CHAPTER XIX

MATERNITY AND CHILD WELFARE

WITHIN the last dozen years there has been added to the vast and varied work of the Public Health Department a huge new sphere of effort—that concerned with the welfare of the mother and her infant child. The awakening of the public to the necessity for such service and its consequent recognition in enactments by Parliament was in no small measure due to the revelations of recruiting during the war,[1] supported as they were by vital statistics which showed in 1900 an infantile mortality of 154 per 1,000 births and a maternal mortality of 4·81 per 1,000 births. It is true that by 1914 these rates had been reduced to 105 and 3·56,[2] but the civic conscience was aroused and, supported by national fears, an administrative organization, for which voluntary effort had shown the way, was rapidly organized and built up with a view to a further reduction of these figures.

Before the end of the last century efforts at alleviating maternal and infantile suffering and reducing the mortality had been commenced in various directions, largely by or under the influence of voluntary organizations; and health visitors were authorized for the metropolis under the London County Council (General Powers) Act, 1908. But any solution of the problem involved obviously depended upon three conditions, neither of which was in existence in the early years of this century. These conditions were: (1) a prompt knowledge of all births; (2) the existence of staffs

[1] C. Porter, M.D., B.Sc., in *The Future Citizen and His Mother*, pp. 1 and 2.
[2] Annual Report of the Chief Medical Officer of the Ministry of Health, 1925, p. 119.

with adequate training; and (3) facilities for the provision of advice, instruction, and treatment where necessary. During the past twenty years legislative and administrative activity have been directed to securing these conditions.

The Notification of Births Act, 1907, required, in the areas for which it had been adopted, the notification by the father or person in charge of the mother, of the birth of any child within thirty-six hours of such birth. Councils of counties and of county districts could adopt the Act, the former for the whole or part of the county.[1] In 1915, experience where the above Act had been adopted being favourable, the Act was put in force in every district, the central authority retaining the power to substitute the county council for the district council, or vice versa.[2] Two further important steps were also taken. Local authorities, i.e. county councils and urban and rural district councils, were empowered to exercise any powers under the Public Health Acts as might be required for the purpose of the care of expectant mothers, nursing mothers, and young children,[3] and such powers could be exercised by a committee which had to include women and which might comprise persons who were not members of the authority.[4]

The foundations thus laid were somewhat elaborated by the Maternity and Child Welfare Act, passed in 1918. Any local authority within the meaning of the Notification of Births Act, 1907, is empowered to make such arrangements as may be sanctioned by the Ministry of Health "for attending to the health of expectant mothers and nursing mothers, and of children who have not attained the age of five years and are not being educated in schools recognized by the Board of Education.[5] The last proviso prevents overlapping with the school medical service. To exercise these powers every council acting under this Act or the Notification of Births (Extension) Act, 1915 (Section 2),

[1] Section 1.
[2] Notification of Births (Extension) Act, 1915, Sect. 1.
[3] *Ibid.*, Sect. 2/1.
[4] *Ibid.*, Sect. 2/2.
[5] Maternity and Child Welfare Act, 1918, Sect. 1.

must establish a maternity and child welfare committee, which may be an existing committee or a sub-committee of an existing committee, and, whilst at least two-thirds of its members must be members of the authority, two at least must be women, and some may be non-members specially qualified by training or experience in subjects relating to health and maternity. Obviously where there are no women on the council the "may" becomes "must" as regards non-members. To this committee all matters relating to the exercise of the powers of the council under the Act or under the Notification of Births (Extension) Act, 1915 (except raising a rate or borrowing money), must be referred, and the council, unless the matter is urgent, must receive and consider the report of the committee before taking any action.[1]

There is thus no lack of power, where there is the will, for any authority to contribute to the reduction of a mortality which hygienic science shows to be far too high. It is not obligatory upon any authority to exercise these powers, but there were at the end of 1927 in England and Wales 419 authorities, comprising 60 county councils, 83 county borough councils and 276 councils of county districts administering schemes under the Maternity and Child Welfare Act.

Such schemes, to be complete, would include the following services [2] towards the approved net expenditure on which the Ministry of Health has power to make grants up to 50 per cent. :—

(I) *Medical Supervision.*—This includes supervision by the medical officer of health with such medical assistance as may be necessary.

(II) *Health Visitors*, whose duties include attendance at centres and the visiting of children under five years of age at their homes.

(III) *Nurses.*—The provision of nursing under the Maternity and Child Welfare Act is in practice limited to the following diseases and conditions :—

Maternity, puerperal fever and pre-natal cases in women, ophthalmia neonatorum, measles, whooping-cough, epidemic diarrhœa, and poliomyelitis in children.

(IV) *Provision of Midwives.*

(V) *Centres.*—These include :

(*a*) *Ante-Natal Centres*, providing medical supervision and advice to expectant mothers.

(*b*) *Infant Consultation Centres*, whose essential function is the supervision of healthy children rather than the treatment of the sick, although provision may be made for the individual treatment of simple ailments.

(*c*) *Treatment Centres* (including dental clinics).

(VI) *Maternity Homes and Hospitals.*

(VII) *Infants' Hospitals.*

(VIII) *Convalescent Homes.*

(IX) *Homes for Mothers and Infants.*

(X) *Homes for Children.*

(XI) *Day Nurseries* (for the care of healthy infants and young children whose mothers are obliged to engage in daily work which takes them away from their own homes).

(XII) *Home Helps* (for providing domestic assistance to mothers during the period of childbirth).

(XIII) The provision of milk and food for expectant and nursing mothers and young children in necessitous cases.

As is to be expected from the permissive character of the Act and the widely differing requirements and financial standing of the various authorities, there are wide variations in the schemes as regards both their efficiency and comprehensiveness. Where a county district is in default the Ministry of Health may, on the application of the county council, transfer the powers of the former to the latter, and

[1] Maternity and Child Welfare Act, 1918, Sect. 2.

[2] Memorandum of Evidence submitted by the Ministry of Health to the Royal Commission on Local Government, par. 191.

since the passing of the Notification of Births Act, 1907, the powers of 616 district councils have been so transferred; and, on the other hand, seven county district councils (five borough and two urban) have had the powers transferred from the county council to them.[1] The Ministry of Health has the further power of approving or otherwise the schemes submitted by local authorities, and as such approval carries with it a grant of 50 per cent. of the cost of the approved service an effective stimulus to efficiency is provided for those local authorities who take their responsibility seriously.

On March 31st, 1927, there were in England 2,324 maternity and child welfare centres known to the Ministry of Health. Of these 1,489 were conducted by local authorities and 835 by voluntary agencies, some of the latter receiving grants indirectly through the local authorities within whose areas they operated. In addition to 52 special centres for ante-natal work, there were 720 centres in connection with which ante-natal consultations were held, and 670 where arrangements for dental treatment were made.[2] At the centres advice and teaching is given to mothers in regard to the care and feeding of their children and the care of their own health, and arrangements made to ensure regular medical supervision of the children's health.

An important feature of the work of the maternity and child welfare committee is the provision of maternity beds for complicated cases, and for those whose domestic circumstances are such that safe confinement at home is impossible. Over 250 authorities have made some arrangements of this nature, and there are 2,290 maternity beds in 149 institutions, 81 of the institutions being provided by voluntary associations, many of which are assisted by the local authorities. In addition, there are 105 homes for mothers (chiefly unmarried) and their babies, with accommodation for 1,490 of the former and 1,327 of the latter; and 38 homes, including residential nurseries for children under five, the

[1] Memorandum of Evidence submitted by the Ministry of Health to the Royal Commission on Local Government, par. 191.
[2] Eighth Annual Report of the Ministry of Health, pp. 51–2.

number of children for which accommodation is available being 965. For ailing babies there are 39 observation wards and homes containing 719 cots, whilst convalescing mothers and their babies and children under five years have 802 beds in 48 homes provided for their reception.[1]

In two directions effort is as yet scarcely beyond the experimental stage. Considerable interest is being shown in the application of artificial light treatment to various forms of disease and in orthopædic treatment for various physical defects and diseases in children under school age other than those suffering from surgical tuberculosis. Knowledge of artificial light treatment is not sufficiently advanced for its indiscriminate adoption, and the Ministry of Health is only prepared to sanction its provision, otherwise than by the light department of a hospital, in cases where there is available a medical officer and nurse with special training and experience. Forty-seven such centres, of which twenty-three are provided by voluntary agencies, have been sanctioned,[2] whilst in the case of orthopædic treatment the arrangements made by 24 county councils, 19 county borough councils and 25 other maternity and child welfare authorities, with an expenditure of £29,000, have been approved.[3]

The importance of milk to nursing mothers and young children, and the difficulty those of the poorer classes have in securing a sufficiency of this essential food, has led to a wide development of the provision of milk at less than cost price to expectant and nursing mothers, and children under five years. This provision is not intended to relieve distress, but only for such as are certified to need it on medical grounds, a distinction difficult to maintain in practice, a fact which probably accounts for the net expenditure of £188,000 in 1925–6 by local authorities on this service.[4]

The economic circumstances of many mothers of young children are such as to oblige them to go out to work. Public opinion has not yet reached the point of making

[1] Eighth Annual Report of the Ministry of Health, p. 53.
[2] *Ibid.*, p. 52. [3] *Ibid.*, p. 53. [4] *Ibid.*, p. 54.

provision to enable such mothers to leave industry and devote themselves to their natural function—the care of their children; but in maternity and child welfare schemes provision of day nurseries, where such children may be cared for whilst their mothers are at work, may be made. Since the war, when the need was greatest, the number of such nurseries has diminished, but there are still 100, of which 81 are provided by voluntary organizations, and these meet a very real need.[1]

Of special concern in the cases of mothers and their newborn children are the diseases of puerperal fever, puerperal pyrexia and ophthalmia neonatorum, all of which are notifiable.[2] Notification is the precedent necessary to treatment which may be provided for in maternity and child welfare schemes.[3] In the case of puerperal pyrexia such provision may take the form of consultation with an obstetric specialist, of skilled nursing, or of institutional treatment, and arrangements have been made by 162 local authorities for one form or another of these.[4] The duty of notifying ophthalmia neonatorum now rests solely upon medical practitioners, but midwives must (1) call in medical aid in any case of inflammation or discharge from the eyes, and (2) notify the supervising authority under the Midwives Acts that such aid has been sought. Where the local sanitary authority is not the maternity and child welfare authority the medical officer of health of the county must receive such notification within twenty-four hours of its receipt,[5] and adequate treatment of such cases by visiting and home nursing or in hospital may be provided.

The medical profession has long had a definite status, and no one may practise as a doctor unless he or she has a legally recognized medical qualification. It was not, however, until 1902 that any steps were taken to ensure that persons performing the important function of midwifery

[1] Eighth Annual Report of the Ministry of Health, p. 52.
[2] See Chapter XVI.
[3] Ministry of Health Circulars, 617, 617A and 722 of 9/8/26.
[4] Eighth Annual Report of the Ministry of Health, p. 50.
[5] Public Health (Ophthalmia Neonatorum) Regulations, 1926.

were required to possess some token of training and knowledge. The Midwives Act of that year established county and county borough councils as supervisory authorities over midwives, who were thereafter to qualify by passing an examination of a Central Midwives Board. Provision was made for special training for six months of trained nurses and for twelve months of others. Centres receive grants-in-aid[1] both for ordinary courses of training and for post-certificate courses from the Ministry of Health, and, since the passing of the Act of 1918,[2] the local supervising authorities may aid such training and make grants for the purpose. There are 73 such institutions recognized by the Ministry, and grant was paid as regards 817 pupil midwives, and also in respect of midwives attending post-certificate courses at four approved institutions.[3]

A further step towards ensuring skilled treatment at childbirth was taken in 1926,[4] when the registration of maternity homes was required and may be refused on the grounds either of unfitness of the person or of unfitness of the place. The Act also empowers local authorities to make bye-laws in respect to records to be kept at, and for the notification of any death in such homes, and provides for entry at all reasonable times to inspect the premises and examine records.

During 1925 midwives to the number of 16,282 gave notice of their intention to practise in England and Wales,[5] but the number practising, largely owing to duplication of notification, is certainly much less. Very many of these work under the direction of District Nursing Associations, which also undertake much health work for county councils, especially in scattered and sparsely populated areas. To increase the supply of trained midwives the Ministry of Health has approved the contributions of 36 county

[1] See Memorandum 102/MCW of the Ministry of Health, February, 1925.
[2] Midwives Act, 1918, Sect. 11.
[3] Eighth Annual Report of the Ministry of Health, p. 49.
[4] Midwives and Maternity Homes Act, 1926.
[5] Eighth Annual Report of the Ministry of Health, p. 47.

councils to county nursing associations in respect of such provision.[1]

The importance of the legislation just outlined is evident from the fact that 59 per cent. of the births in England were notified by midwives,[2] and that upon them, therefore, in no small degree, devolves the responsibility for maternal mortality. Since, however, their training is not equal to that of a medical practitioner they are, in certain circumstances, required to call in medical aid, payment for which is guaranteed by the local authority, which may recover from the patient where possible.[3] Such fee is often a great strain upon the resources of people with limited incomes and, recognizing this, Parliament has empowered local authorities to make arrangements whereby expectant mothers can insure against such liability,[4] and several authorities have such schemes in operation.[5]

There are many cases of maternity where the family is in such poor circumstances that the skilful work of the midwife may be rendered nugatory and the recovery of the patient retarded by the lack of capable help in the home. To meet such necessity some authorities employ specially selected and approved women to assist in the homes of certain necessitous lying-in women. This work is closely supervised by the health visitor, and, when properly done, is of great value in facilitating the speedy recovery of the housewife and preventing the neglect of the family.[6]

The earliest official concerned in the work of maternity and child welfare was the health visitor, and these now form the most numerous and ubiquitous class. The importance of their work and the necessity for their skilled training has been emphasized by the Ministry of Health, to which the responsibility for their training has been transferred from the Board of Education. Since April 1st, 1928, the Ministry

[1] Eighth Annual Report of the Ministry of Health, pp. 48–9.
[2] *Ibid.*, p. 47.
[3] Midwives Act, 1918, Sect. 14.
[4] Midwives and Maternity Homes Act, 1926, Sect. 2 (3).
[5] Eighth Annual Report of the Ministry of Health, p. 51.
[6] See the Medical Officer of Health's Report for West Ham, 1927, for a good outline of maternity and child welfare work in a large town.

will not approve the appointment for the first time as a whole-time officer on health visiting duties of anyone who does not hold the Health Visitors' Certificate or the diploma given under the Regulations of the Board of Education. The new certificate can be obtained only by (1) trained nurses with the C.M.B. (certificate of the Midwives Board) after an approved course of training in the duties for six months; (2) women who have had an approved course of training of two years' duration, together with six months' hospital training, and who hold the C.M.B.; and (3) existing health visitors with three years' satisfactory service.[1] The financial difficulties of training are overcome either by the advance of salary during training or by employment as probationer health visitors at a salary of not more than 75 per cent. of the ordinary commencing salary. There are eight institutions approved for training, and thirty-nine of the fifty-seven students who completed training during the year 1926–7, together with fifteen existing health visitors, obtained the new certificate.[2]

The net expenditure of local authorities upon maternity and child welfare services in 1925–6 was £1,347,850; and during the following year the Ministry of Health paid by way of grants-in-aid £699,847 to local authorities and £209,797 to voluntary societies for the same purpose.[3]

During the first quarter of this century there has been a steady decline of the infantile death-rate (154 per 1,000 births in 1900; 70 in 1926), and a smaller decline in maternal mortality (4·81 per 1,000 births in 1900; 3·86 in 1925).[4] The former is evidence of the good effect of the increasing attention devoted to the child. The latter, which shows that one out of 250 mothers died in childbirth, is "a terrible thing."[5] The Minister of Health is very much alive to the urgency of this problem, and a Maternal Mortality Com-

[1] Ministry of Health's Circular 879 (Health Visitors), March, 1928.
[2] Eighth Annual Report of the Ministry of Health, p. 47.
[3] Eighth Annual Report of the Ministry of Health, pp. xxvi. and 46.
[4] Annual Report of the Chief Medical Officer to the Ministry of Health, 1925, p. 119.
[5] The Right Hon. Neville Chamberlain, Minister of Health, in the House of Commons, May 15, 1928.

mittee has been set up to collate the results of investigations in every area by competent and experienced medical officers of all cases of puerperal fever with a view to determining actual causes leading to maternal mortality. On the other hand, believing that midwifery was "a hard and arduous profession, not well paid," and that if they could get "the class of woman wanted to enter that profession—an educated, humane, sympathetic, earnest woman—the conditions of the service must be made more attractive,"[1] the Minister of Health has, with the concurrence of the Central Midwives Board, appointed a Departmental Committee "to consider the working of the Midwives Acts, 1902 to 1926, with particular reference to the training of midwives (including its relation to the education of medical students in midwifery) and the conditions under which midwives are employed."

[1] The Right Hon. Neville Chamberlain, Minister of Health, in the House of Commons, May 15, 1928.

SPECIMEN CARD USED BY HEALTH VISITORS

SURNAME..... | ADDRESS..... | Date of Birth.....

Other Names (Infant)..... (Father).....

Attended by..... Visited by.....

Method of Feeding..... Advice given.....

Digestion and Bowels.....

Sleeping.....

Clothing.....

Bathing.....

Open Air..... Still Birth..... Misc. .....

Rooms Occupied..... Rent..... Total Cub. Capacity..... Adults.... | Children under 5 ..... 5 to 15 .....

Occupation of Father..... Where at..... Of Mother ?.....

Cleanliness of Rooms..... Of Yard..... Food Store .....

Sanitary Defects .....