'.

Dr. Scott highlighted a related problem in her report to the CMO. She claimed that it was difficult to find the time to see and examine all the expectant mothers attending the clinics in the short clinic sessions. It has been shown that the extension of state intervention into the process of maternity increased the number of public health officials. However, the evidence suggests that local authorities could not supply enough members of staff to carry out the work involved in the policing of maternal and child health. The comments of the CMO and the AMOs working at Centres and clinics in Monmouthshire at various intervals throughout the period studied, stand testament to this situation.

With the involvement of midwives, doctors, health visitors, Centres, clinics, obstetricians and hospitals in antenatal care, co-operation was extremely important. The fragmentation of the care process was fixed with the separation of the antenatal clinics. The Departmental Committee had pointed to the need of close co-operation and this was recognised in Monmouthshire. The CMO made the following observation,

The midwives are giving their hearty co-operation and many of them attended with their patients at the clinics.

Dr. Scott was pleased that midwives 'in most districts' were co-operative and sent patients to the clinics. However, Dr. Gordon, although admitting that 'several' midwives made
full use of the clinics in her control, she was not as satisfied as Dr. Scott appeared to be.

Dr. Gordon remarked

...there are still several [midwives] who neither examine their antenatal patients
nor yet advise attendance at the clinic.  

In 1931, out of the 141 new cases attending Dr. Gordon’s clinic in Newport, forty-four
were referred by midwives and four by their own doctors. Most of the remainder was
referrals from the Child Welfare Centres, only ten attended on their own initiative. 

Therefore, it seems that in Newport in 1931, the majority of the expectant women attended
antenatal clinics through the advice of the Centres and not the midwives, which supports
Dr. Gordon’s grievance.

The situation did improve. In 1936 Dr Gordon reported that out of the 225 new cases she
had at her Newport clinic that year, midwives had referred eighty-two per cent. The
Centres sent eight per cent, doctors four per cent and a further six per cent went on their
own accord. Dr. Gordon’s attitude towards midwives had changed since the inception of
the clinics. She was pleased to see many of the midwives attending with their patients so
that they could keep in touch with the work of the clinic and relate to the advice offered to
her patient. Dr. Gordon noted that if a midwife could not attend with her patient, the clinic
would send her a written report on the outcome of the examination, and so retain links
with the midwife in this way. 

The attendance patterns at the clinics were well-documented in order to examine the
number of expectant mothers attending of their own accord, those that were referred, the
number of times each mother attended and the main reasons for visits to the clinics. As
mentioned, the number attending in 1930 was 1,047 with a low average attendance of 9.9
per session. In 1931, the CMO noted that there was a 'marked improvement in the attitude of expectant mothers'. He claimed that this was shown through the rise in attendance figures to 1,383 with an average attendance of 13.9 at each session. Abergavenny clinic was still found to be disappointing by Dr. Scott. With only seventeen new cases making an average attendance of 2.3 at each of her clinic sessions, she said that she could 'hardly justify the continuance of an antenatal clinic' in Abergavenny.

Other difficulties were uncovered during the first two years of the opening of the clinics. The CMO mentioned that a proportion of the mothers attended for the cheap or free milk that was given to the needy mothers. Dr. Gordon reiterated this point when she reported that there were complaints that an 'ever increasing number of expectant mothers' were coming solely for the free milk. Her following observation implied that women further advanced in their pregnancy were beginning to complain that the number of women attending in the early months in order to apply for free milk, were taking up the time of the MO. Dr. Gordon protested that

...the time taken up by examining endless numbers of early pregnancies prejudices the chances of those seeking advice later on in their pregnancies. Toward the end of a long clinic the examinations have to be often hurried or even deferred.

The situation did not meet with any improvement by 1937. The CMO was forced to admit that with the large increase in the number of expectant women visiting the clinics many had become overcrowded, which meant that women often faced a wait of a few hours before they were seen by the clinic medical officer.

This is bad for the mothers and it prevents the harassed medical officers and nurses from doing their work efficiently.
In 1937, the average attendance per session had reached 22.3, with 2,814 new cases and 4,974 re-visits. 105 The CMO and the medical officers had identified the need for additional antenatal clinics in 1931. 106 However, it was not until 1938 that three new clinics became fully operational in Rhymney, Risca, and Usk, making a total of eighteen instead of nineteen; one clinic in Rumney was moved to Cardiff and was out of the control of Monmouthshire County Council. Dr. Evelyn Owen was in charge of the Rhymney clinic, Dr. Annie Roberts at Risca and Dr. Winifred Probert was at Usk. 107

The CMO had appointed women medical officers to take control of all the clinics in the county. It could be suggested that this movement was a notable improvement in the status of women in the male-dominated medical world. However, women medical officers were appointed by men, reported to men, and were directed to refer complicated cases to doctors and obstetricians who were men. Therefore, it can be suggested that the assumed elevated status of the female medical officer was not equal to that of a male medical man; control was retained in the male dominion. Furthermore, it can be suggested that some expectant mothers might have felt more at ease with medical attention from another woman. It could be one possible reason for Dr. Whitaker to point out that in 1936 there was a change in the mothers’ ‘attitude of mind’. She believed that women were beginning to realise it was in their best interest to attend the antenatal sessions and appreciated the assurance they were offered. She noted that expectant women had started to ‘look upon the examination as mere routine’ and not as an indication that a problem existed. 108

The evidence reveals that by 1938 the number of new cases attending the separate antenatal clinics had trebled since their inception in 1930. Some of the medical officers in charge of the clinics attributed the increase to the desire of a supply of free milk. Others
believed the women were more interested in the advice and reassurance they would be offered. A further analysis of the reports furnished by the medical officers at the clinics revealed the nature of the ailments commonly suffered by expectant women and also the extent to which nutrition played a part in the successful completion of pregnancy and confinement. To set the scene before an analysis of the specific disorders suffered by expectant mothers in Monmouthshire, it is necessary to review some of the research into the effects of nutrition on maternal mortality and infant mortality rates that were published in the 1930s. The scheme conducted by the National Birthday Trust Fund had a direct impact on the health of mothers in Monmouthshire.

**Malnutrition and Maternal Mortality**

Malnutrition and the general ill-health of the mother during pregnancy, became the focus of intensive research in the 1930s in particular, due to the high maternal mortality rate in some parts of the country. The Executive Committee of the National Birthday Trust was formed in 1928 with the prime objective of promoting the welfare of mothers. The Trust decided to distribute some of its funds to certain districts of special need for the improvement of the maternity services. Rhondda Urban District Council in the county of Glamorgan was chosen to be a benefactor of the scheme. It was decided that the extra funds would provide for the extension of antenatal facilities; the services of an obstetric specialist; resident refresher courses for practising midwives; and the appointment of two experienced Inspectors of Midwives ‘loaned’ from the Queen Charlotte’s Hospital in London. A number of smaller benefits were added to the package including a supply of free disinfectant to all midwives. The Rhondda was chosen due to the high level of unemployment prevalent in the county, the lack of hospital accommodation for
confinements and the high maternal mortality rate. The average maternal mortality rate for the six years prior to the introduction of the scheme was a little over seven per thousand live births. The scheme was intended to find out firstly, whether intensive activity of this nature in an area returning high maternal mortality rates would effect an improvement in those rates. Secondly, out of the many improvements in maternity services that were needed, it was hoped to identify which were most urgent. The council accepted the offer and the scheme was implemented in January 1934. However, in spite of the additional effort and facilities introduced into the county’s maternity and antenatal services, the number of puerperal deaths continued to rise and reached a peak in the same year of 11.29 per thousand total births. 109

It was shown in the previous chapter that maternal deaths in Monmouthshire, while fluctuating over the period 1921 to 1938, did not reveal an appreciative decline for the seventeen-year period. In 1921 the figure was 42 and in 1938 the total number of maternal deaths stood at 38. 110 The antenatal facilities in Monmouthshire, though limited were more advanced than those of the Rhondda. Nevertheless, the implementation of separate antenatal clinics did not see a reduction in maternal deaths in Monmouthshire. Therefore, it can be argued that other factors were at work acting adversely on the health of mothers. The same conclusion was arrived at following the National Birthday Trust’s scheme in the Rhondda.

The Nutrition Experiment of the National Birthday Trust

When the scheme was first introduced, the high maternal mortality rate had not been largely associated to malnutrition or inadequacies in the mothers’ food intake. It was decided that only a small amount of funding would be allocated to the supply of additional
foods for mothers in 1934, since the 'apparently adequate milk distribution made by the local authority to necessitous cases was thought to be adequate'. However, the evidence revealed that malnutrition was so marked that the original scheme should be supplemented with extra food for the mothers in 1935. Lady Rhys Williams of the Rhondda was the Secretary of the Joint Council of Midwifery and one of the initial instigators of the nutrition experiment of the National Birthday Trust. She pointed out that an extension of the original scheme with the introduction of extra food for the mothers should be implemented

...with the sole object in view of helping to save the lives of undernourished mothers, and was not planned as in any sense a scientific experiment with regard to the value of any particular foods. 111

There were problems with the nutrition experiment. Fresh food was not always available and tinned or bottled foods were occasionally needed. It was difficult to keep track of the number of mothers in receipt of the food at any one time and the exact amount consumed by each mother. Nevertheless, it was noted that 'a sharp fall in the puerperal death rate followed immediately upon the introduction of this scheme'. 112 The maternal mortality rate dropped from the 11.29 it had been in 1934, to 4.77 in 1935. It was decided that the result in the Rhondda was witness to the success of the introduction of additional foods for the mothers, particularly since there were no deaths among the mothers receiving the food. There was a possibility that the reduction might have been caused by other factors including an improvement in the midwifery and medical facilities. Therefore, it was decided that the feeding scheme should be tested. Lord Bute, a notable local dignitary, offered the opportunity to test the results with a grant of 2,500 pounds.
The scheme was extended to the adjoining towns of Aberdare, Caerphilly, Gelligaer, Llantrisant and Pontypridd. It was decided that should a corresponding decline in the maternal mortality rate become apparent in the new towns as it had in the Rhondda in 1935, then a case would be established. The resulting ruling would be in favour of the view that maternal mortality and puerperal sepsis were due to malnutrition, rather than the lack of medical care and facilities. The evidence collected from the medical officers in the towns concerned in the experiment revealed that in the first six months the maternal death rate did fall in the ‘other causes’ category. The average maternal death rate over an eight year period from 1927 to 1934 from sepsis was 2.20. This average rate decreased slightly to 1.875 in the first six months of 1936 following the introduction of the scheme. The average rate for ‘other causes’ was 4.45 and this was the area where the reduction was marked: in the first six months the rate fell to 1.875. The overall average death rate was 6.65. This reduced in the first six months to 3.75, which was an even higher reduction than that experienced in the Rhondda Valley in 1935.

The evidence pointed in both cases to the larger reduction in the ‘other causes’ rate than in the septic rate. Lady Rhys Williams confidently called for further investigations to be made concerning this evidence. The fall in the ‘other causes’ rate in the Rhondda was as great as 79.53 per cent in 1935. In the five towns, the reduction was 57.66 in the first six months of 1936. The evidence suggested that the rate for ‘other causes’ was ‘more markedly affected by malnutrition’. 113

**Further Extension of the Scheme**

The National Birthday Trust received a further grant in 1936 from the Commissioner of Special Areas. The additional grant ensured that the feeding scheme was extended to
Merthyr Tydfil, the whole of the ‘special areas’ of Monmouthshire, the towns of Gateshead in South Shields and Sunderland in Durham. Lady Rhys Williams pointed out that no amount of medical skill could save the lives of women ‘whose constitution has been undermined by prolonged malnutrition, whether this be due to poverty or merely ignorance’. It was hoped that an extension of the scheme to these economically deprived areas would help to improve the general health of the mothers. The administration of the scheme was transferred to the Research Committee of the Joint Council of Midwifery at the request of the National Birthday Trust in May 1937. By that time all the ‘special areas’ of England and Wales were included.

The report of the Committee mirrored Lady Rhys Williams’ earlier remark. It was noted that the scope of the scheme did not allow a comprehensive inquiry into the reduction in the premature birth rate in the case of mothers receiving extra food. The point was made that since the mothers were usually provided with the food in the last three months of pregnancy,

...the full effect, if any, upon the prematurity rate of the additional foods would only be felt if they were provided not later than the fourth month of pregnancy.

A total of 11,089 mothers attending antenatal clinics were included in the experiment. Medical officers at the clinics took on the ‘onerous work’ recording details and reporting the results to the Committee. A ‘striking distinction’ was revealed following the initial findings of the Committee. There was a difference between the mortality rates of mothers attending the clinics, whether receiving the additional foods or not, and the mortality rates that existed among the mothers in the same areas neither attending clinics nor receiving special foods. Medical officers in charge of the scheme at antenatal clinics pointed out to
the Committee that many of the mothers attending the clinics were given additional milk and vitamins. These women were classed as ‘unfed’ cases from the point of view of the Committee since they did not qualify for the additional foods under the scheme. 118

Nevertheless, the Committee concluded that the period of fifteen months, over which the ‘Nutrition Scheme’ had been administered, did support the view that the ‘fed’ cases improved over the ‘non-fed’ cases in the clinics. In all the categories, the death rates of mothers who had attended the clinics were better than those mothers who had not attended. 119

The results of the Interim Report of the Committee covering the period from July 1937 to September 1938, revealed that in the ‘fed’ clinic cases, the death rate from sepsis was 0.18; in the ‘non-fed’ clinic cases 0.81, and in the ‘non-fed non-clinic’ cases the rate was 1.04. The ‘other causes’ death rate in the ‘fed’ cases was 1.71; in the ‘non-fed’ clinic cases it was 1.97 and the last category showed up as 3.67. Finally, the total maternal death rate for the ‘fed’ clinic cases was 0.89; in the ‘un-fed’ cases it was 2.78 and the ‘non-fed non-clinic’ cases returned a total of 4.71. In each section the ‘non-fed non-clinic’ cases revealed the highest returns. In addition, the statistics revealed that both stillbirth and neonatal death rates were lower in the ‘fed’ cases than in the other two categories with a total infant mortality rate of 58 in the ‘fed’ clinic cases; 71 in the ‘non-fed’ clinic cases and 92 in the ‘non-fed non-clinic’ category. 120

Lady Rhys Williams pointed out that in the initial seven-year period used to collect information for comparisons, 1927 to 1933, it was found that

...1,759 more mothers and 25,423 more infants died amongst a population of 6,148,000 living in the distressed industrial areas of Durham, Glamorgan,
Lancashire, Monmouthshire, Northumberland and Yorkshire, than amongst 6,035,300 in London and Middlesex. 121

Furthermore, Lady Rhys Williams said that in the same period the infant mortality rates in the five principal coal-mining counties averaged 50.98 per cent more, and the maternal mortality rate 41.05 more than those found in Middlesex and Essex. She continued to point out that the large differences could not be attributed to climactic conditions, poor housing or the employment of girls and women in industries. She declared that the ‘one outstanding difference’ was economic and therefore nutritional. Lady Rhys Williams claimed that ‘probably 70 per cent, or more’ of the families living in the London area could afford to provide a reasonable diet for themselves, whereas ‘fully 70 per cent’ of the families in the distressed areas lived below the poverty line. 122 Later in the chapter, an examination will be made of the effect of the nutrition experiment on the general health of mothers in the ‘special areas’ of Monmouthshire.

**Nutritional Factors and the Antenatal Period**

A healthy diet in the antenatal period was classed as being vital for the safe delivery of both mother and infant. At the National Conference on Maternity and Child Welfare at Liverpool in 1936, the President of the Maternal and Child Welfare Group, Dr. G.C.M. M’Gonigle, stated that the national conscience had been ‘deeply stirred by the questions of maternal mortality and nutrition’. He felt that ‘a bold policy’ to ensure the nutrition of the expectant mother would have the necessary support. 123

Dame Louise McIlroy, formerly Professor of Dietetics at the University of London, presented a paper at the Conference. She claimed that a general estimate placed the
proportion of people whose diet was inadequate and deficient at fifty per cent. This left
them 'exposed to the dangers of deficiency diseases'. Furthermore, she continued,

The influence of diet is of paramount importance in the prevention of most of the
complications of pregnancy. 124

Dame McIlroy was convinced that toxaemia, a high-ranking cause of maternal deaths,
should be classed as a deficiency disease and that the disease could be prevented with
adequate supplies of carbohydrates, proteins, vitamins and mineral salts. Furthermore,
adequate nutrition of the mother was required because without it, the unborn infant
depleted the maternal sources. In turn, this situation produced symptoms such as tiredness,
muscular cramps, nervous disorders and other ailments in the mother, 'the foetus becomes
a parasite rather than an integral part of the mother hostess'. 125

In the same year the BMJ published reports on various research that had been conducted
concerning nutrition during pregnancy. One article pointed out that with the classification
of maternal mortality associated to childbirth listed as puerperal sepsis, haemorrhage,
toxaemia, or accidents and diseases aggravated by pregnancy, it was reasonable to assume
that only two of the categories were directly linked to nutrition; puerperal sepsis and
toxaemia. The article stated that evidence had been put forward suggesting that puerperal
infections could be reduced by the inclusion of vitamin A in the diets of expectant women
However, it was argued that reports from more than one hospital had shown that with
'good obstetrics', puerperal infection could be eliminated. The article pointed out that if
the reports were to be accepted it followed that
...the only form of maternal morbidity and mortality which cannot be prevented by
good midwifery and which may be due to dietetic factors is that associated with
the toxaemias of pregnancy. 126

It was admitted that the evidence to support the claim was scanty. However, the overall
effects of an inadequate diet on the mother and infant were claimed to be conclusive, as
various experiments that had been conducted on pregnant animals had shown. Researchers
had drawn up a table of daily nutritional requirements during pregnancy. The diet included
two pints of milk, two servings of green vegetables, one or two eggs, fresh fruit, sea fish
twice or three times a week, liver once a week and the addition of daily cod liver oil. The
BMJ claimed that when this table was compared with the average diet of the country, it
was doubtful whether ‘one pregnant woman in ten ingests half the amounts of minerals
and vitamins’. The concept and content of the suggested diet were not criticised by the
BMJ; the criticism was aimed at the economics of the daily requirements.

The only criticism of such a diet is that it would cost two or three times the amount
of money available to a large section of our population for the purchase of food. 127

In 1937, the conclusions of a report by the Ministry of Health on an investigation into
maternal mortality in England and Wales included a note on the nutrition of mothers. It
said that no expectant or nursing mother requiring extra nourishment on health grounds
should fail to receive help, and recommended that there should be further research into
‘the possible influence of the dietary upon child-bearing’. 128 The report had directed its
investigation on available maternity services and the ways in which those services could
be improved rather than concentrate on the general health of the mother. It can be argued
that the focus on nutrition was limited.
The 1937 Report on Maternal Mortality in Wales

The Ministry of Health published a Report on Maternal Mortality in Wales in 1937, which contained a section on nutrition. However, the report pointed out that the information collected regarding the subject was of a general nature, since the extent to which malnutrition existed within a community could not easily be determined. It was decided that if evidence of malnutrition were established, the question would still arise concerning the effect of under-nourishment on maternal risk. Therefore, the report stated that an assessment of the state of nutrition 'must largely be a personal matter'. The report pointed out that when depressed economic circumstances existed there were numerous unfavourable factors at work affecting the health of mothers; nutrition was only one of those factors. It was found that out of 187 women attending ten antenatal clinics in South Wales, eighty per cent were in reasonably good condition and twenty per cent were in a poor condition. The report continued to explain that no undue consternation was felt over the percentages, since out of the number of women attending antenatal clinics it could be expected that a certain proportion would show some stress associated with their condition. Additionally, there were other women who suffered from definite disabilities including cardiac or renal diseases.

However, out of 655 mothers attending Centres in South Wales with their children it was a more disturbing story. Thirty per cent were found to be in an unsatisfactory condition, which were manifest in

a general listlessness, in apathy, by an appearance of age beyond the actual years, occasionally by some degree of emaciation, but more especially by anaemia which in some cases was severe.
The report offered the opinion that thirty per cent was 'unduly high' for a working class area, since it had also been found that the majority of the cases did not result from 'an obvious pathological condition'. It was claimed that in the rural districts the standard of living was generally low. The majority of food produced on farms was sold and very little found its way into the home. Eggs, milk and butter were produced for sale and the staple diet revolved around bacon, broth, tea, bread and butter.

However, the interviews conducted for this study involving mothers living on smallholdings in Monmouthshire and Pembrokeshire mentioned earlier in this chapter, contradict the generalisations in the report. The women interviewed explained that they had an adequate supply of eggs, milk and butter. Fruit and vegetables were available from the gardens or allotments in the urban districts. A reasonable amount of pork from pigs and beef from cattle were also eaten, particularly for those mothers living on small farms.

As mentioned earlier in the chapter, a barter system operated where possible, to exchange produce and other goods.

The results of the 1937 maternal mortality report's investigations did not produce conclusive evidence to link poor nutrition to maternal deaths. The whole report centred on maternity services. This was in keeping with many of the other government reports of the 1930s. It was emphasised that no matter how efficient maternity services were effective results would be limited unless women recognised their personal responsibility 'for care and attention to the hygiene of pregnancy'. The report concluded that a number of maternal deaths were caused through the 'ignorance, carelessness or neglect by the mother'. The latter comment is reminiscent of attitudes towards mothers in working-class districts in the first quarter of the twentieth century.
Through the reports of the individual antenatal clinics in Monmouthshire, it is possible to see the extent to which expectant mothers in working-class districts coped with pregnancies. The record of the ailments on which advice was given and treatment received gives some indication to the general health of the mothers in Monmouthshire in the 1930s. However, it should be remembered that the evidence used was collected from the medical officers’ reports concerning expectant mothers attending the separate antenatal clinics. Expectant mothers also attended the Maternity and Child Welfare Centres. These were covered in depth in an earlier chapter. Finally, there were still many women who did not think it was necessary to attend antenatal clinics for various reasons, as interviews with women in Wales revealed. As a result, the evidence used to determine the general health of the mothers in Monmouthshire is limited to those women attending the antenatal clinics. The following section analyses the reports of the medical officers in charge of the separate antenatal clinics to determine the general health of mothers attending those clinics in Monmouthshire in the 1930s.

The General Health of Expectant Women Attending Antenatal Clinics in Monmouthshire: 1930-1938

The most common problems faced by expectant mothers attending the antenatal clinics in Monmouthshire between 1930 and 1938 were constipation, debility and malnutrition, dental carries and anaemia. In 1930, expectant mothers also attended the Maternity and Child Welfare Centres and continued to do so throughout the 1930s. As the antenatal clinics became more established the medical officers at the Centres referred expectant women to the clinics instead. The Centres’ records show that in 1930 expectant and nursing mothers asked for advice concerning constipation 905 times. There were 421
consultations concerning debility and malnutrition, 359 cases needed treatment for dental carries and 253 expectant mothers were found to be suffering from anaemia. At the sessions, advice was also given for pains associated with pregnancy, such as headaches and back problems. Varicose veins were aggravating the condition of some women. In the first full year of operation for the separated antenatal clinics, 1047 new cases attended those clinics.

At the separate antenatal clinics, Dr. Scott remarked that the majority of pregnancies were successful and did complete the full term normally. However, she pointed out that even with normal pregnancies advice was given on minor ailments, 'which in turn helps the general comfort of expectant mothers'. Dr. Scott's attitude towards the mothers was one of compassion and her comments reveal that she was not viewing the state of pregnancy as purely a medical condition. In 1933, Dr. Scott noted that the chief ailments still included digestive troubles, dental carries, varicose veins and anaemia, which were also the main ailments found in the expectant and nursing mothers attending Centres. She claimed that it was the multiparae mothers whose condition showed to be the least satisfactory 'due to too frequent pregnancies and not altogether due to poor economic conditions'. Younger women attending clinics in Monmouthshire were fitter than the mothers who had experienced one or more pregnancies. Dr. Scott advised mothers to eat more fruit and vegetables and drink plenty of water. The advice did not seem to have a great effect, since in the following year Dr. Scott found that there was still many mothers suffering from malnutrition in the county clinics. However, she believed the condition was due to 'wrong feeding, over-work, or over-production...'. 
Dr. Gordon, reporting on the work of the Newport clinic in 1936, did not offer an explanation as to the reason for less than three per cent of the 225 patients attending for the first time having 'excellent nutrition'. An additional 8.2 per cent were classed as having 'subnormal' nutrition and 2.3 per cent showed malnutrition due to under-feeding. Dr. Gordon stated that pyorrhoea and anaemia usually accompanied subnormal nutrition.

The high proportion of expectant mothers requiring dental treatment at all the antenatal clinics in the county substantiates Dr. Gordon's remarks.

At the Blaina clinic, eleven of the 139 new cases were found to be malnourished and Dr. Scott discovered that many of the mothers suffered from varying degrees of anaemia. Forty-nine of the mothers developed toxaemia. However, the Blaina clinic did not return the highest number of cases of toxaemia in the county. Ebbw Vale had ninety-eight out of the 173 new cases showing signs of toxaemia, Tredegar, 122 out of 234 new cases, and Pontypool found that ninety-nine of the new patients had varying degrees of the disease.

The Special Areas of Monmouthshire, which covered all the industrial districts, continually returned comparatively high rates for anaemia, toxaemia and malnutrition. In contrast the clinic reports from the rural districts, which were not classed as Special Areas, often showed that while many might have had low incomes in the rural districts, the cases of malnutrition numbered few among the mothers attending clinic sessions. Dr. Scott's report for the clinic at Chepstow in 1936, for example, stated that none of the expectant mothers showed signs of malnutrition, although many were poor. Nevertheless, out of the seventy-seven women attending the clinic, thirty-one did develop toxaemia. The puerperal death rates from toxaemia were studied for the final 1937 Report on Maternal
Mortality in Wales. It was revealed that toxaemia death rates increased from 1.4 per thousand live births for the years 1924-28, to 1.78 for the years 1929-33 in the Special Areas. In the other areas of Wales the rate fell fractionally from 1.42 to 1.41, and could be seen to be lower overall than the rate in the Special Areas. ¹⁴⁵

A similar pattern emerged with cases of malnutrition between the industrial Special Areas and the rural areas of Monmouthshire, although there were exceptions to the rule at times, such as the high incidence of toxaemia at Chepstow in 1936 mentioned above. In 1937, the Chepstow clinic had six cases of malnutrition, which was 7.4 per cent of the cases attending the clinic. ¹⁴⁶ This percentage was favourable to some of the industrial districts. Then in 1938 Dr. Scott reported that the rate had reduced further to 1.8 per cent with only three cases of malnutrition, ¹⁴⁷ which was very favourable in comparison to the industrial districts. Abergavenny was another of the rural areas excluded from the scheme of the National Birthday Trust. At this clinic Dr. Roberts expressed pleasure that attendance figures had improved for the year making a total of fifty-seven expectant mothers on the register, as opposed to thirty-six the previous year. Dr. Roberts was convinced that the rise could not be connected to the distribution of free food, which had been a strong criticism against the need for separate antenatal clinics; no food was given out at the clinic under the National Birthday Trust scheme. ¹⁴⁸ The Monmouth clinic served both Monmouth urban and rural districts, although the urban district was mainly rural in nature and did not come under the scheme either. Dr. Owen found that only three of the fifty-two new cases suffered from malnutrition. However, several mothers were 'needy' in 1937. ¹⁴⁹ The following year the number of new cases dropped to forty-three. Altogether, there were still
only three cases of malnutrition reported and the main ailments suffered by mothers were constipation and dental carries.\textsuperscript{150}

**The Initial Results of the Scheme in Monmouthshire**

The National Birthday Trust food scheme was introduced into the Special Areas of Monmouthshire in 1936. By the time the reports for that year were submitted to the CMO, the medical officers at the clinics in the industrial districts were able to comment on the initial results of the extra foods. Free food was supplied to fifty women in Newport whose husbands were unemployed. Twenty-five more expectant mothers were also given dried milk and some fresh milk. Dr. Gordon reported that due to the extra food

...the standard of nutrition was raised and the way was paved for breast-feeding.\textsuperscript{151}

Dr. Gordon’s comments revealed her commitment to the natural feeding of infants. In Rhymney eighteen expectant mothers were given ‘Dorsella, Marmite and Ovaltine’ through the Trust’s scheme. Dr. Owen’s remarks while in charge of the Rhymney clinic reflected Dr. Gordon’s. She reported that the foods had offered ‘undoubted benefit’ to the general condition of the mothers.\textsuperscript{152} Dr. Whitaker, at the Abersychan clinic also noted that the ‘general physique’ of the mothers had improved. A pleasing benefit she wished to report was that the usually high percentage of ‘abnormal’ cases that were evident over a number of previous years had not been maintained.\textsuperscript{153} The following year Dr. Whitaker again mentioned the lower incidence rate of abnormal pregnancies at her clinic, and emphasised that it was ‘possibly due to improved physique and general health as a result of assisted food supply’. At Abersychan, free food was given to every necessitous case showing signs of ‘strain’ or toxaemia. Dr. Whitaker pointed out that the improvement in the condition of the mother was ‘quite definite’ and newly delivered mothers frequently
told her that ‘the child has proved to be better than in any previous pregnancy’. 154 By 1938 Dr. M. MacQuillan had taken over from Dr. Whitaker at the Abersychan clinic. However, the absence of any mention of malnutrition substantiates Dr. Whitaker’s comments concerning the improvement in the condition of the expectant mothers. 155

Other clinics in the industrial centres reported an improvement following the introduction of the free food scheme in 1936. In Blaenafon, 10.5 per cent of the mothers attending in 1937 were classed as suffering from malnutrition, while in 1938, the percentage had dropped to a little under nine. Furthermore, Dr. Scott reported that other factors rather than insufficient food caused the malnutrition evident in these cases. She had found that in three of the cases, the family was small, the husband in regular employment and the home conditions were comfortable. Two of the cases concerned wives of unemployed men. The sixth case involved the mother of a large family who was married to a working man. 156

Often, the causes of malnutrition were ambiguous. Nevertheless, it can be suggested that the evidence in the reports of the medical officers show that in most cases the mothers were helped by extra food, which improved their general well-being.

In Blaina improvements were also evident. In 1937, 13.4 per cent of the mothers showed signs of malnutrition, while the report for 1938 put the total at 7.3 per cent, which was a significant reduction. 157 The percentage for Ebbw Vale dropped from 4.0 to 2.5. 158

Pontypool displayed the same pattern by decreasing from 5.9 to 4.0 per cent in the same period. 159 The clinics’ reports indicate that improvements were not evident in every industrial district. In these latter districts it was usually found that some other factor was at work influencing the incidence rate of malnutrition. In New Tredegar the number of malnutrition cases rose from eight in 1937 to thirteen in 1938, which was a rise from 5.3 to
7.1 per cent. Dr. Scott found that the majority of the thirteen women came from Aberbargoed district and that they were mostly multiparae. Dr. Roberts also referred to multiple pregnancies in her clinic reports, although she did not give any actual figures for malnutrition in the Abertillery district. However, she pointed out that around fifty per cent of the expectant mothers attending the clinic had received food under the National Birthday Trust scheme for economic reasons rather than due to any degree of malnutrition. She observed that

Malnutrition is shown mostly in multiparae who have had a large number of pregnancies, or whose pregnancies have been too close together.

Comparison Between Primiparae and Multiparae

In 1930, which was the first year that the separate clinics came into operation, Dr. Whitaker noted that it was encouraging to see the high number of primiparae attending her Abertillery clinic and felt this was indicative of the ‘real work’ of all antenatal clinics. Young women expecting their first child, she said, came for advice on their condition, whereas the multiparae attended due to lack of nourishment. Thirty-seven per cent of the women at the Abertillery clinic that year were primiparae, which was a comparatively high percentage to other clinics in the county; the average was around twenty-five per cent. There was an increase in the number of primiparae attending sessions, as the clinics became better known to younger women. In 1936, Dr. Scott reported that at the Blaenavon clinic almost fifty per cent of the women attending were primiparae. As with other aspects, the pattern was not repeated at every clinic. Nevertheless, the attendance for primiparae did increase over time. In 1938 it was more usual to see between one-third and
one-half of the women attending for their first pregnancy instead of one-quarter, which was the general rule in 1930.

In 1938, the reports revealed that the Oakdale clinic remained at the low percentage of twenty-six. In contrast, the Newport, Abertillery, Abergavenny, Abersychan and Monmouth clinics returned a percentage of between thirty-three and forty-nine. Rhymney showed a full fifty per cent attendance by primiparae. 164 It was often found that the multiparae were more prone to anaemia and malnutrition in the late 1930s. Additionally, when complications arose during pregnancy or confinement, the multiparae were again mentioned more frequently than the primiparae were in the reports of the medical officers at the clinics.

Dr. Roberts reported four miscarriages and eight stillbirths out of the 400 women attending the antenatal clinic at Abertillery in 1938. All the miscarriages and six of the stillbirths were multiparae. Dr. Roberts reported that in general, the primiparae were in a satisfactory condition; signs of malnutrition were only found in the multiparae. Dr. Roberts returned a similar report from her clinic at Risca. Furthermore, she noted that the only primipara to have a miscarriage was 'elderly'. The remaining two miscarriages recorded that year occurred in women who had had multiple pregnancies, as found in Abertillery. 165

Some of the other 1938 reports were not as detailed as Dr. Roberts on the comparison between primiparae and multiparae women. None of the reports revealed the age of the expectant women or the actual number of births they had experienced. Therefore, a definite conclusion cannot be reached. However, given the general evidence contained in the reports referring to multiparae, it seems that the health of the women who had
delivered more than one infant was more at risk in the late 1930s in Monmouthshire than the women who were expecting their first child at the same time. Additionally, mothers who had already had multiple pregnancies and who were in poor health were more likely to experience difficulties during subsequent pregnancies and confinements.

The 1937 Report on Maternal Mortality in Wales examined the ages of mothers and the number of children they had in certain age groups to determine the extent to which age and parity reflected maternal mortality rates in Wales. It was found that even though the birth rate had fallen over a forty-year period prior to the report’s conclusions, there had been little change in Wales in the average age at marriage. The main reason for the declining birth rate was attributed to the extension of knowledge concerning the restriction of family size, in other words, the growth in the use of contraceptive methods to limit the number of children a woman conceived. The report stated that one of the results of restricting family size was that it increased the proportion of first pregnancies. When births were spaced further apart, the mother tended to be older at the birth of second and subsequent children. It was noted that an increase in the number of first births as well as a higher average age in child-bearing women, would tend to imply that there would be an increase in risk to the mother and would be reflected in the maternal mortality rates. However, it was claimed that this result would only be evident if there were no other factors at work impinging on the maternal death rate.

One of the factors identified was that there were fewer women giving birth to a large number of babies. Furthermore, it was found that in 1934, out of a sample of 35,367 births studied for the report in Wales 21,686, or sixty-one per cent ‘occurred in the age-parity groups showing a maternal risk below average, and mostly in the under-thirty age groups’.
Therefore, the Report concluded that there were no grounds for assuming that the use of contraceptives and the consequently higher proportion of first pregnancies had significantly influenced maternal mortality in Wales. Nevertheless, the Report recognised that if maternal mortality rates were an indication of sickness and ill-health among child-bearing women in Wales, then there would appear to be a high rate of sickness among the mothers. The Report stated categorically that

...an excessive incidence of intercurrent disease among the expectant mothers in Wales has been an important contributory cause in producing the high maternal mortality rates, for intercurrent disease superimposes another risk upon the normal risks attending pregnancy and childbirth.

The evidence revealed that in the industrial districts of Wales the effect of the depression had been harsh, and the incomes in rural Wales were usually low. Anaemia and debility was not uncommon and was partly the result of poor nutrition. However, it was conceded that while ‘inadequate dietary and wrong feeding may be factors in the production of the high maternal mortality rate in Wales’, the influence of these factors could not be accurately assessed.

It can be suggested that the results found in Monmouthshire using the reports of the medical officers at the antenatal clinics, supports the conclusions of the Ministry of Health. However, given the evidence it can also be argued that additional nutrition appeared to be beneficial to the general health of expectant mothers in some industrial districts of Monmouthshire. Nevertheless, the maternal mortality rate in Monmouthshire did not decrease as a result of the improved nutrition of the mothers. Therefore, no further conclusion can be established except for the improvement in general health.
Minor ailments were also an indication of the amount of sickness prevalent among expectant mothers, as were the incidence rate of stillbirths and abortions. For this reason the following section will briefly identify some of the minor problems that faced mothers in Monmouthshire and the effect this might have had on their health, then examine the incidence and causes of stillbirths and abortions.

**Dental Problems**

Apart from risks connected to age and parity, which affected the health of mothers and their ability to survive the trauma of birth, dental problems were constantly mentioned by the medical officers as being an underlying cause of infection in the mother. In the reports from the Centres and clinics it was revealed that mothers in Monmouthshire neglected dental hygiene, although there were adequate facilities for the treatment of any defects. For instance, in 1930 the Centres’ reports show that 359 expectant and nursing mothers had some kind of dental defect. In 1932 the figure had dropped to 191, then gradually rose to the high figure of 623 in 1936. Expectant women were also examined for dental defects at the antenatal clinics from 1930. As mentioned previously, defective teeth and related problems were included in the main ailments listed as needing prompt treatment. Women were referred to the county dentist, as were the women attending the Centres. However, it seems it was a difficult task to encourage many of the women to attend for treatment.

By 1938, a common concern of all the medical officers at the antenatal clinics regarded the high proportion of women who refused dental treatment when advised to attend the clinic’s dentist. They preferred to have the treatment after the birth of the infant.

Whenever details were given concerning the state of expectant mothers’ teeth the same pattern emerged. Dr. Scott found that out of forty-two women in Pontypool requiring
treatment, only fifteen agreed to attend the dentist. At Tredegar the number was twelve out
of thirty-four women; in New Tredegar it was nine out of thirty, and in Blaina five out of
twenty-four. The majority of the reports from other medical officers returned the same
story. 170 An additional dental clinic was opened at Abertillery in 1938. Dr. Roberts
disappointedly found that ‘so far very few women have availed themselves of this facility’.

171 Furthermore, Dr. Roberts pointed out that at the Risca clinic, the women who showed
signs of malnutrition were also the ones who showed the highest degree of dental caries
and oral sepsis. She claimed that efforts to persuade the mothers to attend the clinic dentist
were ‘quite futile’. Her concluding remark echoed Dr. Craig, the general practitioner at
Kendal who had voiced his opinion in 1929 concerning the link between dental caries and
puerperal infection and death. [See Chapter Five, Maternal Mortality.] Dr. Roberts said

   It is surprising that there are not more cases of Puerperal Sepsis among patients
   such as these. 172

The evidence suggests that mothers were not taking advantage of the facilities available to
them for dental treatment in the late 1930s and could have increased the risk of puerperal
infection by refusing to attend the county dentist. However, it can also be suggested that
refusal to attend until after the birth was a means for the mother to retain freedom of
choice over the treatment she was willing to receive and when she would receive it,
regardless of the consequences. 173

In 1933, only twenty-three per cent of expectant women attended antenatal clinics, the
majority chose to stay away. By the end of 1938 there had been an increase in the number
of expectant women attending antenatal clinics. Nevertheless, there were still only sixty-
two per cent of the women giving birth that year paying an average of one visit each to a
Clinic for the duration of their pregnancy. The 1937 Report on Maternal Mortality in Wales strongly advocated that the mother should take responsibility for her own health, physical fitness, personal and domestic hygiene. The report emphasised that regardless of the efficiency of services for the safe delivery of both mother and child, unless women recognised their own responsibilities the services offered could not be effective.

Additionally, the report pointed out that research into maternal deaths had found that some deaths were caused through the ignorance, carelessness or neglect by the mother. In a sample of 1,079 maternal deaths occurring during the 1929 to 1934 period, it was observed that 195, or eighteen per cent of the deaths might not have happened if the mother, her relatives and friends had taken due care and attention to their responsibilities.

Concern as to the effectiveness of antenatal clinics was reflected in the remarks of all the medical officers in Monmouthshire in charge of the clinic sessions. There was an obsession to report an increase in attendance figures, even when the numbers rose by very few. When attendance numbers dropped, disappointment was apparent in the reports from the medical officer at that clinic. The reference to a disappointing attendance figure was often accompanied by a shift of blame to the expectant mothers for their lack of responsibility. When faced with the continuing rise of maternal deaths in Monmouthshire in the 1930s, the CMO stated that he found the increase in the maternal mortality rate ‘surprising’ considering the efforts of the council to reduce it. The CMO’s comment confirms that the antenatal care available in Monmouthshire was not having the expected effect and that other factors were at work, which might have endangered the mothers’ health.
Other Ailments Prevalent in Expectant Mothers in Monmouthshire in the 1930s

For the purpose of this study, anaemia, malnutrition and toxaemia have not been classed as minor problems and have been discussed in previous sections. Therefore, these maternal problems will not be mentioned in any detail in this section. However, it is necessary to mention some of the other conditions in order to determine the extent of sickness and general debility faced by expectant mothers in Monmouthshire. It has been shown that many expectant mothers did not attend antenatal clinics. Additionally, the evidence contained in the medical officers’ reports and the oral interviews conducted for this study revealed that many women suffered minor problems such as tiredness, aches and pains, and digestive upsets without attending to the disorders.

Many women accepted feeling unwell at times as their ‘lot’ in life. The letters received by the Co-operative Women’s Guild concerning the health of women around 1914 and the classic account of working-class wives in the 1930s collected by Margery Spring Rice substantiates this claim. Often women believed that they were in good health even though they were suffering from a number of complaints, which would have made daily tasks more tiring to complete. When they did want help with the housework, husbands rarely offered it. Many women found that they could not afford to go to a doctor for treatment so carried on without complaint.

Selected Comments from Interviewees

Mrs. S. of Caerphilly claimed she was ‘fairly well’ throughout her pregnancies. However, her remarks concerning the details of her pregnancies revealed that she suffered from severe pain in the back and side following the birth of her last child. With her first pregnancy, Phyllis remembered ‘feeling tired all the time’ and had sickness, swollen feet
and 'water trouble'. She thought the discomfort was normal and did not consult a doctor for treatment. Margaret also suffered with sickness throughout her pregnancies. She put it down to the cod liver oil she was taking and did not ask for advice.

Mrs. P. mentioned that if she felt ill she would not ask her husband for help with the housework. She said it was 'unheard of, husband wouldn't have liked it'. Mrs. B. originally of Swansea had three miscarriages, one before her first living child and two after. When she had her last miscarriage, she remembered feeling that there was no point in calling out the doctor, so she coped with it herself. Many of the interviews undertaken for this study reveal a similar story. Rarely did any of the women consult a doctor for what they believed were minor complaints that came with the natural process of childbirth. A common remark was that 'you had to put up with it'. The results of the interviews conducted point to women accepting poor health as part of their lives as mothers, with few actually asking for help to cope with the health problems they faced. The evidence suggests that women attending the Centres as expectant or nursing mothers and the expectant mothers attending the antenatal clinics, did so more for the sake of the infant or expected infant rather than for their own health. Many of the mothers were found to be suffering from anaemia, debility, constipation, varicose veins and more serious complaints including toxaemia, a contracted pelvis or other malformations, when they had a general physical examination at the Centre or antenatal clinic. Without the examination minor and more serious conditions might have remained largely undetected and untreated.

**The Wives of Coal Miners**

Until the pit-head baths were established, women in coal-mining districts of Monmouthshire had to struggle to carry water regardless of their pregnancies, to fill baths
for their husbands returning home from work at the collieries. Evidence placed before the Coal Industry Commission in 1919 revealed the plight of many miners’ wives throughout the country. Mrs. Hart, of Wigan said that the miner’s wife was ‘little better than a slave’. Mrs. Andrews of the Rhondda Valley, reporting on a comment made by a midwife in the same district said

...the majority of cases she has had of premature births and extreme female ailments are due to the physical strain of lifting heavy tubs and boilers in their homes. Mr. Walford, coroner for the Abergavenny district pointed out that the practice of filling tubs with very hot water for miners to bathe in their own homes after their shifts at the mines, unfortunately led to many children dying of scalds incurred following a fall into the tub. Mr. Walford claimed that every winter he held more inquests on miners’ children who had died from scalds or burns than on miners who were killed underground. It can be argued that a great deal concerning the every-day lives of expectant mothers in Wales remained hidden from view. The reported ailments suffered by the women who attended both the Centres and the antenatal clinics might not have revealed the whole picture. The absence of pronounced symptoms of malnutrition did not necessarily mean that the mother had sufficient food and adequate nutritional requirements for good health. Insufficient or inadequate nutritional requirements coupled with a heavy workload might affect a mother’s general health and the outcome of her pregnancy.

Abortions, Miscarriages and Stillbirths

In 1919, the CMO for Monmouthshire declared that ‘illegal practices for the induction of abortion’ were carried out in and around the county. His comment reflected his concern
that the stillbirth rate had risen in the county from 299 in 1918, to 420 in 1919 with 122 additional infants surviving for a few hours. He pointed out that one woman who ‘habitually engaged in this practice’ in the Rhymney Valley was connected to the death of a woman in the county of Glamorgan. A charge of manslaughter had been brought against her and she received a sentence.  

Attitudes towards women attempting to secure an abortion or women performing an abortion on another woman were socially constructed through the representation of their acts as criminal. Competing ideologies of reproduction can be identified through the attitudes of middle-class medical professionals, politicians and the judiciary.

Many women who were caught attempting to terminate a pregnancy, often through economic reasons, were harshly treated at a time when many women were not able to secure adequate birth control advice. An example of the results of a woman forced to extreme measures was the case of Lillian Arthur. She was a married woman who was found dead after she had attempted to abort her baby in 1920. The Judge involved in the case pronounced her guilty of ‘self-murder’ and left her family to support the stigma of criminality.

Birth control was not freely available to women for the majority of the time-scale covered in this study. There is a lack of any mention of contraceptive advice being offered to women attending the antenatal clinics in Monmouthshire, regardless of the number of miscarriages or stillbirths they might have suffered. The first birth control clinic to be established in a hospital in Monmouthshire was at the Abertillery District Hospital. A midwife was sent to Dr. Marie Stopes’ clinic in London to receive training and sit for the Certificate for Constructive Birth Control. In 1925, the Birth Control News [BCN] sported
the headline ‘Wales Leads’. However, the hospital clinic, which was for married women only was not successful. Its proposed opening clashed with many angry church officials and supporters who believed birth control in any form was criminal. Church groups staged demonstrations in and around Abertillery, which eventually forced the closure of the Birth Control Clinic.

The BCN printed letters from mothers, fathers and expectant women asking for advice on ways to control family size. The evidence contained in the letters suggests that there was a strong need for advice. The correspondence was also an indication the poor health of many women who had experienced multiple births. One woman said ‘...the thought of another burden makes me feel desperate’. She continued to explain how she had witnessed neighbours ‘performing monkey tricks on themselves with button and crochet hooks’. She claimed that she had not resorted to those methods herself because she ‘lacked the courage’. However, she maintained that she felt sympathy to any woman who was forced into such a situation and pleaded for help for her and other women.

The majority of the letters sent to Dr. Stopes reveal similar experiences. Analysing the comments of Dr. Stopes in the BCN and other publications, it can be argued that her attitude towards family limitation was steeped in eugenicism. This can be detected in her following remark; ‘Constructive Birth Control will fill the comfortable cradles, and empty the gutters’.

It is not the intention of this study to advance further into the arguments for and against birth control; suffice it to say that attitudes were mainly set against a woman who attempted to abort a foetus for whatever reason. Many medical practitioners looked on the high number of stillbirths as being an indication of the extent of criminal activity, rather
than failure on the part of authorities to safeguard pregnancy and childbirth for the successful delivery of both mother and child.

When faced with a further increase in stillbirths in 1920, Monmouthshire's CMO was certain that 'a fair proportion' could have been saved 'had the foetus been given a fair chance of development and of survival'. The number of stillbirths had risen from the reported 420 in 1919, to 468 in 1920, excluding 106 infants surviving only for a few hours after birth. The incidence rate continued to rise with a total of 599 cases of stillbirths and infants dying within a few hours in 1921; the figure was equivalent to 4.7 per hundred live births in the county. The CMO pointed out that it was difficult to conduct a satisfactory inquiry into the causes of abortions and stillbirths, since the mothers resented the intimate nature of the questions 'bearing largely, as they do, upon venereal disease...'.

It seems that the supposed causes of stillbirths were mainly blamed on the mothers for numerous reasons; attempting to procure abortions, contracting venereal disease, refusing to attend Centres or staying away from the later antenatal clinics. Midwives also bore part of the blame for the high stillbirth rate, since they were the main birth attendants.

A 'Fashion in Abortions'

A debate on the question of criminal abortion and measures needed to restrict the sale of abortifacients was held between members of the Medical Legal Society and the Child Welfare Group of the Society of Medical Officers of Health in January 1929. The members put forward their opinions on abortive measures procured by the mother and arguments for and against placing restrictions on the sale of some of the drugs known to be commonly used for aborting a foetus. Dr. R. A. Lyster believed there was 'a fashion in abortions' and declared that
Abortion was a grave national danger in its effect on the physique of women and children, but a campaign embarked on too precipitately without due regard to possible changes in public opinion might create more difficulties than it settled. Dr. F. J. McCann agreed that abortions seemed to be on the increase and pointed out that abortion from natural causes was not uncommon. Some medical officers had put the proportion as being one in five or six full-time pregnancies. However, Dr. McCann claimed that it was ‘probably not an overestimate’ to say that out of the total abortions, twenty-five per cent were criminally induced. He commented on the ‘remarkable’ range of instruments that women employed to induce an abortion, including skewers, hooks, hairpins, twigs and bodkins. These objects were in addition to other preparations that could be bought in a chemist such as quinine, Diachylon or lead plaster, and pennyroyal. Mr. Beckwith Whitehouse added that in his part of the country, Worcestershire, women also used tansy. In London’s East End, Miss S. Musson, general secretary of the National Council for the Unmarried Mother spoke of the cases that had come to her attention. She mentioned that a common practice among the women was to drink a preparation made with gunpowder and gin. Another preparation common to the area was called ‘hickery-pickery’, which was a mixture of aloes and canella alba. The above observations highlight the point that many women used preparations known to grow locally, or used mixtures that other women in the area believed worked effectively. The ‘recipes’ for the preparations were transferred from woman to woman by word of mouth in a secretive way. The evidence collected by contemporary medical professionals together with comments contained in the letters to Dr. Stopes serves as an example of the use of gossip among women.
However, the main discussion in the debate mentioned at the beginning of this section centred on the sale of certain drugs, which were meant to be used as abortifacients. These preparations were sold to women through shops, hawkers or advertisements in newspapers. Dr. McCann referred to the ‘nefarious traffic in abortifacients’ where drugs were advertised ‘to cure irregularities, suppressions, and obstructions’. Agreeing with Dr. McCann, Dr. Spilsbury added that these were mainly the ‘drastic purgatives, for which there was, no doubt, a big sale at the present time’. 198

Mr. H. D. Roome, prosecuting council to the Crown highlighted one infamous court case concerning the sale of drugs meant to induce abortion. The Reverend Francis Bacon was described as a ‘clerical abortion-monger’. He conducted a mail-order business with a preparation including varying potencies of quinine, aloes and ergot. He claimed that the preparation would cure all female irregularities, and stated that it was not to be taken by pregnant women. The Reverend Bacon’s wording was planned to act as his defence should he be reprimanded. However, the clever wording worked to advertise the mixture, in a covert way as an abortive measure. The point made by Mr. Roome was that the legislation was clear and efficient under the Offences of the Person Act, 1861. It stated that it was a criminal offence for any one to supply or administer an instrument or poison to any woman in order to procure an abortion. The sentence was five years penal servitude for supply, or a life sentence for administering instruments or drugs. 199

Some of the drugs used in illegal preparations were beneficial for a variety of illnesses when used in the correct way by qualified medical professionals. Therefore, some medical practitioners believed that a tightening of the legislation could do more harm than good. Another strong argument against prohibiting the sale of abortifacient drugs was that it
would induce women to resort to the more dangerous mechanical methods of interference, such as the crochet hook or knitting needle, with the resultant danger of sepsis.

Nevertheless, it was agreed that advertisements were a source of danger to women at a vulnerable time in their lives.

The Advertising Association decided to distribute a circular to all newspapers in the country. It was pointed out that the advertisements were ‘a source of grave danger and abuse’. There were no guarantees that the substances could secure an abortion and there could be harmful results if the substances were taken in large quantities. The Association advised newspapers to refuse to print such advertisements. The evidence reveals that the language used in these advertisements were persuasive and could have influenced many women fearful of bringing another child into a poor economic situation. In Monmouthshire, one product advertised in The Star of Gwent used a method of familiarisation to attract the attention of women. It was called ‘Mrs. Rose’s Female Mixture’ and claimed to ‘positively remove obstinate obstructions’ of any cause within twelve hours. It was guaranteed to be ‘the most powerful on earth’.

In 1924, Monmouthshire’s CMO emphasised that part of the solution to the high number of stillbirths in the county could be found in antenatal care. However, he stated again that there was strong evidence that illegal practices were prevalent in the Eastern and Western Valleys of Monmouthshire and called for criminal proceedings to be taken against the offenders. The CMO’s comments substantiate the points made later in the BMJ on the growth of criminal abortion practices. Nevertheless, it is difficult to obtain positive proof that many such incidences took place due to the secretive nature of the way in which information was gathered for personal use. A woman could go openly to a chemist for a
preparation that had treatment properties for genuine ailments. Furthermore, with certain local knowledge the same mixture might be abused to effect a different result.

Out of the women interviewed for the purpose of this study only two mentioned having knowledge of preparations or other methods to procure abortion and none admitted use themselves. Mrs. G. remembered a friend of hers who had used a preparation in tablet form, which was freely available at the local chemist for the treatment of a common complaint. Her sister had told her that if she took enough of it she would lose the baby. Another common remedy used by a few of Mrs. G’s friends and neighbours was to sit in a very hot bath and drink a bottle of gin. It was not known if this method resulted in a miscarriage for the women who tried it. Sissy knew of someone who had ‘done something to herself’, although she was not sure what had happened to her. The collected evidence suggests that some women did obtain abortions and the process was surrounded with secrecy. Supposed ‘cures’ for unwanted pregnancies were passed from woman to woman and could vary from one county to another. Due to the secretive nature of the details, a definite conclusion on the number of abortions through criminal interference cannot be met. Therefore, the exact number and nature of criminal abortions conducted in Monmouthshire is elusive.

**The Situation in Monmouthshire**

In 1924 the CMO voiced his ‘serious concern’ over the stillbirth cases in the county. He mentioned that apart from the loss of lives when the birth-rate was decreasing,

...the wasted energy involved in stillbirth, and the shock and intense suffering caused to the mother, must be considered.
The situation in Monmouthshire created concern on two fronts, which were the decreasing birth rate and the effect of stillbirth on the mother. A fair proportion of maternal deaths in Wales and in the county of Monmouthshire was caused directly or indirectly through abortions and miscarriages.

With this in mind Dr. Mary Scott, AMO produced a special report on stillbirths in Monmouthshire in 1928. It was found that the incidence rate was above the average for English counties. She looked at the incidence, causation and prevalence of stillbirths and came to the same conclusion reached by the CMO in 1924; action to prevent maternal mortality would lead to a reduction in stillbirths. The medical officers of the county believed that antenatal care was the solution. Responding to Dr. Scott’s report, the CMO hoped that when expectant mothers ‘fully realise the necessity of antenatal examination and advice and take advantage of the facilities provided’ there would be a corresponding reduction in the stillbirth rate.

However, the maternal mortality rate in 1934, four years after the introduction of the separate antenatal clinics was 6.2 per thousand live births. Even though the rate showed a decrease from 1933, which returned a rate of 7.19 it was considerably higher than the rate for England and Wales. Taking into account the total live and still births, the maternal mortality rate was 5.9 for Monmouthshire and 4.6 for England and Wales. It was found that 37.5 per cent of maternal deaths were from some form of puerperal septicaemia, and one-third of these was the result of miscarriage ‘either natural or induced’. Thirty per cent were due to toxaemia and the remainder was allocated to ‘accidents of labour’. In 1933 and 1934 ten maternal deaths were directly attributed to abortion. However, as mentioned earlier, the exact number would have been hidden among the puerperal
septicaemia or ‘other causes’ heading and only directly attributed to abortion if there was evidence pointing to that cause. The maternal death rate in 1935 rose again to 6.4 per thousand total births against the England and Wales rate of 4.1, and was higher than the rate found in Monmouthshire in 1930. The CMO commented that the only good point was that there was a ‘marked decrease’ in the number of deaths from abortion; four had been recorded and mention was made that these were not deliberate. The CMO stated that the decrease

...may indicate that women are beginning to realise the very grave risk they run when they attempt to procure abortion either in themselves or others. 210

The abortion deaths were starting to show a decrease. Nevertheless, the CMO was disappointed at the continuing high maternal mortality rate. Almost seventy per cent of the deaths were attributed to puerperal septicaemia and toxaemia. The CMO referred to the belief that when the abortion rate decreased there would be a corresponding decline in the puerperal septicaemia cases. However, the figures revealed that the puerperal rate had increased. 211 In 1938 the number of stillbirths in the county was 283, which amounted to 5.72 per 100 live births, and although it was a decrease of 1.2 on the 1937 figure, it was still ‘abnormally high’ and compared unfavourably to the figure for England and Wales. The rate per thousand of the population was .60 in England and Wales, while in Monmouthshire it stood at .92 of the population. 212

The reports from the antenatal clinics revealed that the majority of stillbirths and miscarriages suffered by the mothers attending during their pregnancies were due to high blood pressure or albuminuria in the later stages of pregnancy and were often found in multiparae women. It is probable that the women attending the clinics did so out of
concern for the safe outcome of their labour. Therefore, it can be suggested that any woman wanting to secure an abortion would not have attended a clinic. Reports in the early 1920s referred to venereal disease as a cause of stillbirths. This did not seem to be a problem by 1938. Few women attending the clinics were reported to be suffering from a form of the disease. The highest number of cases was returned from Newport with ten, followed by Crumlin with eight suspected cases and Risca with seven cases. No mention was made by the medical officers of any connection between stillbirths and venereal disease, just the passing note on the number sent for examination. 213

The main ailments suffered by mothers had been consistent throughout the period covered by this study. Anaemia, constipation, dental caries and varicose veins appeared in varying degrees each year. The more serious complaints were sent for examination to Cardiff. However, the clinic reports also reveal that there had to be a considerable degree of severity before this happened. Reasons for referral were usually toxaemia, albuminuria, malpresentation, contracted pelvis and cases of high blood pressure. At the Ebbw Vale clinic in 1938, fifty-six expectant mothers were found to be suffering from high blood pressure, albuminuria or both, and five showed malpresentations. Only four were referred to the obstetric specialist at Cardiff, two with contracted pelvis conditions and two with toxaemia. 214 In New Tredegar, Pengam, Pontypool and other clinics, the pattern was the same, with New Tredegar referring none of the forty-eight women with high blood pressure and albuminuria, or the eight with malpresentations to Cardiff. At Pontypool where four women were referred, one was suffering from a ‘marked degree’ of toxaemia. She had a premature stillborn baby before she could be admitted to hospital. 215 The evidence suggests that expectant mothers attending for the purpose of securing a safe
pregnancy and delivery did not always receive the same attention and treatment. These examples are not exclusive to 1938 and can be identified throughout the 1930s after the separate antenatal clinics were introduced into Monmouthshire. These examples might have been an indication of the ineffectiveness of a fractured system of antenatal care.

Sir Kingsley Wood, the Minister of Health received a deputation from the National Council of Women [NCW] in 1936, concerning the maternal mortality rate in the country and the deaths attributed to abortion included in the figures. The object of the deputation was firstly, to urge that the Government should appoint a committee to look into the legislation relating to criminal and attempted abortion with the view to improving the situation. Secondly, the NCW requested that official returns should show the number of deaths from abortion separately from general maternal mortality figures. The Minister was not particularly accommodating, saying that every effort was being made by the Ministry to conduct the relevant research concerning maternal mortality. Additionally, he believed the problem to be a social one and was pressing for slum clearance to reduce overcrowding and encouraging local authorities to implement extended antenatal care to women. He ended his reply to the NCW by reflecting the opinion of many politicians and medical professionals of the time. He stated that however efficient and comprehensive services were ‘their effect depended on the extent to which women took advantage of them...’.  

**Concluding Remarks on Antenatal Care in Monmouthshire**

It was shown earlier in this and previous chapters that expectant mothers in Monmouthshire did not take full advantage of the services available to them at antenatal or dental clinics. Monmouthshire County Council adequately provided mothers in the county with antenatal care, particularly following the introduction of separate clinics in 1930,
compared to most of the counties in Wales. However, the geographical nature of the county and the limited opening times of the clinics did mean that the distance some women had to travel to reach their nearest clinic was sometimes prohibitive, particularly in bad weather. The same problem was evident with the Centres. Reports from the medical officers in charge of the clinics reveal the amount of sickness prevalent among the expectant women who bothered to attend. Minor ailments were dealt with as effectively as possible, although the only treatment given to the mothers included mild laxatives, cough medicine, and creams for skin complaints. Vitamins and occasionally iron tonics were also given. However, if a woman needed additional treatment she was referred to her own local general practitioner. Large quantities of special foods were distributed to antenatal clinics under the National Birthday Trust Fund’s scheme in an attempt to reduce the high maternal mortality rate in Wales. Many of the medical officers at the clinics found the general physique and health of the expectant mother improved following the introduction of the extra foods into their diet. The CMO pointed out

...there is little doubt that this [the food] has also been an important fight against sepsis. Patients whose general health has improved ...are better able to resist infection, or, if infected are better able to fight and overcome that infection. 217

Attendance figures at the antenatal clinics increased over the period studied, which implies that more women were requesting care during their pregnancies. However, it can be suggested that the increase in attendance was partly the result of pressure from the middle-class care providers including health visitors. Another factor leading to the increase in the attendance of younger women was the effect of media attention concerning high maternal mortality rates. Nevertheless, the evidence
contained in the MO's reports and the fifty interviews conducted for the purpose of this study reveal that many mothers chose not to attend antenatal clinics. It can be argued that women retained their choice concerning the amount of public, as opposed to private contact they wanted while they were in a pregnant state. Their final decision was often influenced by the traditional mores of their social group.

Given the evidence and regardless of the comparable antenatal facilities available in Monmouthshire, the original argument of many medical officers that antenatal care would reduce maternal mortality statistics throughout the country was not upheld in Monmouthshire. More women died as a result of childbirth in 1938 with a rate of 7.6 per thousand live births, than in 1930, which was the first year of the extended system of antenatal care in Monmouthshire and returned a rate of 5.3 per thousand live births. 218

Chapter Six: Notes


2 Ibid. 23 March 1929 p.553.

3 Ibid. p.554.

4 Ibid. 11 May 1929 p.870.

5 Ibid. p.871.

6 Ibid. 8 June 1929 p.1058. Letter signed ‘P.W.’

7 Monmouthshire County Council [MCC], Maternity and Child Welfare Committee [MCWC]. Annual Report for 1929 Blackwood and Oakdale Centres, Dr. Whitaker, pp.31 2.

8 Ibid. Usk Centre, p.31.

10 Interview with Sissy by Jan King at Bettws Residential Home, 8 October 1994.


12 *BMJ* 23 March 1929 p.554.

Dr. Rocyn Jones, County Medical Officer [CMO].

14 *BMJ* 23 March 1929 p.555.

15 *BMJ* 23 March 1929 p.555.

Professor Strachan was the County Obstetrician. Women exhibiting abnormalities during pregnancy were sent to him in Cardiff for examination. Professor Strachan’s speech delivered on 24 June 1937 is printed on pages 12 to 14 of the above Report.


18 MCC., MCWC *Annual report for 1929* Vital Statistics Table for births and p.13 for maternal deaths.


23 *44th Annual report of the Local Government Board 1914 - 1915.*
Supplement containing a report on *Maternal Mortality in connection with Childbearing and its Relation to Infant Mortality* p.64.

24 Ibid. p.65.


26 Ibid. p.65.
37 Interview by Jan King, with Mrs. E. G. of Saundersfoot, at Mrs. L. J’s home in Saundersfoot, South West Wales, February 1992.

38 MCC. MCWC Annual Report for 1920 Dr. Scott, p.19.

39 Ibid. p.23.

40 Letter addressed to Jan King from Mrs. K. G. of Rogerstone, following a request for information, February 1993.

41 Mrs. T., Mrs. M., Mrs. S., Mrs. W., Mrs. O. T., Mrs. L., Mrs. G., Mrs. L. L., Mrs. D. L., and Mrs. P. were interviewed at Blaen-y-Pant Residential Home at Malpas in May 1993. There was laughter and nods of agreement all around following the response of Mrs. L. L. when asked if she went outside the home in the advanced stages of pregnancy: ‘I used to hide my tummy under big clothes when I began to show’. The reaction of the group confirms Sissy’s story.

42 Mrs. M. Of Cardiff was born in 1910 and had her first child in 1933. She was interviewed at Pant-y-Celyn Residential Home, Bettws, by Jan King, December 1994. The other women interviewed on the same day at separate times were Mrs C., Mrs. R-M. Mrs. M. M., Mrs. T., Mrs. H., and Mrs. M.

43 Letter sent to Jan King from Mrs. A. C., of Ebbw Vale, 2 February 1993, following
a request for information. Mrs. A. C’s first child was born in 1935.

Response following a talk given by Jan King, concerning antenatal care in Wales in the 1930s, to the Sunshine Coast Welsh Society’s Christmas party at Eumundi, Queensland, Australia, December 1996. Around two hundred people, mostly former residents of Wales, gathered together from three Welsh Societies in Brisbane, Ipswich and the Sunshine Coast of Queensland.

MCC, MCWC Annual Report for 1920 Dr. Steel, MO Abergavenny p.27.

Ibid. Annual Report for 1921 CMO, p.5.

Ibid. Dr. Austin, p.24.

Ibid. Dr. Steel, p.29.

Ibid. Annual Report for 1923 Dr. Ellis, AMO Cwm, p.25.

Ibid. Annual Report for 1922 Dr. Werden, MO Aberbargoed Centre, p.27.

Ibid. p.27.


Ibid. p.23.

Ibid. Annual Report for 1920 Dr. Griffiths, MO Abercarn, p.27.

Ibid. Annual Report for 1919 Dr. Martin, MOH Blaenavon Centre p.28.

Ibid. Pontypool Centre, p.28.


Letter sent to Jan King from Mrs. E. L., Community Midwife from Worcester, relating to her mother’s experience in 1931 while pregnant with Mrs. L’s sister. 17 May 1993.

62 Interview by Jan King with Mrs. G. L. J. at her home in Saundersfoot, South West Wales, 6 February 1993.


64 Interview by Jan King with Mrs. B. at Mrs. J’s home in Saundersfoot, 6 February 1993.

65 MCC, MCWC Annual Report for 1921 Dr. Steel, Abergavenny, p.29.

66 Ibid. Dr. Scott, p.19.

67 Ibid. Dr. Ellis, p.27.

68 MCC, MCWC, Annual Report for 1924 p.27.


70 MCC, MCWC, Annual Report for 1919 Figures taken from the individual reports of the medical officers and can be seen from page 12 to page 36.


72 MCC, MCWC, Annual Report for 1929 Taken from Table G., 'Details of Attendances at the Centres'.

73 Ibid. p.13.

74 Ibid. p.14.


76 BMJ 17 August 1929 p.315.

77 Ibid.

78 Ibid.


80 Ibid. p.108.

81 Ibid. p.109.
83 Ibid. Schedule of Antenatal Clinics.
84 Ibid. Dr. Scott, p.15.
86 Ibid. p.14 and the Schedule of Antenatal Clinics.
87 Ibid. Dr. Scott, p.21.
88 Ibid. p.21.
93 Ibid. Dr. M. Scott, p.21.
94 Ibid. Dr. M. Scott, p.21.
95 Ibid. p.21.
96 Ibid. CMO, p.14.
97 Ibid. Dr. M. Scott, p.21.
102 Ibid. CMO., p.13.
103 Ibid. Dr. Gordon, p.20.

105 Ibid. Schedule of Antenatal Clinics.


108 MCC., MCWC Annual Report for 1936 Dr. Whitaker, p.20.

109 Lady Rhys Williams, Honorary Secretary of the Joint Council of Midwifery, ‘Malnutrition as a Cause of Maternal Mortality’ Public Health Oct 1936 p.11.

110 MCC., MCWC Annual Report for 1921, and each year in between to 1938. The maternal death figures are on various pages of each report. They will usually be found between pages 7-13 of the individual reports.

111 Lady Rhys Williams, ‘Malnutrition as a Cause of Maternal Mortality’ Public Health October 1936 p.11.

112 Ibid. p.11.

113 Ibid. p.12.

114 Ibid. p.13.

115 Interim Report of the Research Committee of the Joint Council of Midwifery upon the Nutritional Experiment in the Special Areas 1938 p.2.

County Record Office, Cwmbran, Gwent, C/Misc. R.0082.

116 Ibid. p.7.

117 Ibid. p.4.

118 Ibid. p.5.

119 Ibid. p.8.

120 Ibid. Table of Results, pp.9-10.

121 Lady Rhys Williams, ‘Malnutrition as a Cause of Maternal Mortality’ Public Health October 1936 p.17.

122 Ibid. p.17.

124 Ibid. Dame Louise McIlroy, p.19.

125 Ibid. p.19.


127 Ibid. p.1259.


130 Ibid. p.93.

131 Ibid. p.94.

132 Ibid. p.115.

133 Ibid. p.116.

134 MCC., MCWC Annual Report for 1930. Information taken from a list in the report, ‘Details of Mothers’ Most Common Ailments on which Advice was given at Welfare Centres’.

135 Ibid. The ‘Schedule of Antenatal Clinics’.

136 MCC., MCWC Annual Report for 1931 Dr. Scott, p.18.


138 MCC., MCWC Annual Report for 1934 p.11.


140 Ibid. Dr. Scott, Blaina Clinic, p.12.

141 Ibid. Dr. Scott, Ebbw Vale Clinic, p.13.

142 Ibid. Dr. Scott, Tredegar Clinic, p.14.

143 Ibid. Dr. Scott, Pontypool Clinic, p.13.
144 Ibid. Dr. Scott, Chepstow Clinic, p.13. Figures also taken from the 'Schedule of Antenatal Clinics'.


146 MCC., MCWC Annual Report for 1937 Dr. Scott, Chepstow Clinic, p.15.

147 MCC., MCWC Annual report for 1938 Dr. Scott, Chepstow Clinic, p.12.

148 MCC., MCWC Annual Report for 1937 Dr. Roberts, Abergavenny Clinic, p.23.

149 Ibid. Dr. Owen, Monmouth Clinic, p.22, and the ‘Schedule of Antenatal Clinics’.

150 MCC., MCWC Annual report for 1938 Dr. Owen, Monmouth Clinic, p.21, and the ‘Schedule of Antenatal Clinics’.


152 Ibid. Dr. Owen, Rhymney Clinic, p.20.

153 Ibid. Dr. Whitaker, Abersychan Clinic, p.19.

154 MCC., MCWC Annual Report for 1937 Dr. Whitaker, Abersychan Clinic, p.24

155 MCC., MCWC Annual Report for 1938 Dr. MacQuillan, Abersychan, p.16.


161 MCC, MCWC Annual Report for 1938 Dr. Roberts, Abertillery Clinic, p.15.

162 MCC, MCWC Annual Report for 1930 Dr. Whitaker, Abertillery Clinic, p.22.
163 MCC, MCWC Annual Report for 1936 Dr. Scott, Blaenavon Clinic, p.12.

164 MCC, MCWC Annual Report for 1938 Dr. Probert, Oakdale Clinic, p.16. Dr. Gordon, Newport Clinic, p.14. Dr. Roberts, Abertillery Clinic, p.15. Dr. MacQuillan, Abersychan Clinic, p.16. Dr. Owen, Monmouth and Rhymney Clinics, p.21

165 Ibid. Dr. Roberts, Abertillery and Risca Clinics p.15.


167 Ibid. p.115.

168 Ibid. p.115.

169 MCC, MCWC. Information taken from ‘Details of Mothers’ most Common Ailments on which Advice was given at Welfare Centres’ for the years 1930 to 1936 inclusive. Page numbers vary with each Report.


171 Ibid. Dr. Roberts, Abertillery Clinic, p.15.

172 Ibid. Dr. Roberts, Risca Clinic, p.15.

173 Ibid. Dr. Scott, Tredegar Clinic, p.14.

174 MCC, MCWC Annual Report for 1933 p.11. and Annual report for 1938 p.11. CMO’s comments.


176 MCC, MCWC Annual Report for 1933 CMO., p.11.


179 Interview by Jan King with Phyllis at Bettws Residential Home, October 1994. Phyllis’s first child was born in Newport in 1939 when she was twenty-five.

180 Interview by Jan King with Margaret, Bettws Residential Home, October 1994.
Interview by Jan King with Mrs. L. P. at Blaen-y-Pant Residential Home, Malpas, 19 May 1993.

Interview by Jan King with Mrs. Lily B. at Mrs. J’s home in Saundersfoot, 6 February 1993.


Ibid. p.13.


MCC, MCWC Annual Report for 1919 CMO., p.6.

The Times 7 February 1920.


See local newspapers such as the South Wales Gazette June to November 1929.

BCN No. 1, Vol. 1, May 1922.

Ibid. May 1922. Dr. Marie Stopes opened the first Birth Control Clinic in Britain in Holloway, London, March 1921. In 1925, the Clinic was moved to Tottenham Court Road. The Clinic was opened daily for married women without charge. For books of interest on birth control including the philosophy of eugenics, see the list below.

MacLaren, A., [1978] Birth Control in Nineteenth Century England
Banks, O., [1984] The Birth Controllers
Hall, R., [ed] [1978] Dear Dr. Stopes: Sex in the 1920’s

MCC., MCWC Annual Report for 1920 CMO, p.7.

MCC., MCWC Annual Report for 1921 CMO., p.7.


Ibid. p204.
197 Ibid. p.204.
198 Ibid. p.203.
199 Ibid. p.204.
200 Ibid. 23 February 1929, p.358.
201 The Star of Gwent 7 January 1898.
202 MCC, MCWC Annual Report for 1924 CMO., p.46.
203 Interview by Jan King with Mrs. F. G. at her home in Cwmbran, December 1988.
204 Interview by Jan King with Sissy at the Bettws Residential Home in October 1994.
205 MCC, MCWC Annual Report for 1924 CMO., p.46.
206 MCC, MCWC Annual Report for 1928 Dr. Scott, p.11.
207 MCC, MCWC Annual Report for 1929 CMO., p.10.
208 MCC, MCWC Annual Report for 1934 p.11.
210 Ibid. p.12.
211 Ibid. p.12.
213 Ibid. Newport and Risca Clinics, p.15, Crumlin Clinic, p.16.
217 MCC, MCWC Annual Report for 1937 CMO., p.11.
CONCLUSION

The first Midwives Act in 1902 consolidated the regulation and registration of female midwives. The Central Midwives Board (CMB), which was established following the Act, was a regulating body for the training, examination and registration of midwives. It has been argued that the CMB was an institution of control professionally, socially and morally for the midwives under its jurisdiction. Deviation from the written rules set down by the CMB meant that a midwife's misdemeanour was conveyed to the Board and punitive measures were enforced for breaking the Board's code of practice. Misconduct could mean erasure of a midwife's name from the Midwives Roll, which subsequently affected her ability to earn a living. The CMB's interpretation of 'misconduct' encompassed the professional, social and moral behaviour of the midwife, whether on or off duty.

Local authorities administered the Midwives Act. The local supervising authority became the policing vehicle for the CMB, mainly through the inspection system. Medical women employed as 'Inspectresses' of Midwives undertook the inspection of midwives. The Inspectresses were under the supervision of medical men. Their duties included submitting reports on the conditions found in the homes of midwives, such as the cleanliness of the rooms and personal clothing. In this way, the CMB promoted intrusion into the private life of the midwife. The 1902 Midwives Act seemed to concentrate more on the registration and regulation of midwives than on the provision of an adequate period of quality training for prospective midwives.

Continuing with this argument, it was proposed that the consequences of limited training opportunities and short practical courses for pupil midwives firstly, led to the need for
unqualified midwives to continue practising, mainly in isolated rural districts, with the
knowledge of doctors. Secondly, it restricted the midwife's repossessions of her traditional
role in the birth process, which mainly became the domain of medical men. The examples
offered in this study concern the status of midwives and the attitude of medical
professionals to their work. The evidence revealed that whereas many midwives were
registered as unqualified and illiterate in the early years following the Act, the blame
proportioned to them related to infant deaths could not be sustained. Nevertheless, the
liberal use by many medical men of derogatory symbolism to describe the female
midwife perpetuated the myth of the ignorant and potentially dangerous midwife well
into the twentieth century.

It has been shown that the female midwife's status in society did not change significantly
until the passing of the 1936 Midwives Act. The 1936 Act was intended to attract more
educated women to midwifery through the offer of salaried positions and benefits such as
holidays and pensions, as employees of local authorities. However, appointment to the
new salaried positions depended on certain selection criteria being satisfied. One criterion
was based on the cleanliness of the midwife's home, which reflected the invasion of
privacy introduced in the passing of the first Midwives Act in 1902. It has been argued
that the 1936 Act, although bringing many benefits to qualified midwives, perpetuated
the social control of midwives through the invasion of their private lives.

**Maternal and Infant Welfare**

The deaths of infants in the early 1900s, according to Sir George Newman, Medical
Officer of the Board of Education, were 'an enormous sacrifice of human life...'.¹ The
high infant mortality rate, in conjunction with a declining birth rate, caused national
concern. Social interventionist policies were believed to be the means to arrest the further escalation in infant deaths and protect the future of the British race. However, as Deborah Dwork points out in her research on the history of the infant and child welfare movement in England,

The philosophy of Eugenics, the policy of national efficiency, and the reaction to the Boer War did not create the infant and child welfare movement, but they did focus attention on and provide a stimulus for it. 2

The poor physical condition of infants born to mothers in working-class districts in particular led to a concentration on the management of childbirth and the whole concept of motherhood and child-rearing practises. Firstly, the quality of help available at the point of birth was considered crucial to the survival of both mother and infant and the continuing health and welfare of them. As mentioned previously, politicians and medical professionals blamed female midwives for infant deaths, particularly those occurring in the first few weeks after birth. The unqualified and uneducated midwives, who were allowed to continue to practice as bona fides following the passing of the first Act, were harshly targeted.

However, close analysis of the work of midwives in Monmouthshire using the 1914 Register of Midwives, the comments of medical officers and infant mortality statistics revealed certain points. The Register of Midwives listed the midwives’ details including age, extent of literacy and qualifications. The evidence suggests that the attendance of unqualified midwives at births in Monmouthshire, whether literate or illiterate, had little effect on the extent of infant mortality in the county; other factors were more influential. Placing the blame on midwives for high infant mortality rates worked to divert attention
from other potential hazards, such as inadequate housing, overcrowding and the poor nutrition of expectant mothers.

Carol Heimer’s Working Paper for the Institute for Policy Research in 1999, argues that certain rules and regulations encourage counter-productive behaviour rather than responsibility. She explained that an example would be focusing on avoiding blame rather than on achieving certain objectives. It can be argued that focusing blame on midwives in the ways illustrated in this study prolonged the realisation of the main objectives of the Midwives Act 1902 and the later Maternity and Child Welfare Act in 1918, which established the Centres.

In addition to placing the blame on midwives, mothers in working-class districts were also criticised. These mothers were believed to be lazy, ignorant and a constant source of danger to the survival of infants. In order to remedy the situation, educating girls and mothers in hygiene, housewifery and child-care became the focal point of state policies affecting women. The educating process began in elementary schools and served a dual purpose in working-class districts. The system ensured that girls would be prepared to enter the workforce as domestic servants. Finally, they were trained for their future role as wives and mothers.

Focusing blame on mothers for infant deaths worked to cover the realities of the mothers’ lives in working-class districts, such as the lack of decent housing, overwork and poor nutrition. The evidence in Monmouthshire concerning the lives of mothers in working-class districts that has been presented in this study, reveals some of the problems that they faced. The evidence further serves to substantiate the argument that the focus on blaming
both mothers and midwives for infant deaths diverted attention from potential dangers, which in turn protracted an improvement in infant mortality rates.

To continue with the discussion on educating the mothers, it was in ‘Schools for Mothers’ and ‘Babies’ Welcomes’ that mothers were instructed in the skills of mother-craft. The emphasis was placed on breast-feeding as the best means to nourish infants.

Contemporary middle-class practises were introduced into the programme of instruction offered at these mothers’ schools. Domestic and personal hygiene methods and the ‘correct’ way to dress, bathe and feed the infant were demonstrated to mothers. Regimental patterns were advised for feeding and bathing infants, and strict instructions concerning the amount of fresh air and sleep infants should have were given to mothers. Lessons in thrift were introduced and mothers were shown how to make new clothes out of old and cook cheap meals.

The Notification of Births (Extension) Act of 1915 brought about the compulsory notification of all births. Whereas some problems were evident in the early stages of the new registration process, as Dr. Lane-Claypon pointed out in 1920, the Act was ‘the nucleus around which centres the great mass of infant welfare work’. The Maternity and Child Welfare Act in 1918 consolidated infant welfare plans for the counties of England and Wales. The evidence suggests a pattern of continuity in the philosophy of educating the mothers in the Maternity and Child Welfare Centres (Centres).

The Centres in the county of Monmouthshire were studied in depth to establish the influence of the scheme on both infant and maternal mortality in the county. The evidence revealed that Monmouthshire introduced a scheme for the improvement of the health of mothers and infants in the county in 1916, which was prior to the statutory
requirements under the Maternity and Child Welfare Act. Therefore, the commitment of Monmouthshire County Council (MCC) to infant and maternity work was strong. However, other evidence found in the reports of medical officers, in housing reports and in contemporary newspapers, reveal that housing conditions in urban Monmouthshire created more problems than the Maternity and Child Welfare Centres could address.

A scheme for maternity and child welfare was implemented in the county with MCC as the central authority; local committees were enrolled for each district. A total of twenty-one Centres were opened initially, with sessions held in the Domestic Arts Centres of schools, or in chapels, churches and school clinics. Buildings were not specifically built for the purpose and generally lacked adequate hot water supplies and suitable facilities for privacy during antenatal examinations.

The aims of Centres were to save infant life, prevent the diseases of childhood and limit unnecessary suffering for the mother during pregnancy. Through the Centres, it was promoted that a healthy mother would be able to breast-feed; the implication being that a healthy baby was breast-fed. All medical officers in charge of the Centres pursued the philosophy of ‘breast is best’ with earnest. The main motivation of the medical officers was a reduction in infant mortality rates with an accompanying improvement in infant health to ensure the survival of the nation.

Additionally, the sentiments contained in the aims of the Centres referring to their role in antenatal care seemed to express concern and an awareness of the trials of pregnancy and childbirth. However, it has been shown that antenatal facilities were limited and not readily available at the Centres. Mothers in Monmouthshire had to wait until 1930 before separate Clinics for the express purpose of antenatal work were established in the county.
Medical women employed by the County Council staffed these separate clinics. Postnatal attention at Centres was primarily concerned with the medical supervision of infants and young children up to the age of five years. The evidence collected suggests that the work of the Centres focused on the health and well-being of the nursing mother and the infant. This was often detrimental to the expectant mother whose specific needs not catered for until the introduction of the separate antenatal clinics.

The theme of educational instruction aimed at improving motherhood, which was established through the earlier ‘Schools for Mothers’ was continued at the Centres. The medical professional’s skill and knowledge was unquestionable and expert, whereas the mother’s natural skill and experience was often unrecognised. It has been suggested that his philosophy tended to trivialise the notion of motherhood generally accepted by mothers in working-class districts. Furthermore, middle-class perceptions of the concept of need in association to motherhood tended to conflict with the real needs of mothers in working-class districts. This situation presented a communication problem.

The way in which information was imparted to the mothers was important. The condescending attitude of some middle-class medical officers in charge of the Centres suggests that conflicts were fixed in the differing social perspectives of the providers and consumers of health care. The concept of the ignorance and carelessness of mothers perpetuated the myth that mothers in working-class districts were mainly responsible for infant deaths. The accusations were particularly aimed at mothers who chose not to attend the Centres and embrace middle-class practices concerning child-care. Additionally, a policy of exclusion was in operation in each Centre, which denied the right of the mother to obtain cheap milk and other foods unless her attendance at the Centre was on a regular
basis. Physical attendance at the Centre was proof to the medical officer that the mother was ‘good’ and worthy of attention. This was in contrast to the ‘ignorant’ and ‘lazy’ mothers that the MOs claimed would not attend the Centres. The continuation of this myth initially denied recognition of the problems facing mothers in insanitary and overcrowded houses over which mothers had little or no control. These insanitary houses were mainly the birthplaces of their children and consequently, the work places of the midwives.

Home visitations to mothers increased through the work of health visitors employed by the local authority under infant welfare schemes. However, health visitors reported more than the occurrence of new births to the medical officers. The general sanitary conditions and domestic cleanliness, together with mention of irregularities in the duties of the attending midwife became part of the health visitors’ work. The Acts, particularly the Maternity and Child Welfare Act, radically changed the nature and role of health visiting from the loosely-structured work of the voluntary philanthropist to the strict regime of the trained official who reflected the social values and educational perspectives of state legislation.

The evidence in Monmouthshire concerning the visitation process show that the number of visits to mothers declined between 1924 (64,266) and 1938 (58,148). However, the visits that were reported as being ‘fruitless’ increased in number from 109 in 1924 to 3846 in 1938. Firm reasons for the ‘fruitless’ visits other than the reported explanation of the mother not being at home at the time of the visit were difficult to determine. Nevertheless, the rise in the number of ‘fruitless’ visits indicate that there were many mothers who had not accepted the process of visitation and the introduction of
officialdom into the private domestic sphere. The extension of the state in this officious manner was further enforced through the use of the uniform. Health visitors and other officials employed by a public body wore a uniform chosen by that body. Through the process of home visitation, the health visitor in her uniform became part of the social control of mothers.

Oral interviews mainly conducted in Monmouthshire for the purpose of this study reveals that the influence of the midwife was stronger than that of the health visitor. The interviewees vividly remembered the attention and advice received from the midwife. Therefore, given the evidence contained in official documents, MOs' reports and the oral interviews it was suggested that government funding might have been utilised more efficiently to secure the aims of the Midwives Act and the Maternity and Child Welfare Act. By directing funding into extending the teaching and practical training of midwives into antenatal and postnatal care, rather than the into the training and appointment of health visitors, midwives might have been able to advise mothers on antenatal and postnatal care more effectively.

Studying the comments of medical officers attending Centres in Monmouthshire over a period of time, a change in the attitude towards mothers in working-class districts can be detected between 1920 and 1938. The initial derogatory 'ignorant' and 'lazy' descriptions attached to mothers in working-class districts lessened as medical officers in charge of Centres throughout the 1920s began to realise the effects of the fluctuating economy on the health of the mothers. One example of this change was illustrated through the reports from Centres. Many of the medical officers stated that breast-feeding had declined
through the inability of mothers to sustain an adequate supply of good quality breast-
milk, rather than through the ignorance or laziness of mothers.

A further example in the change of attitude was revealed through a study of the
comments of two medical men in Monmouthshire, Dr. Drapes and Dr. O’Reilly. Both
men had occasionally criticised mothers attending the Centres. However, in 1934, 1935
and 1938 they blamed the influence of the media for the reduction in breast-feeding. Dr.
O’Reilly stated that modern publicity campaigns were skilfully operated to produce the
maximum profit for the manufacturer, and called for the ‘exploitation of the innocents’ to
be checked through legislation. 6

Nevertheless, a brief return to the myth of the ignorant working-class mother was noted
in Monmouthshire, which highlights the immovability of the stigma created through
myths. In 1928, mothers in Blaenavon were sharply reprimanded, which caused conflict
among the Blaenavon councillors. Then in 1930, when referring to Monmouthshire as a
whole, the CMO pointed to the ‘...ignorance, apathy and carelessness of some mothers,
which continue to rob the cradle and the nursery’. 7 However, overall the attitude of the
middle-class medical professionals towards mothers in working-class districts in
Monmouthshire became more tolerant as a result of the medical officers’ involvement in
the maternity and child welfare system. The integral consultation process at the Centres
brought medical men and women into direct and frequent contact with the mothers of the
county and the difficulties of their every-day lives.

Nevertheless, it was a slow process. In 1938, twenty-two years after the establishment of
the Centres and eight years after the separate antenatal clinics for expectant mothers, the
CMO claimed that neo-natal mortality was ‘still very noticeable’ with 149 of the 275
infant deaths or 54.1 per cent happening in the first four weeks following birth. The overall infant mortality rate had decreased while the neo-natal death rate had remained close to the number it had been before the introduction of the Centres. The evidence suggests that the philosophy of education and the regime of regular infant welfare sessions attended by medical professionals did help to improve infant mortality statistics for the one-month to twelve-month infant. However, the system failed to have an impact on infant life in the first four weeks following birth.

The result of the focus on the health of the infant consequently directed attention from the health of the expectant mother. Furthermore, rhetoric surrounding antenatal provision was punctuated with arguments concerning the need for antenatal work and the nature of the delivery of the service. Evidence reveals that the inter-professional rivalry and disagreements subsequently led to a fragmented system, rather than the provision of continuity of care through pregnancy, birth and the postnatal period. Midwives gradually became involved in a limited way in the antenatal care of expectant mothers through the antenatal clinics. Nevertheless, additional attention was not able to positively influence the maternal mortality rate in the county.

The long period of unstable economic conditions apparent in the South Wales coalfield led to deterioration in the general health of the mothers. Evidence of this was shown in the reports of the medical officers at the Centres and Clinics particularly relating to the ailments suffered by mothers. Substantiation of the claim that one of the major causes of the relatively high maternal mortality rate and the general ill health of mothers in South Wales was linked to inadequate nutrition rested with the nutritional ‘experiments’. These experiments were mainly funded by the National Birthday Trust. A scheme provided
certain foods and vitamins to mothers’ attending Centres and Clinics in districts
designated ‘special areas’ under the Special Areas Act 1934. Reports suggest that the
general health of mothers taking part in these ‘experiments’ did improve. However, an
analysis of maternal mortality rates reveal that the number of maternal deaths did not
decline substantially. Forty-two mothers died in Monmouthshire in 1921 and thirty-eight
in 1938; the seventeen-year period resulted in little improvement in the number of
maternal deaths. Nevertheless, the characteristics of the deaths did reveal that the pattern
in Monmouthshire was the same as that in other special areas in South Wales. The
incidence of maternal death occurred more frequently in the category of ‘other puerperal
causes’ than puerperal sepsis. In conclusion, the education of girls and women in personal and domestic hygiene and
infant care, although criticised initially, does seem to be a factor in the improvement of
infant health. Another factor promoting an improvement was the system of Maternity and
Child Welfare Centres. At the Centres advice and milk were given or sold cheaply to
mothers attending the Centres, and regular attention was paid to the infant by the medical
staff. However, Centres had little impact on the improvement of maternal health.
Evidence reveals that the general health of mothers in Monmouthshire was under-mined
by prolonged poverty to such an extent that intercurrent diseases such as anaemia and
debility, heart disease and tuberculosis, imposed extra risks on an expectant mother at her
most vulnerable time. In the late 1930s, midwives in Monmouthshire were mostly trained
and literate. Therefore, unqualified attendance at births did not feature in an assessment of
the reasons for the continuing incidence of high maternal mortality returns for
Monmouthshire.
A final note should be added concerning the responsibility of the mother for her health during pregnancy. The 1937 *Report on Maternal Mortality in Wales* pointed out that no matter how efficient services for the care of expectant mothers were, the services could not be fully effective unless the woman recognised her responsibility for attention to her own health and hygiene during pregnancy. Evidence found in Monmouthshire points to some mothers refusing to take advantage of the facilities and advice available to them through antenatal clinics, particularly relating to dental treatment. This in turn might have led to further health and dietary problems. The choice not to attend an antenatal clinic was taken by many women in Monmouthshire as oral testimony substantiates. Some chose not to attend for practical reasons such as the long distance to travel. Others stayed away from both Centres and antenatal clinics for numerous reasons including the inability to afford to follow the advice offered to them by the medical officers.

Regardless of the reasons of reticence on the part of some mothers to seek advice during the antenatal and postnatal period, the collected evidence points to the prolonged effects of poverty having a detrimental effect on the general health of mothers in Monmouthshire. The heavy nature of housework in the industrial communities, the fragmented antenatal work and the lack of hospital facilities for problematic pregnancies and labours added to the dangers faced by mothers in Monmouthshire and perpetuated the high maternal mortality rate in the county throughout the period of this study.

The complexity of social policies particularly embracing aspects of health care provision poses special problems, as this study has illustrated. This study has illustrated the various policy-making stages; agenda-setting, policy formation, adoption of the rules, implementation of the policy and evaluation of its effects in relation to the Midwives’
Acts, the Notification of Births’ Acts, the Maternity and Child Welfare Act and briefly the Special Areas Act.

The inability of social policies to suit the needs of every consumer group or each area within one country is apparent. The Special Areas Act was an example of a social policy aimed at specific groups in specific areas. Nevertheless, this study reveals the complexity of the social policies it has examined. The differing reaction to the implementation of those policies from providers and consumers of the related services, are reflected in the inability to draw a definitive conclusion concerning the impact these policies had on the infants and mothers of Monmouthshire during the period studied.

Conclusion: Notes


To illustrate her arguments, Heimer offers examples from a number of areas including environmental regulations, record-keeping practices, academic life and medical care.


6 MCC, MCWC See Annual Reports for the year 1934, 1935 and 1938.

7 MCC, MCWC Annual Report for 1930

8 MCC, MCWC Annual Report for 1938


10 Ibid. p.115.
<table>
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<th>Name</th>
<th>Address</th>
<th>Certificate No. and date of Certificate of Central Midwives Board</th>
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<th>Marital Status</th>
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<td>3893—30th October, 1911</td>
<td>In practice, July, 1914</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Corin, Jane</td>
<td>7. Tredurnton, Postpool</td>
<td>3188—24th April, 1914</td>
<td>In practice, July, 1914</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>Cross, Leah</td>
<td>21. King Street, Aberllefri</td>
<td>3078—27th October, 1914</td>
<td>In practice, July, 1914</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td>Cross, Emma</td>
<td>5. Fair View, Ely</td>
<td>5842—6th October, 1914</td>
<td>In practice, July, 1914</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>Davies, Catherine</td>
<td>21. The Red House, Tredurnock, nr. Caerleon</td>
<td>2072—27th April, 1905</td>
<td>In practice, July, 1914</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td>Davies, Elizabeth</td>
<td>44. Llanc House, Llanc, Crumlin</td>
<td>2644—30th June, 1912</td>
<td>In practice, July, 1914</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td>Davies, Elizabeth Anne</td>
<td>65. Llanc House, Llanc, Crumlin</td>
<td>2050—27th April, 1905</td>
<td>In practice, July, 1914</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td>Davies, Elizabethe Jane</td>
<td>66. Llanc House, Llanc, Crumlin</td>
<td>2014—9th September, 1904</td>
<td>In practice, July, 1914</td>
<td>M</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td>Davies, Elizabethe Jane</td>
<td>68. Llanc House, Llanc, Crumlin</td>
<td>2051—30th October, 1919</td>
<td>In practice, July, 1914</td>
<td>M</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


**Appendix 2**

**Register of Midwives Practising in Monmouthshire 1914: Summary**

Source: Table compiled from information given in the Monmouthshire County Council (1914) *Register of Midwives*

<table>
<thead>
<tr>
<th></th>
<th>Urban</th>
<th>Rural</th>
<th>Residing Outside Practising Within County</th>
<th>Whole County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Midwives on the Roll</td>
<td>214</td>
<td>37</td>
<td>9</td>
<td>260</td>
</tr>
<tr>
<td>Number of Midwives Trained and Certified</td>
<td>88</td>
<td>11</td>
<td>6</td>
<td>105</td>
</tr>
<tr>
<td>Number of Untrained but Certified</td>
<td>126</td>
<td>26</td>
<td>3</td>
<td>155</td>
</tr>
<tr>
<td>Number of Literate Midwives</td>
<td>166</td>
<td>32</td>
<td>9</td>
<td>207</td>
</tr>
<tr>
<td>Number of Illiterate Midwives</td>
<td>48</td>
<td>5</td>
<td>0</td>
<td>53</td>
</tr>
</tbody>
</table>
Appendix 3

Advertisements: Robinson’s Groats and Robinson’s Barley 1916


Save the Babies!

Mothers by taking Gruel made (with milk) from
ROBINSON’S "PATENT" GROATS
for Breakfast and Supper will derive assistance in nursing their babies when born.

Miss Stackpool writes in “Advice to Women” —
“Good Milk Gruel is the best thing to take as a last meal at night, before and after confinement.”

Save the Babies!

TO MOTHERS:—Try and nurse your babies yourselves. If not able to do so, try the next best thing supplied by Nature—viz., BARLEY WATER made from
ROBINSON’S "PATENT" BARLEY
and milk—the Barley Water used as a diluent of the milk, whether fresh, condensed, or in powder form (and under whatever name called), separates the curd and prevents its accumulation in the stomach.

Write for Free Booklet, “Advice to Mothers.”
(Dept. C.C.H.), KEEN, ROBINSON & CO., Ltd., LONDON.
Appendix 4

Advertisement: Sunshine Glaxo 1933

Source: Punch 14 June 1933 p.xxii.

1908 - 1933

"The baby food that progressed with knowledge"

25 years ago Glaxo was introduced. A milk food based on the most advanced knowledge of 1908.

Year by year, with the progression of knowledge, aided by Glaxo research on infant foods and infant-feeding problems, so Glaxo itself progressed.

To-day, Sunshine Glaxo represents the most advanced knowledge of 1933.

SUNSHINE

GLAXO

STANDARDISED IN VITAMIN D
BUILDS BONNIE BABIES

GLAXO LABORATORIES,
4, Osnaburgh St., London, N.W.1
Appendix 5

Central Midwives Board Form of Sending for Medical Help

Source: Form filled in by midwife Mrs. Elizabeth Mullins, Salisbury

FORM A.

Central Midwives Board

Form of sending for Medical Help.

Date of sending for Medical help: 3/5/34

This notice is sent in respect of:

Mrs. Speer

Address: Manor Cottages

Bratford

Medical assistance is sought by:

(a) Here fill in name of patient.

(b) Here insert "me" or "relative or friend" as the case may be.

Date of Confinement: 3/5/34

The case is urgent.

Sent to (name of doctor or institution):

Eden

at (address): New St.

Salisbury

Time of sending message:

By telephone. 10 A.M.

Signed: 3. H. Mullins. 6. 6. 5. 9

(Certified Midwife)

Address: 2. The Grove

West Hamham

--- Information as to stage of labour and other particulars should be given.

Midwife shall make two copies of the above, making, signed documents, three copies in all. The original shall go to the doctor in the first instance (not by the relative or friend only), and the third to the Local Authority as soon as possible after the event.
## Appendix 6

### Total Infant Mortality Rates for the County of Monmouthshire and England & Wales: 1909-1938

<table>
<thead>
<tr>
<th>YEAR</th>
<th>MONMOUTHSHIRE</th>
<th>ENGLAND &amp; WALES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1909</td>
<td>104</td>
<td>109</td>
</tr>
<tr>
<td>1910</td>
<td>112</td>
<td>105</td>
</tr>
<tr>
<td>1911</td>
<td>149</td>
<td>130</td>
</tr>
<tr>
<td>1912</td>
<td>105</td>
<td>95</td>
</tr>
<tr>
<td>1913</td>
<td>115</td>
<td>108</td>
</tr>
<tr>
<td>1914</td>
<td>106</td>
<td>105</td>
</tr>
<tr>
<td>1915</td>
<td>128.5</td>
<td>110</td>
</tr>
<tr>
<td>1916</td>
<td>88.4</td>
<td>91</td>
</tr>
<tr>
<td>1917</td>
<td>84.3</td>
<td>97</td>
</tr>
<tr>
<td>1918</td>
<td>97.6</td>
<td>97</td>
</tr>
<tr>
<td>1919</td>
<td>88</td>
<td>89</td>
</tr>
<tr>
<td>1920</td>
<td>87.9</td>
<td>80</td>
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<tr>
<td>1921</td>
<td>91.5</td>
<td>83</td>
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<tr>
<td>1922</td>
<td>83.4</td>
<td>77</td>
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<tr>
<td>1923</td>
<td>73</td>
<td>69</td>
</tr>
<tr>
<td>1924</td>
<td>75.6</td>
<td>75</td>
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<td>1925</td>
<td>83.8</td>
<td>75</td>
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<tr>
<td>1926</td>
<td>66.1</td>
<td>70</td>
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<tr>
<td>1927</td>
<td>87.3</td>
<td>69</td>
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<tr>
<td>1928</td>
<td>72.3</td>
<td>65</td>
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<tr>
<td>1929</td>
<td>67.7</td>
<td>74</td>
</tr>
<tr>
<td>1930</td>
<td>64.9</td>
<td>60</td>
</tr>
<tr>
<td>1931</td>
<td>71.9</td>
<td>66</td>
</tr>
<tr>
<td>1932</td>
<td>67.7</td>
<td>65</td>
</tr>
<tr>
<td>1933</td>
<td>71.7</td>
<td>64</td>
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<tr>
<td>1934</td>
<td>57.4</td>
<td>59</td>
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<tr>
<td>1935</td>
<td>61.4</td>
<td>57</td>
</tr>
<tr>
<td>1936</td>
<td>61.7</td>
<td>59</td>
</tr>
<tr>
<td>1937</td>
<td>63.9</td>
<td>58</td>
</tr>
<tr>
<td>1938</td>
<td>55.8</td>
<td>53</td>
</tr>
</tbody>
</table>

**Sources:**
## Appendix 7

**Maternal Mortality Rates for Monmouthshire: 1921-1938**

<table>
<thead>
<tr>
<th>Year</th>
<th>Puerperal Fever / Sepsis Deaths</th>
<th>Other Causes</th>
<th>Total Maternal Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>1921</td>
<td>13</td>
<td>29</td>
<td>42</td>
</tr>
<tr>
<td>1922</td>
<td>14</td>
<td>33</td>
<td>47</td>
</tr>
<tr>
<td>1923</td>
<td>9</td>
<td>29</td>
<td>38</td>
</tr>
<tr>
<td>1924</td>
<td>10</td>
<td>23</td>
<td>33</td>
</tr>
<tr>
<td>1925</td>
<td>8</td>
<td>18</td>
<td>26</td>
</tr>
<tr>
<td>1926</td>
<td>7</td>
<td>22</td>
<td>29</td>
</tr>
<tr>
<td>1927</td>
<td>8</td>
<td>29</td>
<td>37</td>
</tr>
<tr>
<td>1928</td>
<td>15</td>
<td>22</td>
<td>37</td>
</tr>
<tr>
<td>1929</td>
<td>21</td>
<td>27</td>
<td>48</td>
</tr>
<tr>
<td>1930</td>
<td>14</td>
<td>20</td>
<td>34</td>
</tr>
<tr>
<td>1931</td>
<td>9</td>
<td>24</td>
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</tr>
<tr>
<td>1932</td>
<td>8</td>
<td>25</td>
<td>33</td>
</tr>
<tr>
<td>1933</td>
<td>1</td>
<td>39</td>
<td>40</td>
</tr>
<tr>
<td>1934</td>
<td>2</td>
<td>33</td>
<td>35</td>
</tr>
<tr>
<td>1935</td>
<td>13</td>
<td>23</td>
<td>36</td>
</tr>
<tr>
<td>1936</td>
<td>16</td>
<td>19</td>
<td>35</td>
</tr>
<tr>
<td>1937</td>
<td>8</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td>1938</td>
<td>13</td>
<td>25</td>
<td>38</td>
</tr>
</tbody>
</table>

Sources: MCC, MCWC *Annual Reports*

1924, 1927 and 1928 on p.8 of the Annual Reports.
1929, 1930 and 1931 on p. 13 of the Annual Reports.
1933, 1934, 1936, 1937 and 1938 on p.10 of the Annual Reports.
Appendix 8

Map of Monmouthshire

Source: Monmouthshire County Council (1954) County Development Plan (Part 1)
County Area: Report of Survey and Analysis (Pontypool: Hughes and Sons)
INTERVIEWS CONDUCTED AND LETTERS RECEIVED

INTERVIEWS

Blaen-y-Pant Residential Home, Bettws, Newport, Gwent.

19 May 1993

Mrs. M.T.  Mrs. D.S.
Mrs. I.M.  Mrs. E.W.
Mrs. O.T.  Mrs. E.L.
Mrs. E.G.  Mrs. L.L.
Mrs. D.L.  Mrs. L.P.

Mill Heath Residential Home, Bettws, Newport, Gwent.

8 October 1994

Margaret, Phyllis, Mavis and Sissy. No surnames were given.

Pant y Celyn, Bettws, Newport

14 December 1994

Mrs. C.  Mrs. R-M.
Mrs. M.  Mrs. H.
Mrs. T.  Mrs. M.

Mavis - no surname given.

Baker Street House, Blaenavon.

March, 1989

Mrs. E.B. and Mrs. D.S.
Mrs. J's Home in Saundersfoot, Pembrokeshire

6 February 1993

Mrs. G.J., A.J., Mrs. L.B. and Mrs. E.G.

Interviewees' Homes in Gwent

1989-1996

Mrs. L.B., Malpas, Newport.
Mrs. F.G., Cwmbran.
Mr. R.P., Cwmbran, formerly Cwmavon near Blaenavon.
Mr. and Mrs. B.L., Cwmbran.
Mrs. N., Cwmbran.
Mrs. G., Cwmbran, formerly Miss G.M. of Blaenavon.

Informal Discussions

Special thanks to the members of the Local History Class, particularly Don, Pauline, Ron and Barbara at the Blaina Institute at which I was a tutor in 1992 and 1993. We had many interesting discussions which offered me a further insight into women's health and family life in the early- to mid- twentieth century in Nantyglo and Blaina.

The Sunshine Coast Welsh Society based on the Sunshine Coast of Queensland, Australia, had a number of meetings which I attended, following my emigration to that area in 1997. Many of the members shared with me their experiences in Wales.
before emigrating to Australia, which again was helpful. Special thanks also to Mr. and Mrs. O’Neill of Mount Coolum, Queensland, Australia, formerly of Blaina, Gwent, for their memories concerning Blaina and Nantyglo in the 1930s.

**Letters Received**


Mrs. B. L., Community Midwife, St. John’s, Worcester. May 1993.


Mrs. A. C., Newport. February 1993.


Mrs. V. C., Beaufort, Ebbw Vale, ref. her mother, Mrs. E. L. January 1993.

Mr. T. L., Coolum Beach, Queensland, Australia, ref. his mother and grandmother in Wales in the 1920s and 1930s. November 1996.

Mrs. C. D., Brisbane, Queensland, Australia, ref. her mother in Wales 1928 and 1936. December 1996.
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(Includes some Parliamentary Papers of national importance)

Articles of Co-partnership Surgeon and man-midwife, Chepstow, (1792) D25.1080
Articles of Co-partnership Surgeon and man-midwife, Chepstow, (1813) D25.1034
Apprenticeship Indenture for man-midwife at Usk, (1841) D43.4270
Apprenticeship Indenture for man-midwife at Monmouth, (1850) D10.303

Monmouthshire County Council (MCC), Public Health Department,
Report upon Maternity and Child Welfare Annual Report for 1918 and Annual Reports up to and including 1938.


MCC, Public Health and Housing Committee Volume 1 (1911-1920) up to and including Volume 3.

MCC, County Medical Officer (CMO), Annual Report for 1909

MCC, CMO, Annual Report for 1913 and Annual Reports up to and including 1938.

MCC, CMO, (1914) A Resume upon Infant Mortality and the Notification of Births Act, 1907

MCC, CMO Report on the Sanitary Conditions of Blaenavon 1909 C.Misc.14 and 1913 C.Misc.18


MCC, Register of Midwives Practising in the Administrative County of Monmouth at 31 December 1914 C. Misc. R. 25

Report of the County Medical Officer on the Co-ordination of Medical and Nursing Services (1919) C.Misc.R.37

MCC, Midwives’ Act 1936 C. Misc. R. 0059

Rural Midwives Ledger (1937-1948) D.98.2


A Study of the Trend of Mortality Rates in Urban Communities of England and Wales with special reference to 'depressed areas'. (1938) C.Misc.R.532

Research Committee of the Joint Council of Midwifery (1939) Interim Report on the Nutritional Experiment in Special Areas (PP) C.Misc.R.82

Records of the Monmouthshire Nursing Association (MNA) 1922-1952 D98. MNA1- MNA12 Various reports and papers.


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Ministry of Health (1938) 19th Annual Report (PP) C.Misc.R.79

Ministry of Health (1939) 20th Annual Report (PP) C.Misc.R.87

LGB, Public Health Annual Report of the Chief Medical Officer of Health (PP) C.Misc.R.493 (1928) .510 (1933) .511 (1936)

Abercarn Urban District Council (UDC), Minute Books A.210.A.M.3 (1898) in sequence up to .29 (1940) Various entries.


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Abertillery UDC Minute Books A.310.A.M.8 (1898) in sequence to .20 (1914)
Clerks Out-Letter Books can also be informative concerning the district. See A.310.A.C.000012 for 1900 and then in sequence for following years.

Abertillery and District Hospital *Minute Book* (1916-1922) D.913.1 *Minute Book* (1923-1925) D.913.2 in sequence to .6 (1937-39)


Bedwellty *Register of Unfit Houses under the Housing Act of 1930* (1934-37) A.220.A.B.6

Bedwellty *Report on the Sanitary Circumstances* ... (1910) A.220.G.R.1

Bedwellty Board of Guardians Minute Books (1897-1930) C.SW.BG.B.M1.10 for 1897 in sequence up to .38 for 1930. Selected reports give an indication of the extent of poverty in the district.

Bedwellty UDC *Minute Books* A.220.A.M.4 (1902-3) and various Books in sequence up to .62 and .63 (1938-39). Selected entries offer an overview of the state of health, housing and sanitation in the district.

Blaenavon UDC *Minute Books* A.410.A.M.9 up to .39

Blaenavon UDC *Notices of Local Government Inquiries* 1877-1913 A.410.A.C.000551

Blaenavon UDC *Housing Committee Reports* (1918-1923) A.410.C.000645 includes letters from council house tenants.


Blaenavon *Census 1911* A.410.A.C.000628

Blaenavon UDC *Newspaper Cuttings Book* (1909-1928) A.410.A.C.13 up to .18

Chepstow UDC *Minute Book* (1913-1919) A.530.M.7 and Minute Books up to .13 (1935-1943)

Chepstow UDC, *Annual Report of the Medical Officer of Health* (1937) A.530.G.R2.3

Chepstow UDC *Inspection of Dwelling Houses* (1910-1911) A.530.B.3

Chepstow Rural District Council (RDC) Minute Book (1911-1918) A.540.A.M.2 and Minute Books in sequence to .7 (1934-1941)

Chepstow RDC, Annual Report of the Medical Officer of Health (1920) A.530.G.R2.1 and Annual Reports up to .21 (1940). The 1937, 1939 and 1940 report includes the UDC reports.


Ebbw Vale UDC Minute Book 1899-1901 A.330.A.M.1 and in sequence up to 1938-1939 A.330.A.M.37


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Nanterderry Hostel for Unmarried Mothers, Annual Report for 1918 up to 1938.

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Newport County Borough (NBC) Health Department Publications M160.614
Hints for the Busy Housewife (1927)
Hints to the Expectant Mother on her Health (1934)
Hints on the Management of Children 1-5 Years (1937)
To Mothers and Fathers (1937) How to Rear Baby (1937)

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Blaenavon UDC Annual Reports of the Medical Officer (1928-1938) pM250.614

Additional Parliamentary Papers and Other Official Documents

Report of the Select Committee on the Midwives Registration Bill (1890) Report of the... and Minutes of Evidence (1892), (1893-94) See also Midwives’ Bills 1896, 97,98,99 and Standing Committee on Law Courts of Justice and Legal Procedure Report on the Midwives Bill (1900)

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Report of the Inter-Departmental Committee on Physical Deterioration (1904) Cd 2175
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Royal Commission on Divorce and Matrimonial Causes (1912-1913) Minutes of Evidence Cmd 6478 and Cmd 6480


LGB (1913) Annual Reports of the Central Midwives Board 1912-1913 Cd 6061

LGB (1916) Annual Reports of the Central Midwives Board 1914-1916 Cd 7764

LGB (1937) *Maternal Mortality in Britain* Cmd 5222

LGB (1937) *Maternal Mortality in Wales* Cmd 5423

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*Report* (1911) Cd 5505

*Report* (1912) Cd 6061

Ministry of Health (Min. H) (1921) *Second Report of the Welsh Consultative Council on Medical and Allied Services in Wales* Cmd 1448

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**Contemporary Newspapers and Journals**

Full details of the specific editions used for the thesis are mentioned in the relevant Chapter Notes. Random research for the years 1870 to 1938 was conducted, particularly for the British Medical Journal, Lancet and the Free Press of Monmouthshire.

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