

# THE CHILD WELFARE MOVEMENT

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## P R E F A C E

THIS work is intended to be a handbook for those who wish to understand something of the machinery for the conduct of work for Maternity and Child Welfare.

It makes no effort to be a comprehensive text-book on either Local Government or Child Hygiene in any of its branches. These matters form part of the framework of the book, but the aim has been to give only such aspects of both these subjects as appeared necessary for an intelligent understanding of the work under consideration.

The book has been written under pressure of other work, which has rendered much revision of the original manuscript impossible for lack of time. The subject-matter of the book has been dealt with for some time past in lectures to students of the Household and Social Science Department of King's College for Women. Now that the College is undertaking the training of health visitors under the recent Board of Education Regulations, a short text-book on matters with which all health visitors should be familiar seemed opportune, and the request to write a handbook served to supply the necessary stimulus. The opinions expressed have been formed primarily as a result of four years' work practically all over the country, when serving as Medical Inspector for Child Welfare under the Local Government Board.

It is believed that record has been made of opposing

views whenever there is known to be a definite school of thought of opposite tendencies.

It is usual, however, in life to find that the cause of divergence of views is due primarily to inadequacy of explanation. This arises especially in connection with Child Welfare work, when, for example, those with urban experience only, discuss matters with those working in rural districts. The conditions are so different in these areas as to justify apparently opposite views. When the district under discussion is specified, it will usually be found that any remaining difference of opinion is on unimportant matters only, or due to the fact that one side contemplates an ideal regardless of cost or feasibility, and the other envisages such development as may be capable of accomplishment under existing powers and conditions.

No attempt has been made throughout the book to deal with the work of the Poor Law Guardians, either under the Poor Law or under the Children Act of 1908. While theoretically, no doubt, many phases of their work fall under the general meaning of Child Welfare work, it is not included under what is ordinarily understood by this term.

Further, it is probable that the whole Poor Law system will now be short-lived, and as Public Health workers are not closely concerned with its working as at present carried out, it appeared unnecessary to deal with it.

The chapters on Local Government are inserted with the view of explaining certain points in the machinery, upon which information is not readily accessible.

They are not intended to form a treatise on Local Government as such.

I am indebted to St. Katharine's Royal College at Poplar, and to Dr. Harold Waller their Medical Officer, for permission to print samples of their record cards. To the Controller of His Majesty's Stationery Office for

permission to reproduce the Act and Circulars which form the subject-matter of Appendices III., IV., V. (A) and (B), and VIII. The documents are not printed by Authority.

Further, I desire to acknowledge with many thanks the permission given by the Medical Officers of Durham County, Hertfordshire, and Birmingham to reprint the subject-matter of Appendices VI. and VII.

I am also greatly indebted to Mr. H. O. Stutchbury, of the Ministry of Health, for kindly reading many of the chapters, especially those on Local Government, and for numerous valuable suggestions; and to Dr. Major Greenwood, who was good enough to read over the chapter on Infant Mortality.

J. LANE-CLAYPON.

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# THE CHILD WELFARE MOVEMENT

## CHAPTER I

### INTRODUCTORY

THE rapid growth of the child welfare movement has tended to the concentration of attention on the activities of the movement, so that the causes which led to the movement, and the principles underlying it are sometimes passed over by those engaged in the work.

In common with the initial phases of other movements, the cry for improvement in the condition of infants and children was made by a few pioneers many years before a sufficient impetus had been given to the work to secure its public discussion. It is probable that these pioneers did not themselves appreciate the greatness of the work they felt constrained to begin. Different methods were used in the several different countries, but the primary cause of the effort was the same in all—namely, an attempt to reduce the number of deaths among infants. There is no reason to suppose that the death-rate among infants was higher at any time during the nineteenth century than it had been in earlier times—on the contrary, such evidence as there is shows that in all probability the number of children who survived and reached adult life, as compared with those that died, was considerably lower in the preceding centuries. The number of both births and deaths was almost

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certainly less during the last half-century than previously. As civilisation progresses the value placed upon life is increased, and a high death-rate comes to be regarded as a blot on the nation and produces efforts to bring about its reduction. A reduction in the number of births appears also to be a natural accompaniment of advancing culture.

The keeping of accurate registers of births and deaths is comparatively recent in this country, and it is probable that, apart from a few of the smaller and more advanced European countries, only Great Britain, France, and Germany possess records which may be regarded as sufficiently accurate for all practical purposes. Even for these countries the figures dealing with similar matters cannot be compared with one another, since the bases of their preparation are not necessarily the same. Speaking generally, there is a close relationship between the vitality of a nation and its rate of increase. The rate of increase is clearly determined by the excess of births over deaths. Where the excess becomes very small, it behoves a nation to take active steps to preserve its future. In France, for many years before the war, there had been no appreciable excess of births over deaths and the population had remained almost stationary, but with a tendency to decrease. In other countries where figures are obtainable there was still a large excess of births over deaths, but the excess was diminishing fairly rapidly.

It was necessary either that there should be a reduction in the number of deaths or an increase in the number of births, or, in the opinion of some, both these changes should take place. The first efforts were made towards a reduction in the rate of mortality among infants. It is probable that many of those who took part in the beginning of the movement were actuated fully as much by philanthropic motives as by an appreciation of the need of the work. In France, however,

the early efforts were a direct response on a small scale to a known need, and the same must be said of the similar efforts of local authorities in this country. The aim was the prevention of preventable deaths among infants.

In England in the 'seventies and 'eighties the first efforts were directed to the visitation of infants in their homes. In France in the 'eighties, the movement commenced by encouraging breast-feeding among the mothers who were confined in a maternity hospital and by giving them suitable advice. The name of Professor Budin will always remain associated with this, the first infant consultation (*consultation des nourrissons*). The success achieved by this infant consultation led to the establishment of similar organisations for artificially-fed babies, and, in addition to the advice, a supply of good milk was provided either free or at a small charge. These institutions were known as *gouttes de lait*. It should be noted that medical advice was given to the mother as to the way she should feed her child with the milk. The provision of food for the hungry makes a powerful appeal to most people, but, as will be shown, the provision of milk for infants, without instruction as to the method of using it, does not produce the satisfactory results which had been anticipated.

Milk depots for the supply of milk, without, however, the medical advice, found some footing in this country. The first depot was opened at St. Helen's in 1889. Although certain of the depots opened rather later by Liverpool, Battersea, Lambeth, Leicester, and a few other boroughs are still open, for the most part they have been closed, or, as at St. Helen's, have become depots for the provision of dried milk when ordered by the medical officer of the infant consultation. (For further details see pp. 56 *et seq.*)

Belgium started in yet another direction and opened schools for mothers. During the early years of the

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present century the movement, as represented by one or more of the above methods of work, spread into the western nations of Europe. The progress became very rapid about the year 1906 and after. In this country, the local authorities developed home visitation, aided by the Notification of Births Acts of 1907, and a considerable number of them opened centres for infant consultations. At first many of the centres which were started in different places were supported and managed by voluntary agencies, and some home visiting was also undertaken by them. It is almost a practice in this country for voluntary effort to take the first steps in any new branch of work, and the country usually refrains from spending public money, either taxes or rates, upon experiments. As the movement has grown, the local authorities have continually taken over more of the work of the voluntary societies, who have either joined in with the official work of the district or have diverted their energies to new developments.

During the last ten years the general movement has spread widely, until, at the present time, there is hardly a country, however primitive, that is not stirred by the need for improving the condition of its children. The experience gained has led to the continual introduction of fresh branches of work and of new methods. Organisations have been started and grown with almost incredible rapidity until the varieties and complications of activities are almost bewildering.

The development of home visitation and work at the centre, whether by infant consultations or by schools for mothers, showed that new branches of work must be opened up if satisfactory results were to be obtained. The home visiting without work at the centre was proved to be insufficient, and the work at the centre required close co-ordination with the home visitation. This is necessary in order that the medical officer may be cognisant of the home conditions on the one hand,

and that the health visitor on the other hand may know the advice which should be given in carrying out her work in the home. The schools for mothers realised the need for medical advice in addition to their classes, and the infant consultations found it necessary to make arrangements for assistance for the mothers in regard to advice as to clothing and instruction in the care of infants generally.

At the same time that the work for infants was developing, the medical inspection of school children was introduced and its importance recognised almost at once. The inspection showed a deplorable condition of ill-health among children entering school, and brought into prominence the urgent need for supervision of children in the early years of life. It was, however, realised that care must be extended still further backwards and that many of the ailments arising in young children before they attend school have their origin in defects of health during infancy, which again in many cases are due to ignorance on the part of the mother or to unsatisfactory environment of one kind or another. There can be no question that the work of school medical inspection has afforded a very powerful stimulus to the child welfare movement.

Then, again, those concerned with the work soon discovered that if their efforts were to be effective it was not sufficient to deal with the child after birth. The care of the children before and at birth has been shown to be a most essential feature of the work, and this clearly involves the care of the mother. For some years past pre-natal work has been recognised as an essential feature of child welfare work. There are, however, certain inherent difficulties connected with it which have prevented the rapid expansion of the work.

Further, it has become increasingly evident that the care of the mother at the confinement is an immensely important factor in child welfare work. Such care



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brings the child welfare movement at once into close touch with those who are concerned in the practice of midwifery, and it is to be hoped that the co-operation necessary to secure the most satisfactory conditions for the infant and its mother may form a leading feature in child welfare work in the immediate future.

Investigations into the causes of infant mortality have shown the immense complexity of the problem of the prevention of infant deaths. The conditions of employment of the parent, the home conditions, general sanitation, feeding, etc., all play a part in the health of young children.

The child welfare movement has also brought into prominence the need for further curative measures in many directions. At the present time there appears to be a distinct tendency for the child welfare movement to expand on the curative side of medicine. It is perhaps not unnatural that there should be this tendency in view of the large amount of ill-health for which at present inadequate provision is made. At the same time, it should never be forgotten that child welfare work is essentially preventive: its object is to preserve the health of healthy infants, and to give such advice as may assist the mother in bringing up her child so as to avoid all unnecessary ailments or disease.

Preventive work is at all times more difficult, and in some ways less attractive than curative, but its importance can hardly be exaggerated: it is the essence of public health work.

Child welfare work should, however, be linked up with curative measures, since all disease cannot be prevented, and adequate treatment is necessary to secure a return to health. The various activities and their relationship to other agencies will be considered fully under separate headings in subsequent chapters. It may safely be said that at the present time no

country is so fully covered by organisations for child welfare as England and Wales, and in no other country have the State and the local authorities together produced such complete arrangements for carrying out improvements in the health of the children of the nation.

While much was being done before the war, under the pressure of that upheaval undreamed-of developments have occurred. The country is still assimilating the lessons learned in the furnace, and the time to strike is when the iron is hot. It behoves us to increase our efforts, and to fill up the gaps in our organisations and in our knowledge. There is much ignorant talk and loose thinking on child welfare work in all its branches. It does not perhaps impede the progress of sound work, but, if only the energy thus employed were directed on informed lines, it is impossible to say how greatly it might assist.

Certain aspects of information have not been readily accessible hitherto. This book will be only one of many, but it is hoped that it may prove a slight addition to the literature upon the subject, and may at least aid the rising generation in their efforts to learn about the needs of their fellow-citizens.

## CHAPTER II

### ON NOTIFICATION OF BIRTHS IN RELATION TO CHILD WELFARE

The early workers in the cause of infant welfare found themselves face to face with a grave difficulty at the very commencement of their work. This difficulty lay in the absence of information as to the whereabouts of the infants who were to be the objects of assistance.

The workers set before themselves the prevention of infant mortality by means of advice as to the care of the infant and the improvement in the general conditions of the home.

There were two methods of finding the homes where babies had been recently born—the one by direct house-to-house visitation, and the other by applying to the Registrar of Births.

Up to 1837 there had been registers of baptisms kept in the various churches and chapels, but these records were admittedly far from being complete. In this year the registration of all infants within forty-two days after their birth became obligatory on the parent.

The Manchester and Salford Ladies' Health Society seems to have been the pioneer agency in child welfare work. The society was founded in the 'sixties by ladies who were impressed with the unhealthy conditions of the poorer homes. They did not themselves undertake the visiting, but employed other women to do this. These were untrained, but at that time there was little in the way of training which could be taken by women. The towns were divided into districts, and

each worker visited in her own district. It was, however, soon realised that the method of house-to-house visitation involved much loss of time and energy since in many houses there were no infants, and the society was concerned with infants only.

After a while it was arranged that the Registrar of Births should supply to the society lists of the births registered in order to reduce the difficulty. The registration is confidential, and special permission from the Registrar-General was necessary to secure the information. Even then, however, it was found that in quite a number of cases the child had died, or its parents had removed from the neighbourhood before it was possible to visit.

Some years later other towns in Lancashire appointed women who had been trained as sanitary inspectors to undertake similar work on similar lines. These women carried out much valuable work, but it was impossible to cope with the problem with any real effect, so long as the whereabouts of the children were not more accurately known.

It was realised that a more effective method of dealing with the position must be introduced, and that something must be done to secure notification of the homes where infants had been born at an earlier period of their lives than that compulsory for registration.

The first effort at notification of births seems to have been made in Salford in 1889. In that year the medical officer of health asked all the midwives practising in the district to notify to him at once the names and addresses of the women they attended. This information was then passed on to the visitor for the district. In 1906 Huddersfield obtained parliamentary powers for the compulsory notification of births to the medical officer of health.

This was followed in 1907 by the passing of the first Notification of Births Act, introduced by Lord Robert

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Cecil as a private Bill. The measure was taken over by the Government of the day and passed into law under the guidance of Mr. John Burns, then President of the Local Government Board.

This Act was an adoptive Act, and must be distinguished from the Notification of Births (Extension) Act of 1915, which is considered later.

The Act of 1907 permitted Local Authorities to adopt a system of compulsory notification of births, subject to the consent of the Local Government Board.

The Notification of Births Act might be adopted by any Local Authority. Such local authorities are county boroughs and counties, other boroughs, including Metropolitan boroughs, urban and rural district councils. (Cf. Chap. XXII.)

The detailed procedure was as follows :—The adoption being decided upon by the council (usually on the recommendation of the health committee), the town clerk applied to the Local Government Board for permission to adopt the Act. The permission was at first given only if the Board were satisfied that provision was being made to utilise the information obtained by home visitation, and after such proposals had been duly advertised in the local papers. These conditions being satisfied, the Local Government Board, with the concurrence of the local authority, fixed the date on which the Act would come into force.

Although the Act gave power to the county councils, except the London County Council, to adopt the Act, the Local Government Board did not at first encourage these authorities to undertake the work. It is, however, precisely in the scattered districts which are found in country areas that the work is most difficult to carry out. A number of smaller districts were willing to do something to improve the condition of the babies born in their area, but were unable or unwilling to employ

some one specially for this purpose. Events have shown that the county council is the proper authority to take on the work, at all events for the less populated areas within its boundaries. A few county councils, notably Warwickshire and Worcestershire, who were most determined to get the work started, succeeded in persuading all the districts within their purview to adopt the Act, and then to arrange with the county council to do the work. This policy did not, however, tend to promote the adoption of the Act in rural areas, and after a few years it was found necessary to secure the adoption of the Act by county councils wherever possible.

When adopted and in force, the Act required the parent, or any other person present at the birth, or in attendance upon the mother within six hours after the birth of the child to notify, within thirty-six hours, the occurrence of the birth to the medical officer of health for the district. Failure to notify might involve a penalty not exceeding £1.

Notification is required of all viable children whether alive or dead, that is, of all children born after the twenty-eighth week of pregnancy.

It is important to note that the duty of notification was primarily laid upon the parent, because it has often been contended that the duty was laid upon the doctor or the midwife in attendance, and great objection raised to the absence of a professional fee for notification.

The error has no doubt arisen from the fact that doctors and midwives are the only persons authorised by law to attend births, and are registered and known. It is therefore easier to draw the attention of doctors and midwives to the requirements of the Act than to inform the parents. Moreover, the Act provides that notification forms shall be provided by the local authority free of charge and prepaid for the post so as to avoid any expense to the person notifying.

As it would be impossible to send one to the parents,

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who are not known beforehand, it was evidently necessary to send the forms to the doctors and midwives, who could then either hand the form to the parent or fill it in themselves. The notification form is either a folder or a postcard addressed to the medical officer of health. A sample folder is shown below.

### THE ROYAL BOROUGH OF KENSINGTON.

#### NOTIFICATION OF BIRTHS ACT, 1907.

No. 3552.

*I hereby give you notice of the birth of a child \* at*  
(Address) .....  
*State whether born alive or dead.* .....  
*Sex* ..... *Date of Birth* .....  
*Name of Parent* .....  
*Parent's occupation* .....  
*Name and address of the person giving the notice.* .....  
.....  
*Doctor's Name* .....  
*Midwife's Name* .....  
*Date of Notice* .....

\* This notice applies to any child born "after the expiration of the twenty-eighth week of pregnancy, *whether alive or dead.*"

#### NOTIFICATION OF BIRTHS ACT, 1907.

##### SUMMARY OF THE PROVISIONS OF SECTION ONE.

The "duty" of notifying a birth to the medical officer of health devolves, in the first instance, upon the *father* of the child, if he be living in the house at the time of the occurrence of the birth; and if not, then upon "any person in attendance upon the mother at the time of, or within six hours after the birth." The notice must be "given by posting a prepaid letter or prepaid postcard . . . within thirty-six hours after the birth"; or by delivering a "written notice of the birth at the office or residence of the medical officer within the same time." The notification is in addition to, and not in substitution for, the requirements of any Act "relating to the registration of births," and it applies to any child born "after the expiration of the twenty-eighth week of pregnancy, whether alive or dead." Liability to penalty not exceeding twenty shillings is incurred by any person who fails to give notice of a birth in accordance with the Act.

Slight variations occur in the forms used in the different areas, but the differences are not important. The Act only allows a halfpenny to be spent on postage for each form. Some local authorities used halfpenny postcards, but the publicity involved proved an objection, and some form of folder is commonly used.

The majority of births are now attended by midwives (cf. p. 147), and it has been found that the notification forms are in most cases filled in by the midwife in attendance; the medical practitioners fill in a proportion of the notification of births attended by them, and the small remainder are dealt with by the parents or some other person present at the birth.

A comparison of the births notified with those registered shows, in most districts, that all births are not notified. The percentage of notification varies from 80 per cent. to 90 per cent. in most areas, while a few claim that complete notification is secured. The cases not notified are usually those among better-to-do persons occurring in doctors' practices.

The notifications are carefully preserved in the Public Health Department, the information given entered in a register and the appropriate visitor supplied with the details necessary for her work (cf. p. 19).

The Act was adopted at once by a large number of great towns, and certain of the Metropolitan boroughs. In 1909 it became compulsory for the Metropolitan area by order of the Local Government Board. Rapid extension of its adoption took place in 1912-14, and in 1915, 80 per cent. of the whole population of England and Wales had come under the Act. The Notification of Births Extension Act of 1915 brought in the remaining 20 per cent. compulsorily. In effect the remaining 20 per cent. of the population were almost entirely in rural areas, there being then only an insignificant number of towns which had not adopted the Act. The rural districts had special difficulties in carrying out any work



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under the Act, and had therefore not applied for its adoption.

The Act of 1907 carried with it no powers to spend money out of the rates on work undertaken under the Act, and no Exchequer grants were available (for further information, see Chap. XXV). The only way in which it was permissible for local authorities to pay the salaries of the visitors employed by them, was to regard them as sanitary inspectors. A Bill (The Health Visitors' Bill), introduced by Mr. Burns to remedy the difficulty, failed to secure passage through the House of Commons. Power to employ health visitors was given to the Metropolitan boroughs by the London County Council General Powers Act of 1908.

Those local authorities whose accounts are subject to government audit<sup>1</sup> found themselves in a somewhat ambiguous position until the Act of 1915 gave definite power to levy rates for infant welfare work. In 1914 Exchequer grants became available, but there was no clear parliamentary authority for the spending of rates on infant welfare work. Many of the larger local authorities had undertaken considerable annual expenditure for this purpose, and much work was being carried on before the Act of 1915 was passed.

Apart from the activities of local authorities, much work was being done by voluntary agencies. This was especially the case in certain towns where the local authority was either unwilling or afraid to incur expenditure. In some of these, the names and addresses of the infants whose births were notified were passed on for

<sup>1</sup> The accounts of county councils, of certain of the municipal boroughs, the Metropolitan boroughs, the urban districts and rural districts are audited by government auditors attached to the Local Government Board (now the Ministry of Health), whose duty it is to disallow all expenditure for which there is no statutory authority. Those members of the authority who give instructions for any unauthorised expenditure are liable to be surcharged and to be required to repay the money.

visiting to the voluntary agency. In others, the local authority employed a visitor to pay the first visit, and the voluntary agency was supplied with notes of those requiring visiting. A great variety of arrangement obtained, but during the past few years the work of home visitation under the Notification of Births Acts has been taken over almost exclusively by the local authorities, and in the provinces at the present time there are few areas where voluntary agencies undertake this work. In London, however, there are several districts where voluntary agencies do the visiting after notification.

The notification of births forms the nucleus around which centres the great mass of infant welfare work. It is true that it is frequently too late after the birth to repair defects in both mother and child, and that, wherever possible, care should be begun at a much earlier period. At the present time, however, ante-natal care can only be effectively carried out in a comparatively small proportion of cases. Alteration and development in many directions are necessary before ante-natal work will replace or render unnecessary the notification of births.

In addition to the notification of births, the notification of infectious and infective diseases is also of importance to child welfare work. As such notifications are carried out on different systems, it will be more convenient to deal with them under other headings (see Chap. XXI).

## CHAPTER III

### THE WORK UNDER THE NOTIFICATION OF BIRTHS ACTS

THE initial duty under the Notification of Births Act is the home visitation. Under the Act all births should be notified, whether occurring among rich or poor. If the better-to-do inhabitants are visited as well as the poorer ones, the cost will evidently be greater than if only the latter were regarded as in need of advice. It is contended that the former can afford such assistance as they may need and hence should not be visited. It often happens, however, that those who might be regarded as outside the range of visiting by the health visitor, are glad to avail themselves of her assistance, and it is difficult and probably undesirable to make any distinction in the visiting. In some districts it has been decided that all houses where a birth occurs shall be visited, of whatever social standing, but in many places the visiting is confined to houses below a certain rental. Before the war a rental of £30 per annum was frequently taken as the limitation above which no visits were paid. In every case, however, this was left to the discretion of the locality guided by the advice of the medical officer of health. In each town the streets are well known to the Public Health Department, and little difficulty has usually been experienced in determining the areas and houses to be visited. Very often requests are made for visiting by those who had not been regarded as being in need of assistance.

About 80 per cent. of all births fall within the range of

infant visiting. This figure may appear to be unduly high, but in fact it is remarkably constant, since where there is a large better-class population the birth-rate among them is usually low, the births occurring mainly among the poorer classes. In a few districts the percentage of births requiring visits is considerably above 80 per cent., and may reach 90 per cent. or more.

When the visiting is carried out by a voluntary society it is usual for the society to have a district allotted to them and the medical officer of health sends on to them only the births which he considers suitable for visiting. In some cases the visitor of the authority pays the first visit, and then sends on the name and address to the voluntary agency.

**Date of the First Visit.**—Either a doctor or a midwife attends every birth, and each is responsible for giving advice to the mother during the period usually recognised as the length of attendance.

Doctors usually remain in charge for fourteen days after the birth, and midwives for ten days. The doctor does not, however, usually attend every day, and can hardly reasonably be expected under the present conditions to give the time needed for detailed advice to the mother as to the hygiene of the child, especially in many of the poorer cases. The midwife is expected to attend frequently, and in the case of a great many midwives the necessary advice and care are no doubt given. There are, however, still a number of midwives in practice who are not capable of giving the advice required, since they are themselves untrained, and when they are in attendance at the birth it is usually felt that the visitor should visit at once on receipt of the notification.

The medical officer of health decides the date at which the first visit shall be paid, having regard to the qualifications of the person who is in attendance. It is unusual to visit doctors' cases within fourteen days unless a request for this is made on the notification form, or it

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is known that any special practitioner is glad of the assistance of the visitor. There is no rule as to the date of the visit in midwives' cases, and the practice varies according to the views of the medical officer of health and the known capacity of the individual midwife. Probably, however, in the aggregate the visits are most frequently paid after the period of the midwife's attendance has ceased.

The health visitor has no legal right of entry to a house. She can enter only by the permission of the occupier. The sanitary inspector has the legal right of entry in the performance of his or her duties, and efforts have been made at intervals to secure a similar right for the infant visitor. So far, however, this has not been received with enthusiasm either by the Local Government Board or by most of the local authorities. It is felt that if the visitor needs legal powers to enable her to get into the home, her advice will probably not be followed, and, since she needs to be on friendly terms with the mother, it is preferable for her to obtain entrance by tact alone. In practice a suitable visitor very rarely fails to obtain admission.

**Leaflets.**—A great many local authorities distribute leaflets on how to look after the baby, and these are sometimes sent by post at once on receipt of the notification, and sometimes distributed by the visitor at her visit. The value of these leaflets is much debated. Some people no doubt read them, but many do not, or if they do, make no attempt to follow the instruction. Then again, the instruction given differs widely in different districts, and unfortunately the advice given in the leaflets is by no means always the best, being often of the old-fashioned type. Thus, in London, in adjacent streets, the mothers may receive different or even opposite advice owing to the boundary line between two districts falling in that area. The leaflets vary from small slips of paper with a few salient maxims, to

large cards filled with advice which can be hung on the wall, and are sometimes booklets of considerable size. Their value probably varies with the character of the population and with the degree to which the visitor feels able to draw the mother's attention to them.

**Record Cards.**—One of these is provided in each case.<sup>1</sup> In the larger public health offices, the name, sex, date of birth, address, and any further information obtained from the notification form is usually filled in by the clerical staff. The record cards show almost as great variety as the leaflets. The object of the card is to record such information about the child as may be considered of value in connection with its health. This will include the place in the family, the number of other children, the general condition of health of the parents and children, the conditions of the home, whether airy or confined, sanitary or insanitary, the methods of feeding the child, and other relevant matter. It is evident that all the information cannot be gained at one visit, but must be obtained gradually. As the visitor gets better acquainted with the mother, she usually has no difficulty in gaining any information she needs. In fact, she usually receives far more than is required for her record card.

It is not advisable to fill in the cards while paying the visit. The information should be memorised and written down on the record card outside the house, preferably round the street corner. Some local authorities provide neat little cases or satchels for each visitor and a fountain pen, so that the card can be filled up while on a round, thus saving the time which would be required later at the office if notes are to be copied on the cards. Space is provided on the cards for notes as to the progress of the child at subsequent visits, and it is very desirable that the record should be continued up to the age at which the child attends school. The card,

<sup>1</sup> Samples are shown in Appendix I.

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or an abstract of it, should then be available for the school medical officer, and will be of the greatest assistance in dealing with health questions while the child is at school. Where the child attends a child welfare centre, arrangements are necessary to render the information obtained at the visits available for the medical officer at the centre, and also that information obtained at the centre should be available for the visitor (cf. pp. 46 and 47).

(For a sample record card see Appendix I.)

**The Duties of the Visitor.**—Health visitors appointed by the local authority form part of the staff of the Public Health Department and are under the medical officer of health. In most large towns there will be assistant medical officers of health, and in this case one of the assistants will probably be specially appointed to supervise the child welfare work. Sometimes an assistant medical officer of health is appointed expressly for this work, and may also be the medical officer of the child welfare centre or centres.

A health visitor should always remember that it is her duty to carry out the instructions of her chief loyally whether his directions correspond precisely with her own views or not. It is usual for a definite time to be set apart when the visitors can see the medical officer. These interviews afford a valuable opportunity to the medical officer of hearing the information a visitor may have to impart about her district, and of giving the advice of which the health visitor may be in need in regard to any special case.

The date at which the visit is paid will affect the duties of the visitor. If paid early after notification, while the mother is still in bed, the most important duty will be to make inquiries about the feeding and to persuade the mother to breast-feed the child, but it will usually be undesirable to remain more than a few minutes. It is often possible to note the sanitary con-

ditions of the premises at the first visit, since this does not disturb the mother. One examination is not sufficient, but the visitor, throughout the period of her visiting, be it long or short, should see that insanitary conditions are noted and dealt with. At subsequent visits she will become more closely acquainted with the affairs of the family. While always ready to listen, the visitor should not appear inquisitive, and any information obtained is strictly confidential and must on no account be communicated to neighbours. Some people consider it advisable that the visitor should inquire into the wages earned by the father or by the other members of the household, if any. This inquiry is, however, often very naturally resented, and sometimes the woman herself does not know what her husband is receiving. The object of the inquiry is to ascertain what the mother is able to afford for the child, and whether the money is sufficient but is being misspent. A tactful visitor is nearly always able to judge whether the mother is able to afford all that is necessary for the child without asking about the family income.

It is well to remember that, in a sense, the visits are in the nature of an intrusion and that the visitor is admitted by courtesy and not by right. She should therefore refrain, unless in very special cases, from behaviour which she would not adopt on any friendly visit to her own acquaintances.

**The Sanitary Condition of the Premises.**—The visitor must note the general condition of the house or dwelling: the condition and cleanliness of the walls and floors: the arrangements for ventilation and presence of any overcrowding: the water-supply: the nature of the sanitary arrangements: the condition of the backyard or garden, if any: the arrangements for the disposal of refuse: the facilities for getting air for the child: for the storage of food, especially for the infant's milk, if artificially fed. There will also be other points which



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will present themselves to the experienced visitor. When defects are present, the visitor must endeavour to get them remedied. Ordinarily, she will report defects in sanitation to the medical officer of health or to the sanitary inspector, but certain of the above matters can often be remedied by the people themselves if they are persuaded of the desirability for doing so.

She should be sufficiently acquainted with the law and with local practice to be aware which of these matters require reporting and which do not.

Where the visitor is qualified as a sanitary inspector she can, if desired, deal with the defects herself. This may, however, lead to difficulty with the landlord, and, in general, it is the practice for the visitor to hand over any procedure which may be necessary to the recognised officer. In view of the present housing conditions, the people are frequently afraid of any representation being made to their landlord, lest they should be turned out in favour of other more complaisant tenants, and often beg the visitor not to let the landlord be annoyed by requests for improvements.

In some few places the practice of allowing the visitors to deal with sanitary defects discovered by them obtains, and has been found to be entirely unobjectionable. At the same time, the majority of medical officers of health seem to prefer that the sanitary defects should be referred to the sanitary inspectors, and this view is taken by the Ministry of Health in a recent circular on child welfare.

**The Hygiene of the Infant.**—The visitor should be prepared to give advice as to the feeding of infants both before and after weaning, and of young children. She should be fully acquainted with the technique of breast-feeding, and should do her utmost to secure this for the infant. Failing the natural method, she should be able to advise simple methods of artificial feeding, and should instruct the mother in the necessary

details. Further, the clothing, bathing and general cleanliness of the child, its sleeping arrangements by day and by night, the amount of fresh air it obtains, the ventilation of the room or rooms it may occupy, and the state of the bowels and of the skin all fall within the province of the visitor. Where there is an infant welfare centre in the neighbourhood, and this is usually the case at the present day, the visitor should invite the mother to attend, and should tell her the day and hour when the centre is open.

In a few places the visitor is provided with a hammock which can be suspended from the hook of a spring balance. The baby (usually with its clothes, since the mother does not want the trouble of undressing it) is placed in the hammock, and the weight entered on the record card. Apart from the error of the clothes, which will inevitably differ at each visit, the child rarely remains still in the hammock, and the level of the pointer oscillates on the scale, rendering it impossible to read with any degree of accuracy. Such a method as weighing is of little or no value, and weighing is best omitted from the duties of a visitor on her district.

There is a superstition which is very prevalent in many parts, to the effect that if a baby is weighed it will die. The origin of this belief has, so far, it is believed, not been explained, but it seems possible that it may be a survival in an altered form of the dread of punishment similar to that visited on Israel and Judah after the numbering of the people by David.

A health visitor must realise the importance of detecting early indications of oncoming trouble. If, for example, the child is not thriving, or its progress from being quite satisfactory becomes less so, she should not wait until the trouble, whatever it may be, has got well established, but should endeavour to ascertain what it may be that is the cause of the lack of progress. It may be that on careful inquiry she may find that the mother

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has been giving different food, or has failed to give the child fresh air, and so on. If, however, there is no apparent cause she should endeavour, if possible, to persuade the mother to bring the child up to the centre to see the doctor, or if this is already being done, she should advise that the mother should not fail to attend on the next possible occasion. Where the child is clearly ill, it will probably be advisable to recommend the mother to seek the advice of her own doctor, but some centres consider that the child should be sent on to the family doctor from the centre rather than by the health visitor.

A visitor must in no case undertake treatment as distinct from hygienic advice.

**Social and Industrial Conditions, etc.**—A visitor will need to know about the conditions of work, etc., which concern the families she is visiting. In a rural area the life is bound up with the various seasons, with the weather, the kind of crops most prevalent in the particular districts, etc., and the visitor will do better and more intelligent work if she makes herself acquainted with these and similar matters.

Most districts have conditions which are common to other districts of similar type, and also other special conditions peculiar to the locality.

In the towns or industrial areas she will need to know about the conditions under which the men and women, the boys and girls, work: of the chief types of amusement available, the social organisations to which they may or should belong. For instance, in a mining area, the work of the housewife is rendered very arduous by the shifts worked by her husband and perhaps by a lodger or relation living with them. In other districts there will be other difficulties connected especially with the prevailing employment of the inhabitants.

She should know something at least about the question of insurance under the National Insurance Act, of trade

unions and their rules, of clubs of various kinds, in fact, all that affects the lives of those she visits should be of interest to her.

Certain of the above matters are technical and not easy to understand without explanation. Such explanation should now be given in the training for health visiting which requires instruction in social and economic conditions.

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.

**Other Matters.**—The formidable list of subjects already enumerated does not, however, complete the duties of an infant visitor. As she becomes friendly with the mother she will find that her advice is asked on all kinds of matters, some of which may have only an indirect bearing on her work. She will often need to bring to bear all her past experience in order to answer the questions put. In some homes circumstances are found which present very real difficulty to the visitor. Here and there a mother is found who seems to have no affection for her children, who are neglected and wretched. The efforts and persuasion of the visitor may, with patience, succeed in effecting astonishing transformations. Occasionally, however, it may be necessary for more drastic treatment to be adopted. In such a case, the medical officer of health may consider it advisable to refer the case to the officer of the National Society for the Prevention of Cruelty to Children, a procedure which often secures good results.

There are few visitors of experience who have not in their memory cases which have required continual and persistent visiting, advice and cajoling, in fact, all forms of inducement for a prolonged period before that realisation of her duties in the mother has been pro-

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duced which makes her secure healthy conditions for the child.

The visitor must remember that she is not a missionary but a health agent. Her duty is not to condemn or to preach. She will inevitably find immoral conditions among some of those she visits, but except in so far as those conditions may cause direct injury to health they are not her concern. Voluntary workers may find it difficult to refrain from advice and admonition in these matters, but the health visitor must discreetly avoid any interference in the lives of those she visits. If this is realised she will often be given opportunity of assistance which she would otherwise miss.

Whoever would do useful work among the poorer classes must try and understand the views upon various matters held by those among whom the work is to be done. It is too frequently forgotten that the life of those who live in humble circumstances is altogether more primitive than is usually the case in the classes from which the workers are most often taken. Different classes of society are prone to condone different faults. It is always easier to see the faults of those among whom we have not been brought up; but, except in so far as health may be concerned, it is no more the duty of the health visitor to expatiate to those she visits upon their faults, than if she were visiting her own friends. A friend who is inclined to chide is not likely to receive confidence or to be allowed to give aid or advice.

## CHAPTER IV

### THE RELATION OF THE CHILD WELFARE VISITOR TO CHARITABLE AND SOCIAL ORGANISATIONS

At the present time the whole attitude of many thoughtful persons is undergoing, or has already undergone, much change from that of some twenty years ago or less. The old idea of giving money or other material assistance to cases of obvious poverty without further inquiry has now nearly passed away. It is recognised that apparent poverty may be due to other causes than lack of income, and that investigation is needed, because indiscriminate and unsuitable gifts are more likely to do harm than good. The official recognised organisation for public relief is the Poor Law, but, from various reasons, mostly well known, recourse is only had to the Poor Law by those who are unable to obtain help in any other way, or who have been proved impossible to aid from other sources. Until recently, at any rate, the Public Health Department has not had power to give material aid in any form, and material aid has usually been regarded as undesirable. All forms of work which tend directly to prevent disease are now coming to be regarded as a duty which has to be carried out by public bodies, and as conferring benefits, which are the right of the public and in no sense charity.<sup>1</sup>

Every visitor among the poor will not fail to meet

<sup>1</sup> It is impossible to say how far the present position of the Public Health Department may be modified if, and when, the abolition of the Poor Law comes to pass.

cases of poverty where common humanity appears to demand instant material aid. In one or two towns the infant visitors have been allowed to collect money, and to distribute it among cases which appear to be necessitous. Ordinarily, however, it is agreed that material relief should in no case be given by the infant visitor. In the first place, the inhabitants of her district should not regard her as a source of aid in apparent poverty, which will be the case if she distributes relief, and, secondly, such relief is palliative only, and may be directly detrimental unless given with due knowledge of the family circumstances. The visitor is hardly ever a trained relief worker, and does not therefore know the best means of affording lasting aid. Organisations of various forms, to which cases can be referred, exist in nearly all districts. It is sometimes said that certain well-known organisations are too slow or too particular in their methods, but even if this statement be deemed justifiable, there should be no difficulty in arranging for speedy relief apart from the infant visitor. The visitor should be well acquainted with the various possible sources of aid in her district, and she should refer the needy cases to whichever of these sources appears to be the most appropriate to each case as it arises.

The provision of free or cheap dinners or food for mothers and of milk for infants is a very debatable point. So long as such aid is provided only on medical orders, and this is clearly understood by the recipient, little or no objection need be raised from the point of view of relief. It will nearly always be a temporary measure to tide over a special period in the life of either child or mother. The distribution without much investigation of free orders for milk for infants needs to be closely watched lest it should tend to encourage artificial feeding.<sup>1</sup>

<sup>1</sup> It is greatly to be hoped that the present high price of milk may produce greater attention to breast-feeding on the part of

Again, there will be cases where it may seem that letters for some convalescent home or rest home for mothers with some form of aid for a child are required. The infant visitor should not herself take any steps to provide such aid, but she should possess a sufficient knowledge of the aim and objects of the manifold charitable and social organisations, both generally and in her own district, to be able to direct the mother or herself to make application to the appropriate agency, either directly or through the chief health visitor, according to circumstances. It has often happened that a well-meaning ignorant visitor has expended much time and trouble in securing what appeared to her to be the right form of assistance, when the case was well known to existing appropriate agencies who either had already made similar arrangements for aid, or who knew that the proposed form of aid was entirely unsuitable for the particular case. Overlapping of effort should be avoided and no one set of workers should trench upon the field of others.

all concerned and that it will not lead to an increased supply of free or nearly free milk for artificial feeding.



## CHAPTER V

### POINTS IN THE ARRANGEMENTS AND THE CONDITIONS OF WORK OF AN INFANT VISITOR.

It is assumed in this chapter that the visitor undertakes no other work than that connected with infants. In the earlier years of the movement it was common in the towns to allot to the health visitor other duties beside those arising under the notification of births. The work in connection with and arising out of the medical inspection of school children, and the work among tuberculous persons were the most important of the other activities. In the towns, however, the visitors are now increasingly being given only the work among mothers and children under school age. In the counties, on the other hand, owing to the relatively scattered position of the population the tendency is to place a variety of duties upon the health visitor for each district. It is easier, however, to deal first of all exclusively with the work among infants and afterwards to consider the modifications (cf. Chaps. X and XI).

The arrangements made for the work of the visitor will depend a good deal on the nature of the district, whether the population is congested or scattered. In a large town it is usual to employ a number of visitors, of whom one is the chief visitor. The town is then divided into districts and a visitor allotted to each. The size of the district will depend upon the average number of births which occur in the year. As a rule, the

poorer the district, the smaller it will need to be. In addition to the number of births, the facilities of transit will be considered and the areas arranged so that there is the least waste of time in getting to and about the district.

The chief visitor may have a small district of her own if she has time, but in a really large town it will probably only be possible for her to supervise and arrange the work of the other visitors and to visit especially difficult cases when her assistance is requested.

The notification of the births will be handed to the visitor of the district who will be responsible for visiting. Although it may be the nominal practice to visit doctors' cases on the fifteenth day and midwives' cases on the eleventh, it is not always possible for this to be done without undue loss of time, unless the area worked by one person is very small and congested. A visitor learns to arrange her work beforehand, so that there are a number of visits to be paid in adjacent streets, and it may cause the loss of eight or ten visits if she is obliged to pay a single visit in a district where no other visits happen to be due. The less congested the area, the more difficult it is to adhere at all strictly to any set day for the first visit.

Opinions differ widely as to the frequency with which visits should be paid. It is usually agreed that much must be left to the discretion of the visitor. There will be a number of cases where an occasional visit is all that is necessary. The mother may be well-to-do and the child well cared for. In such a case the visitor may pay a quarterly visit or she may ask the mother to send a card if there is anything she would care to see her about. It is rather surprising to find how much advantage is taken in some districts of this offer: it might have been thought that the trouble of writing would have acted as a deterrent.

Again, there will be other cases where much assistance

is needed and where weekly or more frequent visits will be necessary if any improvement is to be effected. Then there are the cases where fairly regular visits are desirable. Some people consider that monthly visits are too frequent for the average case, while others regard a fortnight as the longest interval which should be allowed to elapse at any rate in the early months after birth. There can be no rule laid down—much depends upon the character of the people and of the visitor and each case must be dealt with on its own merits. Again, as the child grows older fewer visits will be necessary. If the visiting is continued up to school age, as should be the case, it may roughly be computed that the number of visits in the four years from one to five will be about equal to those necessary in the first year alone.

It has been found that on the average a visitor engaged only with children under one year, can undertake the visiting for approximately twice as many births in the year as one who continues visiting up to school age. Here, again, however, there will be much variation. The most recent circular upon the subject issued by the Local Government Board allows 400 births to one visitor. Certainly not more than 200-250 children up to school age can be dealt with by one visitor. At first, under the Notification of Births Acts, it was a not infrequent practice for one visit only to be paid, subsequent visits not being regarded as falling into the same category. Later, as the work developed, it was realised that one visit without re-visits was waste of effort and visits were usually continued up to the end of the first year.

In 1915 the Local Government Board regarded 500 births as the number which could be allotted to one visitor. Great consternation and doubt were expressed by many councils at the immense number of visitors who would be necessary under such a proposal. It is now generally known that much effort is wasted if the

visiting ceases at the end of the first year and in some places already the aim is to allot not more than 250 births per annum to each visitor and to require visiting up to school age.

The number of visits which can be paid in the day or the year will again depend on the nature of the district, on whether the visits are early visits or late ones—as a rule early visits take longer than those paid when the child is older. Ordinarily a visitor will not be able to accomplish more than fifteen to seventeen visits in the day under favourable circumstances. When the homes visited are not grouped, or when there are several first or early visits, it will not be possible to pay so many. Again, much will depend upon the distance from her office, which is usually the Public Health Department, and which may be some distance from the district to which the visitor is allotted—also whether she bicycles or walks or takes a tram, etc.<sup>1</sup>

Then, again, the amount of office work required will affect the number of visits paid. If the visitor has to spend an hour or more copying notes and records either before going out or after returning from her work, there will be less time for visiting. The hours available for visiting are ordinarily rather limited. The tidy mother does not like to be found at her work, and she likes a little time for clearing up after the children (if any of school age) have been got off to school. Therefore usually it is best not to visit much before 10 a.m. unless the visitor knows the mother, and is sure of her welcome. Then, visits should not be paid during the dinner hour, especially if the husband comes home to dinner; moreover, preparations for dinner are necessary,

<sup>1</sup> It is usual where the tramways are owned by the Corporation to give free or reduced tickets to the visitors when using the trams for their work. Their travelling expenses incurred in connection with their work are paid. It is usual also to provide the health visitor with an annual sum for the upkeep of her bicycle, and in some cases the bicycle itself is provided.

and the housewife who has just left time to get dinner ready may not be pleased at a ten minutes' interruption at a critical moment in her culinary arrangements. In the afternoon, of course, they are often out, and the children return from school at 4 p.m., or earlier in some places, in the winter. Visits paid at inconvenient times do not conduce to a welcome or to obtaining good results. A certain number of visits will often be abortive, the mother being out, but after a little while the habits of the district or of particular women get known, and the visitor develops an instinct for finding the mothers at home.

In a scattered area, or in the country, it is impossible to arrange for more than occasional visits owing to the distance apart of the homes. Much will naturally depend upon the size of the district the visitor has to work, but generally very different standards of frequency are adopted in towns and in country districts.

Where there is a child welfare centre in the visitor's district, arrangements are usually made for her to attend the centre. It is sometimes urged that by doing so the visitor cannot pay as many visits as are required for her cases. Both from the point of view of the visitor as well as of the mother, it is essential that she should arrange to attend the centre. She will be more successful, because more interested, in persuading the mother to come up if she knows she will be there herself, and the mother will feel less strange if the visitor is there to welcome her. Again, it acts as a stimulus to the visitor and, if she is present at the consultation, as should be the case, she is better able to see that the advice given at the consultation is carried out.

The Ministry of Health are now advising local authorities to arrange as far as possible that each visitor shall be attached to a centre, and that the area served by the centre shall be coterminous with the visitor's district, or where the centre serves the districts of two

visitors, separate sessions should be allocated to the different districts. The centres would thus be small centres, and their primary function would be the giving of medical advice. There would thus be many small centres, each serving a particular locality, and a few larger centres where other activities are available, serving the districts of a number of visitors.

**Still-Births.**—A feature of the visitor's work which obtains almost universally among the staffs of local sanitary authorities is the visits paid in regard to still-births. The problem of still-births is very intricate. It was not usual to register children who were born dead, but notification of all viable children (*i.e.*, after the twenty-eighth week of pregnancy) is required whether the child is born dead or alive. Formerly, the still-born child was not infrequently taken to the undertaker, who placed it in any coffin which was about to be taken to the cemetery, and the child was buried without further ado. But, with the notification of still-births, the practice ceased, and the medical officers of health required the visitor to pay visits to the homes of all still-births, and to make special inquiry into the occurrence. Although, doubtless, some still-births are unpreventable, it is probable that a fair proportion could be prevented, and in certain cases no doubt a still-birth is not regarded as a misfortune.

In one large town no burial of a still-birth may take place until the body has been seen by the visitor for the district, or by the chief visitor, and a permit for burial received from the Public Health Office. Accurate figures as to the number of still-births are only available for a few towns. The midwives usually notify all the cases occurring in their practice, but it is well known that this is not the case in doctors' practices. Hence the still-births notified do not give a correct figure. The only method of obtaining the true figure is from the returns of the cemeteries, through the certificates of death. The figure of 3 per cent. which has been widely

published as the average figure for still-births is subject to the limitation of available information mentioned above.

**Ante-natal Work.**—Experience has shown that visits paid at the times above described are very often too late. The child has been taken off the breast, and efforts to restore natural feeding are unsuccessful, or no effort at all has been made by the mother to undertake this duty, and artificial feeding is firmly established when the visitor arrives. Again, unsatisfactory clothing has been provided, and the money having been spent, no more is available—ailments in the mother or conditions in the home could have been attended to had the visits been commenced before the child was born. These and other considerations have led to the demand for ante-natal visits on the part of the visitors.

There can be no doubt of the need for ante-natal care, but it is questionable whether it can be regarded as falling within the purview of the work of the visitor. When a doctor has been engaged, ante-natal visits should not be paid without his consent and approval, although the nature of the ante-natal care given by the visitor or by a midwife should not include anything in the nature of treatment. Under her Rules (cf. pp. 129 *et seq.*) the midwife is responsible for her patient as soon as she has been engaged to attend the confinement. In the case of trained midwives, there can be little doubt that ante-natal visits should be carried out by them, but where the midwife is herself untrained the position is very different.

There is the difficulty of knowing where the cases are that require ante-natal visits, since there is no definite means of ascertaining their whereabouts. A visitor who knows her district will probably not have much trouble in knowing of the majority of cases, but she must be careful not to interfere with the midwife or doctor engaged by the mother. Apart from these considerations it is evident that she must have had experi-

ence in maternity work, and know what advice to give. This at once raises the whole question of the training of visitors as midwives. It is generally agreed that without a midwifery training, they cannot undertake ante-natal work, but also the mere training in midwifery is not enough, and actual practical experience in midwifery on the part of the ante-natal visitor must be regarded as essential. The visitor should have been a practising midwife if she is to undertake this work. This subject is considered further in later chapters.

The Ministry of Health have recently stated that ordinarily the midwife should do the ante-natal work for her own cases, although at the present time, where all midwives are not trained, this may not be possible.



## CHAPTER VI

### THE CHILD WELFARE CENTRE

REFERENCE has already been made to the child welfare centre as exemplified by the infant consultation and the school for mothers. At the outset these branches of work were very simply arranged, and did not overlap one another. The primary function of the infant consultation was the medical advice to the mother on the means she should employ to preserve the health of her child. It was not usual for the attendance to be continued after the child had reached one year of age.

The school for mothers was intended to be educational, the object being to instruct mothers in these matters which relate to the welfare of infants generally, and not to the particular child of the individual mother.

It was soon found that neither of these activities was self-sufficient. At the infant consultation it was realised, for example, that the clothing of the children was often quite unsatisfactory, and that the mother had no idea how to make proper garments. Many of them did not sew at all, and had never cut out a garment in their lives. They did not know how to mend or alter, how to prepare the food for the growing child after weaning, and were frequently ignorant of the rudiments of housecraft.

At the schools for mothers, on the other hand, it was found that the mothers were not able to adapt the information given on general lines to their own children,

but were continually asking for advice on special points. It was gradually recognised by the schools for mothers that they needed an infant consultation, and the infant consultations on their part realised that they needed some arrangements for the instruction of the mothers in the care of infants and of the home generally.

The functions of the two varieties of centres thus tended to approximate, but it was only rarely that any change of title was made, and in many instances schools for mothers were started whose work was essentially that of an infant consultation, but the title "school" happened to appeal to those who were responsible for commencing the work.

At an early stage in the movement it was found that if the work was to be as useful as possible, it would be necessary for the homes of those attending the centres to be visited. The establishment of centres and the initiation of the work under the Notification of Births Act commenced about the same time.<sup>1</sup> The home visitation was at first only undertaken by the large towns which adopted the Act as soon as it became operative. Even then the visits paid were by no means frequent, and often amounted to one visit only. In many districts there were at first no arrangements at all, the Act not having been adopted by the authority of the district.

In some areas there was visiting and no centre, and in others there was a centre and no notification of births. In the latter cases the visiting had to be done from the centre, if it was done at all. In the early years the centres were, with very few exceptions, commenced and worked by voluntary workers. Usually a number of ladies banded themselves together to form a committee, which was responsible for all matters connected

<sup>1</sup> The first infant consultation in this country was started by Dr. Eric Pritchard at Marylebone in 1906, and the first school for mothers by a number of ladies in St. Pancras about the same time.

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with the centre. The cost was not great in those early days.

The accommodation usually consisted of not more than two rooms of small size, for which a rent of perhaps 2s. 6d. a week was charged for the one afternoon it was opened. All the workers were voluntary, and the doctor was asked to give his or her services. As time went on and the work increased, it became impossible for the visiting to be done by the ladies themselves. In some districts it was arranged that the visitor under the Notification of Births Act should attend the centre and undertake the visiting of the homes of those attending as a part of her ordinary work. In other places it happened that there was no official visitor, or that the ladies preferred to keep the visiting under the control of the centre. In this case it was common to employ a trained visitor who worked with the centre only. She visited those mothers and only those who attended the centre, for the primary reason that the whereabouts of the others were not known. It often happened that the centre could undertake more work than it was actually called upon to perform because the centre was not known outside a very limited area. Quite commonly the medical officer of health was asked to supply information as to the address of more mothers if the Notification of Births Act had been adopted for the district.

The medical officer of health was often willing to send on lists of the births in a given area, which area was then regarded as allotted to the centre, on the understanding that the centre then assumed responsibility for all the births so notified to them, and that they furnished such information about the children as might be called for.

Only in rare cases, however, were the first visits paid from the centre. Usually these were paid by the Council's visitor in order that the condition of the home,

etc., might be ascertained and reported to the Public Health Department. Speaking generally the dual system of visiting does not work out very satisfactorily. The centres often failed to keep in touch with those infants whose mothers did not bring them to the centre, so that they received no visits at all. They have been handed over to the centre, but the centre, finding that they do not attend for medical advice, gradually ceases visiting. Those who do not attend a centre are frequently more in need of visiting and advice than those who do, and in this way many cases in real need of advice may be neglected. It is seldom that a centre can afford to provide a staff of sufficient size to visit cases other than those who form the clientèle. The mass of homes whence the mother does not attend at a centre must be visited by the official workers employed by the Council under the Notification of Births Act.

Another arrangement sometimes made was that the centre should send weekly or fortnightly lists of the infants who were being visited by them, and it was then understood that the visitor from the Public Health Department would not visit in those homes. Any line of demarcation is, however, always likely to leave gaps, and as a result a certain number of the children are not visited regularly.

— The only satisfactory method of visiting is for the official health visitors to be responsible for all the visiting and for them to attend the centre and be thus personally in touch with it.

On other grounds also it is essential that the visitors should attend the centre in their own district, whether the centre be worked by a voluntary agency or by the Council. If the visitor does not know what advice has been given by the doctor at the centre, it is probable that much of the advice will be wasted. The mother often wants assistance in carrying it out and the visitor

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cannot help her adequately unless she knows what advice has been given. Then again, it is good for the visitor herself. She gets a variety of work and is kept up-to-date and alert by contact with the other activities of the centre in addition to the fact that she learns by hearing the advice given by the doctor.

It is difficult to emphasise too strongly the need that the visitor should attend the centre. The two branches of work—home visiting and consultation—are not separate parts of the work but are interdependent, and any system which does not secure the closest co-operation will fail to effect the best work. The visitor will take more interest in the work if she follows the infant in all its phases of care, while the mother will be drawn closer to the visitor if they meet at the centre. Even if the visitor has to pay rather fewer visits in the week the time devoted to work at the centre is well spent.

At the present time hardly any visiting is done by voluntary agencies outside London. The development of the work at the centre itself has been a determining factor in the handing over of the visiting to the official visitor. The funds of a voluntary society do not ordinarily admit of the employment of more staff than is necessary to actually carry on the work at the centre.

The large present-day centre has moved far from the simple activity of the infant consultation. It will be interesting now to study shortly the reasons for this development. The need for the infant consultation and the teaching of the mothers has already been considered, and the other phases have arisen as the work expanded. In some districts one activity came first and in others different work was taken up in different order, but now many centres in large towns have a number of these activities at the same centre.

It was found that many mothers were unable to attend the centre owing to the fact that they had several children under school age who could not be left at home

alone. If these children were brought to the centre in considerable numbers the disturbance caused was great. They could not reasonably be expected to sit still during the whole session and inevitably they made a good deal of noise. So a "toddlers' room" had to be arranged where these small children could be taken on arrival and cared for during the time the mother was at the centre. Ladies are usually willing to take charge of these little ones, and a list of those undertaking this duty should be arranged for each session.

The need for medical supervision of those children under school age is now fully realised and provision is made at many centres for their examination and for advice as to their hygiene. Such examination need not take place frequently, but it is found better to arrange the work among older children on a different day from that among children of one or two years of age. The practice varies considerably according to local circumstances, some centres keeping those under two years in one category while others make the dividing line earlier. Others again do not make any clear division.

Then it was found that many of the children were suffering from some mild nutritional disturbance which would yield to a few days in hospital with regular feeding, etc. Hence arose the desire for some accommodation whereby these children might be supervised for a few days and got into good habits. It is quite impossible at present to send these children into an ordinary hospital as the accommodation is hopelessly inadequate for even serious cases of illness. Hence certain centres have started so-called "observation wards" where they can keep the children for a few days. In some cases these wards are used also for children who, from one cause or another, have no one to look after them for the time being. This may be due to the mother's illness or some other cause. These beds should not, however, be used for cases of serious illness.

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Another branch of work is that among the mothers themselves, especially before the birth of the child. Ante-natal work is increasing and its importance is being realised. This branch leads into the whole sphere of maternity and midwifery work, and some centres now employ midwives of their own.

The provision of dental care has been found to be one of the most valuable branches of work at a centre. This is needed for all ages, for the mothers and for the children who, too soon after cutting their first teeth, show signs of dental decay and before they reach the age to attend school have already in many cases sustained permanent injury to both teeth and jaw.

A large centre may therefore be a veritable hive of activities, but it is advisable that there should also be numerous smaller centres where the ordinary infant consultation with its advice and instruction for mothers is offered without all the expensive varieties of work of a large centre. The various phases will be dealt with in more detail in the next chapter, only those forms of work which are found in nearly all centres being dealt with in this chapter.

**Accommodation Required.**—Two rooms is the least number required for even a small centre, and three are desirable. For a centre where more than some ten or twelve children attend at a time, three rooms must be regarded as essential. Sanitary accommodation and a place for keeping perambulators are also necessary. One of the rooms will serve as a waiting-room where the mothers sit on their arrival. There should be some method of warming the waiting and other rooms in winter, and adequate ventilation should not be forgotten. Another room is needed as a private consultation room for the doctor who will see the infants one by one. The children are weighed, either in the consultation room or in the third room, according as is preferred by the doctor. In any case, the remaining room should be

available for undressing the children before they are seen by the doctor. The consultation room should have a good light, and this requisite will probably determine which room shall be allotted for this purpose.

White overalls or coats should be worn by all the workers, and hats should be removed. Some form of receptacle which can be easily washed should be provided for the clothes of each child so that there is no mixing of garments. Only a few children will be in the undressing room at once, some of them waiting for the consultation and others dressing after it is over. In some cases the consultations are held in the morning, but the majority of centres are open in the afternoon. At many centres, especially where the agency responsible is voluntary, it is not unusual to provide tea and a bun or biscuit at a small charge.

**Weighing.**—It is essential that the children should be undressed for weighing and for the medical examination. No accurate figure for the weight can be obtained if some or all of the garments are left on. It is argued by those who approve this method that the mothers bring the children up in the same clothes on each occasion so that the error in weight due to the clothing is always the same. It is difficult to see how such a statement can be made seriously, since not only must the clothing change from week to week, but it should be different in winter and summer, and, moreover, as the child grows, it will need new and larger garments. There is no virtue in weighing as such; its object is to note the progress of the child. It is especially valuable when the progress is slow or absent, when an ounce or two either way may be of much importance in deciding the advice to be given. Care should be taken with the weighing and a good balance used. The Post Office balance, which only weighs to within about four or more ounces, especially when the child is moving in the scale pan, is of little or no value for this purpose. Weighing which is care-



less or inaccurate may as well be omitted. There is more difficulty in accurate weighing than might be supposed, and most people have a sort of personal equation which makes their reading rather different from that of others; wherever possible, therefore, the same person should weigh on each occasion.

The undressing also enables the state and nature of the clothing to be seen. The kind of clothing provided is frequently quite unsuitable, and may be improved by appropriate assistance and advice. Moreover the mother will be more careful in regard to cleanliness if she knows the child is to be undressed. It is sometimes argued that there is little to be gained if the cleanliness is for one day in the week only, but at least one clean day is better than no clean day and may be the forerunner of others.

The scale pan should hold a piece of wool or a blanket to keep the infant from feeling the cold of the metal, and a fresh piece of clean paper over the blanket should be used for each child. The blanket or wool must be of known weight.

**Record Cards.**—Various forms of medical records are kept at child welfare centres. The object of the record is to provide information as to the condition of the child at its first attendance, together with such details as are necessary of its place in the family and home conditions, and to which additions may be made on each occasion of the child's attendance. When the centre is large, a system of card indexing will be necessary, and this will be kept either in the waiting-room or in some further adjoining room. On the arrival of the mother the record is found, or a fresh one prepared if it is a first attendance, and placed ready for the doctor, and handed to him or her when the infant concerned is in the consultation room. It is usual, also, to give the mother a card on which the baby's weight is entered and notes of the instructions she has been given.

(Samples of such record cards are shown in Appendix I.) The information obtained by the visitor on her visits after the notification of the birth may be used for the details of home conditions, etc., and any alteration in these noted.

The record cards should not be fuller than is really necessary. A card that requires much time and leaves space for all manner of details will, in all probability, not be filled up as carefully as one which, being less elaborate, can be properly dealt with in the time available. It is not necessary that any more than the salient features should be recorded in ordinary cases.

The record cards should be available (or copies of them) for the school medical officer when the child attends school. It is the only means whereby an accurate record of the child's previous health history can be obtained. The record card would, for example, show at a glance the ailments which it had suffered from including the infectious diseases and would furnish valuable data for research on all these points.

It will evidently take some years before such records are generally available, but their importance is very great and no time should be lost in getting the whole system of records in hand.

**Frequency of Attendance.**—The medical officer decides the frequency of attendance at the consultation. A good arrangement is for the date of the next attendance for consultation to be written on the record and on the mother's card. It may be that the doctor will wish to see the child every week for the first two or three weeks of its attendance, and that unless some unforeseen difficulty occurs, the visits can then be lengthened to fortnightly, or later, monthly, or, as the child gets older, quarterly visits. It is found, however, that in many cases it is advisable to allow the mothers to attend as frequently as they wish on the special afternoon, as it conduces to attendance on the consulta-

tion days. The baby can be weighed by the workers but not sent to the consultation room unless some untoward event has supervened which renders this necessary.

**Clothing.**—Child welfare work has brought into prominence the question of clothing, but it is doubtful whether the full importance of proper clothing is even now properly appreciated. While details can be sought for in the text-books on infant hygiene, a few remarks upon this matter will hardly be out of place here. It looks almost as if there were no age at which clothing is more oppressive than during the early months, or perhaps years, of childhood. The unfortunate infant is obliged to wear exactly what its mother or nurse thinks would be good for it, or ornamental for the outside garments. The child wants freedom to stretch its arms and legs, freedom of movement for its chest and body, but custom has prescribed that the clothing of the infant shall do its utmost to hamper the poor little mite in its efforts to grow healthy and to develop on the lines intended by nature.

To take the undergarments first. Who has not seen the terrible article known as a binder? Some bandage is necessary until the child has parted from the remains of its umbilical cord, but not afterwards. The practice of days gone by still persists in many homes of sewing a piece of flannel as tightly as it is possible round the abdomen of the miserable infant. Sometimes the binder is so tight that the child literally cries with the pain, as is evinced by the sudden cessation of the cry when the binder is released. Even if this degree of duress is avoided the binder is uncomfortable, and usually works its way up towards the chest where, becoming crumpled up in layers over the lower part, it effectively prevents the expansion of the chest in breathing. If it should remain in the position intended by the nurse or mother, it tends to produce internal discomfort, and is by many

regarded as one of the causes of constipation in infants. If the binder be knitted, as is now sometimes the case, the wool may shrink, and the binder become hard and excessively tight for the infant. But custom has prescribed it, and, tight or loose, comfortable or uncomfortable, it is placed on the often stoutly resisting child.

Then there is still in some parts, the horrible little cotton shirt with short sleeves, which is followed by another binder, stiff and starched this time, and extending over the greater part of the distance between the arms and legs of the unfortunate infant. Binders have nothing to recommend them, and should be omitted from the infant's wardrobe. The writer remembers attending a consultation where needles and cotton were actually provided by the centre for the sewing up of these instruments of torture after the weighing.

Then there is the flannelette petticoat with calico bodice, as soon as the child is a little older, which, owing to its lack of warmth, has to be duplicated and reduplicated until sometimes as many as four or more of these garments are piled on the child to keep it warm. The outer and outdoor clothes are little better. The long frock with heavy embroidery and frills, stretching over the toes and weighing them down, the short sleeve tied up with ribbon, the thick pelisse, the padded bonnet without any ventilation, and the woollen veil, which effectually negatives any benefit the child might obtain from being in the fresh air, should all be dropped in favour of more hygienic garments. The ideas of many on the subject of clothing are still tainted with suggestions of the dark ages, and that not alone among the poorer classes.

The child wants to be kept warm in winter by a few woollen garments. A woollen vest with long sleeves, a longer woollen garment, extending so as to enclose the feet, and an upper garment of reasonable length and weight will suffice for indoor wear. Napkins should be

of soft material, such as Turkish towelling, and should be washed between each use. In summer the clothes should be modified to the change in temperature. One cause of trouble for the poor mother is the custom of wearing long clothes up to about two months old, when a fresh set of short clothes has to be provided. The now prevalent fashion of so called three-quarter length garments can be used from birth onwards until the child begins to walk, by which time they will, in all probability, be worn out. Unfortunately the clothing is provided before the child is born, and the mother is reluctant and often unable to change it. Good progress has, however, been made with the mothers who attend many of the centres. Model garments should always be on view, and the workers be prepared to show the mothers how the garments can be made. Where classes are held, some mothers will be able to attend them, but many will be unable to do so. These last can be aided by helping them to cut out or to put the pieces together. In other centres, paper patterns are sold for 1d. Again, rolls of flannel, etc., may be bought at wholesale prices, and sold in quantities for single garments at cost price. There are many methods in practice for helping the mothers with the clothing of the infant, and all are valuable. At some centres the mothers can pay in small sums weekly, and then purchase material as they need it.

**Talks or Lectures.**—These are also not infrequently arranged, and may be given by the doctor or by some of the visitors. Long talks should be avoided. Probably ten to fifteen minutes is as long as it is possible to retain the attention of most mothers who attend, whose schooldays are long past, and in whom the power of concentrated attention is small. Opinions vary considerably as to the value of lectures.

**Classes.**—It is often difficult for a mother with one or more young children to attend classes. These are more

easily attended by mothers with children at school. A large attendance is seldom obtained, but even if only a small number of mothers attend, these may be able to help those who are unable to do so.

Various classes are held, often differing at the same centre year by year. They will include cooking, laundry, mending, cutting-out, sewing, knitting, millinery, etc.

In some districts a fully trained Domestic Economy teacher is provided, who devotes her whole time to this work.

## CHAPTER VII

### THE CENTRE (*continued*)

IN addition to the phases of work already described, there are a number of other branches of assistance with which it is very desirable that centres, in at any rate large populous areas, should be associated, although not necessarily carried on at the centre. Such are ante-natal work, arrangements for securing aid from the various social agencies, and of food or milk for necessitous cases of mother and children, and also of dental care, the importance of which is difficult to over-estimate. Further forms of aid are dealt with in the next chapter.

**Ante-natal Work.**—As the development of child welfare proceeded, it became clear that it was not sufficient to deal with the child after birth. The health of the mother during pregnancy, and the conditions obtaining at the birth are known to exercise all-important effects on the future health of the infant. The conditions present at the birth of the child fall essentially within the purview of the doctor or midwife, since they alone are authorised to attend and take charge of confinements. These conditions can, however, be modified by care before the time of confinement. There are many matters calling for attention. The mother's health, the presence or absence of ailments, whether directly connected with the pregnancy or not, her habits of life, her food, clothing, exercise, etc. : the provision

for confinement, both for herself and for the baby: the baby's clothes, sleeping place, etc. In fact, as in the case of child welfare work, ante-natal work has both preventive and curative aspects.

Every mother should be placed in the path of health, both for herself and for her infant. Many are ignorant, and do not know what they should do, nor how to do it. They are usually very glad of advice and assistance, if tactfully given by the right person. While many women do not need treatment at all during their pregnancies, it can hardly be denied that a general medical examination is advisable. Often some slight chronic trouble is present, which may produce trouble or difficulty during or after labour. Among these are cardiac disease, bronchitis, bad teeth, chronic septic trouble in any part, etc. Such matters clearly demand medical care, but the patient does not always know of their presence and may not regard them as deserving of any attention. In such a case the condition will ordinarily not be discovered until it is too late to avoid the consequences of neglect.

When a doctor is engaged to attend the case, a complete routine examination is not usual unless the mother complains of some ailment.

If a midwife is engaged she must refer cases of ailments to a doctor, but she will find it difficult to persuade many mothers of the desirability of the trouble and expense of the medical examination unless there is some definite complaint. Power to pay doctors' fees in cases of pregnancy was conferred by the Maternity and Child Welfare Act, but so far, no special fee has been fixed, and arrangements for providing it are, at present, very limited indeed. The task of advising the mother how to secure adequate and suitable provision for the confinement should be, and is regarded as, the duty of the midwife in those cases where one is engaged. But, in the present conditions (see Chap. XVII) many mid-



wives cannot afford the time which would be required, and, moreover, the untrained midwives are usually not in a position to offer such advice.

These considerations have led to the demand for ante-natal care at the child welfare centres, and this is provided at a considerable number of them.

Great care should be taken, however, to co-operate with the doctors and midwives practising in the district. In some districts where co-operation has been established from the first, the centre has proved of great benefit to all concerned. The midwives have felt that they were receiving due consideration, and that they were in no danger of losing their cases. Unfortunately, these important considerations have not always been borne sufficiently clearly in mind at all centres, and much opposition has been aroused among the doctors and the midwives of the district.

Ante-natal work has undoubtedly been brought into prominence by the efforts of the centres who are in a position to see the disastrous effects of the neglect of ante-natal care in all its branches, and there is no more vital need for child welfare than adequate care of the mother before, during, and immediately after childbirth. While the centre has a place in this, and can do most valuable work, it is a late arrival in the field of midwifery work, and more good will probably result by endeavours to improve existing agencies than by trying to take over a part of their work. The centres feel that they can achieve more in a short time than is likely to be the case if the ante-natal work is left to be gradually undertaken by midwives and hospitals. It is true that the progress with these agencies taken over the whole country is bound to be slow, but it is doubtful whether the process of, as it were, superposing ante-natal work over a structure which, although imperfect, already exists, and should be made to bear it, will fulfil the purpose intended. Ultimately the work must be

done by doctors and midwives, either in the home or in hospitals, as a part of the medical service of the country. There is room for all, but the shortest cut on a steep path is not always the quickest. Much technical matter is bound up with ante-natal work, certain aspects of which will be dealt with in connection with the work of midwives.

**The Provision of Dinners for Mothers.**—At most centres in a poor district need will arise among a few mothers for the provision of a good meal. Such provision, when made, is confined to expectant or nursing mothers, and is designed to secure a healthy child, and, later, to maintain breast-feeding. Some people disapprove altogether of this provision on the ground that the aid is purely temporary, and that, in many cases, the mother could perfectly well afford to provide herself with adequate food, but that she is either too ignorant of cooking or generally unwilling to exert herself, and it would be better to persuade her to look after herself than to feed her. Doubtless these criticisms are just, but there are cases where the mother is too depressed, or too ignorant to be able to manage for herself during pregnancy. Very careful investigation should, however, be given to each case lest the system should degenerate into mere charity.

In some places the dinners are provided elsewhere than at the centre, or arrangements are made with a cheap restaurant or the invalid kitchen to feed special cases. The beneficial effect secured by providing a good meal, even four times a week, is surprising, and may enable breast-feeding to be continued for the full nine months.<sup>1</sup>

<sup>1</sup> Although adequate food conduces to breast-feeding, too much food appears to have the contrary effect. Women of the better-to-do classes who are persuaded of the importance of eating largely to maintain the mammary secretion, do not obtain successful results. The process is a natural one, and an ordinary diet should be pursued as far as possible. The mother should eat sufficient,

The meal usually consists of either a good thick soup with vegetables, and perhaps suet dumpling, or meat, with potatoes and vegetables, followed by a good plain pudding, sometimes with stewed fruit. The menu will vary greatly with the opportunities for buying food. The sum paid by the mother is generally about 50 per cent. of the cost price, and may be much less—a few dinners are often given free. Under the Maternity and Child Welfare Act of 1918, money may be obtained from the rates for the provision of food for mothers. It is usual to require a certificate, either from the medical officer of the centre or from an experienced health visitor, for admission to the dinners.

**The Provision of Milk.**—There is probably no branch of child welfare work which has attracted more attention than the provision of milk for artificially-fed children. The dislike of hunger is a primitive instinct, and the appeal for food finds an echo in the hearts of most people. How much more is this the case when the only food required is milk, as is the case with young children in the early months of life.

The provision of milk was one of the main early aspects of the child welfare movement, and only after many years was the fallacy appreciated. There were two errors—one, the most important, concerned the whole question of artificial feeding. There was a widespread belief that the human species was becoming effete and unable to provide breast-milk, so that artificial feeding was necessary. The experience gained during recent years has shown that nearly all women can breast-feed their babies if they are taught how to manage the feeding. The mammary gland is still capable of function, but it has often been asked to put up with treatment which defeated the object in hand. Probably the two-hourly feeds, still, alas! advocated by many, but over-feeding has been found to have a detrimental effect on the supply of breast-milk.

have done more than anything else to discourage breast-feeding. The milk depot encouraged the belief that artificial feeding was necessary and eased the path to the mother. It undoubtedly tended to discourage breast-feeding—there was ordinarily no medical supervision, and the mother not unnaturally thought that as the milk was specially provided it must be good, and she might be spared the trouble of breast-feeding, seeing that all was ready prepared for her.

The other main source of error arose from the tendency to regard the feeding as the most essential need for the well-being of the infant. While it is, of course, true that the child will die if it is not fed, it may also die, even when receiving sufficient food, if its general condition and surroundings are unsatisfactory. Milk depots, originally believed to be a prime factor in child welfare, have been found to be only an accessory feature.

The early milk depots provided pasteurised milk in bottles of different sizes according to the age of the child. There were standard mixtures and standard quantities to the feed. The depot cannot make up special feeds for each child, the labour and time required are prohibitive in cost. Yet the more experience is gained with regard to artificial infant feeding, the more clearly does it appear that each child must be considered individually. There is no standard amount or standard mixture which is exactly suitable for children of different ages or of different weight. The six or seven stock mixtures of the milk depot of fixed amount, and arranged for a definite number of feeds in the day, are not satisfactory.

The milk depot cannot be run without considerable expenditure of money. The mother cannot ordinarily afford to pay more than the cost price of the milk itself. In addition to the initial outlay on plant, there is the cost of labour, of the fuel for the pasteurisation, the

continuous wear and breakage of bottles in the process of heating, the rent of the depot, etc.

Even when worked with regard to economy, the milk depot is an expensive matter, and the money available would be better employed in other branches of child welfare work.

The expense of the milk depots, and the fact that they did not appear to be producing the effect anticipated, prevented their development on a large scale in this country. Also, it was realised that very few mothers were able or willing to send regularly to the depot for the milk, and that, at intervals, the child was fed as the mother might decide, from milk obtained at any dairy. The milk depot is not educative. It does not teach the mother how to feed her baby even artificially, and rather discourages breast-feeding, unless proper medical supervision is arranged for.

If cow's milk is supplied in any form, it should be on the advice of a doctor only, and should only be given on the condition that the child is brought up regularly for medical supervision.

The pasteurised milk depot gradually gave way to dried milk as this commodity was placed on the market. At the present time only a very few places provide any other form of milk, and the majority of centres make some arrangement for the provision of such milk.

This is not the place to embark upon a discussion on the merits or demerits of dried milk as a food for infants, but a few remarks may not be out of place. Usually the milk is purchased wholesale and sold at cost price retail. A considerable saving to the mother is thus effected. The use of dried milk has now been very large for a number of years, and much experience in its use has been gained. Yet, although there have been many years of experience on the question of artificial feeding for infants, the details are still the subject of warm dis-

cussion, and no agreed system is advocated by those concerned.

There is probably no one subject in medical literature which has formed the subject of more discussion than milk in its various aspects. One school of thought pressed for the use of raw milk, and another for the use of sterilised milk, and so on. Now we have the discussion on dried milk as against other forms of cow's milk. It is hardly likely that any one form of artificial feeding will find acceptance with all advocates, just because the whole procedure is artificial.

A breast-fed baby has, as it were, greater license. It can take more milk than it really wants, and within reasonable limits no harm results. Its digestive organs can deal with varying quantities of the natural food. But cow's milk, of which the constituents, while similar in type to those of human milk, are yet different in composition, requires much more care if the digestive organs are not to be upset. Over-feeding with cow's milk will lead to a degree of indigestion which is not found in breast-fed babies, and a host of other troubles follow in its wake. It has been justly said that a baby lives on its alimentary canal in the early months of life. If the functions of that complicated organ are deranged, the whole organism suffers, and may die as a result.

There is a school of thought that regards all dried food as unsatisfactory, because certain so-called "vital" properties are believed to be destroyed in the process of drying, or even of the heating in pasteurisation. This remark at once leads to the much vexed question of the extent of heat employed in heating milk, and on this matter there is great confusion in the literature, both of thought and of language. It may therefore be well to set out the true position. Pasteurisation means that the milk, or whatever substance is under consideration, is heated to a temperature considerably below boiling

point, and 180° Fahrenheit is the usual figure given in this country. As soon as the temperature is reached, or at most, after two minutes at this temperature, the milk is rapidly cooled by the use of cold or of iced water, and should subsequently be kept at a low temperature until it is used.

In conversation the term "pasteurisation" is frequently used to denote any form of heating milk where a low temperature is subsequently applied. For instance, it is applied where the milk is raised practically to boiling point, and even when such a temperature is maintained for prolonged periods.

Then again, the term "sterilisation" is applied when really pasteurisation is meant. Many people call milk which has been heated in any way "sterilised," whereas this term should only be applied to milk which has really been rendered sterile. Sterility is difficult to obtain with milk, and a temperature above boiling point will be required. Again the term "boiled" is often used without any comment as to the method used, that is, whether boiled over the flame or in a jacketed pan, and without any reference to the length of time of boiling. All these matters make a difference.

There is no advantage at all in heating milk beyond the temperature required for pasteurisation. The object of heating is to kill certain germs which may be harmful. These are killed by pasteurisation, and the other varieties, while reduced in number, are not all killed even by boiling. The pathogenic germs reach the milk from two main sources, the cow herself and the workers on the farm or dairy. A great many cows in this country are suffering from tuberculosis, and the bacilli are passed out in the milk. Although with precautions much can be done in a good dairy farm towards eliminating this disease, it is hardly possible with our present methods to state definitely that any given specimen of milk contains no tubercle bacilli. Again,

cows suffer from inflammation of the udder, and in such cases streptococci are found in the milk which may cause bad sore throats in those drinking it. Both varieties of bacteria may be passed into the milk when there is no obvious disease in the cow when examined by the veterinary surgeon.

Then again, the milkers, or those handling the milk at later stages of its transit, may be carriers of disease, such as tuberculosis, enteric fever, or diphtheria, and outbreaks of scarlet fever have been traced to the milk supply. Many possible sources of infection can be removed almost entirely with due care, but it will probably not be possible to be certain that there is at no time a source of infection among the workers. The dangers from the cow are even more real, because infection with tuberculosis is widely spread in many herds.

Some heating of the milk is essential in order to remove the risk of harmful bacteria. No milk should be taken raw. But, as already explained, pasteurisation if properly carried out is sufficient. The heating should be carried out after the milk has been put in the receptacle from which it will be taken by the individual and not before. It is sufficient to heat the receptacle in a vessel of water, and to allow the water to boil for two or three minutes. The milk does not reach the temperature of the water. The receptacle should then be plunged into cold water, and remain there until required for use.

There has been, and still is, much discussion as to the detrimental effect of heating milk. Certain substances known as "vitamines" are necessary for the maintenance of health. Their absence may cause infantile scurvy and possibly rickets. These substances, which are present in small amounts in milk, are stated to be destroyed by heating. But here much confusion has been caused by the lack of definition in regard to the length of time the milk has been heated. In some of the experimental work undertaken, the milk was heated



for an hour at boiling point, and was then found to have suffered the loss of some of the vitamine-content. But, if pasteurised, it appears that no appreciable loss is incurred. There is nothing to be gained by heating beyond this point, so that from this aspect, pasteurised milk can be safely used; nor is the food value of the milk reduced—in fact, heated milk is found to be more easily digested than raw milk.

In the processes of drying milk may, for a few seconds, be exposed to a temperature somewhat above that used in pasteurisation. The special methods employed reduce the time of heating, and it has not yet been shown that the vitamine-content of dried milk is reduced appreciably below that of the original milk. It is not unlikely that some small loss may occur. Practical experience has, however, shown that dried milk can be used for infants with excellent results, if proper precautions are taken. Over-feeding with dried milk, and its subsequent digestive disturbances, seem to occur more readily than with pasteurised milk. But this may be due to the instructions on the tins of the milk, which often advise a great deal too much milk and too many feeds. Although the mother may be told to follow the doctor's instructions, and not those on the tin, it does not follow that she will do so, and many women think that the more a child can be got to take, the better it will be. Hence unfortunate results may occur owing to the excess of zeal. It is so easy just to add a little more of the powder, and the directions printed on the tin will appeal to the mother.

Some doctors advise that fruit juice, of one kind or another, should be taken with dried milk after the first few months. It is very doubtful how far this is necessary, but many children who are fed artificially seem to improve more rapidly with the addition of fruit juice or of a small amount of fruit puree after about six months of age.

The report issued by the Local Government Board<sup>1</sup> on the use of dried milk, shows that dried milk properly used is a satisfactory artificial food for infants. It cannot, however, be too clearly stated that no known artificial food can adequately replace natural feeding.

Dried milk has the advantage of being comparatively sterile, and of keeping for some time after the tin is opened, also only the amount needed at each feed is used, and there is no waste involved.

Milk is undoubtedly a necessity for children up to about eight or nine months of age, but the milk should be that of its own species, namely, mother's milk. It is probable that breast-feeding is now more common than it was a few years ago, but there are still too many children who are fed artificially: for these cow's milk in some form is necessary. After the age of eight or nine months milk gradually ceases to be a necessity as the child's organs become able to digest other food. Its value as a foodstuff decreases, and the child needs variety of food. Milk is not a foodstuff of great value for adults. No other species of young take milk after weaning, and there is no real need whatever for the human infant to do so. We have got accustomed to the idea of milk, and to regard it as a necessity for children and for cooking. But at the present price of milk especially, much better food value can be obtained with other less costly foods. The statements as to the immense quantities of milk often said to be necessary for children are quite erroneous.

Then again, so much is talked of the value of milk for expectant and nursing mothers. There is no special value in milk for mothers; any other good nourishing dietary will do equally well, or better. It sometimes seems that people are under the impression that milk taken by the mother is utilised directly by the mammary

<sup>1</sup> Report to the Local Government Board by F. J. Coutts, M.D. (Food Reports, No. 24).

gland for its secretion, and mothers are advised to drink milk half an hour before they feed their babies. Milk, like all other good foodstuffs, is broken down into the simple substances, and the mammary secretion, like the other secretions, requires building up from simple bodies.

A number of local authorities are preparing to spend considerable sums on the provision of milk for mothers and infants. It is well known that infant mortality was low during the worst cotton strike, when, although poverty was great, the mothers stayed at home and breast-fed their babies, and the same effect is stated to have been produced in Germany during the recent war. It is hoped that local authorities will pause before spending large sums of money on milk. There is no doubt the money could be better employed.

The following letter, which appeared in *The Times* on 3rd September 1919, is of interest in this connection:—

#### “MILK FOR CHILDREN

“*To the Editor of ‘The Times’*”

“SIR,—You will remember that during the war we were accused of murdering German babies through the reduction of milk supply attributable to some extent to our blockade. The current number of the *Revue Internationale de la Croix Rouge* shows that infant mortality in Germany decreased, especially in the big towns. In 1914, 15·1 per cent. of infants died within the first year in the whole of Germany; in 1916, 14·8 only. In the towns of over 15,000 inhabitants the figures were 14·1 and 13·3 per cent. In Switzerland in towns of over 10,000 inhabitants the fall was from 9·9 to 6·9 per cent. Here follows the explanation:—

“Comment expliquer ce fait curieux outreusement que par la pénurie du lait en temps de guerre et l’augmen-

tation par compensation de l'allaitment maternel.' The whole article is written to prove the greater life-chance of the mother-fed infant. It looks as if the coming scarcity of milk in England may induce English mothers to nurse their own children (if they can), and so give them a better start in life, besides diminishing our present mortality rate of 10·7.—Yours faithfully,  
 "W. A. B."

**Dental Work.**—This is undertaken at a fair number of centres, and in other places some arrangement is made, either with a local dentist, or with a school clinic or hospital for providing such treatment for cases sent on from the centre.

The vital importance of sound, clean teeth is being increasingly recognised among all classes. The utterly deplorable state of the mouth of large numbers of people requires remedying before we can hope to become a healthy nation. A decaying tooth is, in fact, an open sore, the exudation from which, being continually mixed with saliva, is for the most part swallowed, but also infects all parts of the mouth and lips and fouls the breath. Bad teeth are a source of great danger to the possessor. Small, or in bad cases, large doses of toxic material are being continually absorbed, and affect the condition of the whole body. Waller<sup>1</sup> has shown that the removal of bad teeth in a nursing mother effects a tremendous improvement in the growth of the child, and increases the mammary secretion. It is horrible to contemplate the effect on an infant of being frequently kissed by a mother whose very breath is infective, and most people who have had to do with child welfare work will recall cases where the dummy teat, in itself a vicious thing, has been rendered actively harmful by being previously sucked by a mother with a foul mouth. The mother has got so

<sup>1</sup> *Lancet*, November 1916.

accustomed to the condition of her mouth that its disadvantage to the infant does not occur to her.

Dental care should be regarded as an important branch of ante-natal work. The old idea that it was dangerous to give gas to a pregnant woman has been found by Waller<sup>1</sup> not to be correct, and the bad teeth constitute a risk to the mother of septic complications at the confinement. Any septic spot will be liable to cause trouble after a confinement, and bad teeth have been found to be the cause of death in a number of cases. In addition, there is the great improvement of health which follows on the removal, either by extraction or stopping, of the decaying spots.

The provision of dentures will be necessary in a number of cases, and may require a great deal of trouble. It is usual to endeavour to obtain a part of the money at least from the mother herself; there are also, in some places, voluntary funds, and the centre, if necessary, will find some of the cost, and can receive a part repayment from State funds.

The cost of establishing a separate dental department is considerable, owing to the special fittings and instruments required. In London a few of the large centres have opened dental clinics for their patients, which are also used by the London County Council for school children, the Council paying a *per capita* grant for the use of the clinic.

It is difficult to overrate the value of dental care, and the increasing number of clinics is a hopeful sign.

The number of school children under school age whose teeth require attention is lamentable.<sup>2</sup> Bad first teeth affect the second teeth, so that the former should be carefully attended to.

The recent work by Mrs. Mellanby<sup>3</sup> shows that the growing teeth are affected by rickets, in which con-

<sup>1</sup> *Loc. cit.*

<sup>2</sup> Cf. figures in Appendix II.

<sup>3</sup> *Lancet*, December 1918.

dition the enamel is not laid down properly, and the underlying dentine is thus deprived of its protecting coat. The condition also adversely affects the development of the jaw.

Lawson Dick<sup>1</sup> found evidence of rickets in the teeth of 52 per cent. out of 586 rickety children examined by him in the course of school medical inspection.

Mellanby<sup>2</sup> has shown that an unsuitable dietary is a primary factor in producing rickets and badly formed teeth in young dogs, and there is every reason to believe that this is applicable to children.

**Social and Charitable Work.**—Child welfare work is not a form of charity, and this should never be lost sight of. In the work of the centre there must inevitably be cases where various forms of charitable aid will be required. But such aid should not be given by the centre itself. Those who work at the centre should be aware of the various charitable agencies which exist, and should use their efforts to secure assistance from the appropriate agency. The agency concerned will have proper channels of information and of assistance, which should be made use of.

Co-operation and co-ordination of effort should be aimed at in all cases. The charitable agencies will have cases they wish to refer to the centres, just as the centre has cases to refer to the charitable agency. If each organisation tries to do the work of other bodies there will be overlapping of effort, waste of time and money, and, which is not less important, the work will probably be less well done, owing to the absence of special knowledge on certain points.

The responsible workers at every centre should regard it as a part of their duty to be acquainted with the work of the various agencies for social and charitable

<sup>1</sup> *Proc. Roy. Soc. Medicine*, 1916, vol. ix. pp. 83-9.

<sup>2</sup> *Report on the Accessory Food Factors* by the Medical Research Committee, 1919.

work of the district : they should go further and make themselves personally acquainted with those who are carrying out the work. Personal acquaintance removes many sources of difficulty and prevents many troubles. A little time devoted to a personal interview with the responsible agent of the society in question about a special case is time well spent.

Doubtless, with the expected passing away of the Poor Law and the presumable increase in the powers of the local authority for material assistance, there will be a greater tendency to dispense such aid at centres for child welfare. It will be a tragedy if centres which have the opportunity for doing such admirable preventive work come to be regarded as organisations for the distribution of material relief.

## CHAPTER VIII

### THE CENTRE (*continued*)

THE varied activities which have been described in the preceding chapters would, by common consent, be described as falling under the heading of preventive work. That is to say, the measures are all directed towards the maintenance of health and the prevention of disease. There are in addition several branches of work which are being increasingly undertaken at child welfare centres which are less directly preventive in their scope.

Such measures trench closely on curative medicine. The dividing line from the work of some centres and that of certain phases of work at some hospitals is fine and in many instances difficult to draw.

The several branches to which reference is made are :

1. The provision of drugs and beds for children.
2. The provision of treatment for children from two to five years of age.
3. The provision of facilities for treatment of maternity cases.

There is much divergence, both of opinion and practice, in regard to the provision of drugs and of arrangement for treatment generally at child welfare centres. The point is one of great importance and it will be well to consider the position fairly fully.

1. **The Provision of Drugs.**—There can be little doubt that the provision of treatment in any form was not contemplated when the infant welfare move-



ment was first started. It is, however, clear that no movement of such a kind could continue long without meeting the numerous cases of ill-health which are too frequent among children of (apparently) all countries. With the greatest care, illness is unavoidable among a number of infants, and the clientèle of the infant consultation soon had sick children for whom they sought advice. It was necessary either to send the child to a hospital or to a private doctor, or conversely, to treat the child at the centre. This last method was recognised as being ordinarily undesirable on many grounds. The local doctors and the hospitals objected strongly as causing overlapping of effort, and also because except in cases of minor ailments better facilities for treatment were available at the hospital than at the centre, and the local doctors very naturally objected on the ground of the treatment at the centre being free. They contended, very justly, that many of those attending the centre could well afford a doctor's fee, and that the cases should be referred to their doctor, or, if too poor, to the local hospital if there was one.

Another point which does not always receive the weight it deserves is the fact that the centres are only open on certain days and hours, and a sick child may need care within those specified times. The mother must then (unless it should occur on the day she is due at the centre) take the child to another doctor or to the hospital. Objections are raised, not unnaturally, at taking over from another practitioner a case which has become acute. The objection is not mitigated by employing a local practitioner as the medical officer to the centre, who can then see acute cases at either his or their own home. This is open to the serious charge of taking patients away from their own doctor, since many of those who attend the centre will have their family doctor, who may not be the medical officer of the centre. Cases where the ailment is liable

to need attention before the next consultation should in no case be treated at a consultation.

On the other hand, the centres feel that it is not satisfactory to send children from the centre to the hospital or doctor for minor ailments. Very often the child requires some treatment, but the mother has not considered it worth while to pay for the doctor or to wait some hours, as she may have to do, at the hospital. Not infrequently, therefore, the child remains untreated and progress is impeded. Clearly, it seems simpler for the centre to undertake the treatment of such cases. Again, it is argued that the local doctor may not pay much attention to slight matters which the centre has detected. Compared with the troubles with which he is dealing among his patients, the little trouble of the infant, not severe in itself but requiring attention, seems hardly worth while to treat. While it is said that the general practitioner is not interested in the minor ailments of children, he or she is not likely to become more interested if these cases are not referred to him or her.

Troubles due to errors of dietary have always been regarded as falling within the work of the centre, since for the most part they can be cured by alterations in the dietary and other points of general advice. It is usually agreed that sodium citrate, dusting powders, single doses of aperients and one or two other similar substances may be regarded as legitimate for child welfare centres. But general cases of sickness requiring drugs should not be treated at the centre.

There is also another subtler objection but one which is nevertheless real. If drugs are given freely at a centre, there is a strong tendency to give them in cases which do not really need them, and which, if due care were exercised, could be dealt with at an earlier stage by hygienic methods. This last is vastly more educative for the mother and better for the child, but it is greatly

to be feared that, if drugs are allowed, there will be a tendency to turn to them. The centre would thus approximate to the out-patient department of a hospital and have travelled far away from the original cause of its establishment. If, after due consideration, treatment is encouraged at the centres, it should be administered on separate days and only in cases of minor ailments.

Then there are rickety children requiring treatment over long periods with expensive material such as cod liver oil. For the most part doctors are not anxious to have many of these cases, as they need a good deal of advice, and the mothers are frequently unable to pay either the fees for the visits or the cost of the drugs and food prescribed. It is common for centres to buy cod liver oil in large quantities and also malt, and to sell these at cost price to those children for whom it is prescribed by the doctor at the centre.

A useful practice has developed for the summer at certain centres where there is a garden. Certain cases of dietetic troubles, or other forms of minor ailments which may be considered suitable, are put in the garden during the day. They are brought by their mothers in the morning. The mother can also come to feed if the child is on the breast. Excellent results have been obtained by this method, especially in the case of babies who have developed the habit of screaming or who are suffering from too frequent or unsatisfactory feeding.

The improvement obtained in many of these cases is quite remarkable, and the mother is able to see for herself that only simple measures are being adopted. The nervous, irritable infant calms down under regular feeding and open air and obtains the sleep it needs.

There seems no doubt that a number of troubles arise in infants from nervous conditions, and it is stated that these have been increased since the beginning of the war. Very often there is no organic trouble at all, but the child

needs quiet and good care in order to establish its health and ensure satisfactory progress. Hospital treatment is not required but the home care is not sufficient.

Then there are cases of more severe nutritional disorders. Such ailments should certainly not be treated at centres unless special provision is made. This has been recognised, and a number of centres are now making special arrangements for dealing with some of the babies who attend the centre but fall sick. Every child welfare centre has cases on its books of children who are not acutely ill but are perhaps suffering from some nutritional disturbance which does not yield to the mother's care, requiring more attention than she can give. These cases often need only a short period of adequate care in order to be re-started on a satisfactory basis. To meet this need wards have been opened and a nursing staff provided to look after babies, while the advice is given by the doctor of the centre. These wards are variously called "observation wards," "babies' homes" or "baby wards," and it is not intended that they should take cases of illness which require full hospital care.

The beds for the purpose above described, whether in summer in the garden or in a ward, are undoubtedly of great value, but the whole question of beds in connection with child welfare centres needs to be approached with caution. So long as they are kept for cases which do not require and perhaps are not suitable for hospital treatment, no objection on general grounds need be raised, but, on the contrary, the beds are valuable.

If, however, they should be allowed to become merely small hospitals, the effect would be disastrous. Small hospitals are either extravagant, both of skilled service and of money, or they are of inferior quality. If acute cases are admitted there should be a resident medical staff and this is costly for a few beds only.

The centres were established for preventive work, and while it is no doubt difficult to draw a hard and fast line

of distinction between the different spheres of work, as a whole purely curative work should be discouraged at child welfare centres. At the moment the position is complicated by the wholly insufficient provision of hospital beds for children all over the country. Such accommodation as exists is already severely taxed to provide for the acute cases of illness even in districts where in-patient care is available at all. The Ministry of Health makes grants towards the maintenance of beds connected with the centres, but not towards the beds in a hospital, unless the beds are reserved by arrangement with the local authority for the use of patients sent in through one or other of the channels of child welfare work recognised by the authority.

The problem is not easy—voluntary funds at present supply the upkeep of practically all hospitals, other than Poor Law infirmaries, and until recently,<sup>1</sup> the rates might not be drawn upon for sick children outside the Poor Law. The Maternity and Child Welfare Act of 1918 gives power to build and maintain maternity hospitals, but the expenditure of considerable sums of money on children's hospitals has not so far been very favourably viewed by the Local Government Board. This branch of work is directly curative and should be undertaken in connection with any adequate organisation for medical services generally, rather than as an extension of child welfare work. In the meantime, a few of the larger local authorities are giving grants towards the maintenance of children's beds in connection with centres on the understanding that a number of them are reserved for patients from the municipal centres for child welfare. These beds are usually reserved for cases of alimentary disturbances.

It may be necessary for a little while to allow or even

<sup>1</sup> Power to spend money on hospital beds for children under five was conferred by the Maternity and Child Welfare Act of 1918. See Appendix III.

to encourage somewhat the provision of treatment at the centres. But the aim should be to provide proper facilities under the recognised auspices for dealing with sick children, namely, the hospitals and local doctors, and to reserve the centres for preventive work.

Human nature will probably always have a greater attraction towards cure than towards prevention. It is impossible to tell at once what may have been prevented, but curative measures show results in a short time. The ideal is that there should be no ailments needing cure. At the present time there is a great deal of illness among children, and if treatment were definitely taken on by the centres they would soon be flooded with curative work and the preventive work would be crowded out. In some centres this is already the case. The question is not simple and involves many issues, but no effort should be spared to keep the preventive aspect prominently forward as the main object of the centre.

It is difficult to say how far treatment is undertaken at centres throughout the country, but there is reason to believe that the tendency has been growing of recent years and that care is necessary to prevent an undue development in this direction. Even if a medical service should be established, under which provision were to be made for the treatment of all persons, it is greatly to be hoped that the preventive aspect of the child welfare centre would be clearly maintained.

The above remarks apply specially to children under two years of age. After the child reaches three years the nature of its ailments approximates more to those of older children and are of a different nature.

**2. Provision of Treatment of Children from two to five years of age.**—The child welfare movement, when it first began, was directed to the prevention of mortality among children under one year of age. Gradually it was realised that much valuable work was undone

by the absence of provision for the care of the child at later periods. The physical condition of children attending school had been attracting attention about the same time. It was realised that much of the educational opportunities offered could not be utilised adequately by the children on account of their ill-health. In 1908 power was given to the local education authorities to provide for the medical inspection of school children, and several authorities soon got to work. The amount of ill-health among the children which was then revealed was very appalling. The children examined on entering school were found to be suffering from one or more ailments, in nearly two-thirds of all cases. Some of them had probably been subject to the trouble for a considerable time before they entered school, and it was recognised that they should have received treatment at an earlier date. At first treatment was not provided by the local education authorities, but it was found if the parents were merely advised to take the child to a doctor or hospital even if arrangements were made by the authority, that very frequently no action was taken by them.

Hence, special clinics for treating common ailments have been growing in number under the auspices of the local education authorities. Such clinics usually make provision for dealing with enlarged tonsils and adenoid growths, with defective vision, minor troubles of the eyes, discharging ears, minor skin troubles, and in many cases a dental clinic is arranged.

The truly alarming amount of ill-health among entrants brings out very clearly the urgent need for dealing with these children before they enter school. This should be undertaken as a branch of child welfare work.

After about the age of two years the child's ailments approximate to those of older children and at three years of age there is little distinction between theirs and those of children entering school.

Medical supervision should be exercised right up to school age, and home visitation is usually necessary as well. When the child attends school it can be reached with ease, but it is more difficult with the younger children who are at home. The mothers often will not bring them up to the centre and home visits will be required for the detection of ill-health. These visits will be paid by the visitor, who will urge the mother to attend the centre if the child is not progressing favourably. There should ordinarily be special days, as already mentioned, for children of this age, unless only the medical inspection is undertaken on that day.

The question of treatment for children of this age assumes a different aspect from that among the younger children. Greater facilities are required which are frequently not available in a doctor's surgery, nor in the homes of the patient. It is no use referring many of these cases to the local doctors on these grounds, and the local hospital often does not undertake work of this type. Again there is the difficulty of fee. The mother may be unable or unwilling to pay the fee for such treatment by the local practitioner, even though the fee be in reality moderate. Further, if all these cases were to attend the surgery, the doctor would be overburdened with them. At present in the majority of instances they are not treated until they enter school.

The need for provision of treatment for these children is now being recognised and in some places provision is made, but the work among children from two to five years of age lags sadly behind in its development as compared with that of children under two and over five.

It will evidently be waste of effort to provide separate clinics for children under school age, and so far as it is at all possible arrangements should be made for the children to be treated at the school clinics. Hitherto some difficulty has been experienced owing to the fact



that the child welfare work has been undertaken by the Public Health Department, and the work among school children has been under the local education authority. Further, in some areas, the authority may vary and the two branches of work be under two separate authorities. Now that the Ministry of Health is responsible for the health of school children, these difficulties should be minimised, and it is to be hoped that a great extension of work among children under school age will result.

As the provision of medical service for the whole country improves, the work, both among children of school age and under school age, will no doubt be brought in to form part of the services provided.

While it is not possible here to deal at length with the ailments of these children, it will be of interest to show something of the prevalence of the various troubles. The figures of the ailments found on medical inspection among the children of London in 1917 are given in Appendix II, and further information can be obtained by reference to the very interesting reports published each year by the Medical Officer of the Board of Education, Sir George Newman, where the figures are given in greater detail for the whole country.

**3. The Provision of Treatment for Maternity Cases.**—There is no need at the present time to emphasise the necessity for the care of the mother both before and after the birth of the child. The early work undertaken in connection with the medical examination of expectant mothers showed that there was a great deal more ill-health among women than had been believed. Ante-natal work, as already described at the centres, does not necessarily imply the treatment of ailments. Such treatment, however, must be arranged for somewhere if the best results are to be obtained from the work. The same difficulties arise as in the question of treatment among the children, only

the case is more urgent. The health of the mother affects that of the unborn infant, and there is only a limited period within which to take action.

The facilities at present available for the treatment of minor ailments is as insufficient as in the case of infants. Some doctors are interested in this branch of work, and do much good among their patients, and also take trouble with cases sent on to them from midwives. Often the treatment most needed is merely rest and general care, which may be the most difficult of all for the mother to secure.

In some large towns homes of rest for such cases are now available, but in many instances the absence of the mother from home involves grave difficulties.

Pregnancy should not be regarded as a pathological condition, and the general improvement in the conditions of life among the poorer classes which the war has brought about should materially assist in reducing the amount of illness among the poorer mothers. The treatment of the present ill-health among them is, however, of great importance.

The provision of treatment at a centre involves some complications. Every woman must be attended at the confinement by either a doctor or a midwife, and ordinarily she will be sent up to the centre by whichever of these she has booked with. There will, of course, be a few cases which attend on their own account, and before they have booked. The centre should, however, induce them at once to book with either a doctor or a midwife, or, it may be, with the out-patient midwifery department of a hospital.

But this, in effect, removes the woman from the care of the centre, unless the doctor or midwife agrees that she shall continue to attend.

It is impossible to say if there is any practice on the question of treatment, as each centre doing ante-natal work will make its own regulations. Also com-

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paratively little of this work is carried out as compared with the infant welfare work.

The provision of facilities for confinement is not ordinarily undertaken by the centre. A few employ a midwife to attend the cases, especially if there is a shortage of midwives in the district. Some local authorities are now working small maternity hospitals with great success, but usually separate from the centre.

The question of the provision of maternity beds is discussed in connection with the midwifery service in Chap. XVIII.

Generally the position is that the centres are fully alive to the need for the treatment of ante-natal cases, but the difficulties are great, both on the grounds above mentioned, and also because it is difficult to get hold of the mothers, many of whom do not realise that they need care, and do not, therefore, make any effort to apply for it. As the women themselves get to appreciate the need for improvement in their own health the nearer will the problem be towards its solution.

## CHAPTER IX

### THE ORGANISATION OF CHILD WELFARE WORK IN URBAN AREAS.

IN the preceding chapters the work of the visitor under the Notification of Births Acts, and the activities at or connected with a centre, have been considered, reference being made occasionally to the machinery for carrying out the work. If the full benefit is to be obtained without overlapping and unnecessary expense, a great deal of forethought and watchfulness is required on the part of those who are responsible.

In a few areas, notably in Metropolitan boroughs, the greater part of the work is carried out by voluntary agencies. In the provinces generally the amount of responsible voluntary work is relatively small as compared with that of the local authority.<sup>1</sup> There can, however, be no doubt that the responsibility for the work, for its organisation, economical working, and avoidance of overlapping, rests everywhere on the local authority. The refusal to undertake their responsibilities does not remove the duty.

In this chapter the general organisation alone will be dealt with, the part played in it by voluntary agencies being considered afterwards.

<sup>1</sup> Recent figures obtained by courtesy of the Ministry of Health show that out of a total of 1583 centres throughout England and Wales 875 are worked by voluntary agencies. Of the 875, 153 are in the Metropolitan area. Of the 908 centres worked by local authorities, 622 are in the hands of municipalities, and 286 in those of county councils.

The Notification of Births Act of 1907 might, subject to the consent of the Local Government Board, be adopted by any local authority. It was found in practice that individual rural districts could not, other than in rare cases, work the Act without undue expense and difficulty. For the most part, at the present time, the work in rural districts, and in the smaller urban districts, is in the hands of the county councils. In this chapter the work in county boroughs, boroughs and urban districts of populations of not less than 20,000 is considered. In rural districts, the sparseness of the population renders a different organisation necessary.

The history of Local Government in this country forms a most interesting study, but one which is entirely beyond the scope of this work, except in so far as it refers to child welfare work. In order to make the descriptions given in this book intelligible, Chaps. XXII to XXV have been added, which supply, it is believed, sufficient information to make the position comprehensible to the student of child welfare. Here only a few preliminary remarks are made. The whole country<sup>1</sup> is divided up into sanitary areas whose boundaries are clearly defined. Each of these areas has its own council, consisting of a fixed number of persons who are elected by ballot by those inhabitants who are entitled to votes. In boroughs, the mayor is the chairman of the council, and other councils elect their "chairman." The councils are divided into sub-committees which deal with the detailed work falling upon the council. This differs according to the powers placed in the hands of the council concerned. All sanitary authorities have powers to deal with sanitation, and the detailed work is carried out by a public health committee, subject to the approval of the council.<sup>2</sup>

<sup>1</sup> England and Wales alone are under consideration in this book.

<sup>2</sup> Cf. p. 219 for information as to the Maternity and Child Welfare

While the town clerk or the clerk to the district council is the officer appointed to carry out the decisions of the council, the medical officer of health carries out certain duties under the direction of the council and of its public health committee.

The staff of visitors are appointed by the public health committee, and work under the direction of the medical officer of health as a part of the staff of his department.

The number of health visitors required will vary with the number of births, and with the amount of other work required to be done by the staff. The medical officer of health divides the area to be worked into districts, and allots a visitor to each district, the size of the district varying with its character. Centres should be arranged so as to be convenient for each district. Whether one centre can serve the districts of two health visitors will depend upon the situation and character of the districts. It is found that only a proportion of all the infants visited are brought to the centre. With the development of the work, the proportion is showing a well-marked increase. Some few years ago 25 per cent. of all infants visited was a high figure for entries at the centre. The more usual figure was 15-20 per cent. Now, in a fair number of towns, the proportion has risen, and 33 per cent., or about one-third of all infants visited, may be found on the registers of the centres. In a few districts the figures reach 50 per cent. of all cases visited.

It has been proved by experience that, allowing for departures from the district and irregularity of attendance, from 125-150 infants in the year is as large a number as can reasonably be dealt with for one consultation a week. This does not allow of more than an average of ten medical consultations per

Committee, now a Statutory Committee under the Maternity and Child Welfare Act of 1918.

infant, or about thirty consultations per consultation session, throughout the year. For one medical officer, thirty patients per half-day is almost too many for each to receive proper attention. At many centres a considerably larger number of children are sent through to the doctor at each session. But there are limits to the endurance of a medical officer, and it is generally admitted that twenty-five is really as many as can be dealt with adequately. There is no point whatever in merely passing infants through the consultation room so rapidly that there is no time for a proper consideration of each case. At some centres the children are sent up to the doctor whenever they are brought up, with the result that many of them have simply to be told to go on as before. It is waste of the doctor's time to send children who are progressing favourably to the doctor every week or fortnight. The intervals of the visits should be determined by the medical officer, and adhered to unless some untoward occurrence has supervened.

Supposing that not more than 150 infants be reckoned for each weekly consultation session at the centre, and that an attendance of 33 per cent. of all infants visited is allowed for, then each centre can deal with not more than 450 births, or with about the numbers allotted to a full-time visitor taking infants up to one year only.

It has been already explained that both visiting and attendance at the centre should be carried on up to school age, and that on this basis only about 250 births per annum at the outside can be allotted to each full-time visitor. Also that extra consultations should be arranged for the older children. Roughly, in a district of about 450 births, there should be at least one consultation day per week for infants, and one for young children under school age. The demarcation line is varyingly fixed between one and three years of age. In

such a district, it would be necessary to employ two whole-time visitors to carry out the child welfare work only.<sup>1</sup> These two visitors should then both attend the two sessions, and each be in the consultation room when the infants from their districts are being seen by the doctor. Each visitor should be able to spare two half-days a week for work at the centre, and the value of this arrangement has already been dwelt upon, both from the point of view of the mother and the visitor herself.

When work is being started in new districts it would be unnecessary to allow for the attendances of so high a percentage of infants visited. Probably for the first two years it suffices to allow for the attendance of about 15 per cent. of all infants visited. Also, the older children, not having been regularly visited at an earlier age, would not attend in large numbers. If the visitors are doing other branches of work, which occupy about half of their time, then the number of infants and of older children they can visit will be correspondingly reduced. This may render their attendance at the centre more difficult, since the centre may then serve four visitors' districts, without any increase in the number of children under school age. The difficulty can be met in various ways, and, although it may not always be easy, it is of the utmost importance that the visitor should attend the consultation when the infants she visits are being seen, and every effort should be made to secure this.

It is found that it is usually difficult or sometimes impossible for a mother to come to a centre which is more than half a mile away from her home. This involves the establishment of centres not more than a mile apart. The population and the number of births in

<sup>1</sup> This standard of staff is very rarely reached as yet, and would doubtless be regarded as excessive by many. It is, however, necessary if the best work is to be done.



any area of half a mile radius will differ in different towns, and in different parts of the same town. Hence, evidently, the number of centres required, and the number of visitors' districts each centre can serve, will differ, and no generalisation as to areas can be made. Where the district is congested, the centre can be open five days in the week, and two medical officers can attend on the same occasion, if necessary. This clearly involves the provision of sufficiently large premises in order to avoid overcrowding and delay at the centre.

The transport facilities available in the district will also affect the position and number of the centres required. Tramways being cheap, accessible, and the service frequent, the mothers may be able to attend from rather greater distances, although the expense and difficulty of carrying by tram several small children who cannot be left alone at home must not be forgotten.

Again, it is not necessary that all the activities described should be available at each centre. Mothers who are able to attend classes can probably go farther than for the consultations. They will usually attend one course in the winter or they may attend alternate winters, and so on. The medical consultation is the central activity of the centre, and this should be provided at all the centres. Other activities can be distributed in other centres. Thus, in Cleveland, Ohio, the sub-centres are open in the morning for medical consultations. Any case requiring treatment is sent on at once to one of the main centres, where, if necessary, it is referred to the children's hospital for in-patient or out-patient care; the hospital is regarded as part of the general scheme, but a distinct branch of the work.

Each town will need to have its own scheme, adapted to suit its distribution of population, tramways, etc.

**Staff of the Centre.**—The essential staff of the centre will be the medical officer and the health visitor. If the centre is very large, it is often found necessary to

appoint a superintendent of the centre. The superintendent will be responsible, under the medical officer of health and the consultation officer, for all the arrangements of the centre; for the adequate keeping of the record cards, and probably for some home visiting of special cases. The precise duties will differ in different places. When the numbers attending are very great a clerk may also be employed to assist the superintendent.

Further, there is a need for other workers, who need not be highly trained, and who will take charge of the "toddlers," talk to the mothers, help with the classes, etc. These duties can well be carried out by conscientious voluntary workers, although at many centres such help is not available.

At some centres in the largest towns, arrangements are made for consultant physicians for maternity cases. Again, where ante-natal care is undertaken, this may or may not be placed in the hands of the medical officer of the infant consultation. Great latitude must be allowed, and the intention in this book is merely to show the general lines upon which this work is carried out.

## CHAPTER X

### THE COMBINED DUTIES OF A VISITOR IN THE DIFFERENT LOCAL AUTHORITIES IN URBAN AREAS

REFERENCE has already been made in various places to other forms of work which a visitor may be called upon to undertake. When infant welfare work was commenced, it was usual to place the duties upon the female sanitary staff, who did yeoman's work in a large number of districts. As the work grew it became impossible for the existing staff to carry out both phases of the work, and gradually official visitors were appointed as infant visitors, usually termed health visitors. This latter term at present may or may not include infant visiting, depending entirely upon the nature of the health visiting work allotted to the worker.

It has already been explained that all local sanitary authorities were given power to adopt the Notification of Births Act of 1907, and to undertake work for child welfare at the cost of the rates by the Act of 1915. In order to understand how other duties have fallen to the health visitor some digression is necessary.

The Education Act of 1902 made all counties, county boroughs,<sup>1</sup> and boroughs having populations of 10,000 and over, and urban districts having populations of 20,000 and over, education authorities under the Act. All rural districts or urban districts, and boroughs of insufficient population to become education authorities in 1902, come under the county for educational purposes. When

<sup>1</sup> For further information, see Chap. XXII.

the medical inspection of school children was introduced in 1908, power to carry on the work was given to all the education authorities. The development of the inspection led to the following up or home visitation of many of the children. It was speedily realised that it would be more economical, and altogether more generally satisfactory, to combine the work of following up with the infant visitation.

The same visitor would visit for children of all ages, and time of travelling, and therefore cost be reduced. Hence many local education authorities place the school work upon the infant visitor. Some districts keep the work and workers quite separate, and there is a growing tendency in this direction in the large towns.

In 1911, with the introduction of the Insurance Act, and the tuberculosis work in connection with it, further home visitation was required. The duty of carrying out this work was placed upon the county boroughs and the counties only, so that the non-county boroughs and urban districts who are education authorities were not directly affected by the Act in this particular. A fair proportion of county boroughs have a special staff for the tuberculosis work, but a considerable number place this work also upon the health visitor. Some of the county councils make arrangements with the boroughs and urban districts, whereby their health visiting staff undertakes the tuberculosis visiting on behalf of the county.

In 1913 the Mental Deficiency Act was passed, but its execution has been delayed owing to the war. The duties are in the hands of county councils and county borough councils. This requires home visiting for many of the cases, and the work has already, in some districts, been placed on the health visitors.

The work which may fall to a health visitor may, therefore, comprise infant visiting, an attendance at the centre, including work among children up to school

age, the following up after school medical inspection, and, in addition, tuberculosis visiting among both sexes and all ages, also possibly, the work among mentally defective persons. School and tuberculosis work usually involve attendances at the inspection and dispensary respectively, so that a good deal of time is taken up by these branches of work. There is great advantage in the combination of duties for a health visitor. A change of work keeps her interest from flagging, and some branches of work are less exacting than others. Infant visiting is, as a whole, the most exacting, because the visitor has no assistance at her first visit, or after, unless the children attend the centre. In school and tuberculosis work the diagnosis and lines of action are laid down by the medical officer.

In a district with 500 births a year it may be estimated roughly that, allowing for the visitation of infants up to one year of age only, the school work will take about as much time as the infant work, and the tuberculosis work about one-seventh of the whole time required for the other two services.

The work of a health visitor may, therefore, be very varied. In some districts other special forms of work are undertaken and laid upon the health visitor.

In a few places the health visitors act as inspectors of midwives. This is considered fully in later chapters.

The compulsory notification of measles cases which came into operation in the year 1916, and was recently rescinded, brought into prominence the need for visitation of notified cases. This duty is not infrequently laid upon the health visitor, but since it involves other considerations, it will be dealt with in relation to infectious diseases in Chap. XXI.

## CHAPTER XI

### CHILD WELFARE WORK IN COUNTY AREAS

IN the preceding chapter the work of a child welfare visitor in an urban area was dealt with: where the population is more sparse the work partakes of other aspects. In towns with proper adjustment of districts there should be no appreciable loss of time in getting about from one home to another. When the population is so small that the visitor has an area of a number of square miles allotted to her, the loss of time involved in travelling becomes a feature which must be seriously considered.

It will clearly make for economy if the visitor is given as many duties in her district as possible, so as to bring about the greatest concentration of work.

It is uneconomical for rural districts to undertake their own infant welfare work because they can ordinarily only give the visitor the one duty. The county council, which is responsible for the school work and the tuberculosis work, must send a visitor into the rural district area for these purposes. Thus two visitors incur loss of time in travelling over the same area for different purposes. Such loss of time means increased expenditure on the work, and at the present time the tendency is for the rural work to be undertaken by the county council.

The county council will appoint the visitors, and in most cases where whole-time visitors are employed the several duties of infants, school, and tuberculosis

work are placed upon the same visitor. It is difficult for those who are not well acquainted with the conditions of rural England and Wales to realise the time required to get about some of the areas. The train services on the small local lines are usually infrequent and inconvenient. The main roads are usually good, but the byroads are often very bad in the winter. Some of the remoter houses have no road near them, and are a mile or more away from other houses.

In each county area<sup>1</sup> there will be small towns forming centres with populations of sufficient size to form centres of work for the visitors. Around these will be the rural areas with populations gathered here and there into villages of varying sizes, but with one or more houses some distance removed from any village. Arrangements have to be made for the visitation of all the individuals falling under any of the schemes for the health of the population of the county. It is usual, if possible, to place one or more visitors in a town, and allot to them the surrounding areas as districts. The number of districts will depend upon the population and other considerations. Bicycling is almost essential for a visitor in a rural area—the distances are too great for walking, and in a few cases only will the railway afford adequate facilities for transit. It is of great advantage for a visitor to have a nucleus of homes near her dwelling. She can often do visiting near by when, owing to bad weather or other circumstances, she might be unable to visit in distant places.

It will be impossible for her to visit on any definite date after the birth other than occasionally, since she will arrange her work so as to spend a whole or part of a day in the same district, visiting infants, school children and tuberculosis cases in the same day, together with

<sup>1</sup> The administrative county for purposes of the work of the county council, consists of the geographical county minus the county boroughs; cf. Chap. XXII.

any other visits connected with such other duties as may be laid upon her.

The county councils are not sanitary authorities, and cannot deal with sanitary defects, such as defective sanitation, insufficient water supply, etc., which must be carried out by the local sanitary authority, namely, the urban or rural district councils, and arrangements for co-operation between the two councils on this side of the work are essential. It is of the utmost importance that the visitor employed by the county should be on perfectly friendly terms with the responsible people of the council or councils of her district, even though such councils may sometimes appear to her to be irritating and slow in their methods. The officials of the smaller councils are hampered by the poverty of the council and by the vested interests with which the councillors may be closely connected.

The number of births which can be visited by a county health visitor will depend upon the position of the population, whether aggregated or entirely scattered, and upon the time taken by her other duties. It is not possible to require the same number of visits per annum to each case in the country as in the towns, since the average time taken per visit, allowing for the journey, will be greatly in excess of that in a town. Some visits may take almost the whole morning or afternoon if the house is far removed from neighbours.

In some counties there will be districts where very little rural work will fall to the lot of the visitor who may be located in a town or large village which requires her whole time. Arrangements for centres are clearly more difficult than in urban areas, the mothers have farther to come, and if they can find means of conveyance or can walk, they will hardly be able to attend as frequently as in the towns—also it will be more difficult to obtain the services of a medical officer. A great variety of arrangements are made. In some cases, a doctor will attend



monthly, and the visitor fortnightly, to weigh babies, and give advice in the absence of the doctor. Or the county council may employ a medical officer to visit the centres in the county on different days, either weekly or fortnightly according to the work required.

When the district is so sparsely populated that only some five or six mothers can attend at a session, it is doubtful whether the cost of establishing a centre is justified. A good deal will depend upon what charge is made for the rooms, and on existing local conditions generally.

The arrangements for visiting, record cards, etc., do not differ from those already described for the urban areas.

The above description of work applies in a fair number of counties. But it is now necessary to consider a wholly different system operating in some of the counties, and which, in order to understand it, requires a clear idea of the work of county and district nursing associations.

It is now many years since certain well-disposed persons in different villages or towns inaugurated bodies known as nursing associations. The object of the associations was to provide nursing for the sick poor who were unable either to obtain any nursing aid, or whose relations were not sufficiently skilled to give the aid required. These persons banded themselves together with the object of providing funds to pay for the services of a nurse. The greater part of the nurse's salary was paid by the association, a small part only being provided by the very low fee charged for the services of the nurse.

The nurse was under the control of a committee for all matters other than professional, when she was required to work under the doctor called in by the people concerned.

Many associations also provided midwifery aid for the district, and it then became necessary to employ a nurse who was able to undertake this branch of the work.

This last item is more usually required in rural areas than in small towns. Here independent midwives are probably available, whereas in rural areas they are unable to obtain a livelihood with midwifery work alone.

The formation of district nursing associations spread fairly widely, especially in some counties, but it is evident that their existence depended entirely upon the financial position and inclination of the better-to-do inhabitants. Hence, the district nursing associations were formed most readily in towns, and less readily in the sparsely populated areas, where, however, the need for them is often greatest.

The area which can be served by a nurse who is provided with a bicycle in a rural district is about 2-2½ miles in radius, so that, in order to cover the whole of a county, a very considerable number of district nursing associations are necessary. In every county there are districts where no provision can be made without an almost prohibitive expenditure of money, and even at the present time, only two or three counties have a service which extends over the whole area.

The district nursing associations soon began to experience difficulties—the first was finding the nurse—some nursing training was required, and a midwifery training if this work was to be undertaken. The cost of training was considerable, and comparatively few women were prepared to defray the cost of their own training, especially in view of the relatively small salary which could ordinarily be offered.

Then, if a nurse was ill or needed a holiday, it was difficult to find some one to replace her. These and other considerations were effective in producing another body—the county nursing association—which, while not itself undertaking any nursing or midwifery work, could act as a more influential central body.

County nursing associations have been formed in nearly all counties, and they have been the means of

providing or obtaining funds for the training of women as nurse-midwives, and of assisting district nursing associations in their other difficulties. They have usually secured help from the education committee of the county council for training, but have generally also raised considerable sums of money privately for this purpose.

Assistance was only provided for those district nursing associations who became affiliated to the county nursing association, and who paid an affiliation fee. In every county there have been and are a certain number of district nursing associations worked mainly by individuals who prefer to retain their private patronage, in spite of difficulties, rather than fall in with any general scheme. It should be remembered that the existence of a county nursing association does not imply that the whole county is provided with nurse-midwives, but only that a central association exists for such district nursing associations as are in being, but it may be that considerable portions of the county are entirely without provision of this nature.

The gradual rise in standard which has been continually demanded in both nursing and midwifery, since the beginning of the present century, together with the cost of living, which had already risen appreciably before the war, have added very materially to the cost of working the district nursing associations.

Moreover, the increasing tendency towards State or rate-aided schemes has made many people less inclined to subscribe to services such as that of district nursing associations. The financial difficulties of the associations have therefore become progressively more pressing of recent years. Simultaneously with this pressure, the work undertaken by the county councils for child welfare, school work, and tuberculosis work, has been developing, and the district nursing associations, powerfully backed by the county nursing associations,

have in nearly every case pressed the county councils to employ their nurses for this work, and to subsidise them for this purpose.

Theoretically, this scheme appears to have everything to commend it, but further investigation is necessary to see how far such an arrangement may or may not be desirable. The primary difficulties arise in connection with administration, and the qualifications of the majority of the nurses.

The nurses in the less populous areas have, for the most part, received a year's training only, which included approximately six months' district nursing and six months' midwifery training. They have received no training in child hygiene, or in school or tuberculosis work. Many of them, although excellent workers, find the keeping of records difficult, and are unable to organise their work satisfactorily without assistance. Administratively, several difficulties arise—the nurses are in the employ of the local associations, and are expected to carry out instructions received from the associations. If, however, the county council is to pay for the time and work of the nurses for special purposes, evidently the nurse must accept and carry out instructions from the county medical officer of health who is responsible for the carrying out of the county work in those branches.

Again, the nurses, if employed by the county for special purposes, must either report to the county medical officer of health, or must be visited by some one deputed by him and authorised by the council to see that the work is being satisfactorily performed. County nursing associations nearly always employ a superintendent, who is a fully-trained nurse, with midwifery training and of experience in both branches. This lady inspects the work of the nurses who are employed by affiliated district nursing associations. If the county councils, who are the authority for super-

vising the midwives in the county, appoint separate inspectors of midwives, a dual system of inspection is established, and difficulty is almost certain to arise.<sup>1</sup>

Many county councils therefore employ the superintendent of the county nursing association as their inspector of midwives under existing circumstances.

Whenever possible, however, medical women should be employed as inspectors of midwives.

If the county council decide to employ the county nursing association, provision should be made for instruction of the nurses in infant hygiene, and in any other duties which may be laid upon them.

There are undoubted advantages in allowing the village nurse-midwives<sup>2</sup> to undertake the child welfare and other county work. The nurse is known to, and knows, practically every one in the district, and it is held that the mothers prefer being visited by some one who lives in the village. Then, also, there is great economy in travelling expenses and in the whole cost of the work. Against these advantages it has to be remembered that the whole-time visitor is usually very much better trained and more efficient, and, if the nurses are to be employed, some arrangement for their training in infant hygiene should be made. Also, the visitor soon becomes known in the district where she works. When the nurse's district is large, or the area populous, she will hardly have time to attend properly to the public health work, and there may be periods when illness is prevalent, and a few heavy cases of sickness may render it almost

<sup>1</sup> The position of the county and the superintendent of the county nursing association is discussed further in connection with the inspection of midwives on pp. 131 *et seq.*

<sup>2</sup> A village nurse-midwife is a woman who has been trained as a midwife with some experience in nursing. The Queen Victoria Jubilee Institute for Nurses trains fully-trained nurses in midwifery and in school work if the nurse wishes to undertake district work. She then becomes a "Queen's" Nurse. County nursing associations can be affiliated to the Institute, and obtain privileges with corresponding obligations.

impossible for her to attend to any other duties than her nursing.

An important point arises on the financial side. Owing to the increasing difficulty of maintaining the nurse-midwives, it may be impossible to retain their services at all unless the grants for public health work are available. In such cases the county council is faced with the risk of allowing a valuable service to disappear for lack of funds. There is power to subsidise the nurse for her midwifery out of county funds, but such a subsidy might have to be unreasonably large in order to maintain the midwife, as compared with the number of midwifery cases attended by her, whereas, with the grant for the special services, a smaller subsidy would be sufficient.

The training of the village nurse-midwife for nursing is a much-debated question, and one which will no doubt receive attention in the near future. At present, it hardly falls within the range of child welfare work, although it is easy to show that sick-nursing and child welfare work are closely connected. As it involves the whole question of nursing in all its branches, and raises large administrative and economic questions, it will not be considered here.

In counties where there is a county nursing association, the council may employ the nurses in the villages, and may provide whole-time visitors in the towns and in those districts where, owing to the sparseness of the population, it has not been possible to provide nursing aid. In the now few counties where there is no county nursing association the county will provide its own service of visitors, but not the village nurse-midwife, since there are no powers to provide a nursing service out of the rates, although it seems probable that this power must soon be given.

If, and when these powers are given it is not unlikely that the work of the county nursing associations,

being thereby placed on an altogether different basis, may show a tendency to pass into the hands of the county councils. The county nursing associations have a wide and powerful influence for good, and have deserved well of the country. They took up the work when it was difficult, and often little appreciated even by those who were aided. If the time should come, when, as is common in this country, the permanent effort passes from the hands of a voluntary agency, into that of the State or of a local authority, it is to be hoped that they will receive at least some of the thanks and praise which is due to them.

## CHAPTER XII

### THE TRAINING OF HEALTH VISITORS.

So far nothing has been said on the training or qualifications which should be possessed by a health visitor. It seemed better to give first of all an account of her work and then to consider the question of her qualifications.

The value of the sanitary training was very early recognised, as is shown by the very general appointment of women sanitary inspectors as health visitors. A little later, trained nurses began to take up the work as a profession, and undoubtedly in many ways they are very suitably trained persons. A nurse's training does not, however, include any knowledge of either infant or child hygiene, and very few nurses have acquired more than a rudimentary knowledge of these matters during the course of their training. Again, it was realised that a midwife's certificate was of great value to those working on child hygiene. No definite ruling as to the qualifications of those employed by child welfare agencies has been laid down except for the Metropolitan area. Regulations were issued by the Local Government Board for the qualifications of health visitors in the Metropolitan area in 1909. These regulations, while not being without their use, were so wide that, in effect, they would not necessarily have achieved much. They required a health visitor to have one or other of the following qualifications :

- (a) a medical degree ;
- (b) a nurse's training ;



- (c) a midwife's certificate ;
- (d) some nursing training and the health visitor's certificate of a society approved by the Board ;
- (e) the previous discharge of duties of a similar character in the service of a local authority.

Fortunately, the good sense of the borough councils, acting on the advice of the medical officers of health, backed by the fact that the appointments must be approved by the Local Government Board, prevented any misuse of the last words, and so far as can be ascertained, no one without at least one of the above qualifications other than (e) was appointed in the Metropolitan area.

In the provinces there was no rule, although a very large proportion of the women appointed as health visitors were trained women.

Some medical officers of health consider that all health visitors should have had a full nurse's training. Others attach comparatively little importance to this and favour a sanitary inspector's training. Others regard the possession of Central Midwives Board certificate as essential. The course of training required for these special certificates in each case covers more ground than is necessary for child welfare work, and omits other important aspects.

The nurse receives a prolonged training in the technique of surgical and medical nursing for adults, but, under the arrangements prevalent in most training schools, she will rarely see a normal baby, and it is very unlikely that she will be instructed in the hygiene of any stage of life, infant or adult, man or woman. She will have no knowledge of sanitation in the home, since the ventilation, etc., of the hospital wards is arranged without her, and usually follows a fairly fixed routine ; there is no reason why she should be acquainted

with any of the difficulties of hygiene in the ordinary small home. She may be without any knowledge of midwifery, especially normal midwifery, and have had no contact with any matter relating to the hygiene of pregnancy. It is not to be expected that she should have, for these matters do not form any part of the essential recognised training as it stands at present, and it is the exceptional person who acquires proficiency in any branch of work without training.

On the other hand, the trained nurse has acquired habits of order and discipline, and of regularity in her work, and these qualities are of untold value to all workers. For school or tuberculosis work the nurse's training is of more direct value than for child welfare work, although even for this, as has been stated, there are many advantages in the training.

The training of a sanitary inspector covers many matters which are acknowledged to be essential for health visitors. It also involves other aspects which are clearly of little or no value; such, for instance, as meat inspection, the details of the laying of drains, etc., and again it provides no instruction in child hygiene.

The Central Midwives Board certificate is even more specialised, and the training does not ordinarily include much training in infant hygiene. It should, however, be at once stated that this deficiency is met in some of the training schools, and the need for it for the practising midwife is very generally recognised.

No training gives so close an acquaintance with the difficulties of the working mother as a midwifery training when taken in the "district," that is, midwifery work carried out in the home. The psychological value is great, but the training does not include enough child hygiene and other similar matter, nor can this be included in the available time.<sup>1</sup> If the period of training

<sup>1</sup> The present length of training for a midwife is six months, or four months for one who is a trained nurse.

were extended to enable a sufficiently large acquaintance to be gained, the length of time would in itself render the midwife's training almost prohibitive for the health visitor who must learn other matters as well.

No one of these trainings can therefore be regarded as adequate without further special training. Many health visitors are required to hold more than one of these certificates in order that they may have been trained in several aspects of child welfare work. The Medical Officer to the Local Government Board recommended<sup>1</sup> that health visitors should possess two out of the three qualifications :

Nurse's training ;

Sanitary Inspector's certificate ;

Central Midwives Board certificate.

Actually a considerable number of health visitors hold all these qualifications, but it must be admitted that, especially during the war, women have been appointed who do not fall within these requirements.

Moreover, there are certain important matters which a health visitor should know which are, as already pointed out, not included in the training for any of these certificates. Infant hygiene is one of them. It is sometimes supposed that there is no special instruction needed in infant hygiene, and that general knowledge and training will supply all that is necessary. Doubtless some points in child hygiene are similar to those for adults, but there is a great deal which is not supplied by the instinctive reasoning processes of the average person.

Then, again, none of the above trainings supply any knowledge of general social conditions, and it has been explained in the preceding chapters that this is of great importance.

Efforts have been made by various bodies in London and the provinces to arrange trainings suitable for

<sup>1</sup> *Memorandum on Health Visitors, etc.*, 1916, p. 7.

health visitors, and although certificates have been given fairly widely, the results achieved have, for several reasons, been below what might have been anticipated.<sup>1</sup>

It is difficult to say precisely why the certificates did not meet the situation, and, as the Board of Education has now issued regulations in agreement with the Ministry of Health, there is no object in making further inquiry into the cause.

Of recent years, many women have taken the Central Midwives Board certificate in order to qualify them as health visitors. This has caused considerable difficulty in arranging for the training of those who intended to practise as midwives, since the number of places for midwifery students is necessarily limited by the material required to train on.

A midwifery training is no doubt a valuable asset to any one who is working among the poorer classes of the community, be it as public health or social worker. The material for training must in the first instance be available for those who intend to practise midwifery, whether independently or attached to hospitals. Moreover, when due provision has been made for the training of midwives, it will clearly be for the midwives to undertake the ante-natal and early post-natal care of the mother and child. The health visitor will come in after the period of the midwife's attendance. (Cf. also the Ministry of Health's circular, Appendix IV.) Just now, and for some few years to come, the position is more difficult. Many of the midwives have neither time nor training to undertake the work as it should be done. It is a wiser policy, however, to look ahead and make provision for better midwifery service, than to require all the health visitors to hold a midwife's certi-

<sup>1</sup> It was necessary for these certificates to be recognised by the Local Government Board as falling within the qualifications laid down by them for health visitors in the Metropolitan area. Outside this area no regulations were in force.

ficatc. Moreover, the mere possession of a midwife's certificate does not carry with it more than a rudimentary knowledge of ante-natal hygiene, and practical experience must be added to the midwife's training before good ante-natal care can be given. The health visitor must follow the midwife or doctor, and carry the child up to and through school age, and her training should be directed towards this end.

The Board of Education regulations which have been recently issued provide a curriculum of study and practical work for the health visitor which seems to cover all the requirements, and when in full working order should secure an admirable training for those intending to take up any form of work for maternity and child welfare. The courses of study will be held at institutions connected with universities, which must make due arrangement for practical work.

The training includes :

- (1) A general knowledge of elementary physiology, so that having some understanding of the working of the body, in health, they may appreciate the object of the measures adopted in preventive work.
- (2) A short course in artisan cookery, so that the health visitor may realise the limitations and difficulties caused by a small income, and by the necessity of cooking with only a few cookery utensils.
- (3) A full course in general hygiene and in infant and child hygiene work of all forms, with much practical work at a centre, and also instruction and practice in school clinics and in tuberculosis work. Also instruction in infectious diseases and minor ailments of children, together with some acquaintance with maternity work.
- (4) Lectures on social work, its methods, objects,

etc., and some practical work, in order that the visitor may have at least some knowledge and realisation of the difficulties, and of the facilities which are available to deal with them.

The regulations for training should, if properly carried out and enforced, lead to a great improvement in the quality of the work of the health visitor, and thence to her status and salary. This last has improved latterly, and is likely to improve still further as the value of the work is more appreciated and the general level of training raised.

Some 3200 health visitors, some whole-time and some part-time, are now employed by local authorities in England and Wales.<sup>1</sup> Many hundreds more will be required as the work expands and health visitors seem likely to become a permanent part of the staff of every large public health department. Anything approaching a detailed discussion on the future development of health visiting would only be out of place in a work such as this.

In pointing out the defects of the training and the needs of the future, a tribute should be paid to the excellent work of many health visitors, both in the early days when the whole movement was on its trial, and at the present time. It is to their efforts and personalities that the work owes its present position.

Reference has just been made to their personalities, and no account of the training and qualifications of a health visitor would be complete without some remarks upon this vital point. Personality counts so much in all relations with our fellows, but in no type of work is it so important as in any branch of work where home visitation is concerned. There is no one type of personality required for the work—there is room for all types—but if any one quality can be singled out, then

<sup>1</sup> A few hundreds of these are employed by voluntary agencies.

sympathy were surely that one. Good, even excellent work, is done by women of widely different temperaments, wholly divergent outlooks, sociable or even almost unfriendly manners, if the mothers whom they visit feel that the visitor is there to sympathise and not condemn, to advise and not to lecture. If the visitor remembers that we are all ignorant, and that the difference between her own knowledge and the mother's is almost imperceptible compared with the sum of all knowledge, that mistakes are often due to ignorance or carelessness, to despair or hopelessness; if she will put herself in the mother's place and ask herself what she might have done had she been brought up in a similar manner, had her opportunities been as limited, her cares and anxieties as great, she will not fail to aid the mother and to secure the carrying out of her advice.

The visitor is there to lead and educate and not to drive. There are few who will not finally respond, even though it be after several attempts and after the persistent kindly aid and advice have often been many times rejected.

Those who have worked most intimately among the poorer classes of the country are among those who are most appreciative of the working-class mothers of this country. If they have a family, their work may be almost incessant, and their patience sorely taxed. What they achieve is wonderful, and, provided that they have matters explained carefully and in simple language, so that they can see the reason why the advice is being given, they will often carry out directions of a difficult character with astonishing skill. They like having explanations as to why things should be done, and every health visitor should be able to give simple reasons for her advice. She must not be impatient if the reasons are not remembered on the first occasion. It all appears simple to the visitor, but it is new to the mother. Those even among the so-called educated classes who remember

and grasp what they are told on the first occasion are comparatively few in number, and may safely be regarded as having more than the ordinary amount of intelligence.

It is hard to estimate the extent of the results already achieved by health visitors, but it can safely be asserted that, as a result of many efforts, the general level of knowledge among all classes on the subject of infant hygiene has risen enormously during the last decade, and a considerable part at least of this result may be attributed to the health visitor.

Movements have cumulative force, and the next decade will almost certainly see advances compared with which the present progress will appear very small, but it is the beginning which is always so difficult.



## CHAPTER XIII

### THE POSITION OF VOLUNTARY AGENCIES IN CHILD WELFARE WORK <sup>1</sup>

THE child welfare movement illustrates very well a characteristic feature of many movements in this country. A beginning is made by a body composed of a few philanthropically disposed persons, who feel that some effort must be made to meet an existing need. Although the towns commenced the home visitation of infants many years ago, yet a great part of the early work was due to voluntary agencies, or to the initiative of private persons. Home visitation was attempted in a number of districts, and, in a very few cases, was continued for a good many years. As a whole, however, home visitation proved too exacting a work for the majority of untrained and unpaid workers, and the visiting was either taken over by the local authority, or a salaried worker was employed by the society.

The main sphere of voluntary work has been in the centres. A very large number of these were opened by voluntary bodies, and in many cases worked for a number of years by voluntary effort. In the Metropolitan area, some of the early centres are still under voluntary control. At first, the medical officer received no salary. As the centres increased, both in number and in size, it became evident that a salary must be paid to the medical

<sup>1</sup> Throughout this chapter and elsewhere in this book, the term "voluntary" is used to denote untrained as well as unsalaried work, unless otherwise specified.

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officer, and it also became usual for a trained salaried worker to be employed to superintend the work of the centre, where this last was of any size. The cost of the centres thus rose gradually and rendered their maintenance very difficult. In 1914, when Exchequer grants were first given, a great stimulus was given to voluntary agencies by the receipt of 50 per cent. of the expenditure. At the same time, however, local authorities also received grants and their work was expanding rapidly. The Local Government Board required all centres worked by voluntary agencies who received a grant from them, to co-operate with the local authority in its work for child welfare.

In addition to the ever-increasing cost, the subscribers began to realise that the work could be taken over by the local authority, at the cost of the rates, and the collection of money became more arduous.

In the provinces, comparatively few of the older centres are still worked by voluntary agencies, and even where this is the case many of them are receiving substantial subsidies from the rates for some, at least, of the branches of work. A number of fresh centres have sprung up under voluntary auspices, with the definite object of proving to the local authority that there was a need for a centre in a particular district. When this need has been proved, it was hoped that the local authority would be prepared to take over the centre, and in some cases a more or less definite undertaking to this effect was obtained in the first instance. While a great many voluntary bodies undertaking child welfare work have ceased to exist, many have given up their work most reluctantly, and others are struggling hard to maintain themselves. Some, in all a not inconsiderable number, have relinquished one form of activity to commence another, generally one for which money from the rates was not at that time available. In this way it has been possible to enlarge

the work in many directions and to gain valuable experience.

At the present time there are few branches of work connected with a centre for which the money cannot be levied from the rates. Practically, the only phases which still require unaided voluntary effort are material assistance and medical or surgical treatment in the homes; rate and State aid are available for all branches of midwifery and maternity aid, and for certain branches of medical and surgical care among children.

Why then, it may be asked, do voluntary agencies struggle to continue their work? No one answer to the question can be given; the position is not very simple. In some cases the local authority will not take over the work until they are convinced that all possible voluntary effort is exhausted. The council does not see any reason why the rates should be charged when the money can be raised from other sources.

There is a school of thought which regards voluntary work with much approval, and considers the work of local authorities unsatisfactory on the main ground that it is too official, too unsympathetic, and so forth. They fear that the salaried workers will not listen as patiently as the voluntary worker to the difficulties of the mother, that order and method will be carried out to the elimination of all pleasantness and sociability.

These, and other objections, are freely talked of by voluntary workers, who fear that the result will be the extinction of the good work they have carried on with so much labour and pain. It may be said at once that these fears have proved to be wholly without foundation. The municipal centres grow in size and increase in number and obtain most satisfactory results; nor are there complaints of any lack of sympathy.

Without depreciating much excellent voluntary work, it must be admitted that, with a fair number of notable exceptions, there is less efficiency in voluntary child

welfare work than in that carried out by local authorities. This efficiency is found to be tempered by sympathy and kindness and the fear of officialism has lost a good deal of its force. On the other hand, complaints are made of voluntary work in general. It is less regular and reliable than salaried work, except in the case of very special persons. The average voluntary worker is prepared to relinquish her work at the call of other duties or even pleasures. She is not paid and the society she works for has no hold on her. They may have her services when it is relatively easy. Again; in the summer, when the work is often very heavy, the voluntary workers leave in a body for their holiday, and the work falls through or is left in the hands of the salaried members of the staff. There are one or two voluntary agencies where the workers have consistently remained faithful to their work and have arranged their holidays in relays. Honour and thanks are due to them, but they are the exception to the rule.

Voluntary workers not infrequently have ideas of their own on methods of work, and, when the funds are in their control, they have the power to carry their theories into practice. The conditions accompanying the giving of grants have had the effect of levelling up a number of centres and of preventing many excrescences. It is unfortunate that voluntary workers in control of their own society do not always seem prepared to adapt their view to the good of the greater number. Hence, it is often far from easy for a local authority to work side by side with a voluntary agency, and, in general, it is found necessary to assume the control of a centre which is taken over or heavily subsidised by the municipality.

If the centre is of considerable size, it is possible to divide the activities and to leave certain of them in the hands of the voluntary workers and under their committee of management. Such activities are most

frequently the various classes which are held, the provision of teas, or of food, competitions, and so forth.

In any case efforts should be made to secure the services of voluntary workers for this style of work, and also for assistance in the less responsible duties connected with an infant consultation.

There is a sphere for the voluntary worker in child welfare work, but it is a subordinate sphere, because the untrained worker is not fitted for the branches of work where training is essential. A few trained but unsalaried workers exist, but they are rare, and ordinarily the voluntary worker is untrained. Some attend a few courses of lectures and acquire a fair amount of rather unsystematic information, which renders them more intelligent in their work but does not raise them to the level of a properly trained worker.

Generally, the function of voluntary workers is to be pioneers to carry out new ideas on a sufficiently satisfactory basis to render it evident that the expenditure of public money upon those particular lines of work is justifiable.

Hard and honourable have been the tasks laid upon and carried out by voluntary effort in this country, but the work once justified, the primary need for voluntary aid has ceased, and the efforts should then be directed into other channels. Pioneer work seldom receives the meed of recognition and of praise which is its due; but the pioneer who is a student of history will realise that the human race has ever paid more attention to the final success rather than to the uphill path laid out by the toil and trodden by the weary feet of the originators.

## CHAPTER XIV

### OTHER PHASES OF CHILD WELFARE WORK

IN this chapter a few remarks are made on the provision and work of day nurseries or crèches, on nursery schools, and other "homes" for infants or young children.

Day nurseries and nursery schools are non-resident institutions, whereas in a "home" the children are nearly always resident. Both day nurseries and nursery schools are eligible for grants-in-aid. Nursery schools now fall under the Education Act of 1918, and receive their grant from the Board of Education. For a time also crèches were under the same Board, but, with the establishment of the Ministry of Health, they passed out of the province of education and came under the auspices of the Ministry of Health.

Both the Board of Education and the Ministry of Health issued memoranda dealing with the requirements and general arrangement which are necessary in order to obtain State aid. The memoranda cover so much of the working of these institutions, that any further disquisition on them would, in effect, be merely another presentation of the same facts. There are, however, certain aspects of the work, especially of day nurseries, which do not fall within the province of such a memorandum. These points relate to the general advisability of the institutions and to the precautions which are necessary. A Government Department does not ordinarily discourage any form

of work which may have useful aspects. Its object is to cultivate the good points, and to reduce the difficulties which may arise, in order to secure the maximum value of the work.

The main difference between a crèche and a nursery school lies in the age of the children, and, consequently, in the provision made for them. Children are usually admitted to crèches after the first month or six weeks of life, although this is really far too young, and they may remain up to the age of three, or sometimes rather older. (Cf. paragraph 2 of the memorandum in Appendix V.) Nursery schools are for children of about two or three years of age until they attend school, which is usually at the age of five. Different arrangements are required for the two types, and the objects also are different.

Nursery schools provide occupation, and should inculcate habits of order. The term "school" is lightly interpreted, and the children much enjoy their games and little lessons.

There is more risk of infection from a number of children of this age than with those at school, but as a whole, the *nursery school* may be regarded as a valuable institution. The regulations issued by the Board of Education deal with the psychological as well as with the physical side of the work of nursery schools. Although it is hardly possible to print the regulations as a whole in the text, Appendix V, which is a reprint of the regulations, is intended to be regarded as belonging to the main text, and should be read with it. It has already been mentioned that the child of two or three years of age partakes, in regard to its physical side, of the nature of the older child. It has ceased to be an infant, and both its mental and physical needs are distinct from those of the younger child.

The *day nursery*, however, requires very careful

watching. It is by no means a movement which should be allowed to spread to any great extent: it does not stand alone, but involves many other very important social matters.

The object of a day nursery is to provide some place where a woman who is going out to work may leave her child. Some amount of work by married women, or widows with children to look after, may be unavoidable, but ordinary outside work should not be done by a woman with young children under three. There are plenty of women with older children, or no children, who can go out to work, and during the years when the children are young the mother should stay at home.

At present, no doubt, this is a counsel of perfection, and there are many women who are obliged by the conditions of their existence to go out to work in order to earn money.<sup>1</sup>

It has been proved beyond a doubt that, generally, all aggregations of young children involve a risk. There are subtle troubles, presumably bacterial in origin, which, while not amounting to any definite ailment, affect the general well-being of the young child. These "infections" appear to arise with the utmost ease when young children are close together, and the "infection" is carried from one to the other.<sup>2</sup> The cause is unknown, or there may be many causes, but the

<sup>1</sup> During the war crèches became almost a national need. The conditions were quite exceptional, and the work of the mother was for the time being of such value to the nation as to justify the risk to the child. The provision of crèches attached to factories does not appear to command great success.

<sup>2</sup> This aspect of work among children was studied very closely in Germany many years before the war; it is unfortunate that, although the German literature contained abundant references to this difficulty, no nation paid any serious attention to it. America is now realising the position, and there are signs of an awakening here among some leaders of thought in this country, but insufficient appreciation of this danger has often led to trouble.



general fact remains securely established, repeating itself whenever opportunity occurs. The child so "infected" just does not progress; it looks pale, and is not putting on sufficient weight; or there may be a rash or some slight skin trouble. The manifestations are various, but the net result is that the child's condition, while not serious, is unsatisfactory. The axiom laid down by the German investigators that each infant in an institution where there were other infants, should be regarded as a source of potential infection for others, is true. It has arisen out of a wider experience of less satisfactory arrangements than the one postulated, but its recommendations have been amply justified when carried out in practice. The axiom applies most forcibly to resident institutions, but is operative also in one like a crèche, where the children are close together during the day. It is merely a question of the duration of the time of potential infection: the child is exposed to risk for a shorter period and its return home at night is very beneficial to it. On the other hand, the cots in a crèche, and the quarters generally, are usually much closer together and the service provided less well trained than in a resident institution for children.

The general position has been appreciated for many years in hospitals. All those who are connected with children's hospitals are aware that very young children should be sent out of hospital as soon as they are at all well enough, and, ordinarily, very young children do better in a woman's ward than in a ward by themselves. The cause is the potential infectivity of one child for another, and the "infection" can be transmitted direct or carried by the attendants.

A crèche, to be satisfactory, must be run on what may appear to be unnecessarily expensive lines, as will be explained shortly. Moreover, there is the further possibility of the introduction of one of the

ordinary infectious diseases, if such a disease arises in the home of one of the infants.

If every effort is to be made to avoid the communication of infectious disease from one child to others, then every child must be carefully examined by a skilled worker each day when it arrives. Any case of suspicious rash, or running of eyes and nose, should be placed in an isolation room until seen by the doctor of the crèche, who will determine what shall be done.

In order to avoid the other less known and intangible "infections," scrupulous care and cleanliness is necessary, and the younger the child, the greater the care required. The attendant should wash her hands after performing any office for an infant before handling another. Aprons and dresses must be clean, and not be sources of infection from the last child taken on to the apron. Bottles, etc., must be kept separate for each child. The same cots must be kept for the same child, or cleaned if used for another one. The bath must be washed with disinfectant between use by each child. Changes in the child's clothing must be made in the cot and not on a pillow used in common for all the infants. In fact, the precautions necessary are elaborate, and hardly ever fully carried out.

The children habitually in a crèche very rarely are as healthy as the children outside: the white, rather pinched face and pinkish eyelids are due not only to the absence of sufficient fresh air, but also to the general result of the aggregation of children without the necessary precautions.

In a few institutions an excellent technique of management is observed, and here the troubles above referred to do not loom large, more especially if the children are kept out of doors.

Crèches without a garden or possible source of fresh outdoor air should not be allowed.

In the present conditions of care in crèches the

infant is probably very much safer with a relatively satisfactory "minder" than in a crèche.

If crèches are to be well run, the cost is high, and cannot be met by the daily charge to the mother. Unless, however, the necessary cost can be met, the crèche should not be in existence, from the hygienic point of view.

In addition to the above considerations, the provision of crèches may have the effect of inducing women to go out to work who could afford to stay at home and look after their child. They can supplement their husband's income owing to the crèche. It would be far better for them to stay at home. If their husband's wage is inadequate for existence, it is this which should receive attention, and the true response is not the provision of a crèche. There is a good deal of difference of opinion as to whether women wish to go out to work or not. Doubtless, some prefer being at work, and others would prefer to stay at home: there can, however, be no doubt that by no known means can the mother's care be replaced. The infant should be cared for by its own mother wherever this is humanly possible. The exceptions there may be will only prove the general rule. All mothers who go out to work do not wish to make use of a crèche, even if one were available. The crèche may cost rather less than the charge made by the woman who "minds" the baby while the mother is at work; but the crèche demands regular hours for bringing the child and for removing it, and a complaint is made if the child is not brought clean in the morning. Again, it may be that the crèche hours for reception do not coincide with the work hours of the mother, which may cause an insuperable difficulty. Although there is demand for crèche accommodation, day nurseries can hardly be regarded as supplying a wide need, or as being desirable on a large scale.

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The regulations of the Ministry of Health for day nurseries, given in Appendix V, should be read in conjunction with this chapter.

*Notes on Institutions for Children and "boarding-out."*—Institutions variously termed hotels, hostels, and homes are now being started, which will take in children temporarily in the event of the mother being obliged to be away from her home from some cause or other. There is much to be said for this provision, but the remarks as to the care of the very young children apply with full force in such cases. Unless these homes or hotels are worked on lines of the most scrupulous care, they will not afford the advantage for which they have been designed, namely, the welfare of the children concerned.

In general, infants and young children who are unable to be kept at home during the day, or who have no home, are better boarded out in the homes of others. This applies just as, if not more, forcibly to infants under one year as to those rather older. Even a rather unsatisfactory home is better than a good institution, not only from the point of view of health, but morally and psychologically.

The figures available from countries like Sweden and Germany, where the boarding-out system is carried on widely as the result of experience, leave no doubts upon this subject. Due precautions should, of course, be taken in regard to the homes where the children are boarded, especially if public money is concerned, and these should be inspected by some responsible person *before* the child is sent, as well as afterwards. The previous inspection of the proposed home is of fundamental importance.

It is not proposed to deal here with the whole question of "boarded-out" children. Many Poor Law children are boarded out, and there is supervision of the children who are taken as boarders for gain under the Children

Act of 1908 after the child has been taken as a boarder. The administration of this has now been transferred from the Home Office to the Ministry of Health. All such children should fall under the scheme for child welfare of the district. Definite requirements should be made as to the accommodation provided in the home, and the child should be visited by the child welfare visitor. Further, when a child welfare centre is reasonably near, systematic attendance at the centre for medical advice should be laid down as a condition for permission to retain the child.

The boarding-out system should be developed and improved, when it will be found to be a very effective branch of child welfare.

In each district there should be a list of suitable women, either with small families or without family, who are prepared to accept children of specified ages as boarders for short or long periods. Such premises should be inspected, and notes should be made of the accommodation, etc. It is true that such a system would involve a considerable amount of work in the first instance, but it is work which is well worth doing, and would certainly be found to be very repaying.

It is often stated that any such wide system of boarding-out is impossible in this country; that it may be possible elsewhere, but could not be done here: that, in the first place, it would be impossible to find enough accommodation, especially at the figure usually offered for boarded-out children. This last—the cost—is in reality the key to the whole position. For reasons which are obscure to the ordinary individual, a fee of 5s. per week was considered an adequate boarding-out fee before the war, whereas the exponents of the doctrine of impossibility were prepared readily to admit that the cost in the alternative method—namely, an institution—would be at least three to four times as heavy.

It is difficult to see why the fee for boarding-out

should be kept so low as compared with that of an institution. It is far better for a child to be kept in a good home as a boarder than in any institution, however satisfactorily organised. The charge would certainly be less than the cost of the institution, and the results infinitely more satisfactory. The argument that it would not be possible to obtain a sufficient number of private homes for the purpose is merely theoretical, since no real effort has ever been made when a fee has been offered which is sufficient to cover the cost of maintaining the child in a good home without expense being incurred by the family. A low fee must mean either that the family has a low standard of life, or that it is prepared to incur expense in order to have the child.

The absence of any legal power of adoption might prove a more serious matter, since the family might not want to risk the subsequent removal of the child they had become attached to. But, in the absence of any reasonable effort on the general question, it is impossible to say how far the difficulty might or might not be real.

The Ministry of Pensions have recently laid down regulations for the boarding-out of children of officers or men in the naval, military, and air forces, who, for some reason or another, are in need of proper care. These regulations recognise the need for careful investigation of the homes before the child is sent there, and in general provide the precautions which are essential for boarded-out children. Provision is made for expenditure in regard to board, clothing, dental care, etc. The working out and development of the scheme will provide information and experience of great value.

Institution life is undoubtedly necessary for many of those who, owing to a physical or mental defect, are not able to take their place in the daily life of the world. For normal children it should be discouraged on every count, either temporarily or as a permanent measure. There are no two opinions upon the subject among those

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who have had personal experience of a proper system of boarding-out under proper supervision, and with adequate payment. The promised—presumably imminent—abolition of the Poor Law, together with the taking over by the Ministry of Health of the children boarded out under the Children Act, and the scheme of the Ministry of Pensions, presents a unique opportunity of developing an adequate system of boarding-out. It would, if successful—and there is every reason why it should be so—produce better results at a reduced charge to all concerned.

## CHAPTER XV

### THE CONTROL OF THE PRACTICE OF MIDWIFERY

It is recognised by all nations that assistance is required for all women at childbirth. The arrival of a new individual into the world has held, and will probably continue to hold the imagination so long as the world lasts. Legends and superstitions in wild confusion have grown up around the fact of a birth, and are by no means confined to so-called uncivilised tribes or nations. Rites and ceremonies are as prevalent as the superstitions, and are, most of them, unhygienic and, in general, undesirable in the light of modern knowledge.

The advent of a life into the world is sometimes accompanied by death, either that of the child or of its mother. Doubtless, as with other phases of life, certain deaths are not preventable in the present state of our knowledge and care. It is, however, quite certain that the number of children who are born dead could be immensely reduced by proper measures, and that the same applies to deaths among mothers.

No problem can be handled without experiment, and as experience is gained, the requisite knowledge for dealing with difficulties is acquired. How far the difficulties—or even the need for investigations of death connected with childbirth—were generally realised before the latter part of the nineteenth century is hard to say. Doubtless the matter was in the minds of some people, because no movements commence abruptly; but no widespread movement took place in this country in con-



nection with improved conditions for childbirth until that period.

There are a number of ancient charities founded for the benefit of women in childbirth. They were, however, primarily intended to provide either an asylum for the confinement of the homeless mother, *i.e.* a hospital, or the service of some person for those unable to pay for such service themselves—*i.e.* a maternity charity. The intention does not appear to have been the improvement of existing conditions, but to provide the class of aid then available for the poorest mothers of that district.

During the last fifty years or less, our knowledge has advanced rapidly, and, at the present time, although there is yet much to be learnt, we do at least possess sufficient knowledge to effect great improvement if the necessary effort is forthcoming.

In no nation do the members of the medical profession appear to be the only persons to be called in to assist at a birth. The majority of births have always been handled by other women. Certain women became known as being willing to attend their fellows, and some of them gained very considerable experience in the course of their work. In this country, until 1902, no restrictions were laid down as to the qualifications of any woman assisting at a birth, and any woman might assist another one, although in practice the assistance was probably rendered by a comparatively small number of women. A widow, or some one with few or no home ties, would clearly be a suitable person, as she could leave home at a moment's notice more readily than most.

The Midwives Act of 1902, the first step taken by Parliament to improve the conditions then obtaining, was the result of a long struggle to introduce improved conditions, the importance of which were already known. During the nineteenth century great strides had been

made in the knowledge of treatment and cause of the occurrence of abnormal conditions associated with pregnancy and childbirth. Greatly improved conditions had become available in most, if not all, the hospitals which undertook maternity cases, but the general level of work outside was inevitably low, since any one, however ignorant, might attend and take charge of a case of childbirth.

It is true that childbirth should be regarded as a normal process, and this fact should be borne prominently in mind. But so are the ordinary functions of the body for daily life, eating, drinking, sleeping, etc., and yet it is obvious to any one who will bestow a little thought upon the subject, that a high proportion of the population of most countries do not know, or, if they do know, do not practise those principles which should be adhered to in order to maintain the processes of the body at a normal level. If, therefore, experience alone has not taught how to deal with continuous occurrence, how much less is it likely to have taught the handling of so relatively infrequent a process as that of childbirth.

It must not be supposed that no efforts to secure training for those who wished to practise midwifery had been made before 1902. Many hospitals held courses of training, and gave certificates of proficiency, and the Obstetrical Society of London held examinations admitting to a Licentiate in Midwifery, and which gave the right to a title.<sup>1</sup> It is evident, however, that a course of training will not be taken voluntarily by the average woman who may be prepared to attend a neighbour as a midwife, unless she is compelled to do so by law. Hospitals, and other institutions dealing with maternity cases, employed many trained midwives, and it is somewhat surprising how many women had received training, seeing that there was, in effect, no

<sup>1</sup> The title was Licentiate of the Obstetrical Society (L.O.S.).

compulsion, and only the more enlightened realised their need for it.

The Midwives Act of 1902 required all women wishing to practise midwifery to have received a training, or to produce evidence of having been known to be in *bona fide* practice as a midwife before 1902. These last were untrained, and are frequently distinguished from the former by the term *bona fide*. A few *bona fide* midwives may have received some training, but they hold no certificates to that effect. Both classes of women were to have their names inscribed on the Midwives Roll, which was first made in 1905. The Roll is revised annually under the auspices of the Central Midwives Board.

In addition to this fundamental provision for controlling the practice of midwifery, the Act provided for the establishment of a central controlling body, the Central Midwives Board, which was placed as in the previous case of the medical and dental professions, under the control of the Privy Council.<sup>1</sup>

This body received power to make rules to be observed by all midwives on the roll, to hold examinations, grant certificates of proficiency, and to remove from the roll the name of any midwife found not to obey the rules, or to be guilty of unprofessional conduct.

Further, the Act provided that the supervision of midwives should be in the hands of county councils and county borough councils. All women desirous of practising as midwives were required to send in their names and addresses, together with evidence of training, or of *bona fide* practice before 1902, to the medical officer of health of the council, who, after due investigation, was to forward the completed list to the Central Midwives Board. The notification of intention to

<sup>1</sup> Under the Ministry of Health Act of 1919 the Central Midwives Board has been transferred from the Privy Council to the Ministry of Health.

practise must be made each year, and a fresh list furnished to the Central Midwives Board.

The councils concerned were required to appoint an inspector of midwives to supervise the work of the midwives in their area, and to report cases of irregularity or of breach of rules to the Central Midwives Board.<sup>1</sup> Penalties were also provided for, against those who, not being on the Midwives Roll, practised midwifery for gain, unless in an emergency.

The Act was originally designed to come into operation in 1905, but for reasons which need not be gone into, it did not become operative until 1910.

The movement for the improvement of midwifery care obtained legal powers before that for child welfare, since the Notification of Births Act was passed in 1907. While the Midwives Roll, and the functions of the Central Midwives Board, would, no doubt, have produced a great effect on midwifery work, it is certain that a rapid impetus has been given to midwifery through the child welfare movement. This impetus, however, could not have been given without the Midwives Act of 1902, and the machinery which had been set up under it.

The rules of the Central Midwives Board, which must be observed by all midwives, were first issued in 1911, and were re-issued, with certain alterations, in 1916.

In these rules certain definite instructions were laid down for the practice of midwives, dealing with the provision of adequate appliances, cleanliness of

<sup>1</sup> The Act of 1902 allowed County Councils to delegate the inspection to the smaller Local Authorities, and, in the first instance, many took advantage of the permission. As, however, the importance of the work became recognised, the delegation was rescinded by practically all the counties. Some of the larger borough and urban districts, however, clamoured for the powers of inspection to be placed in their hands as a part of their scheme for Child Welfare. The subject aroused much controversy, but was finally settled against delegation by the Midwives Act of 1918, which rescinded the original clause in the Act of 1902.

person, of the care of the patient, the occasions on which surgical aid should be advised, the keeping of a register of cases attended, and a record of each case—pulse, temperature, and general conditions, etc.—during the period of the midwife's attendance. The midwife was required to attend the mother when summoned, and to be responsible for the care of both mother and child for ten days after birth. If a doctor was called in, the midwife worked under him or her, and, if the mother had not recovered by the tenth day, or the child was still requiring attention, the midwife was to continue to attend after the tenth day.

Great difficulty arose in the case of many of the untrained midwives who formed the majority of those on the first roll. The first Report of the Central Midwives Board, 1905, stated that, as far as could be ascertained, there were 22,308 women who were entitled to be registered. Of these, 12,521 were in *bona fide* practice before 1902, and 9787 held certificates in midwifery, making a total of 22,308. These figures cannot, however, be regarded as absolute, since in the early years many midwives in practice doubtless did not notify their intention, and there was no machinery for getting to know of their whereabouts. On the other hand, of those registered, a considerable number were undertaking little or no practice, and others were attached to hospitals or other institutions. The number of names on the Midwives Roll does not, even now, furnish more than an approximately accurate figure of the number of midwives in practice independently, as apart from those who are trained. The percentages of trained and untrained, as shown by the figures given above, are 43 and 56, that is to say, considerably over one-half of all the midwives in practice were untrained, and since there were probably a fair number not included, and as many of the trained midwives were not in practice, the figures for untrained

midwives in practice were almost certainly much higher. In fact, the bulk of the practice of midwifery by midwives was in the hands of untrained women. Of these a fair number were unable to either read or write, and were wholly ignorant of even the rudimentary principles of modern practice. It was impossible for them to obey the rules, as they did not know what they involved, and some of them could not keep records, as they could not read the thermometer and write the records. It might be thought that such women should not have been allowed to register. This would have led to difficulty. In the first place, the nation has a rooted objection to the summary abolition of any vested interest, however injurious such an interest may be to the community at large. Secondly, in many districts, especially in the rural areas, there was no one else, and the refusal to register such a woman would simply have meant that she or other unregistered women would practise, since the work had to be done by some one. It was better to register them, and hope to improve matters as time went on.

The first need was evidently instruction, which could be carried out in connection with the inspection of midwives. The councils, almost universally, appointed their medical officers of health inspectors of midwives. But this officer could evidently not spare time to undertake anything approaching either a systematic inspection or instruction of the midwives. Arrangements for these are of the highest importance in connection with the improvement in midwifery, and while some districts have carried out both branches with zeal and efficiency, it is regrettable that even now many are sadly deficient in this branch of their work.

The councils responsible for the inspection of midwives are known as the Local Supervising Authority, and the rules of the Central Midwives Board require the midwife to notify to the local supervising authority

all cases where she has advised medical aid, all cases of puerperal fever and of inflammation of the eyes (ophthalmia neonatorum). In 1915, the duty was laid on the midwife of either notifying these last cases herself to the local sanitary authority, or of satisfying herself that the doctor called in would notify. In county boroughs, the local supervising authority and the local sanitary authority are the same, but not in the counties. Special books are arranged for all these purposes. Some authorities have provided them for the midwives in their district free of charge, and others have made a charge for them. Under the Midwives Act of 1918 the local supervising authority is required to provide the books, and to pay postage where such is necessary. The inspector of midwives should visit the midwives after any of the above notifications has been received, and, if necessary, the case as well, in order to ascertain how far any fault in practice may have occurred, and to prevent its recurrence.

It is impossible for the medical officer of health to undertake the work himself. Some one else must be appointed. Some of the county nursing associations which were well-established, had their superintendent, who inspected the work of their affiliated associations. The associations employed trained women almost exclusively, so that the untrained, and others working independently, were not reached in this way. Some counties appointed the superintendent as their inspector, others provided a special officer, while others again employed the health visitor as inspector of midwives. The work is difficult and costly, but immensely repaying and important. The appointment of the superintendent of the county nursing association has advantages, as has already been mentioned (see pp. 97, 98), but it often meant that the medical officer of health left the work to her, and that difficulties arose over the dual control, although

in some cases it worked well. Some local supervising authorities appointed these special officers, who did, and still do, excellent work. They are mostly employed by county councils. They are almost always trained nurses with midwifery experience, and often other additional qualifications. Very rarely, however, has a county appointed a large enough staff to carry on the work adequately. One woman has perhaps been provided to work the whole county with the aid of the train and a bicycle. It need hardly be stated that it was found impossible to carry out the work at all efficiently. Midwives should be visited without previous appointment not less than three or four times in a year, and also after the receipt of notices of advising medical aid, of the supervention of puerperal fever, or of ophthalmia neonatorum.

In order to relieve the county medical officer of the inspection of midwives, some authorities have placed the duty upon the health visitors. In theory this is very economical and satisfactory, but in practice it is not to be recommended. In the counties there is something to be said for it, if all the health visitors were trained midwives, and had all had a good deal of experience of midwifery. But this last asset can hardly be expected and, in fact, is rare among health visitors. It could not reasonably be expected. Hence, it often happens that the midwives are inspected by some one of less experience than themselves. In counties where travelling is difficult, it has been arranged that the health visitor should do some of the routine inspection, leaving the more difficult work for a more fully equipped inspector of midwives. In the county boroughs the suggestion has never had anything to recommend it, except the plea of economy for the ratepayers. Apart from the lack of experience, the health visitor will have too few midwives in her district to be really in touch with midwifery work. If one person does the work for the whole town, she is



constantly dealing with the cases and the midwives, and better work is done. A competent inspector deserves a good salary, and so it is considered less expensive to put the duty on the health visitor as a part of her routine work.

The inspection of midwives requires many qualities and much experience in the inspector. The routine examination of the midwife's bag, etc., is an insignificant part of the work. The inspector must be prepared to give advice and help on all matters connected with the midwife's work. She must instruct the ignorant, and endeavour to keep all the midwives up-to-date in their work and methods.

In a few counties and county boroughs excellent work has been carried out, and the whole level of midwifery work raised. It is astonishing what good results can be achieved by a really good inspector. With the object lessons before them it is remarkable that many authorities have remained very backward in providing suitable persons for the work. The midwives in many districts have not been given a real chance of improving. The Midwives Act undoubtedly intended that the inspectors should produce a general raising of the standard of work. Unless an inspector is appointed who is capable of doing this, and who is not given so much to do that it cannot be well done, the Act loses its value. The Circular of the Ministry of Health of July 1919<sup>1</sup> deals with the question, and urges local supervising authorities to appoint medical women as inspectors of midwives, or, if it is unavoidable that a non-medical woman be employed, "it is essential that she should not only possess the certificate of the Central Midwives Board, but should have had substantial practice as a midwife."

The elimination of the unregistered woman practising as a midwife has been greatly aided by the notification of births. When the notification is signed by some one

<sup>1</sup> Circular 4, given in Appendix IV.

not known as a doctor or midwife, inquiry can be made as to who attended the birth. In this way a number of women who were continuing to practise without being eligible for registration have been discovered. A woman who is on the roll can be controlled by inspection, but a woman who is not registered is difficult to trace without either the notification or a wide knowledge of the district, which last comes only by continuous work therein for some years.

A midwife who breaks her rules is usually warned by the inspector, and if the breach is persisted in the woman can be summoned before the Central Midwives Board, who may caution her or remove her name from the roll. At the present time there is a very serious difficulty in dealing with some of these cases. The shortage of practising midwives is so great, owing to unsatisfactory conditions and remuneration of the majority of midwives, that if, in a rural district, an independent midwife is taken off the roll, she may, of necessity, go on practising, although under the Midwives Act of 1918 she may be prohibited from giving any form of maternity aid other than in an emergency. This difficulty will not be remedied until considerable sums of public money are spent upon midwifery work.

The untrained midwife will soon become a thing of the past, since no more are admitted to the roll. Under continued instruction some of them learn to do their work much better, but, in certain matters, the absence of adequate training can never be remedied. They have, for the most part, not received much education, and many are elderly.

The duties laid upon the midwives are becoming more exacting, and demand more knowledge. The training now extends over six months, and it is not unlikely that a further extension may be required. 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.

A few words are needed upon the subject of midwifery work by doctors. All medical men and women must take a qualifying course in midwifery. After passing the final medical examinations no further experience is required. It is now very widely admitted that the training in midwifery in most medical schools is unsatisfactory and inadequate; that a much higher standard of work is required, and that facilities must be offered for post graduate work.<sup>1</sup>

There is no control over the practice of midwifery by the medical profession, and it is, therefore, all the more important that the work should be of such a character as to render any question of control unnecessary.

<sup>1</sup> Cf. Report on Teaching of Obstetrics, etc., *Proc. Roy. Soc. Med.*, 23rd June 1919.

## CHAPTER XVI

### PRE-NATAL WORK

MIDWIFERY aid may be rendered by either a doctor or a midwife. Although the duties assigned to each are similar in some phases, generally there is a great divergence of function. In order to bring out points both of similarity and of divergence, it will be convenient to regard the whole episode of childbirth as falling into three periods, the pre-natal, natal, and post-natal. The first of these is considered in this chapter.

**The Pre-natal Period.**—This period includes the whole duration of pregnancy, namely, about 40 weeks. Until recently, very little attention has been bestowed upon this period, and such attention was regarded as almost unnecessary by the professions concerned, and as indelicate by those outside. As a matter of fact there is no doubt that this is a most important period, both for the health of the mother and of the child. The teaching of all the experience with child welfare work has been to throw back further the need for care from the period after birth to the period before birth, and then yet further back to the health of the mother before marriage.

Nature has made remarkable provision for the child before birth, and, although our knowledge is still very rudimentary upon many important points, there is no doubt that the child is safeguarded, and many healthy children are borne by rather unhealthy women. But there is always the risk. We do not know how far a

mother may have poor health without affecting the child, and there can be no manner of doubt that it is our duty to secure the best possible state of health for the prospective mother. The appalling mass of minor ailments, borne almost without comment by the working-class women of this country (and probably of all countries), is realised by those who work in some of the more up-to-date maternity departments of our large hospitals.<sup>1</sup>

It is sometimes assumed that the only treatment required during pregnancy is that relating to some trouble directly connected with the organs concerned. It is argued by some that if the general ailments of all pregnant women are to be treated it will involve a tremendous amount of work. This argument, in effect, only illustrates forcefully the prevalence of ill-health due to general conditions among the mass of women of this country. The woman who is anæmic, or suffers from indigestion, or has a number of bad teeth, or has a tendency to chronic bronchitis, or to varicose veins, etc., will probably find her suffering from these causes accentuated during pregnancy. After the confinement her recovery will probably be slower than that of her healthier fellow-woman. Again, how often are conditions which may cause trouble detected too late. Many causes of cardiac disease are not troublesome to the individual concerned so long as she pursues a finely even daily life. But under the strain of the confinement a breakdown may occur, which, if no previous examination has been made, is quite unaccountable, and very alarming. If, however, such an exam-

<sup>1</sup> The amount of pre-natal sickness was hopelessly underestimated in connection with the Insurance Act, which has been one of the means of bringing to light the condition of ill-health of many working-class mothers. So great has been the award of pre-natal sickness benefit to them. So great has been the award of pre-natal benefit that the financial difficulties in which the Insurance Societies find themselves for this item of expenditure have caused much embarrassment both to them and to the Government.

ination has been made, and the trouble is known, proper measures can be taken, and the danger reduced, if not almost eliminated. Many other important instances could be cited.

Another point of vital importance is the search for, and removal of, all septic foci. It is believed that many cases of puerperal fever arise from autogenic infection, through one or other form of septic trouble which could and should have been dealt with in the pre-natal period. Of recent years several cases of death from fever in the puerperium have been found to be due solely to the septic condition of the woman's teeth and mouth generally. No one system of the body works independently of the others. No ailment should be neglected in the pregnant woman, whether it be due directly to pregnancy or not. A medical examination will, doubtless, soon be regarded as a necessary measure on preventive grounds alone, just to be sure that all is in order, but, at present, the idea is new, and will take a little time to mature.

But medical care in the pre-natal period is not the only care required. The mother wants advice for her daily life, for the provision of clothing for the infant, the arrangements which should be made for the confinement itself, instruction as to the importance of breast-feeding and its technique, and many other matters. At no time is the mother more open to instruction than during this long period of waiting, and it is then she needs help with a view to securing the best conditions for the child. The last items can fitly be carried out by a trained midwife if she herself received training on these lines. The revised rules of the Central Midwives Board of 1916 require the midwife to do ante-natal work for her cases. Some midwives have already practised this, but the majority have not as yet done so on various grounds.

It is usual to engage the doctor or midwife some months before the confinement is expected. The object

would appear to have been to ensure that, in the event of a premature birth, the relations might know whom to send for, rather than that any care was expected during this period.<sup>1</sup> At present, although matters are improving, not much ante-natal work is done as compared with that which is left undone. Where a doctor is engaged, the provisions for the confinement, etc., will probably not be gone into, nor does it appear reasonable to expect it in view of the fee charged. This is a strong argument for requiring that there should be a midwife for all cases, even when there is also a doctor engaged. The ante-natal period is the time to deal with these matters. When a midwife is engaged to attend the case, she must, under her rules, satisfy herself that the patient is in good health, and, if not, advise her to seek medical aid. This, however, many women are reluctant to do, both because it usually involves the payment of the doctor's fee, and because they are unwilling to submit themselves to examination.

The ante-natal clinics at the child welfare centres should obviate the difficulty of fees, but many midwives are unwilling to send their patients to them. It is useless to deny that there has been a good deal of ill-feeling on this point, and that a good deal of it is quite comprehensible. There is a most astonishing ignorance on the part of many doctors and nurses as to the position of the midwife's practice. The hospital training schools for doctors and nurses as a whole neither know nor, is it to be feared, care about the midwives who are in practice in the district, and the ignorance results in lack of sympathy when brought into contact with them. The midwife is dependent upon her cases for her livelihood, and cannot afford to lose them. The complaint has been

<sup>1</sup> Also in the days before the Insurance Act and the consequent Maternity Benefit, it was very usual for the midwife's fee to be paid in small instalments before the confinement. This practice carried with it the necessity for booking early with the midwife.

made, with apparently a good deal of cause, that when midwives refer their cases to the centre, the patient may be told that she ought to engage a doctor, or go to a hospital, or she may be alarmed, but in each instance the loss falls upon the midwife. If the patient seeks a doctor, she leaves the midwife, and if she is alarmed she does the same, lest the midwife should try to persuade her to attend again. Hence she frequently goes to another and less conscientious midwife.

If any real widespread good is to arise out of the antenatal work at the centres, the midwives must receive due consideration. They are licensed by the State to practise midwifery, and it is their livelihood. It behoves the centres therefore to treat them with respect before their patients, whether the midwife is actually present or not, remembering that professional etiquette should be observed towards them.

Midwives should be encouraged to attend with their patients, but too often, unless an effort is made not to keep the midwife waiting, she will have neither time nor inclination to do so.

Some midwives have special days or hours when they are at home, and their patients can come and see them. On this occasion they can do much in the way of instruction. At least one visit, however, should be paid to the home to see its degree of cleanliness, and the state of other conditions for the confinement. This visit should be paid fairly early, since other visits may be required to obtain the arrangements which are necessary. The midwife has unexampled opportunities—she influences the mother in a way that others do not. She comes in at a malleable period in the mother's life, and she assists at its most intimate duties. But she must have time to do this, and time costs money, and she must also have training. As the mother would probably be neither able nor willing to pay for the midwife's time for ante-natal care (since



she does not realise its importance) this must almost certainly be provided out of public funds.

**The Handywoman or "Home Help."**—One other matter requires attention before the birth of the child, namely, the care of the home while the mother herself is laid aside. It is usual to engage a neighbour to come in and attend to the husband and children (if any) and to see after the home generally. This woman is often termed the handywoman. A full account of the handywoman is perhaps hardly in place in connection with ante-natal work. But she is an ever-present difficulty, and can be hardly introduced too early into the midwifery picture.

When a midwife is engaged, this woman should not be allowed to do the nursing of the mother: she should confine herself entirely to domestic matters and leave the nursing to the midwife, and the midwife should see that she does so. Unfortunately, many of the women consider their knowledge adequate to interfere. They are usually sent for with the first indication of the onset of labour, and are not infrequently so misguided as to delay sending for the midwife until too late, so that the latter arrives without proper time to make preparation, or even, sometimes, after the birth of the child. Midwives who know that they have to report any untoward occurrence to their inspectors, generally make a stand on the necessity of being sent for in time, but it is none the less a difficulty.

The handywoman is, however, more actively dangerous when a doctor is engaged. The doctor may be on his rounds when sent for, and for one reason or another, may be unable to attend in time. In such cases the handywoman conducts the case herself, and is, unfortunately, often proud of doing so. In fact, it is well known that some of them do not send for the doctor unless they think that there is something wrong, and it is to be feared that they do not always

receive that reprimand from the doctor to which they are certainly richly entitled. Such a delivery is, in effect, illegal, but the woman would plead that the doctor had not arrived, and that she acted for the best. It is very difficult to prove the contrary, although it is well known that some of these women boast of being able to manage quite well without the doctor.

A remedy for this is urgent. The women are ignorant of all the proper care at a confinement; have no apparatus, are often dirty in their person and in their methods, and the risks run by the patient are very real.

The only way to get over the difficulty is to arrange that a midwife shall be engaged as well as a doctor, so that, if the doctor fails, proper assistance is at hand. Further, in such a case, the doctor need not be sent for unless some complication should supervene.

The handywoman usually places a high value on her services, and makes a relatively heavy charge to the mother. These charges vary a good deal from district to district, and in accordance with the work done, *i.e.* the number of children, whether the family washing has to be done, whether food is provided or not, and so forth. Probably the least sum which her services cost is £1 for the fortnight, for which sum very little work could be done, and it may well run to £2 or £3 for the whole period. In order to improve this unsatisfactory state of affairs, schemes have been devised for training women in domestic duties who should replace the handywoman. The woman so trained is termed the Home Help, and it is usual to make a somewhat lower charge than the actual cost of the scheme in order to induce the mother to employ the trained woman as against the untrained. The home help is strictly forbidden to undertake any maternity nursing or midwifery. She is not trained for maternity nursing, and it is illegal for her to do

midwifery. She should not be employed at all on doctor's cases, lest she should come to think that she also can "manage without the doctor." It may be argued that at least she is better and more cleanly than the average handywoman, but the position is only a shade less black, and amounts to condoning illicit practice. Clearly there are many doctor's cases where the doctor is present, but it must inevitably be difficult to be reasonably sure that he will be able to attend.

The home help is usually under some form of inspection: State grants in aid can be obtained by local authorities who provide these women, but at present the movement is not widespread as compared with the total number of births.

Full pre-natal care could be given by the maternity departments of lying-in or general hospitals to those women who apply for midwifery aid. In some institutions a good deal is already done, but the total amount done is small as compared with that which remains to be done.

It must be again emphasised that ante-natal work does not only mean a medical examination of the parts most affected. This is, of course, an essential part of the work, but it is only a part. The work should include the treatment of any abnormal condition, advice as to daily life and habits, and also arrangements for the confinement both for mother and child, and instruction in infant care. The arrangements should be made by the mother herself, who should be told how to carry them out.

The cost, however, is again a difficulty, and would be heavy if ante-natal care were made available for every woman attended by the maternity department. But the opportunity should not be lost. The work is of the utmost importance, and intensely worth doing. Some hospitals already make considerable provision

for it, and others are realising its necessity. Grants in aid, up to one-half of the cost, are given through the Ministry of Health, and are of great assistance. Doubtless, in the course of a few years, the need for ante-natal care will have become appreciated by the majority of the working-class women, and there can be little doubt that when due care is provided and accepted there will be a marked reduction of sickness and, it is to be hoped, of death among both mothers and children.

The widespread campaign on the subject of venereal disease has doubtless emphasised the need for ante-natal care. There appears, however, to be a tendency to assume that ante-natal care implies primarily the discovery and treatment of such diseases. This last is evidently of great value, but the incidence of venereal disease in the population at large is not known with any degree of accuracy. Although certain figures have been widely quoted there is no precise knowledge on this point, and it is difficult to see how any such information which could be considered reliable could be obtained under existing circumstances.

Moreover, the mother does not always by any means suffer much herself from syphilis. It is the child that suffers most in such a case. The mother suffers much more and her health is more seriously impaired by the numerous ailments or pathological conditions which arouse little or no interest in the mind of the public. One is almost tempted to suppose that the widespread prevalence of other troubles as compared with the incidence of venereal disease is the cause of the indifference which is undoubtedly manifested, as compared with the interest betrayed in the whole question of venereal disease. At a recent conference on child welfare a note of warning was sounded by Dr. Eardley Holland on the danger of expecting too great results from ante-natal work in this direction. More, he thought,

could result from improving attendance and care at birth.

Results are often hard to see and take time to become apparent. For many years the opponents of the child welfare movement asked repeatedly for figures, that is, for results, following on child welfare work. It was impossible to obtain such figures, but those most concerned felt sure that the work would bear fruit. Their hopes have been abundantly justified. While the truly satisfactory reduction in the infant death-rate cannot be attributed only to the child welfare movement, there can be no doubt that it has played a part, and the full effects may yet be to come.

Ante-natal work will almost certainly be found to be of a similar nature. It is impossible to suppose that if the general level of health among pregnant women were improved, as it would be by systematic ante-natal work, it would not show favourable results. It is possible that some years will elapse before much good can be seen, and other factors will doubtless have their share, but this is inevitable. A movement which does not carry other factors in its train will not travel far and will probably produce very small results.

Ante-natal work must inevitably bring with it improvement in the clothing, feeding, and general hygiene of the mother and family, with resulting improved health. Some such improvement might admittedly be brought about by other means, such as the improvement in housing conditions, with corresponding domestic facilities, or by improvement in wages, with consequent improved feeding, etc. Some of these are already operative and will doubtless be developed further. All means that can improve the health of the mother should be used as widely and with as little delay as possible.

## CHAPTER XVII

### ATTENDANCE AT BIRTH AND MATERNITY NURSING

THE majority of all births occurring in the home are attended by midwives, and the next largest number by doctors; in addition, there are hospitals and other institutions where women can be taken for the confinement, but the percentage of these cases is small as compared with those attended in their own homes by midwives or doctors, except in London.<sup>1</sup> Here in the year 1915 out of 101,649 total registered births, 32,661 were attended by midwives in their own homes and 38,146 by doctors. The remaining 19,656 births occurred in, or were attended from, hospitals.

Outside London the number of births occurring in hospitals is small, and is negligible as compared with the births attended in the home. The question of hospital accommodation will be considered separately in the next chapter.

The percentages of all cases attended by midwives in the home vary in different parts of the country, but are rarely less than 60 per cent. and frequently higher, reaching over 90 per cent. in a few towns. In some of the remoter districts where there is no midwife, all the cases are nominally attended by doctors. Since in some of these places the doctor is several miles away, it is hardly possible that he will be present at the confinement in every case. Doctors very often have to take

<sup>1</sup> For full figures see table on p. 7 of the Report to the Local Government Board by the Author (New Series 111), on the Provision of Midwifery Service in the County of London.

responsibility for very unsatisfactory work by the handywoman.

Although this book deals primarily with the machinery of the services concerned, the position will be more easily understood if a few remarks are made as to the duties which fall respectively to the doctor and to the midwife. It has already been shown that in regard to ante-natal work there are two aspects—the one general or hygienic, that is, the food, clothing, etc. ; and the other curative—or the treatment of any abnormal condition. We do not know what percentages of cases may require treatment during the ante-natal period, since no figures are available for this country. Further, the figures would differ widely according as they were or were not taken to include all ailments or only those directly connected with pregnancy.

The period of labour is relatively very short, extending from less than an hour up to many hours, or sometimes up to a few days. The general health of the mother undoubtedly exercises an important effect on the time of labour, but we are not at present in possession of any direct investigation upon this point. Fortunately nature still secures a high percentage of labours without complications, although probably many of them would be shorter and less painful if proper attention had been paid to the mother and if she had led a healthy life.

Midwives are not allowed to undertake the handling of complications. They are recognised by statute for attendance in labour, but under their rules, they must summon a doctor if any abnormal condition is found or should supervene in the course of labour. The same applies to any abnormal condition occurring after labour during the period of their attendance on the mother.

The midwife is responsible for the management of the confinement and for the nursing of the mother and child during the whole period of her attendance.

The doctor is, as has been already mentioned, usually

summoned by the handywoman and not infrequently too late. She will probably make rough preparations for the confinement and will undertake all the nursing of the mother and child, which in a midwife's case is done by the midwife herself. The doctor, however, will deal with complications should they arise without further charge, unless a second doctor should be needed. Often there may be little that needs attention, but sometimes both the labour and the recovery may be prolonged and entail much time and trouble to the doctor.

Many people, fearing the additional cost of the doctor in the event of complications after they have engaged a midwife, prefer to engage a doctor and to put up with the inferior work of the handywoman. Others prefer a midwife on general grounds and risk the need for the summoning of a doctor.

The midwife must attend her cases whenever she is summoned, and must not relax her care until the labour has terminated. After the labour she is responsible for the mother and child for ten days after the confinement, or longer, if the recovery is not satisfactory.

The doctor attends at the confinement, and subsequently, if all goes well, will visit the patient three or four times during the following fortnight. The nursing is left to the handywoman.

Good maternity nursing is of immense importance to both mother and child. The rate of recovery and, possibly, the subsequent health of both mother and child, will be affected by the service rendered. Training is required for the work, and it is deplorable that it should be permissible for doctor's cases to be nursed by any ignorant woman whom the mother may choose to employ.

For normal cases and in existing circumstances, on the whole the attention given by a midwife is preferable to that given by a doctor and the handywoman.

There should be a trained midwife for every case



whether a doctor is engaged or not, and the best arrangement would be for both to be engaged, on the understanding that the doctor did not necessarily attend unless some complication supervened; but he or she should have been engaged early and should have examined the patient at least once before the confinement. Of course the difficulty is the cost, but the matter is so important that every effort should be made to provide the best arrangements for attendance at childbirth.

Unfortunately, at the present time, the midwives' fees are not ordinarily sufficient to enable them to spare the time and give their best work to the maternity nursing. A busy midwife, especially, is apt to devote insufficient attention to it. It is, however, most important that due time should be allowed for it, and midwives should not undertake more cases than will admit of sufficient attention being devoted to the maternity nursing.

The time necessary will vary according to the quickness or otherwise of the midwife. It is safe to say, however, that the average time in the early days after birth will be about an hour a day—sometimes three-quarters and rather less on succeeding days.<sup>1</sup> Here, again, time is money, and if adequate care is given an adequate fee must be paid. Very few mothers can or will afford the necessary expense, although there are those who will prefer to pay rather more and get better service. The question of the fee is dealt with in Chap. XIX.

Some associations employing midwives arrange for their midwives to attend as maternity nurses at a lower fee than when practising as a midwife. While the midwife has less responsibility, she has just as much work to do, and fully as much time is occupied. It is difficult to see why a midwife should take a lower fee for such work, since, in the event of the doctor not reaching the patient in time, she has the full responsibility.

<sup>1</sup> Cf. p. 40 of Report to the Local Government Board by the Author (New Series 111).

Also the provision of good maternity nursing is probably fully as important as the provision of trained aid at the confinement.

The care of the infant and the importance of securing breast-feeding are matters to be borne closely in mind during the period after the confinement. Too often breast-feeding is relinquished after little or no effort, whereas it should be persisted in for a month or more before abandonment; it is good for the mother and yet better for the child. The breast-fed baby is saved many of the risks to which its artificially-fed brother or sister is continually exposed. There is no means of replacing the natural food for the infant. Not only is it specially adapted for each species, but it is the means of the transmission of immunity from the mother to the child. During the first few days the child acquires immunity to all to which its mother is immune. The transmission takes place only in the first few days, but the value of breast-feeding does not thereafter become less. The birth-weight, which falls for a few days after birth, is regained more readily. The child has less risk of over-feeding, since it can take rather more breast-milk than necessary with comparative impunity, and its progress is, on the average, better than that of the artificially-fed infant. This does not refer to the question of weight. Babies can be made to put on weight very rapidly on artificial feeding, but the weight is not necessarily health; the flesh is often flabby and the child has an undue amount of adipose tissue. While larger in size, it is frequently unhealthy, liable to colds and bronchitis, and is not infrequently rickety. The smaller child, with firm flesh and rounded but not fat limbs and body, is far healthier, and is infinitely more frequent among breast-fed children than among bottle-fed ones. In fact, it is doubtful whether any artificially-fed child exhibits the same satisfactory conditions as a healthy breast-fed one. Also, many weakly children,

who would almost certainly die on artificial food, are saved by breast-feeding.

The value to the mother of a healthy baby is immense. A healthy child does not cry, and will sleep well or lie quietly in its cot, always provided that it is not spoilt by continuous dandling. Some attention is good for it, and aids its mental development, but excessive petting or dandling renders it nervous and fretful.

Too frequent feeding is a further trouble in many cases. The child that is fed every two hours during the day and once at least during the night, usually acquires indigestion, and is fretful, wakeful, and irritable—in truth, the digestive system has no rest, and resents the continuous work. The mother's system resents it too, and, not infrequently, the loss of the milk supply results. It is very important that the child should be hungry, and should empty the breast when fed. The first milk which comes is very poor in fat, and the last milk very rich. This latter is lost when the child is not hungry, as is the case when it is fed every two hours. The child then does not obtain its proper nourishment, and the gland, not being emptied, tends to cease functioning. The final result is a weakly baby, due to insufficient fat in the food, and a gland that is said to be incapable of functioning. The milk is found not to "suit the baby," and the bottle is instituted, when, since it gets more fat by this process, it begins to improve. The improvement is put down to the bottle-feeding, whereas the whole trouble has been caused by too frequent feeding at the breast.

The majority of babies do well on four-hourly feeds during the day with an eight-hourly interval at night. A few do better on three-hourly feeds during the day and eight-hours interval at night, while premature or very delicate children will require special feeding arrangements. The long interval at night is very beneficial to both mother and child. Adequate uninterrupted sleep is obtained, which is of great value for both of them.

Again, cleanliness in the newly-born child is important. Opinions are becoming somewhat divided as to the advisability of washing the child immediately after birth, as is the present general practice. The child enters the world with a warm layer of grease over its body, and the removal of this layer may be harmful. Probably it was intended as a protective coating for the first few hours after the infant's entry into a cold world. After the first few hours, however, the infant should certainly be kept scrupulously clean. The cut end of the umbilical cord is a wound requiring attention, just as does any other wound. Too frequently trouble arises owing to neglect, and the resulting damage to the infant is almost certainly underestimated. It is probable that the subsequent occurrence of an umbilical hernia—a trouble far too common in this country—is largely attributable to neglect of the umbilical cord. Lack of cleanliness in other parts may give rise to skin troubles which retard progress. Again, cleanliness is essential for the mother. It is true that a certain number of women do recover in spite of much lack of the most elementary cleanliness. But it is a grave risk, and one which need not be run. Moreover, recovery is undoubtedly hastened by a proper care of the body. It must be remembered that there is a wound surface here too, and care is required to prevent infection, a condition of great gravity in the woman after labour, and known as puerperal fever. It is hoped that this short digression upon some of the points connected with the care of the mother and child may be sufficient to emphasise the necessity for training on the part of whoever is to be responsible.

**On Sending for Medical Aid by Midwives.**—In the event of any complications intervening in the course of a case, the midwife is required under her rules to advise the father, or other responsible relation, that medical aid is necessary. Ordinarily, the family attendant

should be sent for, but, in the event of emergency, it may be necessary to send for some other doctor. Many families have no regular attendant, and may have no predilections. In this case, the midwife will exercise her discretion as to the doctor summoned.

Great difficulty has arisen and considerable hardship over the question of the payment of the doctor's fee. The position has been improved by the Midwives Act of 1918, but is not yet quite satisfactory. A doctor who is summoned to attend in an emergency may have to go out at night, and the case may last many hours, and require further attendance on subsequent days. There can be no question whatever that the doctor is entitled to a fee, and that such a fee should be adequate. The father may be in a position to pay the midwife's fee, but not the doctor's fee as well. The rules had not long been in force before trouble arose and representations were made. It was then agreed by the Local Government Board that the fee should be paid by the Poor Law Guardians if it was found that the father was unable to pay. Some guardians insisted that their district medical officer should be summoned, and others agreed to pay the fee of any doctor called in, or such part of the fee as the parent might be unable to afford. It is not necessary at the present time to investigate the causes which rendered this arrangement of little value. That it was so, is clear from the great demand for a revision of the position. This demand caused power to be given (see the Midwives Act of 1918) to local supervising authorities to pay the doctor's fee if the patient or her husband, or other persons, could not do so.

In a great many cases the doctor came on receipt of the summons, for either no fee, or for a very small fee. While, no doubt, there are cases when the doctor has grumbled, or when due time has not been given, it should be remembered that the receipt of a fee has been obtained in very many cases, and that, in innumer-

able instances, the greatest care and attention have been given. Again, many midwives have themselves guaranteed the doctor's fee, or have agreed to receive a lower fee for themselves. In fact, the position was fraught with hardship for all concerned, and a remedy urgently called for.

A few towns, notably Liverpool and Manchester, had instituted schemes for the payment of the doctor's fee, either in whole or in part, that at Liverpool being singularly successful. The Notification of Births (Extension) Act of 1915 gave permission to spend money on the service, and the Local Government Board sanctioned schemes put forward by local authorities in different parts of the country. The aid was only to be given to "necessitous" cases, and the difficulty of definition of the term gave rise to reluctance on the part of some local authorities to inaugurate a scheme.

The Midwives Act of 1918 gave power to the midwife to call in medical aid when required under her rules, and laid upon the local supervising authority the duty of paying "to such medical practitioner a sufficient fee, with due allowance for mileage, according to a scale to be fixed by the Local Government Board."<sup>1</sup> It also, however, gave power to the local supervising authority

<sup>1</sup> 12. The Board have fixed the following scale for the purpose of this section:—

|   |    |   |   |
|---|----|---|---|
| (1) Attendance at confinement requiring operative assistance and subsequent necessary visits during the first 10 days .. .. | £2 | 2 | 0 |
| (2) Attendance at confinement without operative assistance and subsequent necessary visits during the first 10 days .. ..   | 1  | 1 | 0 |
| (3) Assistance for the administration of an anæsthetic .. ..  | 1  | 1 | 0 |
| (4) Any visit not covered by (1), (2), and (3) including any necessary prescription:—                                       |    |   |   |
| Day (8 a.m. to 8 p.m.) .. ..  | 0  | 3 | 6 |
| Night (8 p.m. to 8 a.m.) .. ..  | 0  | 7 | 6 |
| with the addition of the mileage fee usual in the District.   |    |   |   |

to "recover the fee from the patient . . . unless it be shown to their satisfaction that the patient . . . is unable by reason of poverty to pay such fee." This clause, which appears to be wholly favourable to the midwives, has, however, proved a double-edged weapon in the hands of a large supervising authority. This body appointed inspectors to visit all cases where a notification had been received from the midwife that she had sent for medical aid, and the parent's income was inquired into. The result was that many of the patients threatened to engage a doctor only in future, and not a midwife, and the midwives sent a deputation to the council concerned pointing out the seriousness of their position.

The tendency will almost certainly be towards paying the whole fee without inquiry. Some supervising authorities do not appear to worry unduly about the recovery of the fee, and it is probable that the cost of the recovery would absorb a considerable part of the fees repaid. It is hoped that the doctor's fee will soon come to be paid by the local supervising authority in all cases when summoned by a midwife, without inquiry into the patient's means.

The percentage of cases in which midwives sent for medical aid before the passing of the Act has been estimated by various people. For the large towns, the average percentage when help was sought for the mother is apparently between 8 and 10 per cent. of all cases attended by midwives. The figure varies considerably between the different towns, and is lower in the country areas. The figures for London for 1918 show that medical aid was sent for in 8 per cent. of all cases attended by midwives.<sup>1</sup> The midwives will be influenced in sending for the doctor in cases of a less degree of urgency by

<sup>1</sup> See pp. 81 *et seq.* of Supplement to the 44th Annual Report of the Medical Officer to the Local Government Board for 1914-15 on Maternal Mortality.

the distance the doctor may have to come. It will be very interesting to note how far the figure is affected by the schemes for payment of the doctor's fees by the local supervising authorities.

The present training of a midwife does not place her in a position to do more than attend a normal confinement. Doubtless many of the more experienced midwives are fully capable of dealing with certain abnormal conditions. But it would be impossible to make regulations for those who have undergone the same training, whereby additional powers were allowed to those of experience, but without further test. If midwives were to be allowed to do some of the work now done by doctors, a much longer training would be necessary, and the whole position would need very careful consideration. It would, in fact, amount to a recognition of a specialised but inferior grade of medical practitioners, as it would be impossible to require more than a two years' training at the outside. Although arrangements of this nature do exist in other countries, it is doubtful how far it would work satisfactorily here. The whole question is very thorny, and fraught with grave difficulties at present.

**Maternity Benefit.**—The Maternity Benefit of 30s. payable to the mother was inaugurated as a part of the National Health Insurance Act of 1911. It was a recognition of the value of children, and formed a sort of recompense to the mother. It appears originally to have been somewhat vaguely intended to provide the fee for the doctor and midwife, or for both of them. In 1911 a fee of 15s. would have been regarded as a good fee for a midwife, and many doctors were prepared to attend when summoned by a midwife for a similar fee. Thus the 30s. Maternity Benefit might have been regarded as a sort of insurance to the mother against the expense incidental to childbirth.

In many cases the money has not been spent directly on payment connected with the confinement, but has



been used for general family purposes. This has caused a good deal of criticism. It would, however, seem unreasonable to require that the actual money paid over should necessarily be used for the expense of the confinement, since, without doubt, other money spent before the confinement would have been available for general purposes, such as rent, boots, etc. If, therefore, the cost of the confinement has caused delay in purchasing other goods, there seems no real objection against using the Maternity Benefit money for those purposes when it is paid over after the confinement.

Undoubtedly the midwives' fees have been raised as a result of the Maternity Benefit, and there is general agreement that better provision is now made for the confinement than was formerly the case. It must be remembered that the 30s. paid as the Maternity Benefit does not nearly cover the total cost of the confinement. The cost of even simple arrangements will amount to not less than from £3 to £4, and may well reach a higher figure.

Whether the improvements noted have justified the cost of the Benefit to the State can hardly be determined with any approach to accuracy, and its consideration is entirely beyond the scope of this work.

There is no doubt, however, that the amount of money which will be required for the various forms of care for children in the near future, will be considerably in excess of the amount of the Maternity Benefit. One of the real needs of the moment is improved provision and arrangements, including alterations in the law, for the present unfortunate unmarried mothers and their children.

## CHAPTER XVIII

### THE PROVISION OF MATERNITY CARE BY INSTITUTIONS

IN the preceding chapters the work which should be undertaken in connection with every birth, and the duties falling respectively to the doctor and midwife, have been briefly described.

No special remarks have been made as to the place of the birth, although it has been assumed that the birth would take place in the mother's own home.

Any detailed exposition of the work of in-patient maternity hospitals or other institutions would be unsuitable in a work like the present one. Beds for maternity cases are, however, an essential part of any midwifery service, although, fortunately, the number of mothers for whom hospital aid may be regarded as necessary form only a small percentage of the whole. If about 8 per cent. of all cases require medical aid, it may be assumed that only a proportion of these should have been placed in a hospital for their confinement. Medical aid is sought for a large variety of conditions which can hardly be regarded as involving the need for hospital care. It is probable that, if beds were available for 5 per cent. of all births, practically all cases requiring hospital aid could obtain it.

For many years there have been institutions where women could go for the confinement. The Poor Law provided facilities, and there were also maternity hospitals. It is probable that the really destitute alone

availed themselves of the Poor Law service, and inasmuch as it forms only a small fraction of the total work undertaken, it need not be considered further. It should, however, be remembered that beds in Poor Law institutions are available for this purpose all over the country, and that cases of complications are not infrequently sent in to the Poor Law infirmaries in default of other accommodation.

In London there is a fair provision of maternity beds in hospitals, although this statement requires some qualification later. The accommodation consists of those hospitals which take maternity cases only, and of maternity wards in the general hospitals. It has always been recognised that medical students must have some experience in normal midwifery, but general hospitals have not felt greatly drawn towards the allocation of beds for such cases. This is easy to understand. There is an acute shortage of beds for all forms of medical and surgical cases, under existing arrangements, and it was felt that these were more pressing than normal midwifery cases. Therefore, for the most part, such beds as were available for midwifery were rightly reserved for complicated cases. Of recent years, Oxford and Cambridge have required that their students, who must take a certain part of their clinical work in London, shall only attend those hospitals where some beds are set apart for midwifery work. Only four hospitals have responded by providing maternity wards where both normal and abnormal cases are admitted, and where medical students can be taught the practice of normal midwifery. Three others have a few beds which are reserved for the instruction of midwives.

Adequate in-patient provision for training students is not made in a number of the medical training schools, but there will be some increase in the number of beds in the near future. This has been strongly recommended by a special committee appointed to consider the training

of medical students in midwifery.<sup>1</sup> Full details are there given of the total present facilities in the Training Schools; details as to the beds available, and cases treated by the maternity hospitals, can be obtained elsewhere.<sup>2</sup>

As late as the end of 1919 there were in the whole of the general hospitals of London 117 beds reserved exclusively for obstetric cases. In addition, a certain number of gynæcological beds were used for complicated cases of midwifery. In 1916 the eight special maternity hospitals provided the vast majority of the beds, amounting in all to 320, out of the total of 437. This total number of beds provided for aid in relation to 9089 births, which occurred in all the institutions combined.

There were, in addition, some small self-supporting lying-in homes kept mainly by private midwives, where a few hundred births occurred annually. Their numbers are, however, negligible for the present purpose. Since 1916 a number of other lying-in homes have been opened by a few of the borough councils under the maternity and child welfare schemes.

Investigations carried out in 1916<sup>3</sup> showed that about 9 per cent. of all births in London occurred in hospitals. It is very unlikely that the figures for those really needing hospital care are as high as this, and it is probable that 5 per cent. would be a more correct figure. It would appear, therefore, that the actual number of beds available is sufficient for the real medical needs of the population, as well as for a number of persons who come from other parts of the country to be confined in the London hospitals, if all these beds were reserved for abnormal cases, or for those where complications might be antici-

<sup>1</sup> *Proceedings of the Royal Society of Medicine*, June 1919.

<sup>2</sup> Report to the Local Government Board by the Author (New Series 111).

<sup>3</sup> Report to the Local Government Board by the Author (New Series 111), pp. 11 and 12.

pated. But the majority of the cases admitted are normal, and the women ask for admission to the hospital because they feel that it will be more convenient, for other reasons of a private nature. Further, the large maternity hospitals draw their patients not only from all parts of London, but from other parts of the country. There is no systematisation either in regard to the nature of the case or to the district served. There are some districts which have two or three hospitals with maternity beds within a few minutes' walk, while in other less central parts no maternity beds are available within several miles.

All the maternity hospitals, and all the general hospitals with medical schools attached, have out-patient maternity departments for the training of their pupil-midwives and medical students. In some of the hospitals a careful sifting of cases is undertaken when the patient comes up to book, in order to ascertain the possible need for in-patient care, and cases from the out-patient department requiring in-patient care are usually accommodated in the hospital.

While provision is made for at least the most urgent cases, in practically all the hospitals with out-patient maternity departments a great many normal cases are given in-patient care, and it is often difficult for general practitioners to obtain admission for urgent cases occurring in their practices. No attempt is made to serve the general interests of London as a whole—each hospital is an independent unit, responsible to no one, except, possibly, to those by whose contributions it is maintained. No charge is made for the in-patient care, although in some hospitals patients are encouraged to contribute a sum which is inevitably small as compared with the cost to the institution.

Some nominal charge is made in connection with the attendance in the homes at certain hospitals for those who can pay it, and it is usually understood in theory,

at any rate, that women who are able to afford a midwife or doctor should not be attended in their own homes free of charge.

While, no doubt, some general benefit results from the out-patient midwifery work of the hospitals, it is to be feared that, to a great extent, it serves to keep down the level of the midwifery and doctors' fees in the district, and thus inevitably to maintain a low level of practice. If the work undertaken by the hospital were always on a high level, at least it would set an example of good work, but much improvement is needed in that undertaken in connection with some of even the largest hospitals, both on behalf of the women and of the students in training. Maternity nursing is of course provided for the in-patients, but not always for the out-patients. When the cases are attended by the medical students, usually no maternity nursing is provided, except in specially bad cases. Two London hospitals provide maternity nursing for all out-patient cases, but, so far, this is not provided as a routine measure by the other hospitals.

When the cases are attended by pupil-midwives, under the charge of a trained midwife, maternity nursing is undertaken, and the quality of the care bestowed will depend upon the ideals the department may have or be able to execute.

Outside London there is a great dearth of hospital facilities for maternity cases. In many of the large towns there is no accommodation at all except in the Poor Law infirmary, while beds in the smaller towns and in rural or scattered urban areas are so rare as to be of no account in dealing with the needs.

During the last few years a number of small maternity hospitals have been opened chiefly by the local authorities and by the aid of State grants. These will be most valuable and mark an improvement in our present condition.

Many more maternity beds are, however, needed outside London, if even 5 per cent. of all births are to receive in-patient care.

The last few years have witnessed the rise of a school of thought which considers that all births should, if possible, take place in an institution. There has been much outcry about the housing conditions of the country generally, and it appears to be assumed that all houses are unfit for the occurrence of a birth. While no doubt there are a great many houses which are unsuitable for confinements, especially where the present shortage of houses is most felt, there is no need to suppose that the majority of births cannot occur in the home. Again, the absence of the husband on war service, and the increased cost and difficulties of living, etc., have made many women feel that they would prefer to be in a home where they were looked after. A number of nursing homes have sprung up to meet this need, and so long as they are self-supporting they are clearly a benefit to those who wish to take advantage of them.

But the outcry sometimes raised for in-patient care in homes and hospitals for all births is ill-considered. In the first place the cost would be prohibitive. It would be impossible for more than a relatively small proportion of the women concerned to pay the fees which would be necessary to make the institutions self-supporting. Before the war the most economical figures for maternity beds worked out at a cost of approximately £5 per patient for normal cases. This figure does not include any allowance for initial expenditure. The cost will certainly have risen very considerably at the present time, but precise figures are difficult to obtain. A maternity bed can accommodate from 17-20 patients during the year, so that if all cases were to be given in-patient care, at least one bed to every 20 births would be necessary.

Many women, however, much prefer to be confined in their own homes, and many others cannot leave their

husbands and family. Although the mother may be unable to get about, she can, nevertheless, give directions and enable the house to be carried on, and the woman who comes in to help will look after the home if the mother is there. The father who goes out to work cannot look after the children himself, and there may be no accommodation for a woman other than the mother of the family. In this case arrangements must be made for boarding the children elsewhere. If these arrangements are made out of public or private funds, as is suggested at the present, then no doubt the cheapness will be an attraction to the parents, as it will cost less than if the confinement is at home. But it will prove a heavy drain on the funds in question and is, in many cases, an unnecessary expense.

Further, there is no reason why parents should be spared all the trouble of a confinement. It is often very beneficial for the father to have at least some knowledge of what his wife is called upon to go through.

If it be a question of inadequacy of home accommodation, it will be preferable to aim at improving this rather than to demand the opening of expensive lying-in homes.

It is surely better to make efforts and spend money on improving home conditions rather than on the provision of costly buildings and appliances which should only be necessary for abnormal cases. Cleanliness and care are, of course, essential, but these should be procurable in the home of every citizen. Hospital accommodation is hopelessly inadequate in the provinces for even the severe cases, and it seems premature to discuss, as is sometimes done, the erection of hospitals for all normal cases. Let effort rather be directed towards the prevention of complication by ante-natal care and the securing of adequate conditions in the home for uncomplicated cases, with hospital facilities for those cases where complications may be anticipated



and are not preventable in the light of our present knowledge.

The fear of the supervention of sepsis appears to be the chief feature in the minds of some who advocate in-patient care. If precautions were resorted to as above mentioned, especially the elimination of septic foci in the mother, there would be less risk than is at present the case. Even now, in admittedly unsatisfactory conditions, it is astonishing how seldom septic trouble supervenes. Additional facilities for supplying sterilised articles to doctors and midwives would be a valuable part of any maternity scheme for a district, and could be arranged with comparatively little trouble and not much expense.

But it should be remembered that child-bearing is not a pathological condition, and accentuation of the difficulties and possible dangers of childbirth are not likely to encourage the young prospective mother. Many women are most unwilling to enter any institution, and if they felt that childbirth was so serious a process that this was necessary for safety, the effect on the birth-rate would probably not be long delayed.

## CHAPTER XIX

### ON THE PRESENT PROVISION OF MIDWIVES

It will not be necessary to deal further with the medical practitioners as a part of the midwifery service, not because they do not form a very important part of that service, but because there are no special further points to be made. The country is fairly well provided with doctors, although, in rural districts, many patients would be difficult to reach without a very good horse or a motor car, either of which, however, enables the doctor to attend patients at a considerable distance from home.

The midwife who attends for the maternity nursing, and who should devote a sufficient time to each patient to give the required aid, can work only a comparatively small area, even with the aid of a bicycle. A great many midwives use bicycles, but their earnings do not admit of any other form of private conveyance. A midwife can probably take cases about  $2\frac{1}{2}$  miles in every direction from her home, but it is arduous, and any greater distance would be too great a physical effort for most women, since there will be work nearer home and in other directions as well.

There is not a sufficient provision of midwives in many parts of the country. In some of the large towns there are, it is believed, a few midwives more than may be necessary for the needs of the inhabitants, but in the country places there is often no midwife, and in some

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places there is a definite shortage. The causes of the shortage are economic in character, and a consideration of them leads to some very interesting and important aspects of the service. The total number of midwives on the roll is given each year in the Report of the Central Midwives Board. This figure, however, includes considerable numbers of qualified midwives who are not practising and have no intention of practising. Many are married and have no time, and others have taken up various forms of work where their training will be of value to them, but where they do not undertake any midwifery. Health visitors fall into this category, as also do a large number of women who work as private maternity nurses in well-to-do families under doctors.

The numbers on the roll for some of the years are shown below :

|           | Trained. | Un-trained. | Total. | Remarks. <sup>1</sup>  |
|-----------|----------|-------------|--------|--|
| March 31. |          |             |        |  |
| 1905      | 9,787    | 12,521      | 22,308 | —  |
| 1910      | 17,790   | 11,419      | 29,209 | The number of un-trained midwives in practice was believed to be largely in excess of the trained. |
| 1915      | 30,543   | 9,970       | 40,513 | About 53·5 per cent. of the untrained are in practice, and 22·1 per cent. of the trained.          |
| 1917      | 33,548   | 9,401       | 42,949 | About 20·5 per cent. of the trained, and 48·4 per cent. of the un-trained are in practice.         |

<sup>1</sup> From the Reports of the Central Midwives Board.

The number of women on the roll evidently has no relation at all to those in practice. It does show, however, that there is a large reserve of trained midwives available for practical work to meet the shortage, if they can be persuaded to practise as midwives.

The only way in which any estimate of midwives in practice can be obtained is from the lists sent each year by the local supervising authorities to the Central Midwives Board. But these lists do not give an altogether correct figure by merely adding the numbers, because a fair number of midwives live near the boundaries of adjacent authorities and must notify their intention to practise to each authority if they are likely to be employed on any case within the area of that authority. If they do not notify their intention, and afterwards undertake one or more cases in that area, they are liable to be fined rather heavily.

Hence, if the numbers of midwives sent in by all the local supervising authorities are added, certain midwives will be included two or even three times in the list. Again, some of the lists make no serious pretensions to accuracy, because the expenses of the Central Midwives Board were, until 1919, charged on the various authorities in proportion to the number of midwives returned as notifying their intention to practise. The Act of 1918 now distributes the charge in proportion to the population, and it is possible therefore that some modification may be expected in the lists of some of the poorer districts. The Central Midwives Board comment, in several of their reports, upon the inaccuracy of the lists from certain authorities. The larger authorities have usually returned accurate lists, although where the Midwives Act has not been strictly administered it is not unlikely that such lists were not quite correct.

In 1914 an estimate of midwives in practice was made by the Local Government Board from the figures ob-

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tained in the reports of the local supervising authorities. The figures thus reached were as follows :—

|  |        |
|--|--------|
| Total number of midwives in practice . . . . .                       | 14,312 |
| Total number of trained midwives in practice . . . . .               | 6,936  |
| Total number of untrained midwives in practice . . . . .             | 7,376  |
| Total number practising in the Counties (including London) . . . . . | 11,022 |
| Total number practising in County Boroughs . . . . .                 | 3,290  |

In 1915, 1916, and 1917 the Report of the Central Midwives Board gives the following :—

|   | 1915.  | 1916.  | 1917   |
|---|--------|--------|--------|
| Total number of midwives in practice                      | 12,087 | 11,807 | 11,449 |
| Total number of trained midwives in practice <sup>1</sup> | 6,754  | 6,981  | 6,896  |
| Total number of untrained midwives in practice            | 5,333  | 4,826  | 4,553  |

Evidently the number of untrained women in practice is diminishing with considerable rapidity, and the number of trained midwives in practice, in spite of a rapid increase in trained midwives (as shown by the figures on p. 167), is remaining fairly constant. As a result, the total number in practice is steadily decreasing.

Each midwife presenting herself for examination is required to state whether she intends to practise or not. The figures given in the Reports of the Central Midwives Board show that in 1908-9 the number of those who intended to practise was 58 per cent. of all successful candidates. In 1911-12 it had fallen to 48·8 per cent., and in 1915-16 to 47·8 per cent., but in 1917-18 the number rose to 54·6 per cent. In the year before there had also been a slight increase over the preceding year when the midwives entering practice were apparently

<sup>1</sup> These figures for trained midwives in practice include all those who are connected with institutions and are not inconsiderable in number. Thus, in 1915, out of a total number of 495 midwives who notified their intention to practise in the County of London, 118 were connected with some kind of institution for maternity work.

being attracted to the towns. The increase in 1917-18 was, however, due to a rise in the numbers intending to practise in rural areas.

The cause of the increase in rural areas is, no doubt, due to the measures now being taken by county councils and county nursing associations to extend the midwifery work in their areas. For many years past the higher education committees of a number of county councils have awarded scholarships for training midwives, for the county nursing associations. A few associations have their own training homes, but others arrange for training with different training institutions. The midwives are trained free of all charge to themselves, but they must sign a contract to work for, generally, three years after training in any part of the county to which they may be allotted. For some years past the Local Government Board has made grants in aid of midwifery to the county nursing associations, and has also repaid 50 per cent. of any subsidies granted by county councils to maintain and extend the midwifery provision in the county. The efforts thus made are meeting with a good deal of success, and at least one county has no district without a midwife, and several others have nearly reached that desirable state.

In general, however, the position gives rise to anxiety, since if a midwife is too busy, she will not be able to carry out that good work which is essential for the health of the mother and child.

There is one primary cause which is producing the shortage of midwives, and that is the simple one that the fees paid by the patient are too low to enable a midwife to carry on her work properly and yet earn a reasonable livelihood. In the years before the Midwives Act of 1902, many midwives only earned 5s. or perhaps less for a case, but the service rendered was also slight. The work now required of a midwife is exacting and ever-increasing. She has considerable clerical work to do,

keeping registers and sending forms to the local supervising authority, and she is continually being called upon to render more service to each case. The ante-natal work alone will, if properly done, demand a fair proportion of her time. The fees, however, do not rise in due proportion, and in 1915 the average fee was probably somewhere between 10s. and 15s. in the large towns. A few midwives charged higher fees, but others again received less, and bad debts had always to be allowed for, especially among the poorer class practices. The rise in fees up to a possible 15s. has been mainly brought about by the Maternity Benefit, and a further rise in fees has taken place with the increase of wages paid during the war. A fair number of midwives in fairly good class practices obtain fees of 17s. 6d. to 21s.

It is reckoned that, in order to give sufficient attention to each case, a midwife cannot undertake more than 150 cases per annum, and, when the population is scattered, 100 will probably be the highest figure. Suppose that a midwife obtains even 15s. as an average per case, her income will be somewhere between £75-£112 as a maximum per annum. Out of this she has to pay for her apparatus, the washing of dresses and aprons, perhaps the upkeep of a bicycle, for a maid or some one to live in the house to receive messages while she is out, in addition to the ordinary cost of living.<sup>1</sup> Evidently, the life offers no financial attractions at all, and it is no wonder that few trained midwives enter practice independently. Either they will work in connection with associations or hospitals where a fixed salary is guaranteed, or they must receive money from other sources. The only possible source of money is that received by rates or taxes, namely, public money.

<sup>1</sup> For further information on this subject reference should be made to Reports by the Author, in the Medical Officer to the Local Government Board's Annual Report, 1914-15, Supplement, pp. 85 *et seq.*; and Report to the L.G.B. on the Provision of Midwifery Service in the County of London (New Series 111).

Twenty-five shillings is generally regarded as the approximate fee a midwife should receive for her work for each case, including ante-natal work, which is usually reckoned at about 5s.<sup>1</sup> If 120 cases be undertaken on an average in the year, the midwife should have an income of £150, which certainly cannot be regarded as excessive in view of the requirements made.

Various schemes have been put forward for the provision of a midwifery service. For the most part they advocate either the appointment of so-called "municipal midwives," or that the municipality or the State should pay a capitation fee in some form or another to any midwife in practice. It is proposed that the municipal midwife should attend the cases in a certain district, or it might be that there would be a choice of two or three midwives for the mothers of each district. The proposal presents many practical difficulties, and in the few places where it has been introduced it has not been found successful.

As circumstances have altered very considerably since the proposals were put forward, it is hardly worth while to discuss them in detail. Any scheme now put forward would, of necessity, differ in many respects from those of the last few years. It is difficult at present to say how far the grants now available under the Ministry of Health may meet the situation (cf. the circular in Appendix III).

**Rural Midwifery.**—A good deal has been already said as to the arrangements for rural midwives in connection with the work of county nursing associations. These associations do not themselves ordinarily undertake maternity work, but they assist and encourage the work of district nursing associations. The whole country has not by any means been provided with midwives, nor, until recently, has it been possible for any county to be entirely covered by village nurse-midwives. The grants

<sup>1</sup> With the continued gradual rise of prices, these fees are too low.



now available from the Ministry of Health for the aid of midwifery enable the associations to extend their work very greatly. In small districts there is probably no better arrangement than the provision of a village nurse-midwife. There are, however, other less scattered districts where an independent midwife can almost obtain a livelihood, but where there is too much risk attached, and ordinarily no one will practise there under existing conditions. In such cases the county council can subsidise the midwife sufficiently to enable her to maintain herself in practice and thus provide a good maternity service for the district. Many schemes for completing the provision of midwifery aid are now being prepared, and it may be hoped that in a few years' time there will be few districts left unprovided with midwifery aid.<sup>1</sup>

The proposed arrangements for Durham County, which have been approved by the Ministry of Health, are of great interest, as showing the way in which provision can be made for the various types of districts in an area. Durham County contains a number of large villages, or small towns, where independent midwives can only make a doubtful livelihood. The scheme is given in full in Appendix VI (A).

A fee is charged for the services of the village nurse-midwife, which varies in different districts, and depends also upon the circumstances of the patient. Substantial assistance is, however, needed in order to maintain the midwives. The assistance required varies from district to district, and it is impossible to give any average figure, since in the first place, in most cases, they are complicated by subsidies for other purposes—child welfare work, etc.—and further, the cost is so varied that no one figure can give any satisfactory idea of the

<sup>1</sup> Arrangements for the payment of grants in aid of midwifery for county nursing associations are set out in Circular M. & C. W. 7 of the Local Government Board.

position. Leaving aside subsidies, the grants vary between £10 or less to £20 or more.

Some idea of the cost of such schemes is given by the scale of pay of the Hertfordshire County Nursing Association, which became operative in 1918. The scale was then raised appreciably, and is higher than that in most other counties, although, no doubt, many of them will soon be raising their fees to similar levels. The full scheme is given in Appendix VI (B).

The whole position cannot be regarded with any degree of satisfaction. It seems certain that the profession must be made more attractive, and that in order to do this, the money earned must be improved.

Some assistance will be forthcoming in connection with the schemes of the various local authorities, and may possibly be sufficient to meet, at least, the most urgent needs. At present the schemes are, for the most part, in their early days, and prophecy would be unwise.

The Board of Education have recently offered grants for the training of midwives, and this may help, and is, in any case, most welcome, but a slight reduction in the cost of training hardly compensates for a small income in the many years of work which will presumably follow the period of training.

## CHAPTER XX

### INFANT MORTALITY

So much has been written and talked about this subject that any lengthy handling of the question of infant deaths is unnecessary. No book on child welfare work could, however, be regarded as in any degree complete if some reference to it were not made.

The movement, in its early days, was, as has already been mentioned, mainly directed to the prevention of the mortality among infants. The associations and societies which arose in this and other countries all assumed titles showing that they regarded their work as primarily directed to the reduction of infant mortality. One by one, as the work has developed, these organisations have changed their names. It has been realised that the work undertaken was in many ways distinct from what should be regarded as work for the prevention of mortality.

In order to show how this has become evident it is necessary to deal with the more salient points concerning the mortality among infants. The *infant mortality rate* is the number of infants dying under one year of age per thousand infants born. The figures are obtained through the Registrar of Births and Deaths, and are collated at the office of the Registrar-General. Statistics give valuable information as to the general position on many matters, and indicate the directions in which work is required.

The infant mortality rate must be regarded rather as an index of conditions as a whole, and not as affording specific information. Other figures are also important in connection with child welfare, especially the death-rate among children over one year of age. Discussion of the absolute reliability of any statistics used is unnecessary here, where it is proposed only to use the general trend of available figures to "point a moral and adorn a tale."

Vital statistics are based on innumerable complicated factors, interwoven the one with the other, dependent upon the morals, the psychology, the social and economic, the climatic, and all other conditions which go to the making of national characteristics. If one factor is taken alone, very erroneous deductions can be made. The following table shows the infant mortality rates for England and Wales, and the birth-rates<sup>1</sup> for the corresponding years are shown in the adjacent column :

| Year.     | Infant Mortality Rate. | Birth-Rate. |
|-----------|------------------------|-------------|
| 1891-95   | 151                    | 30·5        |
| 1896-1900 | 156                    | 29·3        |
| 1901-05   | 138                    | 28·2        |
| 1906-10   | 117                    | 26·3        |
| 1913      | 107                    | 28·0        |
| 1916      | 91                     | 21·6        |
| 1917      | 97                     | 17·8        |
| 1918      | 97                     | 17·7        |

A superficial glance gives the impression that the two rates must be closely associated. No doubt this is to some extent the case, but, as a moment's reflection shows, the connection is indirect and not direct. While both have fallen, the fall is not parallel, the birth-rate having fallen more rapidly than the infant mortality rate. The primary causes of the fall in birth-rate before the war were no doubt due to the rise in the general standard of

<sup>1</sup> The birth-rate is the number of infants born per 1000 of the population.

living, which rise was inconsistent with the possession of a large family. Hence, only among those classes whose demands on life were low was there an approach maintained to the same birth-rate as in the middle of the last century. In all other classes of society the rate has fallen far more heavily than the general fall in the birth-rate.<sup>1</sup>

During the war the birth-rate has fallen owing to the absence of a large proportion of the male population on war service. The war, with its increases in wages, has brought with it a rise in the standard of living out of all comparison great, as compared with the advance made in any previous period of 4-5 years. At the same time child welfare work has increased enormously, and there is good reason to believe that these factors, especially perhaps the last one, are responsible for the fall in infant mortality to a greater degree than the birth-rate.

The war has furnished an experiment on a colossal scale of the effect on infant mortality of the improvement in general social conditions due to an increase in wages. Some money has doubtless been mis-spent, but the immense improvement in the clothing and feeding of children generally at a time when other means of improvement, such as housing and sanitation, were at a standstill, has furnished an object lesson which should be taken to heart for the future.

There is some divergence of view as to the merit of a low infant mortality rate. Professor Karl Pearson and others regard the production of unhealthy infants as eugenically unsound, and believe that infant mortality is Nature's way of removing the unfit. Doubtless this is true to some extent, and the care and labour

<sup>a</sup> Those who are interested should consult the figures for different professions given in the Annual Reports of the Registrar-General, and in the Census returns, and the Report of the Commission on the Birth-Rate.

bestowed upon the preservation of lives of no obvious value, but of great expense to all concerned, give cause for serious thought, but will not be further discussed here.

**Preventable and non-preventable.**—The early work among infants soon showed that very simple measures were sufficient to effect a reduction in a high mortality rate. The work of Budin,<sup>1</sup> and the figures given by him, showed that a great fall in infant death-rates occurred in nearly all towns where a milk depot and infant consultation had been established. So great and so rapid was the fall, that it was believed that a panacea had been discovered. The fall was mainly in deaths from diarrhoeal diseases, which are in large part due to feeding with contaminated food, or to some other source of direct or indirect bacterial infection.

Infant deaths became divided into the two classes—preventable and non-preventable. These distinctions have proved to be entirely artificial. As knowledge increases it is found that many types of cases, hitherto regarded as non-preventable, are really preventable. It would be a bold step at the present time to go further than the assertion that certain causes of death are non-preventable *in the light of our present knowledge*.

It is now necessary to give some short account of the information gained by the analysis of the infant mortality rate.

If the crude figures of infant mortality be taken it is found that the causes of death can be classified into a few main groups :

1. Wasting diseases (atrophy, debility, marasmus and prematurity).
2. Diarrhoeal diseases.
3. Bronchitis and pneumonia.

<sup>1</sup> The Nursing, trans. by Maloney. Caxton Pub. Co. Manuel Pratique d'Allaitement. Paris: Dom.

4. Measles and whooping-cough.
5. All other causes.

A comprehensive analysis of the figures for 241 urban areas was published in 1913<sup>1</sup> which showed that, taking the figures for the causes of death in the four preceding years 1907-10, the percentage due to the main causes was as follows :

| Causes.                                     | Percentage of all deaths under one year |
|---|---|
| 1. Wasting diseases and premature . . . . . | 44·6                                    |
| 2. Diarrhoeal diseases . . . . .            | 16·5                                    |
| 3. Bronchitis and pneumonia . . . . .       | 21·4                                    |
| 4. Measles and whooping-cough . . . . .     | 7·6                                     |
| 5. All other causes . . . . .               | 9·9                                     |

Analysis of the ages of the children at death, in the same area and for the same period, showed that a very large number of the deaths occurred under one month of age, which suggests that those deaths were due, in large part, to causes operating before birth.

|             | Deaths.                                     |
|-------------|---|
| 0- 1 week   | 24·3 per 1000 of all births under one year. |
| 0- 1 month  | 40·2     "     "     "                      |
| 0- 3 months | 63·5     "     "     "                      |
| 3- 6 months | 22·9     "     "     "                      |
| 6-12 months | 34·2     "     "     "                      |

The mortality rate decreases as the length of life increases—in fact, the child's chances of survival improve.

The deaths during the first month (neo-natal period) will include a large proportion of those falling in group 1.

No further comprehensive report has been published by the Local Government Board, but the reports available for the various large towns and counties show that, while the general rate of infant deaths has fallen, the rate for this group of causes shows an inadequate re-

<sup>1</sup> Supplement to the Report of the Medical Officer to the Local Government Board, 1912-13. Second Report on Infant Mortality, pp. 82 *et seq.*

duction as compared with the total reduction of the infant death-rate. Thus, if the figures for one large town be taken, they are as follows :

|   | 1907-10. |                      | 1916. |                      | 1917. |                      |
|---|----------|----------------------|-------|----------------------|-------|----------------------|
|   | Rate.    | Percentage of Total. | Rate. | Percentage of Total. | Rate. | Percentage of Total. |
| Deaths in Group 1                       | 51·4     | 33·5                 | 31·2  | 28·1                 | 32·0  | 28·8                 |
| Infant death-rate under 3 months of age | 72·0     | 46·6                 | 61·5  | 55·3                 | 60·2  | 54·0                 |
| Total infant mortality rate .           | 154      |                      | 111   |                      | 111   |                      |

and these are presumably typical of other places in the country.<sup>1</sup>

In rural districts the deaths occurring under these headings give as a whole a higher relative percentage than in the towns, since the death-rates from other causes are lower. Speaking generally, it is found that the death-rate in the rural areas is considerably lower than in the towns. The fall in rate has apparently been most marked in the towns, certain of which are rapidly approximating to the figures for some rural districts. Rural districts, however, differ very widely in their conditions, and it is unwise to attempt any close comparison between different areas.

If ante-natal work becomes general, and an adequate midwifery service is set up, the number of deaths under three months should soon begin to fall. The fall may not, however, be entirely attributable to this work, since in all cases where one improvement is made, it usually carries with it improvement in other conditions as well, such as

<sup>1</sup> In this particular town it is noteworthy that, while the total infant death-rate has undergone a remarkable reduction, the deaths under three months of age have decreased so much more slowly in proportion as to raise the percentage of deaths in this period in relation to the whole number.



improved sanitation, etc. Often it is the joint action which causes the effect.

*Group 2* (of diarrhoeal diseases) shows a high rate in many of the towns, especially in industrial towns in the north of England and in South Wales. In the north of England the sanitary conditions are very unsatisfactory and urgently require improvement. It is impossible here to give sufficient figures to deal adequately with this question, and those interested are referred to more extensive works.<sup>1</sup>

Much research has been done on the causation of the summer diarrhoea of infants. The disease attacks children primarily between the ages of a few months and two years. Often of rapid onset, death may supervene in severe cases within 24 hours; even where the disease is not present in a severe form there usually follows a period of marked ill-health and lack of progress which may extend into many months, or, the child, being already debilitated, falls an easy victim to some relatively mild inter-current complaint.

Research has not shown that the disease is due to any specific organism, but it is almost certainly of infective origin, although there are predisposing causes, of which a high summer temperature is undoubtedly one of the most important.

Reports from many medical officers of health of large towns in the north of England, with districts of insanitary condition, show that diarrhoea is especially prevalent in these areas. Bad sanitation and bad housing conditions are usually associated, but it would seem that the sanitation has the most bearing on the prevalence of diarrhoea.<sup>2</sup>

<sup>1</sup> Reports to the Local Government Board by the Medical Officer. Supplement to Annual Report for 1909-10, 1913-14, and 1915-16, and many reports by medical officers of health.

<sup>2</sup> It is impossible to describe the nauseating conditions in some of the towns where the sanitation is worst. The houses are close together, and almost as close to the dust-heap and pail-closets, or,

Any one who has worked in insanitary areas in large towns in summer will need no figures to convince him of the risks run by infants in those districts. The figures (No. 7) in Dr. Robertson's Report on Birmingham Housing (Appendix VII) are very instructive. (Cf. his notes as to the sanitation on pp. 305 and 306.)<sup>1</sup>

Artificially-fed infants suffer more severely from diarrhoea than breast-fed infants, and an increase in breast-feeding will reduce the death-rate from diarrhoea. Recent figures relative to the feeding of infants are not available, but reference may be made to the same publications as those given above. In the Report for 1912-13 (page 4) it was shown that the percentage of deaths due to diarrhoeal diseases in the rural districts is much lower than for the towns in 1910, being 167 per cent. higher among children of 6-12 months of age in the towns than in the country districts. *Groups 3 and 4* can hardly be separated. The majority of deaths from measles and whooping-cough are due to the supervention of broncho-pneumonia, which proves fatal in a large number of cases.

Respiratory diseases are infective in character, that is to say, they are caused by bacterial invasion. Such invasion will usually be most liable to occur in small, stuffy, dirty houses, where ventilation and cleanliness are difficult, or sometimes almost impossible.

worse still, to the privy-midden. These are breeding-places for flies unless emptied at least once a week, which is rarely the case in the privy-midden districts. The flies swarm in the houses, on the walls, the food, the furniture, and settle on the children asleep. These germ-carriers pass from the privy to the houses, and are potent agents for the spread of disease. In some districts a smell which defies description pervades the air, and enters the houses nearest to the privy. The wonder is that any one survives, not that young children die.

<sup>1</sup> Further evidence can be obtained by reference to the Report by the Medical Officer to the Local Government Board. Supplement to Report for 1912-13 and 1913-14, on the conditions in certain towns of Lancashire and on deaths from ages 0-5, published in 1915-16.

The death-rates from these causes are ordinarily highest in the towns where housing and sanitation are unsatisfactory. Further, the rates vary in different parts of the same town. In the residential areas where there is plenty of air, and housing is good, the rates from these causes are low, and they rise rapidly as the quality of accommodation falls and the congestion increases. Overcrowding increases the liability of infection.

The high death-rate from *Groups 2, 3 and 4* (p. 180) persists after the first year of age. It is shown in a Report of the Medical Officer to the Local Government Board<sup>1</sup> that about four-fifths of all deaths in the age period 1-2 years may be attributed to infective diseases of various kinds.

Bad housing and bad sanitation do not only affect children. No more powerful argument as to the effect on the population generally can be found than Dr. Robertson's Report above referred to, and published in the Appendix. (See Appendix VII.)

Intensive work for child welfare has been carried on in the worst wards of Birmingham for a number of years, and although improvement has been effected, the work is clearly relatively powerless against the effects of bad housing and insanitary conditions.

Child welfare work as ordinarily understood, and as dealt with in this book, has effected great improvement in the health of surviving children, and has reduced the infant mortality rate where this was not primarily due to impossible housing and sanitary conditions. Against these, more drastic measures are required, and the present campaign for improved housing and sanitation, costly though it may prove, will be worth all and more than all that is spent upon it, for the health of the inhabitants will improve, and this should appreciably reduce public expenditure in other directions.

<sup>1</sup> Report on Mortality of ages 1-5. Supplement to Annual Report, 1915-16, pp. 13 and 14.

Other causes of infant mortality have been much discussed, but their importance in producing a high infant death-rate cannot be regarded as established.

The employment of married women is one of these subjects. Various works have been produced giving evidence on the desirability or otherwise of the employment of married women.<sup>1</sup> Apart from any special investigation, it must be obvious that, as pregnancy is a physiological process and not a pathological one, some amount of work during this period need not affect the health of the mother. Contrariwise, since an additional strain is placed on the body as a whole by the fact of pregnancy, there is less margin of energy for heavy work. Again, while there are young children at home, especially under school age, the absence from home of the mother must affect their health prejudicially. The argument that the mother's earnings so far improve the home conditions that her absence is of more value than her presence, only furnishes a forcible indictment of our economic arrangements. As a nation, we flatter ourselves that we value home life. Now some one must make a home, for homes do not make themselves, and the home for young children, at any rate, must be made by either the father or the mother, or both. Few people would deny that the mother must take the greater part of this work, and, in face of this admission, the work of the mother with young children is admittedly needed at home.

Then ignorance and carelessness have been stated to be causes of child mortality. But the ignorance and carelessness are surely mainly due to the impossible

<sup>1</sup> Cf. Report on the Work of Married Women, published by the Women's Industrial Council, and the Reports of the Medical Officer to the Local Government Board, 1909-10, p. 56 *et seq.*, and the report on Lancashire, 1913-14 (p. 19), and on Child Mortality, 1915-16 (pp. 73 *et seq.*).

conditions under which so many of these poor mothers have to live. Who would not become careless in the insanitary conditions in which they are set, and from which they cannot move because there is not another home to move to even if better accommodation can be afforded?

If the better-to-do classes of this country had any real appreciation of the conditions under which many of their poorer neighbours live, the housing campaign would have been unnecessary. It is the ignorance of the well-to-do which causes infant deaths, far more than that of the poor mothers themselves. Ignorant the latter may be, but nearly all are teachable. It is hard to be taught unless reasonable facilities for subsequent practice are available.

**Maternal Mortality.**—The deaths among women due to childbirth have been investigated for many years, and a comprehensive statistical investigation was carried out by Sir Arthur Newsholme in 1915.<sup>1</sup> It is very generally admitted that many of these deaths are preventable. But at present it would be difficult to say that the lines of work which would be most effective are well known. Certainly a considerable number of deaths are due to infection and puerperal fever after childbirth, and it is commonly stated that this is due to some carelessness on the part of either doctor or midwife. This is doubtless a common source of trouble, but cases arise when it appears that auto-infection occurs. The point is still sufficiently indeterminate to provoke animated discussion at medical meetings.

Even less information is available as to the other causes producing death, although certain of these are emerging into the light. When an adequate maternity service is established, the work carried out, especially in the wards and laboratories, which will, of course,

<sup>1</sup> Report on Maternal Mortality, already cited.

form part of the service, should show the lines along which prevention can best be secured.

The causes of infant mortality only emerged gradually in the course of work, and the same will no doubt be true of those causes which are responsible for maternal mortality.<sup>1</sup>

<sup>1</sup>Supplement to the Report of the Medical Officer to the Local Government Board 1914-15, and numerous papers in medical publications, of which the most recent is one by Mr. Bonney (*Proc. Roy. Soc. Med.*, June 1919) given at the Gynæcological Section of the Royal Society of Medicine. The interesting discussion which was provoked should also be read.

## CHAPTER XXI

### NOTIFIABLE DISEASES IN RELATION TO MATERNITY AND CHILD WELFARE, WITH NOTES ON MEASLES AND WHOOPING-COUGH

THE diseases which occur most frequently among children after infancy and among adults are not so prevalent among children of tender age. Thus the total number of deaths from notifiable diseases (such as scarlet fever, diphtheria, etc.) among infants under one year is almost negligible, while the deaths from measles and whooping-cough amount to a considerable figure. (Cf. p. 180.) Of the common infectious diseases these last two alone will be considered here.

In 1915 measles and German measles were made notifiable diseases, and a considerable amount of work was inaugurated under the Local Government Board's Order. The experience gained showed that, while the work undertaken was of great value, notification under the ordinary procedure could be dispensed with, and the Order was recently rescinded, as from 31st December 1919. Whooping-cough is fully as troublesome and dangerous a disease as measles, and there is no intrinsic reason why the one should have been made notifiable rather than the other. The outbreaks of measles which occurred in camps during the early part of the war drew special attention to the disease, and it was made notifiable while whooping-cough was not.

Both these diseases are not in themselves necessarily dangerous. Both, however, primarily attack the upper part of the respiratory passages, and both may, therefore,

easily pass by extension to the bronchi and lungs. Measles, as is well known, starts with a running of the eyes and nose, and whooping-cough with an irritating cough. Further, apart from the complications of bronchitis or of broncho-pneumonia (which last is fatal in a high percentage of those suffering from it) there are after effects which may arise from the mildest attack, and which may lead to a fatal result. A great many children have a comparatively slight attack, but remain listless, pale, without appetite, and so forth. These children are fruitful soil for the tubercle bacillus, which takes its victims in considerable numbers from among them. By the time the case is diagnosed as tubercle, the mother has probably forgotten about the attack of measles or whooping-cough, and, even if asked about previous ailments, sees no connection between the two. Measles, perhaps even more than whooping-cough, is often looked upon as a mild trouble which requires no attention. Many cases are mild, but all are liable to the dangerous complications caused by the extension of the disease from the naso-pharynx to the bronchial tubes and then to the lungs. Also a discharge from the ear, which is symptomatic of an unsatisfactory condition, frequently gives rise to trouble after these diseases have passed off.

The Local Government Board enjoined that all cases of measles should be visited, with the object of calling the parents' attention to the importance of care, to the advisability of calling in the doctor, and in addition to afford opportunity of tracing other cases. Also, the visitor was to give advice on general lines.

The provision of nursing aid by local authorities for those in very poor surroundings was allowed under the Public Health Act of 1875, which gave power to local authorities, subject to the consent of the Local Government Board, to provide nursing for epidemic diseases among the poorer classes.



A great many local authorities have adopted measures in accordance with the recommendations of the Local Government Board. No general survey of statistics has been published, but many medical officers of health have expressed their belief in the great value of the aid provided, which they consider has saved the lives of many children.

In the memorandum issued by the Local Government Board on the subject of measles and its notification, the Medical Officer to the Board says: "In the three years 1911-13, 33,457 deaths were caused at ages under five by measles, and at the same ages 83,650 by bronchitis and pneumonia, which, in many instances, are the terminal stages of an attack of measles (or whooping-cough) which is not mentioned in the death certificate."

Other notifiable diseases are removed to hospitals, unless there is adequate means of isolation and disinfection at home, but measles is not taken into the fever hospitals, unless the case is especially bad. Cases of whooping-cough are, if anything, in a worse plight. In many ways a more troublesome but equally dangerous disease than measles, no provision whatever is made for it. A few cases with broncho-pneumonia are received into hospitals, but the number of beds available is almost negligible as compared with the need.

It is not sufficient that the child should be visited during the attack. Visits must be continued until the child has completely recovered, and, whenever possible, it should be examined medically to make sure that there is a satisfactory return to health. The child welfare centre can properly assist in such work.

Actual nursing should not ordinarily be undertaken by the visitor. This should be arranged for through a district nursing association, or in connection with infectious diseases hospitals.

The circular issued by the Ministry of Health in

connection with the rescission of the Notification of Measles Order, impresses on local authorities the importance of providing means for sending children to convalescent homes when recovery is not proceeding satisfactorily. The circular, which contains much further information of interest, is reprinted in Appendix VIII.

Two diseases affecting maternity work are notifiable—**puerperal fever and ophthalmia neonatorum.**

The notifications of the former, puerperal fever, are not accurate, the number of deaths from this cause being, in some districts, in excess of the notified cases. Midwives must notify cases of any suspected infection occurring in their practice to the local supervising authority, and must send for medical aid. The notification to the medical officer of health is made by the doctor. There is considerable divergence of opinion as to the definition of puerperal fever, and this leads to a good deal of unavoidable inaccuracy in notification.

The occurrence of a case in the practice of a doctor or midwife is held to be a sign of lack of care or of proper methods, and this leads to disinclination to notify on the part of the doctor. As already mentioned, although no doubt many cases could be avoided with greater care, the trouble does arise even where the greatest care has been taken. The deaths from puerperal fever are shown in the Reports of the Registrar-General.

Ophthalmia neonatorum has been notifiable for some years. It consists of an inflammatory condition of the eyes which, in bad cases, may spread to the eyeball, and cause partial or complete loss of eyesight. The inflammation is due to infection by micro-organisms which has taken place during the passage of the infant through the vagina of the mother. Infection may also take place from some cause or another after birth. There are several organisms which produce this condition, but

the one most to be feared is the gonococcus, the cause of one of the venereal diseases.

The careful washing of the eyes with a bland lotion immediately after birth, if carefully carried out, will prevent inflammation in the majority of cases. The trouble develops in the first few days after birth, and, if treated at once, can usually be cured. If left alone, it may easily lead to blindness. Midwives are required to notify all cases occurring in their practice both to their local supervising authority and to the local sanitary authority, unless the latter has been notified by the doctor. When the inflammation appears the midwife should send for medical advice at once. (Cf. p. 132.)

Of recent years much has been said about the effect of venereal diseases on infant welfare. The two venereal diseases concerned are syphilis and gonorrhœa.

Syphilis undoubtedly is a cause of still-births, and of other troubles occurring in the children of syphilitic parents. But the statistics on this subject are incomplete and unreliable. There is no real evidence to show that the alarming suggestions and even statements often made on this subject are justified. (Cf. p. 145.)

The work of Fildes,<sup>1</sup> carried out on 1015 women in the East End of London, showed that in these cases evidence of syphilis was found only in 14 mothers, and of the children of these, only 4 showed definite signs of the disease. Unfortunately 6 suspected children were lost sight of. But the 8 investigated later were out of 677 cases, giving a percentage of 0.59, which is hardly an alarming one. Against Fildes' work it has been urged that the majority of the women were Jewesses, and that it is well known that Jews have a lower percentage incidence of venereal disease than English people. No figures appear to be available which prove this assertion

<sup>1</sup> Report to the Local Government Board (New Series), 105, 1915.

which is illustrative of the absence of reliable evidence upon the subject. For further details, the publications of the Eugenics Education Society may be consulted; also the Report of the Royal Commission on Venereal Disease, etc.

**Notification of Summer Diarrhœa.**—A few districts have asked for and obtained power to make this disorder notifiable, either at all times or during certain months of the summer. The trouble usually arises as soon as the weather becomes and remains hot. It has been found that when there is one bad case in the family, there are usually other cases as well which pass almost unnoticed as compared with the severe case. It is very important that attacks of diarrhœa should receive immediate medical attention, and in-patient care may be necessary. The health visitor should be always looking out for these cases during the summer-time and should advise the prompt withdrawal of milk from artificially-fed children, the giving of plenty of water, and medical advice at the earliest moment. In a very hot summer the disease may become epidemic in character, and great difficulty may be experienced in dealing with the cases. In such circumstances it may be desirable for the child welfare centres to undertake treatment of diarrhœa cases at special hours, but the infant affected by diarrhœa should not mix with the healthy infants. Inasmuch as the notification is made by the doctor, it is evidently not made until medical advice has been obtained. As this will usually mean that the child is really ill, the value of the notification is somewhat doubtful, as the cases are not seen in the early stages. In a few areas special beds are available for diarrhœa cases during the summer, but such cases should not be nursed in the same ward with other diseases.

## CHAPTER XXII

### LOCAL GOVERNMENT AREAS

It is hardly possible for the student of child welfare work to have an intelligent understanding of the whole position, without at least an elementary knowledge of local government, as it is carried out in this country.

The study of English local government provides much that is in the highest degree interesting. Unfortunately for the student, there appears to be no concise general text-book on the subject. Most of the available books are either too elaborate for students, or partake of the nature of primers, and do not deal with some of those aspects which are essential for the student of child welfare work.

An attempt is made in these chapters to give some idea of local authorities and local government in relation to child welfare work generally. The public health work of local authorities at the present time includes child welfare work, and this latter cannot be considered apart from the general machinery of public health work.

The whole country is divided up into separate areas for the purpose of public health work, and every inhabitant figures under one and sometimes two local authorities. Each geographical county learnt in the schoolroom is divided in the area known as the county, while certain of the large towns are known as county boroughs. The "county" of local government is the geographical county with certain large towns taken out of it. The

geographical county thus reduced is known as the "administrative county" because it forms the unit county for purposes of government. Each county borough is a separate unit of local government.

There are more administrative county areas than geographical counties, because some of the large counties are subdivided for the sake of convenience, and a few of the smaller counties have been split for reasons which are probably good even if obscure.

Thus, Yorkshire is divided into three "Ridings," West, North and East; Lincolnshire has three "parts," Holland, Kesteven and Lindsey; Suffolk and Sussex are each divided into "East" and "West"; the Isle of Wight has been separated from Hampshire; the north part of Cambridgeshire is termed the Isle of Ely, and the north of Northamptonshire the Soke of Peterborough; each of these having independent administrations.

Apart from these exceptions, the administrative counties coincide, with a few unimportant exceptions, with the boundaries of the geographical counties with the county boroughs taken away. Each county has within it other administrative areas of different types, many of them having been established before the administrative county was defined, and having varying degrees of independence in regard to their own local affairs.

Thus, each county has within its boundaries *municipal boroughs*, many of which are towns of considerable age, having received charters of incorporation in times remote from our own. Certain of the older boroughs have ceased to exist for various reasons, and many of the present boroughs are not towns of any degree of antiquity. Charters are still given at the present time. Besides the boroughs, there are *urban* and *rural districts*; the whole country being completely subdivided into these areas. Some counties have a large number of

boroughs, others very few, and the number of urban and rural areas depends largely upon the population.

The simplest unit within the county is the rural district, and the next in the scale of importance is the urban district, and then the borough. Each of these units is theoretically subdivided into parishes, but as the parish councils or parish meetings take no share in child welfare, they will not be considered here.

London forms a county, and is subdivided into twenty-eight Metropolitan boroughs and the City of London. Each unit mentioned above possesses certain differences in regard to self-government. The powers of urban and rural districts differ in a few particulars. A populous part of a rural area will, however, usually wish to become an urban district, since it then becomes independent of the less populous part of the rural district, and acquires autonomy in regard to sanitation and other matters. The boroughs have certain powers and principles not possessed by an urban district, while certain powers for the whole area are in the hands of the county council.

These powers have been conferred at different times by Act of Parliament. Every Act passed by Parliament must either be carried out by the Government direct, or by some local body. Each area of local government has an elected council which is responsible for the carrying out of the duties laid upon it by Parliament, and it is this council which forms the local authority for the area.

From time to time, as Acts are passed, further duties are laid upon the various local authorities. Formerly there was a tendency to place the powers and duties in the hands of the smaller units. The counties and their councils, as at present established, are of more recent development than the other areas, and it was therefore inevitable that the duties should be laid upon

the existing units. Latterly, however, there has been an increasing tendency to increase the powers and duties of the county councils, rather than those of the smaller units.

Before considering this point in detail some attention must be devoted to the county boroughs. It has already been explained that these are, as it were, carved out of the geographical county, and are independent of it. There are 82 county boroughs in England and Wales. A county borough must have a population of not less than 50,000, or there must be some other special circumstances. County boroughs were set up under the Local Government Act of 1888, and a few old cathedral cities with populations well below 50,000 were allowed to become county boroughs. Since that date all except three of these cities, namely, Canterbury, Chester, and Worcester, have reached the required figure. The county borough is an independent unit of local government, and if the duties and powers conferred upon these bodies are to be efficiently carried out, a large population is necessary. Many people consider that the population limit of 50,000 is too low.

Every town of 50,000 inhabitants does not, however, automatically become a county borough, although it is usually the final ambition of every district of this population.

The Registrar-General in dealing with the figures of birth, deaths, etc., disregards the administrative distinction, and classes all towns with populations of over 50,000 as "large towns," and all towns having populations of between 20,000 and 50,000 as "smaller towns." But this classification does not apply to administrative areas.

Suppose, for example, that a part of a rural district becomes very populous, that part which has the largest population may wish to become independent of the



rest of the area. It may then make application to become an urban district, and to be taken away from the rule of the rural district in which it is situated. The would-be independent district must apply to the county council concerned. If the county council approves, an Order is made creating the urban district. This Order must be confirmed by the central Government department concerned—forming the Local Government Board—now the Ministry of Health.

Again, if the whole of a rural district becomes populous, it may be divided into several urban districts, *e.g.* Croydon rural district was, in 1916, broken up into three urban districts, namely, Coulsden and Purley, Mitcham and Beddington, and Wallington.

Rural districts situated near large towns may, however, have another fate. The town may cast envious eyes at the still available open spaces, and may succeed in getting its own boundary enlarged so as to enclose some part of the adjacent rural district.

Urban districts usually desire to become boroughs, and begin to consider the question as soon as they feel sufficiently important. The acquisition of powers and duties nearly always carries with them increased expenditure. Sometimes, therefore, economy prevails, and a large urban district may refrain from asking for further powers. On the other hand, in the neighbourhood of London, there are a number of very large and populous urban districts which are most anxious to obtain further powers but whose demands have so far been continuously frustrated by the large bodies in their vicinity. Many of these districts have populations of over 100,000, and find their lack of independence very irksome. The further powers sought for can be obtained either by a Provisional Order made by the Ministry of Health, and subsequently confirmed by Parliament, or by a direct application to Parliament.

Boroughs usually want to become county boroughs

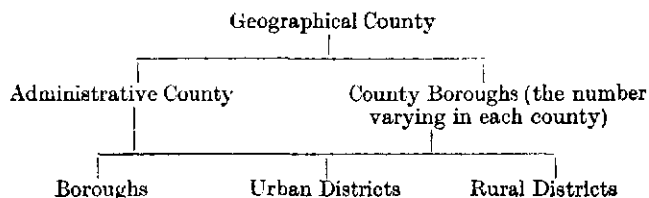
as soon as their population admit of this. In this demand, however, they may meet with strenuous opposition from the county from whose jurisdiction they wish to free themselves. The more populous the county the less opposition is usually raised, but in the small counties the independence of a large borough would seriously affect the financial position of the county. For instance, just before the war Luton and Cambridge applied to Parliament to become county boroughs. After much fighting, the Bill was passed by the Commons and thrown out by the Lords, owing to the pressure brought to bear in that House by the county councils concerned. These towns are the largest towns in Cambridgeshire and Bedfordshire respectively, and they pay large contributions to the county rates. As these applications are often very costly to promote, a borough will not make an unnecessary application to become a county borough unless there is a reasonable chance of success. The limit of ambition has, however, not been reached when a borough has obtained independence and become a county borough. There are still fresh fields of enterprise awaiting it. The larger the town the more does it cast envious eyes on the small districts around it, and wish to include them in its boundary. Thus, in 1912, Birmingham incorporated into its territories several large areas, namely, Handsworth, having a population of 69,000, Aston Manor, with 75,000 inhabitants, and King's Norton, Northfield, with 82,000, together with two rural areas of smaller populations. At the present time several large towns are promoting schemes for including a number of adjacent areas with very large populations, among them are Leeds, Sheffield, Halifax, Nottingham.

In these cases, although the districts lose their autonomy, they usually stand to gain in other ways by being incorporated with a large town.

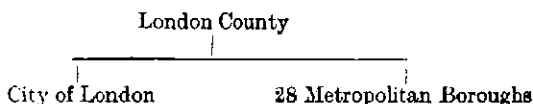
Again, several large adjacent districts may decide to

combine in order to form one powerful unit instead of several small units. The present county borough of Stoke-on-Trent was formed in 1912 by the union of six other districts, of which five form the "Five Towns" of immortal fame owing to the works of Arnold Bennett. Other examples could be given.

It is thus shown that while the whole county is divided into areas of different classes for the purpose of local government, these areas may change their nature and their boundaries from time to time. The local government areas for each county can be shown in diagram as follows :



and in London



All the above areas, except counties, are often termed "Sanitary Authorities," because to them has been entrusted the carrying out of the Public Health Acts. At the time of the passing of the Public Health Acts the counties were in a less defined position than at present, and the duties were therefore laid on the existing smaller local authorities. County councils are therefore not local sanitary authorities although they are local authorities. The same remark applies to the Metropolitan area. The London County Council is *not* a sanitary authority within the ordinary meaning of

the term, but its constituent boroughs and the City have these powers.

**Poor Law.**—The whole country is also divided into Poor Law areas, which do not by any means always coincide with the boundaries of the local government areas. The smallest unit is a "parish," and the parishes are aggregated into "unions." So far as possible the boundaries of unions are made coterminous with those of county areas, even though there may be several unions in the one county.

The Poor Law is hardly concerned with the child welfare movement as ordinarily understood, although there is abundant opportunity for child welfare work among children under the care of the Poor Law. It is not necessary for the present purpose to consider the Poor Law areas any further, although some reference to the machinery under the Poor Law will be necessary in connection with certain aspects of finance.

## CHAPTER XXIII

### LOCAL GOVERNMENT AUTHORITIES: THEIR POWERS AND DUTIES

THE various types of Local Government areas which have been described in the preceding chapter do not possess similar powers, and they have different duties to carry out towards those living within their boundaries. A mere enumeration of the duties and powers which have been placed by Parliament in the hands of these authorities would not alone prove very enlightening, because it would provide no explanation as to the reason why certain authorities should be called upon to undertake certain functions. The only way to obtain an intelligent knowledge of the elementary principles which have governed the allotment of duties and powers, is to consider the development of the Local Government areas with regard to the political position at the time the duties were laid upon the authorities concerned. It will clearly be impossible to give more than a few brief sentences of explanation in a work such as this.

Certain functions of Local Government were being undertaken in this country for hundreds of years before any question of Public Health administration was even considered. The history of England is full of the continuous controversies between the king and the people for the possession of power. The tendency of the nation has hitherto been to demand more and more powers of local self-government, that is, to have powers

of Local Government as distinct from central government.

The first stage was that connected with the suppression of crime and the maintenance of the public peace. Justices of the Peace were appointed from among the landowners of the district in the time of Edward III. in place of the sheriffs. The Justices were appointed by the Crown, and were given powers to deal with local matters of justice, working side by side with the itinerant judges who had been established under Magna Charta. In addition, the Justices were responsible for the control of the police, and at subsequent dates the administration of the Poor Law, licensing, and the care of the Highways were placed in their hands. They thus came to exercise great powers in their own districts, and, being appointed by the Crown and not subject to election, they were relatively independent of control. A good deal of abuse of position crept in and it became necessary to curtail their powers and functions. This was accomplished after much contention at later periods.

The areas of local administration very early became divided into towns and counties. Many of the towns obtained charters which exempted them from the control of the county, and allowed them to control their own affairs subject to Parliament. They had their own Justices of the Peace, and certain of the inhabitants, burgesses, were responsible for the internal affairs so far as any arrangements existed at the time.

The Elizabethan Poor Law required the inhabitants of a district to be charged with the cost of maintaining their own poor, and the money raised for this purpose was known as the poor-rate, and forms the beginning of local taxation in this country. Before the dissolution of the monasteries, the relief of the poor had been carried out by religious bodies. The Elizabethan

Poor Laws placed the duty upon the locality concerned. The ecclesiastical parish was taken as the unit of Local Government, and each parish was required to have an overseer, who should levy the money required in the form of a rate on the inhabitants. These overseers worked under the already existing Justices of the Peace, and were appointed by the said Justices.

Later in the reign of Elizabeth the provision and maintenance of roads was also placed in the hands of the Justices, and it was clearly convenient that the money required should be levied by the overseers who levied the poor-rate. Other money required for expenditure thus came to be levied with the poor-rate, and the practice holds at the present day.

The method of government by burgesses, as found in the towns, gradually became unsatisfactory, owing to the fact that, as time went on, the burgesses became less and less representative of the people, and often did not even live in the town. So great was the dissatisfaction among the people of the towns as a whole that, whenever any new duty had to be carried out, it was common to form a separate body of persons for the purpose. These bodies were known as "Local Boards" or "Commissioners" or "Trustees," and they grew up in different localities for different purposes, and with different powers. There was little uniformity of administration or of powers among the various towns throughout the country.

In 1835 the Municipal Corporations Act was passed by Parliament, after much debate, under which Municipal Government was reorganised. The Act forms the basis of much of the municipal life of the present day. Under this Act a Council was to be formed in each town, the members of which were to be elected by the ratepayers who had lived in the town for not less than three years. The Council was made responsible for the administration of local revenues and finance, and

for certain of the duties hitherto carried out by the Justices of the Peace. These last, however, retained the control of the police and of licensing, together with their judicial functions. Certain differences in these respects were arranged as between different classes of boroughs, but only the broad fact of the division of function in the towns is now under consideration.

The Act further provided for the election of aldermen as well as councillors, and for other matters regarding the carrying out of the decisions of the Council. The towns considered eligible for the powers conferred by the Act were set out in the schedule of the Act, power being given for subsequent additions to the number as, and when, this might be approved by Parliament. Commissioners appointed after the passing of the Act dealt with the boundaries of the towns concerned, and also with the advisability of dividing the town into smaller areas or wards for purposes of the election of councillors. The number of councillors to be elected was also fixed.

The powers possessed by the local boards already referred to were not compulsorily transferred to the Council, but provision was made for their transference if so desired. The boards had been concerned with matters such as lighting, cleansing, paving, etc., their functions differing in the various towns.

Under the Act some 170 boroughs were created, and these were required to reorganise their internal affairs to bring them into conformity with the provisions of the Act. During the years following the passing of the Act, all but a few towns did, in fact, transfer the powers exercised by the various local boards to the hands of the Town Council. The changes arising under the Act of 1835 played an important part in the development of Local Government as we have it at the present day.

It will be simplest to follow the fortunes of the



boroughs a little further before returning to a consideration of the development of Local Government in the county districts.

The Public Health Act of 1848 formed the beginning of Public Health legislation in this country. Under it a Central Board of Health was formed with certain powers to secure improvements in local matters. Generally, it was intended to deal with the water supply, drainage, sewerage, cleansing, paving, and other sanitary questions. Boroughs could adopt the Act and become Local Sanitary Authorities. In other districts where it was desired to adopt the Act, a special Local Board of Health was set up. The Public Health Act of 1858 developed further the powers of the local bodies.

The Local Boards of Health also became the surveyors of highways for their own districts, and took over the powers originally assigned to the bodies dealing with the highways. Parishes having populations of 3000 or over, were allowed to become Urban Sanitary Authorities, to elect their own Board of Health, and to control their own highways.

The later Public Health Acts of 1872 and 1875 further enlarged and consolidated the boroughs and urban sanitary districts as Local Sanitary Authorities to carry out the duties and powers conferred under those Acts. In 1888 certain of the boroughs became county boroughs, and further freedom was allowed them in the exercise of Local Government. As already explained, county boroughs must have a population of not less than 50,000 inhabitants, except in the case of a few ancient cities whose population did not reach this amount. It should also be borne in mind that districts with 50,000 of a population do not automatically become county boroughs, but must be empowered by Parliament to receive this dignity. Since 1888 many duties and powers have been added to those conferred under the Public Health Acts, and this will be dealt with after

the county areas have been considered somewhat further.

The Elizabethan Poor Law applied in the county areas just as in the towns, and its administration was placed in the hands of the Justices of the Peace, as were also the other duties and powers already mentioned in connection with the development of Urban Government. The abuses already referred to arose in similar manner in the counties, and led to a demand for re-organisation, and to a determination that no further powers should be placed in the hands of the Justices. The Poor Law of 1832 provided for the formation of "unions" of parishes for the administration of the Poor Law. The care of the highways had originally been placed in the hands of the parishes, but the areas were too small, and in many cases too sparsely populated and hence too poor, to be able to carry out their duties with efficiency. Under the Highways Acts of the middle of the last century, Highways Boards were formed with larger areas of administration. The Public Health Acts of 1872 and 1875 parcelled the whole country into local sanitary areas, and the unions formed the basis for the rural sanitary districts, so far as this was geographically practicable. Thus, the whole geographical county was divided into urban and rural sanitary districts, boroughs, and county boroughs. Gradually, and after much persistence, the Highways Boards were merged in the rural sanitary areas, and the last of them were finally swept away by the Local Government Act of 1894, when their powers were definitely transferred to the Rural District Councils.

The county of former days still existed, but the county boroughs were taken out of it altogether. Until 1888 its powers were primarily connected as heretofore with the administration of justice, and with those other duties which had from time to time been laid on the Justices of the Peace. In 1888 when the county boroughs were

taken out of the county, a reorganisation of the work was undertaken, and County Councils were set up for each administrative county, and certain of the duties of the Justices of the Peace were transferred to them. The Councils were to be elected on somewhat similar lines to the Councils of the other areas, and it was proposed at the time that these bodies should provide a means for the decentralisation of power.

Certain financial arrangements accompanied the Act of 1888 in respect of the readjustment of duties as between the Justices and the counties and county boroughs, the net result of which was the payment of a grant by the Exchequer towards the cost of the administration of the counties and county boroughs, certain specified items to have precedence in the allocation of the grant.

Provision was also made for the levying of a county rate over the whole area of the administrative county for certain purposes common to the whole area, such as the repair of main roads, the cost of the police, etc. It should be noted that no sanitary powers under the Public Health Acts are conferred on the County Councils who are *not* Sanitary Authorities.

The Parish Councils Act of 1894 provided for the establishment of Parish "Councils" or of "Meetings" in the case of very small populations, and certain minor powers were conferred on these bodies connected with footpaths, burial-grounds, lighting, etc. Many parishes, however, have not taken advantage of the opportunity of self-government thus offered to them.

The Notification of Infectious Diseases Acts of 1889 and 1899 placed the control of infectious diseases in the hands of the Sanitary Authorities, both urban and rural. This should involve the provision of hospital accommodation for such cases. It may be said in passing that the sanitary areas are in many cases too small to be able satisfactorily to carry out the duties

imposed upon them, and that the county, county boroughs, and larger boroughs would, in the majority of cases, be the better units for the purpose.

In 1902 the Education Act and the Midwives Act placed further powers on Local Authorities. The Education Act provided for the formation of Education Committees, which should be responsible for the work under the Act, under the Councils of the various authorities. Those authorities were County Councils, County Borough Councils, boroughs having a population of 10,000 or over at the time of the passing of the Act, and urban districts having a population of 20,000 at the same date.

The medical inspection of school children was made a duty of the Local Education Authority by the Education Act of 1907, and the duty of arranging treatment for school children has been laid upon them by the Act of 1918.

The Midwives Act of 1902 placed the inspection of midwives in the hands of the counties and county boroughs, the counties having power to delegate their powers of inspection to the smaller districts if they so wished. At first, such delegation was widely practised, but later it was found to be unsatisfactory, and the Midwives Act of 1918 rescinded the permission.

In 1907 the first Notification of Births Act was passed, being adoptive in character. This has already been dealt with sufficiently fully, and it need only be again mentioned that the Act might be adopted by any of the authorities, either Sanitary or County. The Local Government Board, however, did not at first favour its adoption by the counties.

In 1909 the Housing and Town Planning Act gave considerable impetus to housing improvements. Prior to this date there had been Acts for the improvement of the Housing of the Working-Classes and the powers and duties had been laid on the Local Sanitary

Authorities and not on the counties. The Housing Act of 1919 lays the duties upon Sanitary Authorities, except in particular cases. Later Acts for Maternity and Child Welfare, namely, the Notification of Births (Extension) Act of 1915, and the Maternity and Child Welfare Act of 1918, placed the powers in the hands of the same authorities as the Notification of Births Act of 1907. But experience had shown that the Acts could be better and more economically worked by the larger authorities, and the tendency now is to eliminate the small authorities, and to allow only the county boroughs, the counties, and the large boroughs and urban districts to undertake independent schemes for child welfare.

Then, again, in 1911, in connection with the National Health Insurance Act, the county boroughs and counties were the authorities selected for carrying out the tuberculosis work inaugurated under the Act. The working of the Mental Deficiency Act (unfortunately postponed in application by the intervention of the war) was also placed upon the counties and county boroughs.

Since the formation of the County Councils on the present basis, most of the fresh duties have been laid upon them and upon the county boroughs, except those duties which appeared to be so closely allied to sanitation as to render it difficult for them to be discharged by any but a Sanitary Authority. Such a matter is housing, but it remains to be seen in the near future how far the smaller Local Authorities will be able and willing to respond to the demand now being made upon them for building houses. The problem of tuberculosis is closely bound up with housing conditions, and sanitation generally, as, indeed, is child welfare work. It is impossible to hope for satisfactory results unless there is close co-operation between both sets of authorities. This has already been referred to in connection with the work of the health visitor in rural areas.

It is not necessary here to enumerate all the other varied duties which have been laid upon the different Councils, but it may be of interest to give a summary of the main branches of work allotted to each. The arrangements in London are of a different nature, and are given separately.

∴ It will be simpler if the duties of the County Councils are given first, since these duties, as well as others, are all laid upon the county boroughs.

*Main duties of the County Councils :*

|                             |   |   |
|-----------------------------|---|---|
| Not directly health matters | { | Control of Police<br>Provision and care of main roads.<br>Provision and maintenance of asylums.<br>Educational work of all kinds, except in most boroughs and certain urban districts (this carries with it school medical work).   |
| Pertaining to health        | { | Duties under the Small Holdings Act.<br>Powers of action in default of smaller authorities.<br>Work under the Rivers Pollution Act.<br>Inspection of midwives.<br>Care of tuberculous persons.<br>Maternity and child welfare (except in some districts).<br>Working of Mental Deficiency Act.<br>Food and Drugs Act. |

County boroughs have all the powers and duties of County Councils, and others in addition. These additional matters may be roughly classed under three headings.

*Main Duties and Powers of County Boroughs :*

As for County Councils, and in addition—

|                 |   |  |
|-----------------|---|--|
| Sanitary powers | { | Sewerage acid disposal and refuse collection, removal, and disposal.<br>Water supply.<br>Housing of the working-classes.<br>Infectious diseases prevention and provision of hospitals for infectious diseases.<br>Provision and charge of common lodging houses. |
|-----------------|---|--|

|              |   |  |
|--------------|---|--|
| General      | { Provision and care of burial-grounds.<br>Provision and care of public baths and washhouses.<br>Provision and care of recreation grounds.<br>Provision and care of public libraries. |  |
| Remunerative |   |  |
|              |   | { Supply of gas.<br>Supply of tramways.<br>Supply of electricity, etc. |
|              |   |  |

Of the above, the sanitary powers belong also to boroughs, urban and rural districts, while, as has already been explained, some boroughs and urban districts have powers connected with police and education. The "general" powers may be placed on the Parish Councils or Meetings, subject to limitations as to expenditure.

In London the Metropolitan boroughs are Sanitary Authorities, but carry out certain only of the above sanitary powers. For example, water supply is in the hands of the Metropolitan Water Board, and the prevention of the pollution of rivers is in the hands of the Thames and Lea Conservancy Boards, while hospitals for infectious diseases are provided by the Metropolitan Asylums Board.

Generally, on other matters the London County Council deal with those which relate ordinarily to more than one borough. Thus, it deals with certain housing schemes, and parks, and open spaces. It also undertakes some parts of the tuberculosis work (some of which is in the hands of Metropolitan boroughs), in addition to the other duties of a County Council.

The inspection of midwives is in the hands of the London County Council, but the work under the Notification of Births and the Maternity and Child Welfare Act rests with the boroughs.

There is here no direct concern with the Poor Law, but in dealing with matters of Local Government it is necessary to mention it, because its working interlaces with that of other branches of Local Govern-

ment, notably on the question of rates, and in connection with the election of members of councils. Also the work under the Vaccination Acts is carried out by the Poor Law officials, both the vaccination officer and the public vaccinator being appointed by the Poor Law Guardians of each Union. Vaccination was introduced at a time when the sanitary districts had not been established on their present basis, and it was found convenient to place the duties under the Acts in the hands of the guardians. Although the responsibility for dealing with all matters relating to infectious diseases is in the hands of the Sanitary Authority, including measures arising in connection with any case or cases of small-pox, routine vaccination is still under the Poor Law Guardians.

All rates, of whatever nature, are still levied through the overseers, and inasmuch as the electors of every district are determined by their position as ratepayers, the lists of voters both for Local Government elections and for Parliamentary elections are made out by the overseers, subject to further control into which it is not necessary to enter.

It remains to give a short account of the machinery whereby the duties and powers are exercised by the Councils.



## CHAPTER XXIV

### NOTES ON THE MACHINERY OF LOCAL AUTHORITIES

THE brief outline already given of the development of Local Government in this country, showed that the persons forming the body or Council responsible for carrying out the various duties are elected by the votes of the ratepayers. The inhabitants who will live under the government of the Council are responsible for placing those people in power who, in the opinion of themselves as ratepayers, will be the most suitable members of the Council. Each locality is in fact directly responsible for the events in its own district. If the ratepayers elect those who prefer economy to progress, they alone have done it. The control of the Central Government on most matters of general Public Health exists more in theory than in practice. Latterly, however, the position has changed owing to the more modern developments in connection with child welfare work in all its branches, and the work under the National Health Insurance Act.

Further changes will probably become operative in the near future, under the schemes expected from the new Ministry of Health.

The elections, in the boroughs, take place in the autumn, on November 1st, in time for the election of the Mayor, or Chairman of the Borough Council, by November 9th. One-third of the Council retire annually, and each member, being elected for three years, is eligible for re-election.

In addition to the councillors there are aldermen, who are elected by the councillors. The aldermen are, for the most part, men who have had a considerable previous experience of service on the Council. The aldermen commonly remain in office for six years—one-half of their number retire every third year. The number of aldermen is one-third that of the councillors, whose number is fixed for each town. The number of councillors varies in the towns from nine to ninety, or more, and the number of aldermen varies in corresponding manner. In the Metropolitan Boroughs, the aldermen number one-sixth of the councillors, and not one-third.

The Chairman of each Borough Council is termed the Mayor, and is a Justice of the Peace as well as Chairman of the Council.

The procedure is very similar in urban or rural districts, but the election takes place in the spring, between 1st and 8th March, instead of in the autumn, and the Chairman of the Council has no special title. He is also a Justice of the Peace.

In the case of County Councils, elections are held in the spring every three years, and all the members retire together. Continuity is preserved through the aldermen.

The cost of the elections is charged to the rates.

It is now necessary to consider the arrangements by which the councillors carry out the duties entrusted into their hands by the electors. Usually the councillors enter office pledged to carry out certain lines of policy. These lines of policy have been set out in their election addresses and speeches, and they have been returned by the electors in order to carry out this policy or policies.

The list of duties shown on pages 211 and 212 is formidable, and it would be entirely impossible for the Council to discuss all matters for which the authority has the

power of action. Therefore the Council works through committees, to which are entrusted the various branches of work. These committees do not possess executive powers, that is to say, they may not carry out the actions they recommend without the consent of the Council. There are some committees which have been laid down by Act of Parliament, and these are therefore known as Statutory Committees. The Council must appoint such committees. The Statutory Committees are at present few in number, and are not applicable to all areas. The number of other committees appointed by the Council to carry out the work of the district, if the district is of any size, is usually greatly in excess of the number of Statutory Committees.

A few of the very small authorities may have so little work to do, and have so small a number of councillors, that the Council does not need any committees to whom it will delegate work. Such small authorities will probably not be carrying out duties in respect of which there is a Statutory Committee.

The oldest Statutory Committee, introduced with the Municipal Corporations Act, is the Watch Committee, which deals with police matters, and is obligatory on those authorities having the control of police. It is composed of members of the Council only.

In 1902 the Education Act made an Education Committee obligatory on those authorities which were to administer the Education Act. Authorities having such a committee are termed Local Education Authorities. There is, however, no separate authority for education, only a separate committee, which is subject to the general control of the Council just as are other committees.

The members of the Education Committee are not all members of the Council. The majority of the members are elected members, but the Council must co-opt other persons, who may be women, on to the Education

Committee. While the control of the committee is kept in the hands of the Council through the majority of members being councillors, there are introduced into the affairs of the locality, persons who are appointed because of their special knowledge of educational matters, who are not pledged by election promises to carry out any special policy.

In 1918 another Statutory Committee was laid down by the Maternity and Child Welfare Act. Here also, as in the case of the Education Committee, the majority only of members must be members of the Council, and the Council may co-opt other persons specially interested or experienced in the work. A further departure in this case is the fact that not less than two of the members must be women.

The formation of these Statutory Committees gives indications of the general development of Local Government. The increase in the number of duties necessitates an increase in the number of committees, and the widening of the basis of membership. The details of the Maternity and Child Welfare Committee will be dealt with lower down.

Practically all Local Authorities, other than the very small ones, have committees for Finance and for Public Health matters. With larger authorities these may be multiplied according to need, and have now become numerous and their arrangement complicated. Except in the case of Education and Maternity and Child Welfare, the members of the committees are all members of the Council.<sup>1</sup> At the beginning of the municipal year, and immediately after the election, the new councillors are allotted to the various committees. Where the councillors and committees are numerous, it is common to have a General Purposes Committee,

<sup>1</sup> Joint Committees appointed under Acts of Parliament between a Local Authority and other organisations are not here under consideration.

which deals with this and other matters of similar nature.

There is no limit to the number of committees a Council may have. The details of the work of each committee, together with the number of members which shall form such a committee, are left entirely in the hands of the Council. The duties of the committees and their methods of work are known as the standing orders, and these are laid down by the Council for each committee.

There may also be sub-committees, formed either temporarily to consider special matters, or permanently to deal with items of the work of the main committee.

The details vary for each district, but follow the general lines given above.

A sufficient time before the rate to be levied for the year will be fixed, each committee is called upon to put forward estimates of the money it will require to carry on its work for the coming year. These estimates are then submitted to the Finance Committee, and afterwards to the Council. If no new work is being undertaken, the estimates are probably not questioned, but if additional expenditure is required, the cause of such expenditure will be explained, and the Finance Committee may reject the application, or may refer it back to the committee concerned with a request for amendment, reduction, or for further explanation, as the case may be. Ordinarily, if the expenditure has once been authorised for certain purposes up to a given limit, the committee is allowed to spend up to that amount without further supervision on the part of either the Finance Committee or the Council. If additional money is required during the year, then supplementary estimates are put forward in similar fashion, and must be passed by both Finance Committee and Council. There are, however, wide variations in the detailed procedure laid down by the different Councils.

The ultimate control rests in all cases with the Council as a body.

The Public Health Committee is not statutory except in the case of County Councils, but is found in every district of any size. The Medical Officer of Health is attached to this committee, and the whole staff of the Public Health Department serve under it. The committee deals with all matters arising under the Public Health Acts, and under any other Act that may be passed and where the Council selects that committee to undertake the work. Thus, when the inspection of midwives became compulsory under the Midwives Act of 1902, and was laid upon the counties and county boroughs, the latter laid the duty almost universally on the Public Health Committee, and, in the counties, a special committee was formed, since at that time the health work of the County Councils was in a more elementary state. As an instance of the latitude allowed to the Councils, it may be mentioned that, in one large county borough, the inspection of midwives was laid on the Watch Committee, and remained in the hands of that Committee until 1915.

The Public Health Committee may have numerous sub-committees to deal with the different items, depending entirely upon the local feeling as carried out by the Council.

In the early days of child welfare work the duties fell upon the Public Health Committees. They appointed the health visitors, and arranged the work which should be undertaken. The Notification of Births Act of 1915 made a sub-committee permissible, but only a comparatively small number of Councils appointed such a committee. If a committee was appointed, the Act provided for the co-optation of women. The Maternity and Child Welfare Act of 1918 made a committee compulsory. This committee might either be a separate committee of the Council or a sub-committee of the Public Health

Committee. It may have co-opted members, and not less than two of its members must be women. The sub-committee or committee must contain a majority of members of the Council. If the sub-committee is made use of, it then reports to the Public Health Committee, which either approves or not, as the case may be. If approval is given, the Public Health Committee then reports to the Council, or if money is concerned, the previous approval of the Finance Committee is necessary. Where a committee of the Council is appointed, the committee reports direct to the Council and not to the Public Health Committee.

In counties it is more usual to appoint a separate Maternity and Child Welfare Committee, and to endow it with considerable powers. The County Council only meets quarterly, except for special occasions, and it would cause hopeless delay and congestion of business if considerable latitude were not allowed. In the boroughs, the Council meets much oftener, and greater control can be exercised.

Power to spend money up to a given amount approved by the Council can be bestowed on the Maternity and Child Welfare Committee under the Act of 1918, and in some cases this is taken advantage of. The Committee may not, however, levy a rate.

In county boroughs the inspection of midwives forms part of the maternity and child welfare work, and the provision of a midwifery service is one of the subjects which is demanding urgent attention. Where a midwifery committee already exists, steps will no doubt be taken to bring all the work under the Maternity and Child Welfare Act under the same committee.

All the work undertaken under the Maternity and Child Welfare Acts will fall within the purview of the Maternity and Child Welfare Committee. The visiting in the homes, the work at the centre, the staff to be employed, the premises to be used, the co-ordination

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with the various agencies at work, and so forth. Very few of the Rural Sanitary Authorities have their own child welfare arrangements. Rural districts and small urban areas can be most economically worked through the county organisation as described in Chapter XI.



## CHAPTER XXV

### THE SOURCES OF MONEY FOR LOCAL GOVERNMENT PURPOSES

A FEW references have already been made to the sources of money which can be utilised in connection with Local Government work. The financial aspect of Local Government is possessed of great interest and of much complexity. It is an ever-present factor in every branch of work undertaken, and often forms the determining feature in favour of or against the most important decisions of a Council.

There are two main sources of money—that obtained locally from the rates, and that obtained centrally through the taxes. Of these two sources, the larger part of the money required for Local Government at the present time is derived from the rates. The rates have been referred to in connection with the Elizabethan Poor Laws, under which each district was called upon to provide the money necessary for its own poor. The money was levied by a charge on property, and the inhabitants paid a yearly sum varying with the amount of property held. The amount of money which would be required to meet the necessary charges was distributed in proportion of the total value of property owned in the district.

The early relatively simple rating system has now become extremely complicated. Different classes of property are differently rated, and the question of land valuation, and many other complex and abstruse prob-

lems are closely bound up with the local rates. It is not necessary for the present purpose to enter into these more detailed questions. It is sufficient to remember that the rates are now levied in various forms on property, in the shape of land, houses, etc., and not on personal possessions, in the way of money, or on goods of any kind.<sup>1</sup>

The poor-rate, which was the first rate to be levied, has been repeatedly added to for the many numerous duties now laid upon the various Local Authorities. Some of the charges are levied under the term poor-rate, but much of the money is used for entirely different purposes. Other rates have been added from time to time and vary in different parts of the country. Many districts have special powers granted by Parliament which enable them to raise money locally from the rates for specific purposes.

Ordinarily, in addition to the poor-rate, there will be at least one other rate, the borough or general rate, levied in the county areas. These rates are required for the numerous duties laid upon the different authorities, including education, sanitation, police, etc.

Many boroughs have property which has been left by inhabitants of the district from time to time for the benefit of the body corporate. The income from such moneys is now inconsiderable in relation to the present expenditure, except in a few isolated cases, and need not be further dwelt upon for present purposes.

Important variations are found in different districts in the amount of the rate per £ of rateable value, both in the total amounts, and in respect of the various rates. There are certain duties in respect of which a minimal expenditure must be made, but on many matters the Local Authority itself determines how far the various

<sup>1</sup> The basis of valuation for the rate has varied from time to time. At the present time occupiers of agricultural land or clerical owners of tithe pay rates at one-half the assessment.

services shall be developed, having regard to the cost which will necessarily be incurred. Thus, a Local Authority which studies the rates more than the health or convenience of the inhabitants, will have low rates—others again can produce a large sum with a small rate, owing to the great amount of valuable rateable property in the district, yet others have high rates owing to the amount of work undertaken.

In all areas certain matters which have been regarded as pertaining to the State, rather than to the locality, have been paid for by the taxes, and not out of local rates. Such, for example, has been the charge in connection with certain matters of local administration of justice, etc., but, generally speaking, it is only comparatively recently that the State has contributed out of taxes to the charges incurred in respect of what are ordinarily considered as directly local matters.

Under the Local Government Act of 1888 a certain sum was contributed by the Government to local affairs out of money raised by taxes. This money was, in part at any rate, paid in consideration of a readjustment in respect of other items, notably the cost of justice, owing to the reorganisation arising out of the formation of the counties and county boroughs. Certain items of expenditure were mentioned as forming a first charge on this "Exchequer Contribution." At the time the contribution was inaugurated it proved a real contribution to the expenditure of the locality. The amount of the contribution has not increased, while the expenditure of the Local Authorities has done so. As a result, the Exchequer Contribution, while undoubtedly very welcome, does not afford the degree of relief to local expenses which was originally the case. Since 1888 other and more extensive arrangements have been made for aid from the Exchequer in the form of Treasury grants in aid. Before considering the special application of these grants to child welfare, a few remarks are

necessary upon the sources of the grants, and the principle of their application.

The money flowing into the Treasury is raised from many sources. It is derived from customs and excise duties, from taxes of all kinds—on land, on income, on licences, etc., and, more recently, on such matters as excess profits and entertainments. Each year the various Government departments are called upon by the Treasury to submit estimates of the expenditure they regard as necessary for the coming year. The Treasury may approve the estimates or may refer them back for alteration. If the Treasury agrees to the estimates, the sanction of Parliament must then be obtained, and the Treasury has to find the money required.

Now the Treasury can only find the money by levying taxes in one form or another on the inhabitants of the country. The disposition of taxation, that is, the items on which the taxes are raised, is a very important matter, and must affect the whole economic life of the country either favourably or adversely. Every one is more or less aware of the immense increase in taxation which has been necessitated by the cost of the war, and which has brought about an inevitable widening of the basis of taxation, together with a large increase in many of the former taxes. In addition to the war charges, there has been a wide demand for aid for local expenditure from the taxes, although the total amount is not large as compared with the cost of the war. The most costly item in aid of local expenditure will undoubtedly be the cost incurred in connection with the provision of houses, though at the moment the charge is not great.

A heavy item of expenditure is the grants in aid of education, and the cost of the maternity and child welfare work is rising rapidly. Further claims in respect of charges connected with the National Health Insurance scheme, and, in other directions, demands

for increased aid, and hence for increased levy of taxes, are continually being made.

The propriety of grants in aid is open to question, and there are not wanting opponents of the whole system. Taxes draw money from sources untouched by rates, which sources should clearly be tapped for contribution towards the public needs. Some of the sources could be reached by an alteration of the basis of local taxation—namely, of the rates, but other sources of revenue would be difficult to deal with locally.

Government, through its various departments, is responsible to the country for the expenditure of the money raised, and it may not allot money to any purpose without ascertaining that the money so allotted is spent in conformity with the object for which it was granted. During the war there has admittedly been great expenditure of public money without due control, but doubtless such control will soon be resumed, and the general statement is not affected.

If money is to be granted out of the taxes for the relief of rates, then the Government department, at whose request the money has been raised in the form of taxes, must see that the money is properly spent. The department must, in effect, supervise the work of the local authority in respect of the items towards which grants are payable. This introduces the system of inspection from the central department. The grants in aid are intended to raise and equalise the general level of work throughout the country, and no doubt this is secured in some measure. The bait of grants appeals with varying force to different authorities, and many of them would prefer to be left without grants and without inspection. With even the most regular inspection and pressure from the department concerned, it has so far been impossible to obtain anything approaching a uniform standard

of work throughout the country in any branch of work whatever.

Whatever the advantages and disadvantages of grants in aid may be, they have presumably come to stay, although it is not unlikely that the present methods of their administration may require modification as time goes on.

Grants in aid are now payable in respect of education, through the Board of Education, in respect of health insurance, through the National Health Insurance Commission (recently transferred to form part of the Ministry of Health), of tuberculosis work, or of the treatment of venereal disease, and of maternity and child welfare work in all its branches.

The contributions ordinarily extend up to 50 per cent. of the total cost incurred, but is higher (75 per cent.) in the case of venereal diseases.

The local authorities concerned are required to submit their schemes to the Government department for approval, and any subsequent development undertaken must likewise receive approval in order to be passed for an increased grant. Inspectors are sent over the country to encourage the development of work on the best lines, and also to endeavour to bring backward authorities farther along the road to efficiency.

The grants in aid are paid retrospectively on the known expenditure for the previous year, which ends on 31st March. The actual expenditure has to be incurred first by the local authority.

The whole financial system is interdependent—locally and centrally, the one on the other, under the system of grants. The system is complicated, and the continued demand for increased grants in aid will increase the complexity. Many people consider that there should be a block grant in aid of local charges, but that the degree to which a locality develops its work should be left to the locality without what is often termed

“Government interference.” In actual fact, the so-called interference is usually not resented by the most progressive local authorities, who are glad to show what they are doing, and to talk over the whole question with some one who knows what is being done in other directions. The term “adviser” would be, in many ways, preferable to “inspector” for those who travel round on behalf of some of the various Government departments, although advice is not possible without the detailed knowledge acquired by going over the work in the form of an inspection.

After a careful survey of the work undertaken, the inspector makes a report to the department on the work, generally coupled with recommendations as to the payment of the grants. Each fresh object of grant necessitates further arrangement for inspection, and increases the charge on the Treasury.

There appears to be an idea in the minds of some people that the Treasury has a bottomless purse into which a hand can be dipped, if only the Treasury will allow it. They do not realise that taxes as well as rates are levied on the nation, although from different sources. It is merely a question of which source shall be used for such purpose, and which fresh sources shall be opened up.

In undertaking fresh developments for maternity and child welfare work, the local authority can, if the proposals are approved by the Ministry of Health, count on a repayment of one-half the cost, in the form of an Exchequer grant.

The amount of money spent in this branch of work is rising very rapidly. Grants for child welfare work were first passed by Parliament in 1914, and only a few thousand pounds were required. Now the figure runs into hundreds of thousands for the Treasury grant, and involves the expenditure of a similar sum from the local rates.

Voluntary agencies are also eligible for grants, but are usually required to co-operate with the local authority in order to secure the money.

No hard and fast rules are laid down as to the activities for child welfare which must be undertaken by an authority to secure a grant. Ordinarily, however, the basic features of home visitation and work at the centre are required, although the latter alone may be arranged in the scattered rural areas.

Loans and grants towards capital expenditure can, if necessary, also be secured from public funds. Suppose, for example, that a local authority wished to build a child welfare centre, assistance can be obtained if the plans and general arrangements are approved by the Ministry of Health. During the war all building was stopped, and no aid was available for capital expenditure. Building grants and aid for the purchase of a site will, however, probably be resumed shortly.

Loans can be obtained from public money through the Public Works Commissioners, subject to the approval of the Government department concerned. Such a loan must be repaid within a fixed term of years. That proportion of the loan, together with the interest on the money, forms a charge on the rates until the whole is repaid.

It is hoped that the above short notes may give an idea of the financial machinery which lies behind child welfare work.



## CHAPTER XXVI

### THE FUTURE

MANY of those who are engaged in child welfare work, or who have followed the progress of the movement, are asking themselves what the next developments of the work are likely to be. It would be foolish to be too sure as to the details of fresh activities of the movement, but there are not wanting indications as to the general lines which will probably be followed in the near future. In the first instance, the main lines hitherto worked upon need brief recapitulation.

The movement started with the avowed object of decreasing the number of deaths among infants under one year of age. The accurate statistics which became available during the middle of the nineteenth century showed the terrible toll taken by death among the infants of the country. The root causes of many of the deaths were obscure, but there was evidently no means of securing any further information except by visiting the homes. The rise of the present system of Notification of Births and of home visitation has been traced in the preceding chapters, as well as that interdependent branch of the work carried out at the child welfare centres.

Very early in the work it was found that it was not sufficient to take the single age period of 0-1 year. The medical inspection of school children began to show the mass of illness which supervened in children under five years of age, while, in fact, experience soon

demonstrated that the child under one year could not be considered alone. The care for its health must continue up to and through school life, and must extend backwards to its mother. The work for child welfare must link up on the one hand with that of the education authorities, and on the other with the whole midwifery service. An urgent need of the movement is the improvement of the whole arrangements for midwifery. But this will undoubtedly bring out the damage already done to the mother's health at the time of marriage. Already voices are being raised in favour of demanding certificates of health in persons about to be married. It is not to be supposed that any such scheme could become effective, even if it were desirable. There should rather be a demand for a general improvement in the health of growing adults, so that the prospective parents of the country should be sound in body.

In fact, the work for child welfare is only one of the numerous branches of work of the whole system for health. It must be increasingly linked up with the other agencies which are already in being, and with those avenues which will be opened up in the near future. Theoretically it is possible to divide hygiene into various branches, such as general or municipal hygiene, domestic hygiene, child hygiene, infant hygiene, and personal hygiene. Given other terms, these become the hygiene of the community, of the family, and of the individual at various ages. They are interdependent, and cannot really be separated. What is done by the child, or left undone by its parents, affects the health of the future generation. What is left undone by the community affects the individual. No one can get away from the bonds which link him or her up to those among whom life is spent, or from the community in general. No one is an independent unit who can do what he or she likes with effects which will operate only on themselves. For good or ill they affect others

morally and physically. Nor let it be supposed that it is only the married who affect the health of the future generations. The actions and attitude of the unmarried of our generation will affect those of later ones.

The supreme aim of the human race is happiness. All are striving after it, but each person will have his own dreams of what to him would, he believes, bring happiness. In whatever form that happiness may be encased, it is certain that a healthy body is of extreme importance, if not essential for its attainment.

Health is a precious gift which the individual must be taught to use and to cherish. This brings with it the need for self-control, and may involve denial of many forms of desires. Because of this, health is too often flung away, and bitterly repented of at a later date. If, however, nature had no weaknesses, it seems likely that the health problem would not exist. We are as yet far indeed from such a state, and as a possibility it is almost inconceivable. But the health question must be dealt with as a whole. So long as it remains in separate compartments, as at present, so long will its progress be hindered. It is not enough to have a Ministry of Health which will co-ordinate the various branches of work. Those who carry out the work must extend their vision and increase their knowledge. They must be prepared to let their work become merged in the whole. The lines of demarcation must be swept away; while health work assists other branches of work for the community, it is conversely assisted by them.

The spirit of communal life which is now arising in this country will undoubtedly prove of immense value to its health, and will help to secure the happiness which is desired by all.

# APPENDICES

# APPENDIX I

## SAMPLE RECORD CARDS AND LEAFLETS

### Record Sheet I

PRIVATE AND CONFIDENTIAL

No.

Date

### HEALTH VISITOR'S REPORT.

---

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Name Date of Birth  
Address  
Father's Occupation Age Health  
Mother's Occupation (past) Age Health  
" " (present)  
Home  
Remarks

Pregnancies { 1st 6th  
2nd 7th  
3rd 8th  
4th 9th  
5th 10th

Maturity Habits Vaccination  
Cot Sleep with Mother  
Bath  
Air  
Comforter  
Clothing

---

Defects

Teeth

Eyes

illnesses

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| Date | Feeding. | Remarks | Date | Feeding. | Remarks |
|------|----------|---------|------|----------|---------|
|      |          |         |      |          |         |

## Record Sheet II

Private and Confidential.

## BIRTH ENQUIRY FORM.

Ref. No. \_\_\_\_\_

No. of Case \_\_\_\_\_ Date of first visit \_\_\_\_\_

Sanitary District \_\_\_\_\_ Date of last visit \_\_\_\_\_

Mother. Name \_\_\_\_\_

Address \_\_\_\_\_

Age \_\_\_\_\_ Race and Nationality \_\_\_\_\_

Living with husband Living apart Widowed UnmarriedGeneral Health Good Indifferent BadCharacter of Confinement.Doctor Midwife Unassisted

Previous History No. of Miscarriages \_\_\_\_\_ Still Births \_\_\_\_\_

Children born alive \_\_\_\_\_ Now living \_\_\_\_\_ Died in 1st year of life \_\_\_\_\_

Description of work before present pregnancy.

Other information \_\_\_\_\_

Work during pregnancy How long ceased before birth.

Precise occupation \_\_\_\_\_

Carried on at home In factory or workshop ElsewhereWeekly earnings \_\_\_\_\_ Nature of work Heavy Light

Special conditions \_\_\_\_\_

Work after birth Resumed \_\_\_\_\_ weeks after birth.

Why resumed \_\_\_\_\_

Precise occupation \_\_\_\_\_

Carried on at home In factory or workshop ElsewhereWeekly earnings \_\_\_\_\_ Nature of work Heavy Light

Special conditions \_\_\_\_\_

Child. Full Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Male Female Legitimate Illegitimate Fostered Promoted Full Time

Condition at first visit \_\_\_\_\_ last \_\_\_\_\_

If death occurs, age at death \_\_\_\_\_ Cause of death \_\_\_\_\_

Feeding during first six months of life.

Breast entirely for \_\_\_\_\_ weeks

Artificial food partly since \_\_\_\_\_ Why? \_\_\_\_\_

Artificial food entirely since \_\_\_\_\_ Why? \_\_\_\_\_

Feeding. By mother By other persons at home Put out, where? \_\_\_\_\_

† Under these headings should be given the reasons for abandoning breast feeding, wholly or partly, e.g., medical advice, illness of milk, resumption of work outside home, etc.





# Record Sheet III

Name of Infant \_\_\_\_\_ No \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Weight \_\_\_\_\_

Age at 1st Consultation \_\_\_\_\_ Weight \_\_\_\_\_

Confinements \_\_\_\_\_

Stillbirths \_\_\_\_\_

Miscarriages \_\_\_\_\_

Children <sup>Living</sup> \_\_\_\_\_  
                  <sub>Dead</sub> \_\_\_\_\_

|                |  |  |  |  |  |  |  |  |  |
|----------------|--|--|--|--|--|--|--|--|--|
| Age            |  |  |  |  |  |  |  |  |  |
| Diet           |  |  |  |  |  |  |  |  |  |
| Cause of death |  |  |  |  |  |  |  |  |  |

## MATERNAL HISTORY

Age at Marriage \_\_\_\_\_

Age at 1st Confinement \_\_\_\_\_

Age at birth of this child \_\_\_\_\_

Health \_\_\_\_\_

Severe Illnesses \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Menstruation { Periodicity \_\_\_\_\_  
                  Duration \_\_\_\_\_  
                  Type \_\_\_\_\_  
                  During Lactation \_\_\_\_\_

Confinement \_\_\_\_\_

Lying-in \_\_\_\_\_

Attended by \_\_\_\_\_

## PATERNAL HISTORY—

Age at Marriage \_\_\_\_\_

Age at birth of 1st child \_\_\_\_\_

Age at birth of this child \_\_\_\_\_

Health \_\_\_\_\_

Severe Illnesses \_\_\_\_\_

Tuberculosis \_\_\_\_\_

Work { Nature \_\_\_\_\_  
          Regularity \_\_\_\_\_  
          Before birth of child \_\_\_\_\_  
          Since birth of child \_\_\_\_\_

Average Wage \_\_\_\_\_

Rest \_\_\_\_\_

No. of Rooms \_\_\_\_\_

Floor \_\_\_\_\_

No. of Occupants \_\_\_\_\_

Consultation \_\_\_\_\_

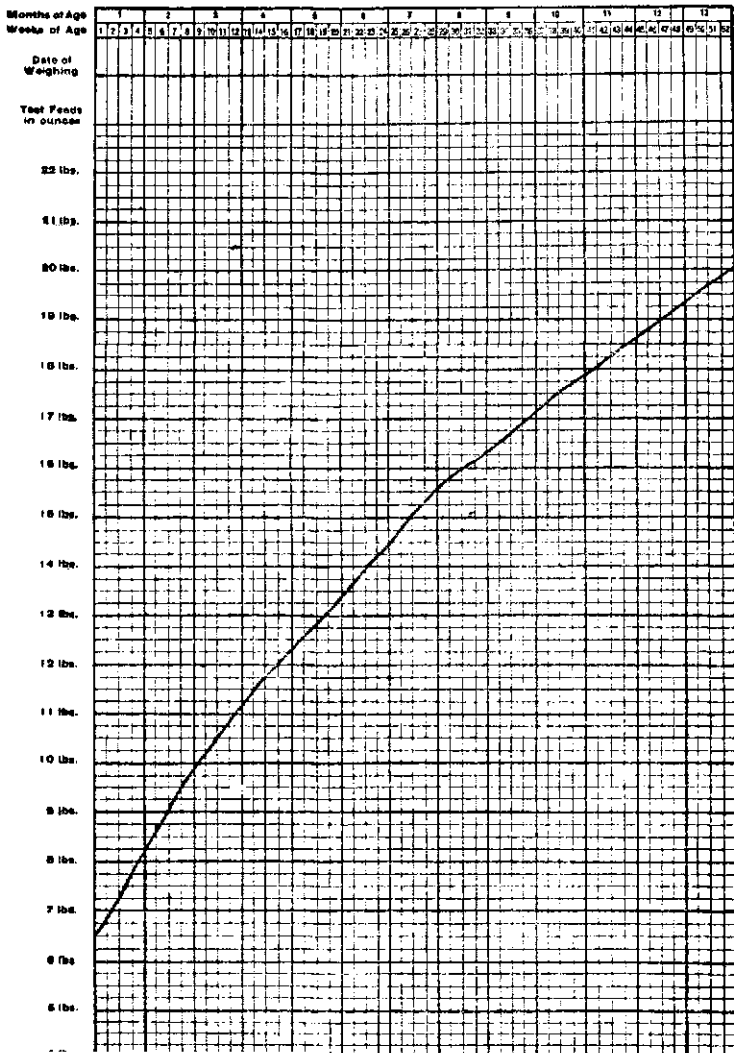
Visitor \_\_\_\_\_

Physician \_\_\_\_\_



Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Feeding \_\_\_\_\_



## APPENDIX II

### FIGURES SHOWING THE AILMENTS AMONG SCHOOL CHILDREN

#### WORK AMONG CHILDREN UNDER FIVE.

The importance of work among children between two and five is shown by the figures of ailments found among entrants on medical inspection, taken from the Report of the London County Council for 1918.

The figures are not complete for the whole country, but the figures for London given below do not differ very materially from those in the Board of Education Report for other parts.

TABLE SHOWING THE RESULT OF MEDICAL INSPECTION IN  
LONDON ELEMENTARY SCHOOLS.

| <i>Number examined—77736.</i>          |       | <i>Percentage</i> |
|--|-------|-------------------|
| Skin diseases . . . . .                | 1813  | 2.3               |
| Enlarged tonsils . . . . .             | 13108 | 16.9              |
| Adenoid growths . . . . .              | 5686  | 7.3               |
| Tonsils or adenoids . . . . .          | 5863  | 7.5               |
| Other throat or nose defects . . . . . | 2067  | 2.7               |
| Enlarged glands of neck . . . . .      | 7402  | 9.5               |
| Dental defects . . . . .               | 21902 | 28.2              |
| External eye disease . . . . .         | 3700  | 4.7               |
| Ear disease . . . . .                  | 1927  | 2.4               |
| Defective hearing . . . . .            | 647   | 0.9               |
| Stammering . . . . .                   | 84    | 0.1               |
| Other speech defects . . . . .         | 343   | 0.4               |
| Heart defects . . . . .                | 1984  | 2.5               |
| Anæmia . . . . .                       | 3645  | 4.7               |
| Lung complaints . . . . .              | 6114  | 7.8               |
| Nervous diseases . . . . .             | 892   | 1.2               |
| Phthisis . . . . .                     | 105   | 0.2               |
| Other tuberculous disease . . . . .    | 222   | 0.2               |
| Rickets . . . . .                      | 1812  | 2.3               |
| Deformities . . . . .                  | 771   | 0.9               |
| Infectious disease . . . . .           | 128   | 0.3               |
| Malnutrition . . . . .                 | 781   | 1.0               |
| Other defects . . . . .                | 2477  | 3.2               |

## APPENDIX III

### MATERNITY AND CHILD WELFARE ACT (8 & 9 GEO. 5), 1918, WITH CIRCULARS 4 AND 11

#### CHAPTER 29.

#### AN ACT TO MAKE FURTHER PROVISION FOR THE HEALTH OF MOTHERS AND YOUNG CHILDREN.

[8th AUGUST 1918.]

BE it enacted by the King's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—

#### *Powers of Local Authorities with respect to Maternity and Child Welfare (7 Edw. 7, c. 40).*

1. Any Local Authority within the meaning of the Notification of Births Act, 1907, may make such arrangements as may be sanctioned by the Local Government Board, 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 recognised by the Board of Education:

Provided that nothing in this Act shall authorise the establishment by any local authority of a general domiciliary service by medical practitioners.

#### *Maternity and Child Welfare Committees (5 & 6 Geo. 5, c. 64).*

2.—(1) Every council in England and Wales exercising powers under this Act or under section two of the Notification of Births (Extension) Act, 1915, shall establish a maternity and child welfare committee, which may be an existing committee of the council or a sub-committee of an existing committee, and all matters relating to the exercise of the powers of the council under

this Act or under the Notification of Births (Extension) Act, 1915 (except the power of raising a rate or of borrowing money), shall stand referred to such committee, and the council, before exercising any such powers, shall, unless in their opinion the matter is urgent, receive and consider the report of the maternity and child welfare committee with respect to the matter in question, and the council may also delegate to the maternity and child welfare committee, with or without restrictions or conditions as they think fit, any of their powers under that Act or this Act, except the power of raising a rate or of borrowing money.

(2) The council may appoint as members of the committee persons specially qualified by training or experience in subjects relating to health and maternity who are not members of the council, but not less than two-thirds of the members of every maternity and child welfare committee shall consist of members of the council, and at least two members of every such committee shall be women, and where the duties of the maternity and child welfare committee are discharged by an existing committee or sub-committee any members appointed under this provision who are not members of the council shall act only in connection with maternity and child welfare.

(3) The committee established under this section shall take the place of any committee appointed under subsection (2) of section two of the Notification of Births (Extension) Act, 1915, and the provisions of that subsection relating to the exercise of powers by a committee shall cease to have effect.

(4) A committee established under this section may, subject to any directions of the council, appoint such and so many sub-committees, consisting either wholly or partly of members of the committee, as the committee thinks fit.

#### *Expenses.*

3. The expenses of any council in England and Wales under this Act shall be defrayed in the same manner as expenses under the Notification of Births Acts, 1907 and 1915, and the purposes of this Act shall be purposes for which a sanitary authority in London may borrow under subsection (2) of section one hundred and five of the Public Health (London) Act, 1891 :

Provided that a county council may, if they think fit, charge all expenses under this Act or those Acts as general county expenses subject to the condition that, if any district council within the county has provided for its district a similar service to that provided by the county council for other parts of the county, the county council shall pay to the district council the amount

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raised by the county council in the district in respect of such service. Any question that may arise between a county council and a district council under this proviso shall be determined by the Local Government Board.

### *Amendment of Section 3 of 5 & 6 Geo. 5, c. 64.*

4. Section three of the Notification of Births (Extension) Act, 1915, shall be read as if the following words were inserted at the end of paragraph (b) of subsection (1) and paragraph (b) of subsection (2) thereof, namely:—

“and for the purpose of any such arrangements may, subject to the sanction aforesaid, exercise the like powers as they are entitled to exercise for the purpose of the provision of hospitals.”

5.—(1) This Act may be cited as the Maternity and Child Welfare Act, 1918.

(2) This Act, except the section thereof providing for the amendment of section three of the Notification of Births (Extension) Act, 1915, shall not apply to Scotland or Ireland.

*Circular (M. & C. W. 4).*

*County Councils (other than the London County Council)  
and Sanitary Authorities.*

### MATERNITY AND CHILD WELFARE.

LOCAL GOVERNMENT BOARD,  
WHITEHALL, S.W.1,  
9th August 1918.

SIR,

1. I am directed by the President of the Local Government Board to bring to the notice of the Council the provisions of the Maternity and Child Welfare Act, 1918, which has recently passed.

The Act widens the powers of Local Authorities in the matter of maternity and child welfare. It enables them to make such arrangements as may be sanctioned by the Board 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 recognised by the Board of Education.

A Council exercising powers under the Act must appoint a Maternity and Child Welfare Committee. This Committee may be specially appointed for this purpose or may be an existing Committee or a sub-Committee of an existing Committee, and

it must include at least two women. Subject to two-thirds of the members of the Committee being members of the Council, persons specially qualified by training or experience in subjects relating to health and maternity who are not members of the Council may be appointed as members of the Committee. A Committee appointed under the section may also appoint sub-committees consisting wholly or partly of members of the Committee. Mr. Hayes Fisher considers it is important that working women should be represented on the Committee. In seeking such representatives the local branches of working women's organisations or the Standing Joint Committee of Industrial Women's Organisations, 33 Eccleston Square, London, S.W.1, might usefully be consulted.

2. The supreme importance of Maternity and Child Welfare work at the present time needs no emphasis. With a view to encouraging the provision of further services, which experience has shown would be of value for conserving infant lives and health, Mr. Hayes Fisher has obtained the sanction of the Treasury to a considerable extension of the scope of the Board's grant. A copy of the new regulations is appended to this Circular.

The additional services for which the grant is now available, subject to the Board approving the arrangements, are, chiefly :—

Hospital treatment for children up to five years of age.

Lying-in homes.

Home helps.

The provision of food for expectant and nursing mothers and for children under five years of age.

Crèches and day nurseries.

Convalescent homes.

Homes for the children of widowed and deserted mothers and for illegitimate children.

Experimental work for the health of expectant and nursing mothers and of infants and children under five years of age.

In certain other respects the scope of the grant has been enlarged.

With a view to assisting Local Authorities and Voluntary Agencies in developing this work, the Board submit the following comments. These should be read as supplementing the observations made in earlier circulars.

#### *Administrative Arrangements.*

3. In their original Circular of 30th July 1914, on the subject of this grant, the Board stated :—

"For the rural and smaller urban areas the Board think it will



generally be found desirable to develop a county organisation, but in all cases the county work should be intimately related with that of the local sanitary authority, and on the other hand any work separately undertaken by a sanitary authority should be co-ordinated with the county scheme."

The Board may also draw attention to the following observations, which were contained in their Circular of the 29th July, 1915, in regard to the Notification of Births (Extension) Act, 1915:—

"The Act contemplates that arrangements for attending to mothers and young children may be made either by County Councils or by sanitary authorities. The Board recognise that the organisation must vary to some extent with local conditions, and that a considerable degree of elasticity is necessary. They are, however, of opinion that it will generally be desirable to formulate comprehensive schemes for counties and county boroughs, although in some cases portions of the services may be undertaken by the larger District Councils with advantage. The councils of counties and county boroughs are the local supervising authorities under the Midwives Act, 1902, and they are also entrusted with the initiation and execution of schemes for the treatment of tuberculosis; if the organisation of a maternity and infant welfare scheme is also undertaken by them, it will be practicable to secure the unification of home visiting for a number of different purposes.

"In all cases, however, in which a general scheme is organised for the county, the work should be carried on in close co-operation with the sanitary authority."

As a general rule, County Councils have adopted comprehensive schemes for all the districts in their counties, except those which by reason of their population and number of births can properly form separate units for these services. Some smaller districts are still carrying on separate schemes, but the most advantageous course usually lies in the amalgamation of these schemes with the county scheme, and Mr. Hayes Fisher is glad to observe that the Councils of many of the smaller districts have agreed to amalgamation and are co-operating with the County Council in this work. Where this has occurred the County Council have generally continued the work of the local sanitary authority with the staff previously employed by the smaller authority, and have availed themselves of the assistance of that authority and of their Medical Officer of Health in carrying it out.

The work to be done is of a composite character, and, while some parts of it may in certain cases be satisfactorily undertaken by the smaller authorities, other parts should be undertaken by

the County Council, and it is therefore desirable that the smaller District Councils should in all cases consult the County Council before considering the provision of separate services.

The County Council and the District Council have concurrent powers, in order that for all parts of the work the most efficient arrangement may be made, but the Board look to the County Council to consider the needs of the County as a whole, and how these needs may best be supplied.

The Board request that each County Council will take this subject into early consideration, and that they will prepare and submit to the Board a report on the work now being undertaken, on the new services which should be established, and on the methods whereby the new services can best be provided. It is important that the County Council in preparing their report should confer with the District Councils in order to secure their co-operation at every stage.

#### *Inspection of Midwives.*

4. In the Board's view each midwife in the district should be seen by the Inspector of Midwives of the Supervising Authority not less frequently than once a quarter, at least until the Inspector is satisfied that the midwife will carry out her instructions satisfactorily. Special inquiries should be made if there is any doubt as to the satisfactory character of the midwifery service, and prompt visits should be paid and reports made to the Medical Officer of the Supervising Authority in such cases notified under Rule 20 of the Central Midwives Board as may be determined by him, and especially when there is a rise of temperature in the mother or a discharge from the eyes of the infant.

It is important that the visits of inspection should be made the occasion for giving general instruction and assistance to the midwives. The Supervising Authority should therefore appoint a sufficient staff of competent inspectors. The Board consider that an Inspector of Midwives should, if possible, be a qualified medical woman; if this cannot be secured, she should be a certified midwife with sufficient experience in the practice of midwifery. It is important that the Supervising Authority should in all cases secure co-operation between the midwives and the local organisation for maternity and child welfare work.

#### *Provision of Midwifery.*

5. The object of the Board's grant in aid of midwifery is to secure that as far as is practicable there shall be an efficient midwifery service throughout the country, and the Board look

to the Councils of Counties and County Boroughs to organise arrangements for securing this. In the Board's opinion it is important that the status of midwives should be raised, and that competent trained women who devote themselves to this service should be adequately remunerated. Unless this is done the Board are satisfied that an efficient midwifery service will not be established and maintained. The Board consider that a competent trained midwife, devoting her whole time to the work, should be able to secure at the present time an income of from £120 to £150 a year.

6. The Board have indicated that a local authority may pay or guarantee the salary of a competent midwife, and they are willing to consider any scheme for improving the midwifery service which may be submitted.

In cases in which a council provide or arrange for a general midwifery service they should fix a general scale of fees, but these may be reduced or remitted in individual cases where the circumstances justify this course. In so far as the fees received do not meet the cost of this service, the Board are prepared, subject to their prior approval of the scheme, to find one-half of the deficiency.

7. In sparsely populated districts where the midwife is supported by a Nursing Association, the Board will base the grant on the number of cases attended during the year, either by midwives or maternity nurses. They will pay a grant to County Nursing Associations in respect of

- (a) the establishment expenses of the County Nursing Association attributable to midwifery,
- (b) the midwifery and maternity cases attended by (1) nurse-midwives of affiliated associations, (2) emergency nurse-midwives of the County Nursing Association, and
- (c) the expenses of the County Nursing Association and of affiliated District Nursing Associations in starting new associations where there is no competent midwife.

County Councils may make contributions to County or District Nursing Associations for these services, and where they do so the Board will make a grant in respect of their expenditure. They will also make a grant on the same basis to County Councils in respect of the midwifery and maternity nursing provided by unaffiliated associations, but they recommend that such associations should become affiliated to the County Nursing Association.

8. In districts with a large population it is possible for the practice of midwifery to be more nearly self-supporting than in more scattered areas. Nevertheless, a number of midwives are maintained in these localities by hospitals, maternity charities, and district nursing associations, and their services are provided

at less than the ordinary fee of the district for women who cannot afford to pay this fee. Moreover, in many cases the ordinary fee is not sufficient to provide a competent trained midwife with an adequate income. The Board's grant is available in respect of the loss on district midwifery, if any, made by these institutions, and it will amount ordinarily to half the deficit on the service.

9. In all cases the grant in respect of midwifery will be subject to the following conditions: (1) that the Board are satisfied that the midwife is competent, (2) that her services are available in respect of all women who need them, and (3) that the ordinary fee of the district is charged, and that it is only reduced or remitted where the circumstances of the case justify the adoption of this course.

10. A Local Authority or Voluntary Agency may provide a midwifery outfit for any midwife employed or subsidised by them. The outfit should be retained if the midwife leaves the service, and should be given to her successor. The grant is available in respect of this expenditure and also of the cost of maternity outfits (apart from bedding) lent by a Local Authority or Voluntary Agency to lying-in women in cases where this is necessary.

#### *Doctors' Fees.*

11. The Board trust that all Local Authorities carrying out Maternity and Child Welfare Schemes will arrange to pay the fees of doctors when called in by midwives during the period of confinement. In cases which are not necessitous the persons concerned would no doubt be willing to bear or repay the cost, but it is important that the doctors called in should be able to look to the Local Authority for their fees where the persons attended are unable to pay, and that they may be so informed. Local Authorities should ascertain which of the general practitioners of the district are willing to undertake to respond to the call of a midwife, and should, if possible, arrange that one of them shall always be available to answer an urgent call. The midwives should be furnished with a list of the doctors who are willing to attend.

#### *Health Visitors.*

12. As a result of their further experience, the Board consider that the standard of 500 births to each Health Visitor, which they have previously suggested, should be modified. The functions of a Health Visitor should comprise the visiting and supervision of all children under school age in the district needing this attention; the visiting of expectant mothers who have

attended at an Ante-natal Centre, or for whom visits are desirable; inquiry into still-births and the deaths of young children; and attendance at the Centre to which women and children, including those whom she has visited in their homes, come for medical and hygienic advice. Where these duties are fully performed it appears to the Board that a district with about 400 births a year will be as much as one Health Visitor can undertake, unless the district is very compact, or is of such a class that many infants do not need visiting. The Health Visitor's district should where practicable be so arranged that it is served by one Centre.

*Qualifications of Health Visitors.*

13. It is not practicable at the present time to prescribe a special course of training or a standard examination for Health Visitors generally. The qualifications prescribed by the Board's Order of 1909 with regard to London are:—

- (a) A Medical Degree, or
- (b) The full training of a nurse, or
- (c) The certificate of the Central Midwives Board, or
- (d) Some training in nursing and the Health Visitor's certificate of a Society approved by the Board, or
- (e) The previous discharge of duties of a similar character in the service of a Local Authority.

The certificate of a sanitary inspector is also valuable. In the absence of one or more of these qualifications, the Board are not prepared to pay a grant in respect of a Health Visitor's salary unless they have adequate evidence before them that she is qualified for this work.

14. Other offices, such as that of Tuberculosis Nurse, School Nurse and Mental Deficiency Visitor, may be held with that of Health Visitor in certain cases, so as to give the officer a compact district, save the time and money spent in travelling, and reduce the number of inspectors who may have to visit a particular house. The salary of a whole-time officer acting as Health Visitor with or without these other posts should as a rule be not less than £120 a year.

*District Nurses as Health Visitors.*

15. In sparsely populated districts it may be convenient to appoint the district nurse-midwives of Nursing Associations as Health Visitors, if the Medical Officer of Health is satisfied that they are competent to perform the work. In some cases it may be found practicable to give the nurse-midwives special instruc-

tion and training in the work of a Health Visitor. More than half the County Councils are now using district nurse-midwives as Health Visitors. The advantages of employing them are that, as a rule, they are well known and well received by the women in a country parish, that their advice is readily accepted, and that the arrangement may obviate duplication of inspection, and save time and money spent in travelling.

16. Where nurse-midwives employed by Associations affiliated to the County Nursing Association are employed as Health Visitors, the County Council and the County Nursing Association may find it advantageous to combine the offices of Superintendent of the County Nursing Association, Chief Health Visitor and Inspector of Midwives, so that the nurse-midwives are inspected by one official in all capacities.

#### *Visiting by Voluntary Workers.*

17. In a few districts voluntary workers, generally without full training, engage in health visiting. Their work should always be done in connection with that of trained and paid officers, and they may usefully assist at the Centres and in the supervision of older children.

#### *Appointment of Health Visitors as Infant Protection Visitors under the Children Act, 1908.*

18. The Local Authority under the Children Act, 1908, is in London the County Council, and outside London the Board of Guardians. It appears to the Board desirable that, where practicable, the Health Visitor and the Infant Protection Visitor should be the same person, and they suggest that the Local Authorities appointing Health Visitors should consult with the authorities appointing Infant Protection Visitors in their areas with a view to securing this.

#### *Nursing.*

19. The home nursing services in respect of which the grant is now available are nursing needed for expectant mothers, maternity nursing, the nursing of puerperal fever, and the nursing of measles, whooping-cough and epidemic diarrhœa in young children, and of ophthalmia neonatorum.

20. The maternity nursing should be undertaken by a woman with the certificate of the Central Midwives Board: failing this qualification, the Board should be furnished with evidence of her competency if a grant is claimed. A scale of fees should be

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fixed for maternity nursing, but the charge may be reduced or remitted in individual cases where circumstances justify the adoption of this course.

21. The Local Authority may, with the consent of the Board, themselves appoint nurses for the purposes specified above, or may contract with a body such as a District Nursing Association for this service. Where they appoint a special nurse, her spare time may well be utilised in the ordinary work of a Health Visitor. Often it is more convenient to arrange with a District Nursing Association for the services of one of their nurses to be available when an infectious disease prevails. Most district nurses are now allowed to nurse the cases of the infectious diseases mentioned in paragraph 19, subject to their taking simple precautions, as to which the Medical Officer of Health can advise. The Local Authority may pay a retaining fee to a District Nursing Association for the purpose of securing that a nurse is always available, and in addition pay a fee per visit or per case. It is particularly important that all cases of measles notified from districts in which deaths from this disease are likely to occur should be visited by a Health Visitor. On her report the Medical Officer of Health can usually decide when nursing is required.

22. In districts in which the County Council undertake the Maternity and Child Welfare work it is convenient that the nurses should be employed by the Council either directly or through the County Nursing Association. Under this arrangement the nurses are available for visiting and nursing in any district in which a nurse is needed.

### *Centres.*

23. The number of Centres has increased considerably during the past year, and much credit is due in this matter to private enterprise. Every Centre, whether municipal or voluntary, should generally be supervised by at least one trained and salaried worker, but unpaid workers interested in its objects can be of great assistance in weighing babies, in entertaining the mothers, and in giving instruction in elementary hygiene, cookery, sewing, etc. Where practicable, there should be a Centre for each Health Visitor's district, and the Health Visitor should attend when the Centre is open in order to be able to supervise the subsequent adoption at home of the advice given at the Centre.

The chief value of the Centre is to provide medical and especially hygienic advice. Mothers should be urged to bring their children, whether ailing or not, for such advice and for periodical

weighings. At the present time doctors are so fully occupied that regular medical attendance at many Centres is impossible, but every effort should be made to secure the attendance of a doctor, if not at every meeting, at any rate not less often than once a fortnight, or, in small Centres, once a month. Medical attendance should be regular and uniform, *i.e.*, the same doctor should attend at stated intervals. The Board do not recommend a rota of doctors; subject to this the doctor may be a local practitioner, the Medical Officer of Health, or the Assistant Medical Officer of Health. If the medical officer of the Centre is an officer of the Local Authority, he or she should be paid a separate salary for this work. It is desirable that Local Authorities should consult the local medical practitioners before making arrangements for medical attendance at a Centre.

24. Cases which are found at the Centre to need anything beyond minor treatment should be referred to their own medical attendant, or, if the woman cannot afford a doctor, to a hospital, if a hospital is available. One Centre may suffice for the treatment of cases from a number of Centres, and such a Centre may be combined with a school clinic, especially for ophthalmic and dental cases. A dental clinic should, wherever practicable, be available for expectant and nursing mothers and for children under five. The grant is available in respect of reasonable expenditure on treatment at Centres, including the treatment of ophthalmic and dental cases. A charge should ordinarily be made for new dentures for women and for spectacles for children, but the Board are willing that the charge should be reduced below the cost price or remitted entirely where the circumstances of the woman or of the child's parents are such as to justify this course.

25. The Board have had under their consideration the question whether cots may be provided as a part of the equipment of a Centre, and after conference with the representatives of a number of hospitals and voluntary Centres, their Medical Officer has advised that, subject to certain conditions, they may be allowed. The arrangements will be subject to revision in the light of experience; for the present they should be generally in accordance with the following conditions if a grant is desired:—

1. Acute cases of illness, such as would ordinarily be admitted to existing hospitals, and cases of infectious disease should not be treated in cots at a Centre. The Centre should, if practicable, be associated with a General Hospital or a Children's Hospital, with a view to prompt admission of acute or serious cases of illness.

2. The experiment of providing cots at Centres should be on a small scale, with not more than two wards with four cots



in each, and the fittings and furniture should be as simple and inexpensive as possible.

3. A whole-time nurse should be in charge by day and one by night, and the nursing staff should, as a rule, be distinct from the staff engaged in the ordinary work of the Centre.

4. If a medical officer is not resident on the premises there should be arrangements for securing his prompt attendance when required in emergency.

The Board would welcome arrangements for the treatment of mothers with their infants when breast-feeding fails. For this purpose it may be necessary for both mother and infant to become in-patients. In other instances the infant may be admitted, the mother attending twice or three times daily in a separate room to give supplementary breast feeds.

#### *Instruction in Hygiene.*

26. The extension of the grant to this purpose has been made in order to make it available in aid of reasonable expenditure on literature, exhibitions, and on collective instruction to expectant and nursing mothers, and also to voluntary and salaried workers where the Medical Officer considers that the instruction is likely to improve their competency to undertake the Maternity and Child Welfare work assigned to them. The expenses of salaried workers engaged in such work may be included in the application for grant under this heading.

#### *Provision for Confinements.*

27. The Board are satisfied that in many areas additional lying-in accommodation is required for normal as well as abnormal confinements, and they have therefore obtained power to make a grant to encourage the provision of such accommodation. The grant for this service will as a rule be paid only to a Local Authority, as the Board look to the Local Authority to provide or arrange for the provision of the accommodation required. Voluntary societies providing homes for normal confinements, if they need financial assistance, should, as a general rule, apply to the Local Authority in whose district the institution is situate.

In order that such homes may be eligible for the Board's grant, they must be willing to receive cases in which the Medical Officer of Health of the district considers that admission to the home is desirable because of domestic conditions.

A scale of charges should be fixed for the use of the lying-in home, but the charge may be reduced or remitted in individual

cases where the circumstances may justify the adoption of this course.

*Home Helps and other Assistance.*

28. In many cases a woman is unwilling to leave her home, even if its conditions are unsuitable for her confinement. If the difficulty arises from the number of children, arrangements may sometimes be made for the children to be boarded out during the mother's lying-in period; if it is due to the need for a person to look after the house during this period, whether the confinement takes place at the home or elsewhere, a Home Help may be supplied for the purpose. The grant is available for assistance of this character where the Board's general consent has been previously obtained to the local arrangements.

Home Helps must, of course, be persons of suitable character. Where the confinement takes place at home they should undertake the necessary duties under the direction of the nurse or midwife in attendance.

The duties of a Home Help would be the ordinary domestic duties usually undertaken by the mother, including cleaning, cooking, washing, care of children, mending and marketing. She should not undertake any work which properly belongs to the sphere of the trained nurse or midwife, nor assist at a confinement unless a doctor or midwife is in attendance.

It is advisable to arrange for special training of Home Helps. This training may be given at Maternity Centres and Day Nurseries, and should include practical instruction in plain and invalid cookery, food values and prices, laundry work, mending, infant care and hygiene. A course of one to three months, according to the previous experience of the woman, should be sufficient.

A scale of charges for the service of Home Helps should be made, but the charge may be remitted or reduced in individual cases where the circumstances justify it.

*Hospitals for Infants.*

29. This grant is now extended to hospital treatment of children up to five years of age, but save in exceptional cases it will be paid only to the Local Authority. It is not available in respect of the hospital treatment of ordinary infectious diseases, except ophthalmia neonatorum, but for the present the Board are prepared to give a grant towards the provision of hospital beds for epidemic diarrhoea, when these beds are provided elsewhere than at an Infant Welfare Centre.

*Food.*

30. The conditions under which this grant will be paid were laid down in the Board's circular letter of 9th February last. The Board consider that schemes for the supply of food and milk should, where this provision is necessary, be undertaken by the authority carrying out the Maternity and Child Welfare scheme. Where the Local Authority of a County District which is not carrying out such a scheme considers that expectant and nursing mothers and young children in its district are not obtaining a proper supply of food and milk, it should consult with the County Council as to the best means of supplying this need.

A scale of charges should be laid down for the supply of food and milk, but the charge may be reduced or remitted in individual cases where the circumstances justify it.

*Crèches, etc.*

31. The Board's grant is available in respect of expenditure by Local Authorities on providing or aiding crèches and day nurseries, and on placing children in the care of foster-mothers who are under supervision by the Medical Officer of Health. The grant is also available for aiding homes where children can remain through the night as well as the day, and is especially intended for the children of mothers who go out to work. A scale of charges should be fixed for these services, but the charge may be remitted or reduced in individual cases where the circumstances justify the adoption of this course.

*Convalescent Homes.*

32. A stay in a convalescent home is specially important for recovery after certain cases of confinement and for some conditions in young children, especially after measles and whooping-cough. It is desirable, therefore, that Local Authorities should, either themselves or through a voluntary agency, arrange for beds in convalescent homes to be available as part of their schemes. As a general rule a grant will be paid to voluntary agencies providing convalescent homes only in respect of accommodation provided in connection with a local authority's scheme and approved by the Local Authority and the Board.

*Homes for Children.*

33. The health of infants and young children who lack the support of a father often needs special attention, and it is on all grounds desirable that the mother and child should be kept

together in such cases, especially during the first year. It is notorious that the death-rate of illegitimate infants, the only infants in this category for whom separate statistics are published, is about twice the death-rate of legitimate infants. To some extent this is due to the difficulty experienced by their mothers in making a home for them. The mothers generally go out to work and leave their infants with foster-mothers. As a result of the war fewer suitable foster-mothers are prepared to take the children at a charge which their mothers can afford to pay. The Board have therefore obtained the Treasury assent to the extension of the grant to homes at which mothers and children can be kept together in certain cases, and to such other arrangements as the Board may approve for attending to the health of the children under consideration. In some cases it may be desirable to pay a good foster-mother to look after a child whose mother cannot afford the whole of its keep, or to assist the mother to stay at home to attend to the child. Any scheme for this purpose should be submitted for the Board's approval before expenditure is incurred on it if a grant is desired.

#### *Capital Expenditure.*

34. The grant is available in respect of the necessary adaptation and equipment of premises for the purpose of Centres, Crèches, Homes and Hospitals. The erection of new premises for these purposes is impracticable at present, and with a view to keeping capital expenditure within the narrowest limits suitable existing accommodation should, where possible, be obtained on lease rather than by purchase. All proposals for acquiring, adapting and equipping buildings for these purposes should be submitted to the Board before expenditure is incurred, with an estimate of the cost, if a grant is desired.

#### *Experimental Work.*

35. Mr. Hayes Fisher desires to encourage Local Authorities and Voluntary Agencies to undertake new work calculated to promote the health of mothers and children, and the Board will consider sympathetically any new proposal submitted to them under this heading. If a grant is desired, full particulars should be furnished of any such scheme and of its estimated cost before expenditure is incurred on it.

#### *Items excluded from Grant.*

36. The grant is not available in respect of the following items, which are frequently included in applications:—

Payments to the Central Midwives Board,

Payments to Registrars for returns of births,  
 Certificates of deaths of midwives,  
 Compensation to midwives for abstaining from work after  
 contact with infection,  
 Expenses of deputations,  
 Rent of premises in the possession of the Local Authority or  
 of the Education Committee,  
 Any part of the salary of the Medical Officer of Health except  
 an additional salary specially voted for Maternity and Child  
 Welfare work,  
 Clerical and other establishment expenses, except additional  
 expenditure specifically necessitated by the scheme.

*Applications from Voluntary Societies.*

37. Grant is payable to voluntary societies on condition that the work is co-ordinated with the work of the Local Authority. It is convenient that applications from voluntary societies should be forwarded to the Board through the Local Authority with whose scheme they are co-ordinated. Where this is not done a copy of the application should be sent to the Local Authority at the same time as it is sent to the Board.

*Use of Abortifacients.*

38. A report was published by the Privy Council Office in 1910 on the practice of medicine and surgery by unqualified persons. For the purpose of that Report the Board obtained some particulars from Medical Officers of Health which showed that the sale of drugs intended to procure abortion and practice by abortion-mongers was prevalent in many parts of the country. From information obtained by Medical Inspectors of the Board in connection with their inquiries into Maternity and Child Welfare work and from other material, the Board have reason to fear that these practices continue. One of the drugs most commonly employed for this purpose is diachylon, and on 27th April 1917, an Order in Council was made adding to the list of poisons for the purpose of Part I. of the Schedule of Poisons "lead in combination with oleic acid, or other highly fatted acids, whether sold as diachylon or under any other designation (except machine spread plasters)". The Board would urge every Local Authority to bring this order to the notice of the druggists and of the practising midwives in their area, to explain to their Health Visitors and to the midwives the risks to life and health involved in the use of diachylon, and in every other way to do

what they can to stop the traffic in abortifacients and the practice of abortion-mongers in their districts.

This Circular will be placed on sale so that copies may shortly be obtained, either directly or through any bookseller, from H.M. Stationery Office at the following addresses:—Imperial House, Kingsway, London, W.C.2; and 28 Abingdon Street, London, S.W.1; 37 Peter Street, Manchester; and 1 St. Andrew's Crescent, Cardiff.

I am, Sir,

Your obedient Servant,

H. C. MONRO,

*Secretary.*

The Clerk to the Council.

REGULATIONS under which grants not exceeding one-half of approved net expenditure will be payable by the Local Government Board to Local Authorities and to Voluntary Agencies in respect of arrangements for attending to the health of expectant mothers and nursing mothers and of children under five years of age.

1. The Local Government Board will pay grants during each financial year, commencing on 1st April, in respect of the following services:—

- (1) The salaries and expenses of Inspectors of Midwives.
- (2) The salaries and expenses of Health Visitors and Nurses engaged in Maternity and Child Welfare work.
- (3) The provision of a midwife for necessitous women in confinement and for areas which are insufficiently supplied with this service.
- (4) The provision, for necessitous women, of a doctor for illness connected with pregnancy and for aid during the period of confinement for mother and child.
- (5) The expenses of a Centre, *i.e.*, an institution providing any or all of the following activities:—medical supervision and advice for expectant and nursing mothers, and for children under five years of age, and medical treatment at the Centre for cases needing it.
- (6) Arrangements for instruction in the general hygiene of maternity and childhood.
- (7) Hospital treatment provided or contracted for by Local Authorities for complicated cases of confinement or complications arising after parturition, or for cases in which a woman to be confined suffers from illness or deformity, or for cases of women who, in the opinion of the Medical Officer of Health,

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cannot with safety be confined in their homes, or such other provision for securing proper conditions for the confinement of necessitous women as may be approved by the Medical Officer of Health.

(8) Hospital treatment provided or contracted for by Local Authorities for children under five years of age found to need in-patient treatment.

(9) The cost of food provided for expectant mothers and nursing mothers and for children under five years of age, where such provision is certified by the Medical Officer of the Centre or by the Medical Officer of Health to be necessary, and where the case is necessitous.

(10) Expenses of crèches and day nurseries and of other arrangements for attending to the health of children under five years of age whose mothers go out to work.

(11) The provision of accommodation in convalescent homes for nursing mothers and for children under five years of age.

(12) The provision of homes and other arrangements for attending to the health of children of widowed, deserted and unmarried mothers, under five years of age.

(13) Experimental work for the health of expectant and nursing mothers and of infants and children under five years of age carried out by Local Authorities or voluntary agencies with the approval of the Board.

(14) Contributions by the Local Authority to voluntary institutions and agencies approved under the scheme.

2. Grants will be paid to voluntary agencies aided by the Board on condition:—

(1) That the work of the agency is approved by the Board and co-ordinated as far as practicable with the public health work of the Local Authority and the school medical service of the local education authority.

(2) That the premises and work of the institution are subject to inspection by any of the Board's Officers or Inspectors.

(3) That records of the work done by the agency are kept to the satisfaction of the Board.

3. An application for a grant must be made on a form supplied by the Board.

4. The Board may exclude any items of expenditure which in their opinion should be deducted for the purpose of assessing the grant, and if any question arises as to the interpretation of these Regulations the decision of the Board shall be final.

5. The grant paid in each financial year will be assessed on the basis of the expenditure incurred on the service referred to in Article I. in the preceding financial year, and will be, as a rule, at the rate of one-half of that expenditure where the services

have been provided with the Board's approval and are carried on to their satisfaction. The Board may, at their discretion, reduce or withhold the grant.

GIVEN under the Seal of the Local Government Board  
this Ninth day of August, 1918.

L. S.

W. HAYES FISHER,  
*President.*

H. C. MONRO,  
*Secretary.*

*Circular No. 5 (M. & C. W. 11).*

*County Councils (other than the  
London County Council), and  
Local Sanitary Authorities.*

### MATERNITY AND CHILD WELFARE.

MINISTRY OF HEALTH,  
WHITEHALL, S.W.1,  
15th July 1919.

SIR,

1. I am directed by the Ministry of Health to enclose forms on which application may be made for a grant in aid of expenditure on Maternity and Child Welfare during the current year.

2. The Treasury have sanctioned an amendment of Article 5 of the Regulations of 9th August 1918, to enable grant to be paid on account in respect of expenditure on Maternity and Child Welfare. The Article now reads as follows:—

“The grant paid in each financial year will be, as a rule, at the rate of one-half of the expenditure on the services referred to in Article 1, where the services have been provided with the Ministry's approval and are carried on to their satisfaction. The Ministry may, at their discretion, reduce or withhold the grant.”

In the present year the Ministry will pay local authorities a grant on account amounting to 40 per cent. of the estimated expenditure of the current year, with the addition of the sum necessary to make up the grant for the preceding year to half the ascertained expenditure of that year.

3. The grant is available in respect of expenditure on adaptation and equipment of premises if paid out of revenue. The Ministry are now able to entertain applications from local authorities for sanction to loans for the purchase and erection of premises urgently needed for public health purposes, but



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before sanctioning a loan for the erection of a building for Maternity and Child Welfare, they will require to be satisfied that no existing building or disused military establishment is available and could properly be utilised. Where a loan is sanctioned, grant will be paid on the annual charge.

4. The nursing of cases of poliomyelitis in young children may now be included amongst the matters in respect of which a grant is payable.

5. The Ministry desire to explain that the grant is not available in respect of the following items, which are mistakenly included in many of the applications received by the Ministry :—

Payments to the Central Midwives Board,

Certificates of deaths of midwives,

Compensation to midwives for abstaining from work after contact with infection,

Expenses of deputations,

Rent of premises in the possession of the Local Authority or of the Education Committee.

Any part of the salary of the Medical Officer of Health except an additional salary specially voted for Maternity and Child Welfare work,

Clerical and other establishment expenses, except additional expenditure specifically necessitated by the scheme ;

and the following incidental expenditure incurred in connection with the activities of National Baby Week celebrations :—

Refreshments,

Prizes and certificates,

Payment of nurses for organising baby shows and classifying babies,

Payments to doctors and nurses for judging babies,

Bands.

6. In future, grant will be payable for hospital accommodation for measles and whooping-cough occurring in children under five years of age, either permanent or temporary in character, provided either at a hospital for infectious diseases or in a separate institution. If this accommodation is provided at a local authority's hospital for infectious diseases it must be so arranged as not to interfere with the accommodation for the other infectious diseases which are usually admitted to hospital.

7. Grant will in future be payable in respect of payments to Registrars for Returns of unnotified births.

I am, Sir,

Your obedient Servant,

ROBERT L. MORANT,

Secretary.

The Clerk to the Council.

## APPENDIX IV

### CIRCULAR BY THE MINISTRY OF HEALTH ON THE TRAINING OF HEALTH VISITORS

*Circular 4.—Local Authorities (M. & C.W. 10).*

To the Clerk of the Local Authority.

MINISTRY OF HEALTH,  
WHITEHALL, S.W.1.

#### THE TRAINING OF HEALTH VISITORS, ESPECIALLY FOR MATERNITY AND CHILD WELFARE WORK.

SIR,

1. The Minister of Health is desirous of inviting the attention of Local Authorities and others concerned in maternity, child welfare and other departments of public health to the important Regulations just made by the Board of Education, after consultation with this Ministry, for the payment, from the Board, of grants in aid of the training of women to become Health Visitors.

2. The functions of Health Visitors have become widely known and appreciated in the last ten years; but it may tend to the better understanding of the purpose of the now projected developments, both in the new Regulations of the Board of Education and in the consequent higher standards to be looked for by this Ministry in local work, to recall here, briefly, the history of their origin and past development. It was the London County Council (General Powers) Act, 1908, which first empowered sanitary authorities in London to appoint suitable women to be known as Health Visitors whose duties would include (a) giving advice on the proper nurture, care, and management of young children, (b) the promotion of cleanliness as the basis of health, and (c) such other analogous duties as might be assigned to them. The Local Government Board were authorised by the Statute to make Regulations prescribing the qualifications, duties, salary, mode of appointment and tenure of office

of Health Visitors appointed under the Act, and it was stipulated that no appointment should be made otherwise than in accordance with such Regulations.

3. Although at the time of the passing of the Act a number of women known as Health Visitors had already been appointed to advise mothers as to the care of their infants, the Board had not then had sufficient experience of the scope of their work, and of the qualifications necessary for it, to justify them at that time in establishing or requiring a special course of training for the Health Visitors who were to be appointed under the Act. The qualifications which the Local Government Board then prescribed in their Order were as follows :—

- (a) a medical degree, or
- (b) the full training of a nurse, or
- (c) the certificate of the Central Midwives Board, or
- (d) some training in nursing and the Health Visitor's certificate of a Society approved by the Board, or
- (e) the previous discharge of duties of a similar character in the service of a Local Authority.

4. At that period, and in subsequent years, great impetus was given to the appointment of Health Visitors by the Notification of Births Act, 1907 (which was made compulsory by the Extension Act of 1915), and by the institution of the Exchequer grants in aid of the local provision of arrangements for maternity and child welfare in 1914. And it may now be said that, although at the present time the number of Health Visitors is still seriously insufficient for the needs of the population, some provision is made for health visiting in most parts of England and Wales.

5. The standard of efficiency of this health visiting, however, varies greatly. Outside London no qualifications have hitherto been prescribed for Health Visitors. But the Local Government Board have constantly recommended that the women appointed to undertake this work by Local Authorities should possess one or more of the qualifications prescribed by the London Order, with the addition of the certificate of a Sanitary Inspector; and investigation has shown that at the present time nearly all of the Health Visitors at work in England and Wales possess one or more of these various qualifications; but this, of course, especially taken in conjunction with the inadequacy of the numbers, is not sufficient to secure such a standard of work generally as the nation has a right both to expect and to receive nowadays in this important sphere of public welfare.

6. The Act of 1908 quoted above, and the Board's Order made under it, permitted the duties of Health Visitors to cover a wide field. In practice, however, their special function in London has usually been maternity and child welfare work with

particular regard to the care of infants. The value of the work which they have done in assisting the campaign against infant mortality has been widely recognised. In addition to the regular visiting of infants in their homes, they are now frequently employed to assist in supervising, under medical control, the health of children under school age, to attend Maternity and Child Welfare Centres, and to investigate the circumstances in cases of still-births and the deaths of young children. The varied nature of their duties requires, it is obvious, a carefully devised course of professional training. But it has been found in practice that the qualifications set out above, though admittedly comprising the most useful existing qualifications for the discharge of these duties, include certain subjects not directly relevant and omit certain subjects on which it is eminently desirable that Health Visitors should be well informed.

7. It may be said, in this connection, that from the beginning it has been recognised that, when circumstances permitted, it would be necessary that a special course of training for Health Visitors generally should be prescribed. Now that the time seems opportune for the institution of such a course, the Ministry of Health have welcomed, and have been glad to co-operate in, the action of the Board of Education, as the Department responsible to Parliament for the provision of education and training, in framing regulations defining the terms and conditions which should govern the disbursement of Exchequer grants in aid of the provision of efficient courses of training for future Health Visitors.

8. It will be observed that the Board of Education Regulations (copy enclosed) which have been framed in consultation with the Ministry of Health, and with direct regard to the duties of Health Visitors as prescribed by the Ministry of Health under the Acts above referred to, make provision (a) for a course of two years for candidates without previous training, and (b) for a course of one year in the case of fully trained nurses, of women with experience of health visiting, or of those possessing a University Degree or its academical equivalent—assuming in each case that the individual possesses sufficient general knowledge or experience to profit by such a course.

9. In view of the great importance of securing the appointment of properly trained persons as Health Visitors, and of the enlarged opportunities that will arise under the developments just described, the Ministry of Health have now decided that, in cases requiring Government sanction and grant, the Ministry will require that all women appointed for the first time as Health Visitors on and after a date of which due notice will be given must have obtained the certificate described in these Regulations

of the Board of Education, with or without other qualifications. Women intending to enter the profession in the future are therefore advised to take a course of training at one of the institutions recognised by the Board of Education, who will announce a list of such institutions. It is to be noted that these requirements by the Ministry as to candidates having been trained in a course under these Regulations will apply only to *salaried* Health Visitors. At many Maternity and Child Welfare Centres (both municipal and voluntary) unpaid workers are engaged, who, where they undertake the regular discharge of definite duties, render valuable assistance to the work of the Centre. These workers should be experienced and competent, and some training is desirable for them also; but they need not necessarily possess certificates given after a formal course of training.

10. It is further to be understood that, until such time as the Ministry consider that there have become available a sufficient number of candidates who have completed a course recognised under the Training Regulations, women who are now acting as Health Visitors, and women who may be appointed during the intervening period as Health Visitors, will not be required to have taken either the full or the shortened course of training as a condition of repayment of half their salary from the Maternity and Child Welfare grant. At the same time, it is hoped that local authorities will afford facilities to such Health Visitors to take an approved course of training where they desire to do so, and where the Medical Officer of Health is of opinion that it would increase their efficiency. The Ministry of Health would also recommend that Local Authorities making new appointments of Health Visitors from the present time, until women qualified under the new Regulations are available, should always endeavour to secure more than one of the qualifications already prescribed for London and recommended for the rest of the country by the Local Government Board, as set out in the third and fifth paragraphs of this Circular. For it should now usually be possible to obtain women possessing more than one of these qualifications: and the Ministry will not, as a rule, be prepared, after a date of which due notice will be given, to pay grants in respect of the salary of any newly appointed Health Visitor who has only the qualification of a midwife or of a Sanitary Inspector, unless she has previously rendered satisfactory service as a Health Visitor in another District.

11. While the Ministry of Health will accept the standard of training laid down by these Training Regulations as a sufficient qualification both for Health Visitors and for Tuberculosis Visitors and Nurses, it is recognised that some local authorities may desire further qualifications in the women they appoint in

those capacities, especially where they are called upon to perform additional duties to those enumerated above. The following observations may be useful regarding such additional duties.

12. It is often urged that, generally speaking, and especially in country districts, the Health Visitor should discharge *all* the duties akin to those of health visiting in the "district" assigned to her, on the grounds that such an arrangement reduces the size of the district allotted, and tends to minimise the time spent in travelling. It also reduces the number of inspectors who may visit a house for various purposes, a matter of considerable importance. This principle, however, needs to be adopted and applied with circumspection and careful regard to local circumstances, and to the conditions requisite for attaining a sufficiently high standard of efficiency, especially in centres of congested population. This is especially true in respect of work in connection with Tuberculosis and Mental Deficiency, which are the other functions most often allotted to Health Visitors in several areas in England and Wales.

13. Many Health Visitors at present act as Assistant Inspectors of Midwives under the Medical Officer of Health or the Assistant Medical Officer of Health. The Ministry of Health consider that the inspection of midwives, including routine as well as special inspections, should be carried out by a medical practitioner, preferably a medical woman; and it is urged that *all* supervising authorities under the Midwives Act who have not already done so, should as soon as possible, appoint on their staff a woman Medical Officer to supervise maternity and child welfare work and to inspect midwives under the direction of the Medical Officer of Health. In cases where it is unavoidable that a non-medical woman should take part in the inspection of midwives it is essential that she should not only possess the certificate of the Central Midwives Board, but should have had substantial experience as a practising midwife.

14. The visiting of expectant mothers before confinement, and of infants during the first ten days after birth, is at present undertaken in some areas by Health Visitors. The Ministry of Health are of opinion that this work should be assigned to the midwife (where a midwife has been engaged by the mother) wherever this can be done consistently with the efficient discharge of the important duties involved. And it is hoped that this arrangement will be greatly facilitated in course of time by the improvement to be expected in the efficiency of midwifery practice arising from the new grants and regulations for the training of midwives that will be shortly issued by the Board of Education in concert with this Ministry.

15. In many rural areas it is the custom to select the District

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Nurses for appointment as Health Visitors by County Councils organising maternity and child welfare schemes. There is no doubt much to be said for this arrangement in rural areas, but in its operation care must be taken to secure the necessary conditions for its efficiency. For the present, although the Ministry of Health will not require as a condition of grant that such District Nurses should have undergone the course of training prescribed by the Board of Education Regulations for the training of Health Visitors, it is strongly recommended that County Councils should arrange that all District Nurses who are to act as Health Visitors should be given the opportunity of practical training for not less than three months under an experienced Health Visitor, and should be required, generally speaking, to take advantage of such opportunities so soon as they are provided.

16. As a general rule the Ministry of Health do not consider it desirable that Health Visitors in populous districts should undertake either midwifery or district nursing. It is better that trained midwives should be appointed or subsidised for the former purpose, and that separate officers should be appointed in these areas as District Nurses, or arrangements made with District Nursing Associations for the nursing services necessary under Maternity and Child Welfare Schemes.

17. Some Health Visitors who possess the requisite qualification have been appointed as Sanitary Inspectors of Nuisances, or as Assistants in those capacities, to discharge the duties of such officers which are usually assigned to a woman. The Ministry of Health will be prepared to approve this arrangement where it is found convenient; but they consider it undesirable that a Health Visitor acting in this capacity should exercise the functions of a Sanitary Inspector or Inspector of Nuisances in respect of the serving of notices and the conduct of prosecutions for sanitary defects discovered in the course of her visits as a Health Visitor.

18. In conclusion Dr. Addison desires, as Minister of Health, strongly to emphasise the necessity of securing that so far as practicable only those women should be appointed to salaried posts for the important functions comprised in health visiting who possess a good general education followed by an efficient course of special training in an institution approved by the Board of Education under the new training Regulations. It must be remembered that the amount of the grants now being paid annually from the Ministry of Health to Local Authorities in aid of their expenditure on health visiting and other elements of their Maternity and Child Welfare Schemes is rapidly increasing, and that Parliament is in fact providing virtually one-half of

what is now spent locally in this field of health work. It is thus incumbent upon the Ministry of Health, as responsible to Parliament for the proper expenditure of these large and increasing Exchequer subsidies, to take all reasonable steps to secure the adoption of every practicable measure for raising the standard of much of the existing work, which has been in some places inevitably of a somewhat indifferent character during the early years of its development. Such a condition of things will be inexcusable so soon as the conditions of working are improved, and the supply of properly trained women for these purposes is increased, in virtue of the further pecuniary assistance from Parliament to be provided under the new Regulations of the Board of Education herein described. It is with this object that the Ministry are issuing this Circular to Local Authorities, in the assurance that it will receive sympathetic and appreciative response from all these Authorities and their staffs, and also from the great band of voluntary workers who devote themselves so earnestly to the welfare of the mothers and children of this country; so that by hearty co-operation between these various bodies there may be secured throughout the country a gradual but steady improvement in the effectiveness of all work attempted in this extremely important sphere of public health.

I have the honour to be,

SIR,

Your obedient servant,

ROBERT L. MORANT.

MINISTRY OF HEALTH,

*July 14th, 1919.*



## APPENDIX V(A)

EXTRACTS FROM THE REGULATIONS FOR NURSERY SCHOOLS, 1919 (INCLUDING REGULATIONS FOR PAYMENT OF GRANT IN RESPECT OF THOSE SCHOOLS), MADE BY THE BOARD OF EDUCATION UNDER SECTION 44 OF THE EDUCATION ACT, 1918 (8 & 9 GEO. 5, C. 39).

BOARD OF EDUCATION.

REGULATIONS FOR NURSERY SCHOOLS.

PREFATORY MEMORANDUM.

1. Section 19 of the Education Act, 1918, which came into operation on the 8th August 1918, reads as follows:—

“(1) The powers of Local Education Authorities for the purposes of Part III. of the Education Act, 1902, shall include power to make arrangements for—

“(a) supplying or aiding the supply of nursery schools (which expression shall include nursery classes) for children over two and under five years of age, or such later age as may be approved by the Board of Education, whose attendance at such a school is necessary or desirable for their healthy physical and mental development; and

“(b) attending to the health, nourishment and physical welfare of children attending nursery schools.”

“(2) Notwithstanding the provisions of any Act of Parliament the Board of Education may, out of moneys provided by Parliament, pay grants in aid of nursery schools, provided that such grants shall not be paid in respect of any such school unless it is open to inspection by the local education authority, and unless that authority are enabled to appoint representatives on the body of managers to the extent of at least one-third of the total number of managers, and before recognising any nursery school the Board shall consult the local education authority.”

2. *Aims of the Nursery School.*—A Nursery School or Class is an institution providing for the care and training of young children aged from two to five years, whose attendance at such a day school is necessary or desirable for their healthy physical and mental development. It has therefore a two-fold function: first, the close personal care and medical supervision of the individual child, involving provision for its comfort, rest and suitable nourishment; and secondly, definite training—bodily, mental and social—involving the cultivation of good habits in the widest sense, under the guidance and oversight of a skilled and intelligent teacher, and the orderly association of children of various ages in common games and occupations.

The child is first and foremost a growing organism: the nursery school will, on the one hand, liberate the growing child from the influences of environment and constitution which retard, confine, and distort its growth, and, on the other hand, will stimulate and direct its growth. It is much more than a place for "minding" children. The need of nursery schools is greatest in the more congested areas of the large towns. The influences which an adequate supply of efficiently managed nursery schools could exercise upon both children and parents in such areas can hardly be overestimated.

#### PHYSICAL CARE.

4. *General Hygiene.*—The provisions of the Act emphasise the need for attending to the health, nourishment and physical welfare of the children. The improvement of their health is indeed one of the main benefits which attendance at a good nursery school should bring with it. In a broad sense, physical welfare will always be in view, and there is hardly any limit to the beneficial influence of a nursery school on this side of its activities. Physical care includes not only opportunities for rest, exercise and physical development, but the provision of a healthy school environment and the inculcation of hygienic habits of life, of which the thorough practice of personal cleanliness is an obvious example. Equally important is suitable provision for the children's food. Meals, including a mid-morning lunch and midday dinner, should as a rule be taken at the school, and it may be desirable, or even necessary, in some cases, to provide the children also with breakfast and tea. The arrangements for meals will need careful supervision. The dietary should be suitable and sufficient. The children should spend a definite part of the day in rest and sleep. Neither the exact time for the rest nor its length need here be prescribed, but it is important that the period should be the same each day; the

teacher will herself decide, according to circumstances, what occupations should precede or follow the period of rest. The rest should be taken on low stretchers, easily set up and stored away, or on clean mats, and should mean lying down and not sitting.

5. It will also be necessary to provide training directed to promoting the healthy development of the body. Appropriate physical training is as indispensable for younger as for older children. In addition to very simple organised exercises, they should be allowed and encouraged to move about freely, to use their limbs as their natural energy prompts, and to play the customary simple group games, with running, jumping and marching. They should be taught to breathe correctly and naturally; and all this should take place in clean and airy surroundings. The importance of facilities for out-of-door life cannot be overestimated. Whether in a garden (under more fortunate circumstances) or on a roof or other playground, kept clean and screened from too much wind, from wet, and from the sun in the height of summer, the children in nursery schools should spend a considerable time in the open air. Nor need the use of the outdoor space be confined to play in the form of free bodily exercise. In warm weather especially the chairs, tables and stretchers can be carried outside, and most of the day's occupations be conducted in the open air.

6. *Medical Supervision.*—As is intimated in Article 4 of the Regulations, a nursery school should stand in close relation to the School Medical Service. Whether maintained by the Local Education Authority or by a voluntary body, the school should be under the supervision of the School Medical Officer. In the case of a voluntary nursery school it may not always be convenient for the School Medical Officer to undertake the whole of the medical inspection, but even in such a case the medical practitioner employed for this purpose should be in touch with the School Medical Officer, who should visit the school from time to time. The medical practitioner selected should preferably live near the school, to be readily available in case of emergency.

7. Medical supervision of nursery schools is desirable for four reasons :—

- (a) To prevent the admission of physically unsuitable children.
- (b) To prevent, as far as possible, the development of physical defects or ailments, and to ensure prompt treatment where necessary.
- (c) To avoid, as far as possible, the spread of infectious diseases such as measles and whooping-cough by providing opportunities for early diagnosis and the adoption of prompt preventive measures.

(d) To create and develop healthy habits of life, and the avoidance of injury to the senses.

Among the children who desire admission there may be some who are physically unfit to attend even a nursery school. In other cases it may be desirable to retain children at the school on the grounds of health for a longer period than usual before sending them to the Public Elementary School.

Various physical habits frequently observed among little children, such as mouth-breathing, squint, near distance eye work, etc., should be detected at the earliest opportunity, and arrangements made for their careful correction. One reason for the provision of Nursery Schools is indeed to reduce the large numbers of preventable defects now observed in entrants to the Public Elementary School, and the associated educational handicap and resulting incapacity. For several years past the degree and character of defects prevalent among children on their first admission to the elementary schools have revealed a widespread measure of low physical condition in children under five, not a little of which might have been prevented if it had been properly dealt with between two and five years of age.

8. *Medical Inspection and Treatment.*—Each child should be medically inspected according to a prescribed schedule as soon as possible after admission, and should be seen, though not necessarily examined, by the doctor not less than once a term. Ailing children may require more frequent inspection. The School Nurse may be employed to assist in the periodical medical examination of the children and in following up the children found to be defective. She may also pay daily visits to the school to make a "health inspection," take temperatures, if and when necessary, and deal with minor ailments. In many cases, however, it would be more satisfactory that the Superintendent or another member of the staff who possesses the requisite qualifications should discharge some or all of these duties. She should weigh and measure the children at least at the beginning and end of each term (preferably once a month), and she should have a definite responsibility for the hygiene of the school, including the cleanliness of the children and the suitability of their clothing and footwear.

9. The facilities for treatment and the arrangements for "following up" provided for children in attendance at public elementary schools should be available for children in nursery schools. For example, a child suffering from squint, nasal obstruction or discharging ears, should be referred to the School Clinic for advice and, if necessary, treatment. Minor ailments, e.g., cuts, sores, chilblains, should be dealt with at the school itself. Particular attention should be paid to correct breathing,

and the school staff should be trained to observe slight departures from the normal, which are the early indications of defects of sight, hearing, or nutrition. They should refer such cases to the Medical Officer.

*Records* of physical conditions, defects and treatment, should be kept on schedules adapted from those in use at the public elementary school, and should be transferred when the child enters the ordinary school. If the child has previously attended an Infant Welfare Centre a copy of its record should be obtained.

10. *Epidemic Disease*.—The prevention of epidemic disease is particularly important where numbers of susceptible children under five years of age are in frequent and close contact. The younger the children the greater is the mortality from such diseases as measles and whooping-cough. Ninety per cent. of the deaths from measles and its complications occur under the age of five years. If the attack of measles, for instance, can be postponed beyond early childhood the illness is likely to be less severe, and there is less liability to dangerous complications or after-effects, such as pneumonia or the development of tuberculosis. Children known to have suffered recently from infectious disease should receive special care and supervision in order to prevent the development of after-effects, such as tuberculosis. Epidemics can be prevented to a considerable extent—

- (1) by daily inspection by a competent observer of each child as it enters the school;
- (2) by the strict adherence of the school staff to rules drawn up for their guidance (*e.g.*, in regard to exclusion of "contacts" or of cases of infectious disease at an early or incipient stage);
- (3) by exclusion of cases of "colds" or suspects;
- (4) by the cleanliness and hygiene of each child;
- (5) by the management of the school on open-air lines.

The School Medical Officer should be responsible for rules designed to prevent the transmission of infection, and for a general oversight of the arrangements. The necessary daily inspections should be carried out either by a qualified nurse or by a senior member of the staff if she possesses suitable and sufficient experience. It should not be delegated to junior or inexperienced members of the staff.

Suspicious cases should be isolated pending medical advice. Arrangements for the examination of suspected cases of infectious disease should be made by the School Medical Officer in conjunction with the Medical Officer of Health (to whom notification of infectious cases must be sent). It may prove convenient to obtain a local doctor to examine such children. In any case

much more effective and systematic steps should be taken through the Nursery School in regard to the diagnosis and following up of measles, etc., than have been practicable in connection with the ordinary Infant School. It is, perhaps, desirable to add that no scheme of Nursery Schools will receive the Board's approval until and unless proper safeguards have been secured.

#### MENTAL AND SOCIAL TRAINING.

11. It would, however, be a mistake to assume that healthy physical development is the sole concern of a Nursery School, and that the growth of the mind can safely be neglected. The school should provide specific training on this side as well as on the physical. It has much to do in the way of preparing the children to begin the work of the Elementary School with well-formed habits, with minds alert and eager to learn and unspoiled by premature attempts to teach what is unsuitable. Formal work in Reading, Writing, and Arithmetic should have no place at all in the Nursery School. The best preparation for the three R's is a training in speech and language. The children should be taught to use their voices naturally, without harshness, and to articulate freely and correctly. They should be encouraged to ask questions, to understand and act upon what is said to them, to talk freely on their own little concerns, to say simple rhymes and poems, and to sing together. Music and singing will help in the training of speech, and by stories told to groups of children they will learn something of the pronunciation and meaning of words. The skilful teacher will know how to entice even the shyest child into talking. The picture books and toys, with which a Nursery School should be well stocked, the garden and the pets that may be kept, will furnish material enough for talking. One of the objects of training in speech is to give the child, often brought up in narrow surroundings, ideas as well as words—things, in short, to talk about. In Wales it is desirable that the language of the Nursery School should be the language of the children's home.

12. *Development of Motor and Sensory Experience.*—A beginning may be made in directing that motor and sensory experience of the child which is vital to its harmonious development. For though manual work as ordinarily understood is more suitable for children over the age of five years, its broad principles may be introduced in the Nursery School. The child learns through action; indeed, true muscular culture is brain culture; and the early spontaneous movements of the child are of great importance as stimulative to the brain centres. Certain forms

of handwork and simple physical exercises—walking, hopping, skipping, marching, running, and arm exercise—are valuable and lead out the child's motor powers. It should be remembered that handwork should be so devised as to provide (a) for an appropriate degree of repetition, (b) for sufficient variety in form and nature, and (c) for tasks which can be completed in themselves at once or in one or at most two lessons. Above all, the handwork and other occupations of the children in the Nursery School should have a purpose. The interest of young children is in occupations which have meaning, which *do* something, and which are followed by results. They like to handle things, and push them about, to make, create, and use; to build towers and destroy them; to collect and have the sense of ownership; to come into contact with and control other forms of existence than their own. All these early natural aspirations should be cultivated, developed and directed in the Nursery School.

13. Another principal aim will be what is sometimes called "sense-training." The purpose of such training is not primarily to cultivate the ability to make minute discriminations between different sounds, textures, weights, or even colours, an ability which may be speedily lost if it is not constantly utilised. It is rather, as regards sight, to teach the child to notice broad rather than fine differences in colour, form and size; as regards hearing, to listen with attention, to respond to quiet questions and commands, to distinguish different sounds, and to develop a taste for pleasant sounds instead of noise; in touch, to enable the child to interpret shape, size and texture through his fingers, and to use his hands and fingers for manipulation, such as the careful carrying of utensils and the gentle treatment of flowers. The child may also learn to distinguish between the scents of various articles and to judge of weight. In the course of these activities the children will add indefinitely to their stock of ideas and of words with which to express them. Closely associated with this aspect of education is the training in balance and equilibrium and in easy and graceful movements in walking; while a sense of rhythm may be fostered through music and dancing. Bad habits both in sitting and in moving, ungainly waddling and cramped postures, should be patiently corrected.

14. *Social Training.*—Much of the training above suggested will, no doubt, have to be accomplished with individuals taken alone or in small numbers together. But the Nursery School should afford scope also for social training; thus the children should be trained to eat properly and in general "to behave mannerly at table." They should assist in laying and clearing the table, and perhaps in some simple washing up. In the same way they can be enlisted in the service of keeping the rooms

tidy, and be taught to put away their playthings in the proper place. If it is rightly conducted, the whole trend of the Nursery School will be to accustom the children to attend to themselves, to fasten and unfasten clothes and boots without haste or carelessness, to keep themselves as well as their surroundings tidy and neat, and to take a pride in helping themselves and one another. Nor need it be feared that such a school will present the over-clean appearance of a too-strictly regulated institution.

Again, even young children can learn to share in games, to play together with common toys, sometimes the older with the younger, and sometimes the older by themselves. The importance of arousing a spirit of co-operation and of mutual help need not be here elaborated. This spirit is not inconsistent with the cultivation of a sense of ownership and of pride of possession; if each child not only has access to the common cupboard or shelves of playthings, but has a few of his own to use or to lend, or is given a plant to tend or duties which he alone is to perform, his personal interest in the school will be increased.

It will probably be found advisable to let occasions of collective work, in stories, games or music, succeed periods when children are left to play as their own choice dictates. Nothing pleases the average child better, after he has played alone with toys and his interest is exhausted, than to join his fellows in listening to a story, in singing or in a game. It is perhaps hardly necessary to say that a "Time-Table" is altogether out of place in these matters, and that the finish of a period of collective work should be determined when the children have obviously had enough. Specified times must of necessity be set for the beginning and end of the session, for meals, and for rest; but nothing more than these need be settled beforehand.

15. Definite and clearly conceived as the training in the Nursery School should be, it does not imply any formal classification. Strict adherence to an age basis in distributing children in classes should be avoided, for, as has already been said, one of the chief elements in the training of the children is the cultivation of the spirit of common play and mutual help, such as is found in every well-conducted household, and not least in families which do not contain nurseries. It is a good rather than a bad thing that the group of children under one teacher or assistant should consist of children of different ages. The child of two or three will not, of course, be able to join in all that children of four or five can do, but he will watch with interest and delight. Nor will he always follow the story to which the older ones will listen with eagerness, but he can be set free to wander and play on his own account. Older children, too, even if they have games and pursuits of their own, do not lose the power of enjoying the



simpler pursuits of their younger brothers and sisters. They will often become interested in the play of the younger children and will be delighted to help and amuse them.

#### ADMINISTRATIVE ARRANGEMENTS.

16. *Site, Premises, and Equipment.*—It is important that the site should be easy of access to the children's homes. It may, indeed, be argued that the healthy physical development of the children in large centres of population would best be secured by placing the school in some open locality away from congested areas, but the balance of advantage is in favour of the school being in close proximity to the children's homes. There are grave difficulties in the way of conveying children to a distant school; they could not ordinarily be accompanied by their elder brothers or sisters; mothers would lose touch with the school and the staff, and would be disinclined to allow their younger children to attend; and, in case of illness, serious difficulties might arise. For these reasons the Board would not, as a rule, be prepared to recognise a nursery school that was not situated within convenient walking distance of the children's homes. The necessity of crossing dangerous thoroughfares must, of course, be avoided.

17. In the choice of premises the following main considerations should be kept in view:—

(a) Some outdoor space in the form of a garden or yard is essential unless the school practically adjoins a park or other open space which can be used instead. Whenever possible, French windows opening direct from the rooms on to a verandah or the garden or yard should be arranged. In some cases it may be possible to provide a roof-playground if outdoor space cannot be obtained.

(b) The rooms should be arranged with a view to an all-day occupation; in each of the principal rooms not less than 12 to 15 square feet of floor space per child should be provided. Light and ventilation should receive special attention. A south or south-east aspect is desirable and open-air conditions should be aimed at throughout.

(c) The necessary accommodation should be available for the daily inspection of the children, for the preparation and service of meals (though a separate dining-room will not usually be needed), and for suitable arrangements for rest and sleep.

(d) Ample provision of cloakroom, lavatory basins, bathroom and sanitary conveniences, should be regarded as particularly important. The arrangements should be as simple and economical as possible, designed to permit of convenient super-

vision of very young children. Assuming a constant supply of hot water, one bath may suffice for, say, 50 children. For about the same number of children four sanitary conveniences should suffice, though in a larger school separate arrangements may be needed for boys of five or six years of age.

The necessary arrangements may be summarised as follows :—

*Lavatory.*—A row of basins ; if fixed they should be sufficiently low for the children to reach. Enamelled basins on a wooden bench answer satisfactorily if a low sink is provided for emptying. A separate numbered towel for each child, a tooth-brush and mug, and a comb are desirable.

*Bathroom.*—A small slipper bath raised above the ground is probably the most convenient.

*Sanitary Conveniences* should usually be provided within the building, or in any case connected with it by a covered way. They must be so arranged as to be easily supervised. Low washdown conveniences are suitable. They should be partially screened, so that the children cannot see one another, though the assistant can easily supervise them all.

*Cloakroom.*—It should be possible to dry wet clothing and shoes. Each child should have a separate numbered peg. Washable overalls and slippers may be provided, and are almost essential in wet weather.

19. The equipment of the children's rooms should be simple, and should include light tables and chairs (of appropriate size, weight, and form), washable rugs, stretcher beds, educational apparatus, and toys.

20. *The Size of a Nursery School.*—It is obvious that a nursery school should be small and homelike ; it should not be comparable in point of size to most departments of urban public elementary schools. About 40 children is probably the ideal number for a nursery school, but it may sometimes be necessary to provide for more than 40 if the needs of a district are to be at all adequately met. The Board will therefore not refuse to consider proposals for a nursery school providing for as many as 80 to 100 children ; but in no case should the number exceed 100.

21. *The Age of Admission and Leaving.*—Under Article 1 (b) of the Regulations a child may not be admitted before the age of two years ; but it is desirable that children should begin to attend the Nursery School soon after that age ; good habits are more easily formed and many ailments to which children are liable are more amenable to treatment at an early age. If a child is already in attendance at a Day Nursery, admission to a Nursery School may be deferred until it reaches the age of three years. The Board anticipate that for the present all

events, children will usually leave the Nursery School at the age of five, or more conveniently at the end of the term in which they attain that age. So long as five years remains the age at which compulsory attendance at school begins in an area, the transfer of children from a Nursery School at a later age would retard their progress and disturb the organisation of the Public Elementary School. Moreover, while the accommodation in Nursery Schools is limited, as it is likely to be for some time, the interests of the younger children should as a rule take precedence of the interests of children between the age of five and six. In exceptional circumstances, however, it will no doubt be desired to retain children over the age of five. Before assenting under Article 1 (b) to such retention the Board will require to be satisfied (1) that the Local Education Authority concur in the arrangement, (2) that the premises and staff are suitable for children over the age of five, and (3) that there are sufficient grounds for the application, *e.g.*, that the children are delicate or require special attention.

22. *Daily Routine*.—The usual hours of opening and closing the school should be respectively somewhat earlier and later than those of the Elementary School, so as to allow elder children to bring and fetch their younger brothers and sisters. Occupations should be both individual and collective. Children should be free to develop their own tastes and interests, but should also learn to associate with their companions and to control conduct likely to annoy others. They should be carefully trained to be self-reliant and to serve each other, sharing together in a love of persons and things; and an atmosphere of freedom, happiness, and mutual affection should be cultivated. The school should provide the child with a joyous experience in all relations, a simple, clean, and wholesome environment in which it can grow in sociability and naturalness. An essential condition of its success will be its homeliness and its retention of the loyalty and confidence of the mothers of the children. These conditions are intimately related to the health of the children.

23. Three of the most important physical advantages to secure in a Nursery School are: (a) *nutrition*—good food, fresh air, cleanliness, and healthy bodily habits; (b) *exercise*—by abundance of free play and informal exercise, and the avoidance of finely-adjusted movements; (c) *rest*—by requiring periods of rest in the horizontal attitude, by short and varied lessons, and by suitable chairs and apparatus, the use of which prevents strain or restlessness. The purpose of the school is not to teach “the three Rs,” but by sleep, food and play, to provide the opportunity for little children to lay the foundations of health, good habit, and a responsive and receptive personality.

Children should be bathed at least once a week. Heads should be combed regularly. The washing of heads, the cleansing of teeth, and the use of the offices must be closely supervised. The children should be trained in cleanly habits, but encouraged to assist themselves as far as possible.

27. Until further experience has been obtained, the Board do not think it desirable to attempt to prescribe a precise scale of staffing for Nursery Schools. They would expect, however, that a Nursery School containing 40-50 children would require the services of a superintendent, an experienced assistant, and a probationer. The number suggested would appear to be the minimum, regard having been had to the special care and attention that it will be necessary to give to children for whom Nursery Schools will be provided. In larger schools additional assistance would obviously be required.

28. Finally, it is a matter of the first importance to facilitate the free interchange of teachers between Nursery Schools and other schools; the creation of a separate caste of Nursery School teachers would be a matter of regret in the interests of the teaching profession. The Board have no doubt that Local Education Authorities and Managers will bear this in mind when considering the staffing of Nursery Schools, and will encourage persons in their employment to obtain, if they do not already possess, qualifications for work in elementary and other schools and departments for younger children.

29. *The Relation of Nursery Schools to other Institutions.*—It has hitherto been assumed for purposes of convenient description that the Nursery School or class will be a separate institution. Proposals may, however, be submitted for the recognition of Nursery Schools or classes which form a part of other organisations. It may, for instance, be desired to establish a Nursery School in the same premises as a Day Nursery or an Infant Department of a Public Elementary School. The considerations already mentioned would apply generally to any such proposal with any modifications required by the circumstances of each case. In the case of association with a Day Nursery, for instance, where the premises would be largely used in common, special importance would attach to the selection of a suitable person as Superintendent who could take charge of the whole Institution. The Board would be unwilling to recognise a Nursery School attached to a Day Nursery unless there were at least 20 children of two years old and upwards.

L. A. SELBY-BIGGE,

31st December 1918.

## APPENDIX V(B)

## MINISTRY OF HEALTH.

## MEMORANDUM IN REGARD TO DAY NURSERIES.

1. Day Nurseries are intended primarily to provide 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 or who are temporarily in distress; when circumstances permit, the Nurseries should also be available for the needs of mothers who, for domestic or other reasons, are temporarily unable to provide satisfactory care for their little children in their own homes, or with suitable relatives or friends, or with good foster-mothers. It is not intended to encourage the establishment or maintenance of Day Nurseries for children who do not come within any of the above categories.

2. Day Nurseries are most suitable for children under three years of age who mainly require special physical care and attention. Infants under nine months should not as a rule be admitted, unless it is shown that their mothers for good and sufficient reason are obliged to work or are unable to continue breast-feeding. Even when some hand-feeding is necessary partial breast-feeding should always be encouraged. Children over three years of age should attend a Nursery School instead of the Day Nursery whenever this is possible. If it is essential for them to remain at the Day Nursery, every endeavour should be made to provide for training in good habits and personal hygiene, and to accustom the children to help themselves and one another as much as practicable. When there are fifteen or more children over three in regular attendance at a Day Nursery, a teacher having kindergarten or nursery school experience should be engaged. Careful inquiries should be made into the home conditions of children who are admitted, with a view to ascertaining the reasons for admission to the Nursery, and the nature of the care available for the child in its own home. No child should be refused admission solely on grounds of illegitimacy. The number of children in a Day Nursery should normally be 30 to 35, though in exceptional circumstances as many as 50 might be accommodated.

3. A Day Nursery may be established and maintained either by a local authority or by a voluntary body; many of those maintained by voluntary bodies receive financial assistance from the local authority; this tends to secure close co-operation

between the local authority and the voluntary body, which is essential to the complete success of a general scheme for Maternity and Child Welfare. Whether the institution is maintained by the local authority or by a voluntary body, it is eminently desirable that it should have a Managing Committee containing voluntary workers and including working women. Their assistance, both on the Committee and in the practical work of the institution, creates an atmosphere of human sympathy and friendship which is eminently desirable. The value of disinterested work of this kind is immeasurable. But voluntary helpers will only be of use if they are competent, attend regularly, and have definite duties allotted to them.

4. The Ministry are aware that it is impracticable to require uniform conditions at all Nurseries, but they consider that a minimum standard of efficiency must be secured, and the following points should be borne in mind in the organisation and conduct of a Nursery :—

(a) Provision should be made for the medical supervision of all infants and young children on admission to the Nursery, and for their examination when necessary. The Medical Officer should be suitably remunerated, and should be appointed to visit the Nursery at frequent intervals. His or her services should also be available at other times in case of emergency. The frequency with which individual children should be examined by the Medical Officer will depend on the state of their health. The Medical Officer should be responsible for arrangements for the feeding and physical care of the children. Daily watch should also be kept over the physical condition of the children in order to deal promptly with any case of illness or possible infectious disease. While much of this work will necessarily be undertaken by the Matron, it should all be subject to the control of the Medical Officer, and under the general supervision of the Medical Officer of Health.

(b) It is essential that the Matron should be adequately trained. For all new appointments, a woman should be selected who has had definite training and experience in the care of healthy children, and either full training in a general or children's hospital, or such training and experience in infantile ailments as will enable her readily to detect the first symptoms of infectious disease. She should also have had satisfactory experience of work in a Day Nursery. Some knowledge of house-keeping is important. A house committee to supervise the domestic arrangements is advisable. Besides the Matron, at least one person will be required, even in a small Nursery, who is competent to assume responsibility

in the temporary absence of the Matron. The number of probationers or other assistants required will depend on the number of children admitted. It will usually be found that not less than one nursery-trained assistant in addition to the Matron is needed for every 8-10 children under two years of age; a nursery-trained assistant and probationer for 15-20 children; a nursery-trained assistant and two probationers for 25 children. Domestic assistance will also be required.

(c) Adequate provision should be made for the suitable feeding of the infants and young children attending the Nursery. The food provided should be appropriate to the varying needs of the children; this is of special importance where the child is suffering from malnutrition. Separate diet sheets should be kept for infants under 12 months and for older children. There should be a daily record of the dinner actually given.

(d) If any child attending a Day Nursery is found to be insufficiently nourished, arrangements should be made to secure that it is supplied with sufficient pure milk and with such other foods as the Medical Officer prescribes for it, not only during the time of its attendance at the Nursery, but also while it is at home. Local authorities are empowered, with the sanction of the Ministry, to supply milk and other food to children under five either at cost price, or, where the parents cannot afford to pay full cost, at such price as they can afford. Most authorities carrying out Maternity and Child Welfare Schemes have arranged for a supply of milk for children under five, and any child attending a Day Nursery who is found to be insufficiently nourished at home should be referred to the Health Visitor or to the Medical Officer of Health of the district, who should take such steps as may be necessary to rectify any errors or neglect. The actual distribution of the milk can often be conveniently arranged through the Nursery.

(e) Since a large amount of sleep is essential to the well-being and progress of children of this age, adequate opportunities should be afforded the children for sleeping under healthy conditions. They should be taken into the open air as much as possible. Attention should also be paid to the training of the children in the elementary rules of health and conduct. The importance of a high standard of cleanliness should not be overlooked. The organisation of the children's play will require consideration.

(f) Children of tender age are specially susceptible to measles and certain other forms of epidemic disease, and the greatest care must be exercised to prevent the admission to the Nursery of any child who is suspected of suffering from any infectious or contagious disease, and at times the temporary closure of

the Nursery may be found essential. Every closure of a Nursery, whether for infectious disease or other cause, should be reported to the Ministry. Every child should be seen by a responsible person daily on arrival. The rules for controlling infectious diseases should be approved by the Medical Officer of Health. Arrangements should be made to store separately and to disinfect the clothes of the children and to provide them with special clothes to wear while at the Nursery. From time to time the disinfection of the whole premises will be desirable.

(g) As a general rule, all children under two years of age should be bathed daily and dressed in Nursery clothes. Children over two should be bathed daily when necessary, and in any case two or three times a week. Separate towels, flannels, etc., should be provided for all children, and older children should be taught the regular use of the tooth-brush.

(h) The character of the accommodation required will vary with the number and ages of the children admitted, but it should normally include (i.) at least two nurseries, one for infants and one for young children; (ii.) suitable provision for receiving and bathing the children and for keeping their clothes; (iii.) a kitchen and larder; (iv.) a milk larder and safe, and place for the preparation of bottles; (v.) proper sanitary arrangements for the children; (vi.) adequate provision for daily laundry and keeping soiled garments; (vii.) provision for heating water separate from that for cooking; (viii.) accommodation for the staff; and (ix.) a small isolation room. Proper arrangements should be made for safety, and for ready evacuation of the premises, in case of fire, and the efficiency of these arrangements should be subjected to frequent tests. Some space in the open air, where children can play, should be provided, and an open-air playground will be required in the case of the nurseries seeking recognition in future. The Medical Officer of Health of the local authority carrying out the Maternity and Child Welfare Scheme for the district should be consulted, in the case of a voluntary nursery, as to the accommodation to be provided, and the maximum number of children to be admitted. Provision should be made for mothers who come to nurse their infants.

(i) Steps should be taken by home visiting or other means to secure that only those children are admitted for whom adequate care cannot be provided in their home by reason of the unavoidable absence of the mother. The necessary home visiting may be done by the Health Visitor of the district, who should be in close touch with the Day Nursery. Day Nurseries ought not to provide for children whose mothers



might reasonably be expected themselves to bestow on them the necessary care and attention.

(j) Accurate records, including a register of attendance, must always be kept. The records kept by the Nursery should include information as to the home circumstances of the child, and the grounds on which it was considered suitable for admission. A note should be kept of the extent to which the children attending the Nursery have suffered from measles or other forms of epidemic disease. All infants under one year should be weighed weekly, and the weights recorded. Older children should be weighed from time to time and a note made of their progress, together with observations of the Medical Officer on their physical condition. Records should be placed at the disposal of the School Medical Officer when the child is of age to enter school.

(k) In some cases it may be possible for a Day Nursery to retain a certain number of children by night as well as by day for a short period, as a temporary measure, when this is made necessary by the illness of the mother or some similar reason. Such children should not usually be retained for more than one or two weeks, and the period of residence should not exceed a month unless the circumstances are exceptional. There should be no attempt to utilise Day Nurseries as residential institutions. Special approval of the Ministry is required for the admission of resident children, and will only be given if suitable night nurseries are available and if there are adequate facilities for play and exercise in the open air. Separate records should be kept of all resident children, stating the reason for admission as residents and the period of stay.

(l) In some districts Homes have been established for children under five whose parents are temporarily unable to keep them properly at their own homes, and such institutions may be found more suitable than a Day Nursery for the retention of such children. Neither a home for children nor a resident Day Nursery should be regarded as affording a satisfactory permanent home for children under five, who should be brought up in circumstances approximating as closely as possible to home and family life.

(m) Where two or more Nurseries exist in the same neighbourhood, the areas which they serve should be defined, or other steps taken to prevent overlapping. Close co-operation is desirable with institutions dealing with Infant Welfare in the neighbourhood. Infant Welfare Centres will often be able to supply information as to suitable cases for admission to the Nursery, and the Nursery may also in different ways be able to afford useful assistance to the Centres. Where a

Treatment Centre or Infant Dispensary exists, arrangements may advantageously be made for that institution to deal with cases requiring specific medical or surgical treatment. No child who is definitely ill should be admitted to a Day Nursery. Children suffering from malnutrition or simple non-infective ailments may be admitted temporarily, but if after a period of observation their condition does not improve they should, if possible, be transferred to a hospital. Hospitals for ailing children have been established in many districts, and arrangements might be made through the Medical Officer of Health for the admission of ailing children into these pending their sufficient recovery for acceptance in the Nursery.

MINISTRY OF HEALTH,  
WHITEHALL, S.W.1,  
*November 1919.*

## APPENDIX VI(A)

### SCHEME FOR A TRAINED MIDWIFERY SERVICE IN THE DURHAM COUNTY

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COUNTY COUNCIL OF DURHAM.

#### REPORT OF THE COUNTY MEDICAL OFFICER ON A COUNTY TRAINED MIDWIFERY SERVICE.

At the last meeting of the County Maternity and Child Welfare Committee, I pointed out that many trained midwives under existing conditions were unable to earn a living wage, and that the scheme of the County Council for subsidising trained midwives appointed by them does not provide adequate remuneration in most cases. By that scheme the Council undertakes under certain conditions to pay a subsidy of £30 per annum to an approved trained midwife, provided her total income from midwifery, including the subsidy, does not exceed £80 per annum, the amount of subsidy payable decreasing in proportion as the midwifery fees exceed £50, so that as soon as a midwife's earnings reach £80 per annum, the subsidy from the County Council ceases. Your Committee then instructed me to prepare a scheme for securing satisfactory remuneration to approved trained midwives. I would point out that since the present county midwifery scheme was adopted, the Local Government Board has issued an important circular, dated 9th August 1918, with regard to the provision of midwives and grants in aid thereof, and the position has been further modified by the passing of the Midwives Act, 1918, which came into operation on the 1st January of this year. The Local Government Board in their circular state that it is important that the status of midwives should be raised, and that competent trained women, who devote themselves to the service should be adequately remunerated, and that

a competent trained midwife, devoting her whole time to the work, should be able to secure at the present time an income of from £120 to £150 a year.

The Board in their circular also make the following remarks which have an important bearing on the matter:—"In cases in which a council provide or arrange for a general midwifery service, they should fix a scale of fees, but these may be reduced or remitted in individual cases, where the circumstances justify this course. In so far as the fees received do not meet the cost of this service, the Board are prepared, subject to their prior approval of any scheme, to find one-half of the deficiency." . . . "In all cases the grant in respect of midwifery will be subject to the following conditions:—(1) that the Board are satisfied that the midwife is competent, (2) that her services are available in respect of all women who need them, and (3) that the ordinary fee of the district is charged, and that it is only reduced or remitted where the circumstances of the case justify the adoption of this course."

I need not in this report refer to the present position of the midwifery service in the administrative county, as this was indicated in my reports to the Council of July 1917, and July 1918, except to say that it is quite inadequate, and in the interests of the mother and infant, urgently needs improvement.

After careful consideration of the matter I put forward the following recommendations:—

(1) The County Council should guarantee to every approved trained midwife devoting her whole time to the work of midwifery a salary of £120 per annum.

(2) In addition such midwife to be guaranteed a bonus of 4s. per case up to 150 cases per annum. This bonus would ensure that a midwife attending 150 cases per annum would have a total income of £150, and would be an inducement to the midwife to increase the number of her patients.

(3) The midwife, except in strictly necessitous cases, to charge a fee of 10s. 6d. for each confinement, which it will be her duty to collect and which will be set against the income guaranteed by the Council.

(4) The midwife to attend all women who need her services within the area in which she practises.

(5) The midwife to attend as a maternity nurse under a medical practitioner when her services are so required and to charge a minimum fee of 5s. for such services, the Council's bonus of 4s. being also payable in respect of each such case.

(6) The midwife to act under the directions of the County Medical Officer and to co-operate with the Maternity and Child Welfare Centre of the district in which she practises, so

far as the interests of the mothers and infants under her care require it.

(7) The midwife to be allowed two weeks' holiday each year, and to at once report absence from duty owing to illness or other cause to the County Medical Officer.

(8) An agreement embodying the above and any other necessary conditions to be entered into between the County Council and the midwife, renewable annually and determinable at any time in case of negligence, incompetence or misconduct on the part of the midwife.

The consent of the Local Government Board would have to be obtained to any such scheme as I have outlined, it being understood that the Board would pay a grant of 50 per cent. of the cost incurred by the County Council.

With regard to No. 3 of my recommendations, it may be reasonably urged that 10s. 6d. is an insufficient fee for the services of a trained midwife, and that such fee should be fixed at £1, 1s. 0d. I have given this matter very careful consideration, and I am inclined to think that in practice the smaller fee, having regard to the conditions prevailing in this county, will be more satisfactory. If a fee of £1, 1s. 0d. were charged, I am satisfied that many women would refrain from engaging a trained midwife, and would continue the present unsatisfactory practice of engaging the handywoman to look after her during the lying-in period, and relying on the doctor to attend when required. Moreover, many untrained midwives are satisfied with a fee of 10s. 6d., and if the trained midwife was required to charge a considerably higher fee, she would be placed under an unfair handicap in competing with these untrained women.

It is possible that there are a few trained midwives in the county earning a larger income than they would be likely to obtain under the salary and bonus scheme suggested in this report, and some of these midwives also charge a higher fee than 10s. 6d. In cases where such midwives are likely to be brought into competition with women appointed under the county scheme this difficulty could be overcome by the Council agreeing to their charging the county fee and paying them the difference between that fee and the higher fee they had been charging. Any such arrangement would, however, be dependent on their complying with the other conditions to be observed by the trained midwives appointed by the Council.

With the object of encouraging the trained midwife to give the necessary attention to ante-natal conditions, I suggest that a small fee of, say, 5s., should be payable by the Council, but this fee should only apply to those cases when the midwife has been engaged for the confinement at least three months before

it is expected, and has complied with other necessary conditions, such as co-operation with the Welfare Medical Officer or other medical practitioner when medical advice was required.

As regards the cost of an adequate trained midwifery service to cover the whole county, one may estimate the total births under normal conditions at 28,000 per annum. Under any circumstances, probably not less than 30 per cent. of the births will always be attended by medical practitioners. Up to the present less than 25 per cent. of the births in this county are attended by certified midwives. The practice of midwifery by the untrained certified midwives is annually decreasing, but it will probably be some years before 50 per cent. of the births are attended by trained midwives. On the basis, however, of 50 per cent. of the births being attended by trained women, this would represent 14,000 births annually which would necessitate the employment of the full-time services of approximately 100 trained midwives.

At the present time less than 60 trained midwives are practising in the administrative county, and the majority of these are not earning an adequate income. The cost to the Council of 100 trained midwives guaranteed a salary and bonus as recommended in this report would be somewhere about £15,000 per annum. Against this would be set the fees earned by these midwives, which, assuming each midwife attended 150 cases at a fee of 10s. 6d. per case, would reduce the amount by £7875, but as many of the midwives would at first not be fully employed, the income from the fees would be considerably below that sum for the next few years, and probably would not exceed £4000 during the first year, though gradually increasing in subsequent years. The total fees proposed to be paid to midwives for ante-natal work would not be large, probably not exceeding £500 per annum, and I am inclined to the opinion that during the first three years of the scheme the total cost, after deducting the fees received, would be about £11,000 per annum. From this would be deducted the grant from the Local Government Board estimated at 50 per cent. of the net cost, so that the charge on the county rates would be approximately £5500 per annum.

Under the Midwives Act, 1918, there will be an additional charge on the county rates, as the Council are required to pay (1) the fees of medical practitioners called in by midwives in any emergency; (2) increased contributions to the expenses of the Central Midwives Board; (3) for all forms and books which midwives are required to fill up and use as well as all postages of forms, etc., required to be forwarded to the Council. I am afraid there is very little hope that the majority of the fees to

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be paid to medical practitioners called in by midwives will be recoverable from the patients.

Further, any complete midwifery scheme will impose financial obligations in the Council in connection with the provision of accommodation in hospitals and lying-in-homes for diseases and complications associated with pregnancy both in the mothers and infants, as well as provision for a certain number of normal cases, such as, for instance, women whose home conditions are insanitary or otherwise unsuitable.

Part of the cost of any scheme for providing "Home Helps" would also have to be allocated to the County Midwifery Scheme, and it appears to be probable that the net cost to the County of a complete scheme would at no distant date total £10,000 per annum. Admittedly this is a very large outlay, but I am fully satisfied that the saving of life and the prevention of disease and suffering which would result would be worth many times that sum.

The relative roles of the County Council and the County Nursing Association in providing a County Midwifery Service require to be definitely settled. It will be remembered that one of the objects of the Association is to assist in the provision of a midwifery service for the administrative county, and to some extent the County Midwives Committee and the County Maternity and Child Welfare Committee agreed that the provision of trained midwives should be referred to the County Association. I am inclined to think, however, that, having regard to the increased powers and responsibilities placed on County Councils under the new Midwives Act and the regulations of the Local Government Board, the Council should not altogether rely on the County Nursing Association to train and provide the necessary midwives, but should proceed with a scheme as suggested in this report. The County Council should work in close conjunction with the Nursing Association, and should give substantial financial assistance to affiliated District Nursing Associations providing nurse-midwives on the lines already approved by the Council and the Association. Some time must, however, elapse before an adequate number of nurse-midwives can be trained and provided by the County Association, and moreover some of the existing District Nursing Associations are averse from employing a midwife even in districts where one is urgently needed. Further, the County Nursing Association has not so fully at its disposal expert medical advice which is needed in organising a complete county midwifery service, and I recommend, therefore, that the County Council should proceed to provide trained midwives in districts needing them where such provision is not likely to be made in the immediate future by

the Nursing Association. The Association will, it is to be hoped, proceed at once with a scheme for training county midwives and a condition might be included in any agreement of service between a midwife and the County Council that any such midwife should, if required, act as the midwife of a nursing association covering the district in which she practises and be responsible to that body, subject to the requirements of the Midwives Acts.

In the event of the County Council deciding to proceed with a scheme for providing a trained midwifery service for their area, I wish to appeal to the medical profession in the county to give it their whole-hearted support, without which it cannot be a complete success. Many medical practitioners who during the last few years have had an opportunity of judging the work accomplished by competent trained midwives have expressed to me their appreciation of such women who, with very few exceptions, may be regarded not as competitors of the doctor, but as co-operators, relieving him of much routine work at inconvenient hours. The midwife is required by law to call in the doctor on many occasions, and the more competent she is the more she will desire his help in difficulty. It is up to the doctor to respond with proper spirit, and to assist in promoting the welfare of a body of women who work under arduous conditions, often of considerable responsibility, for a very small remuneration. Moreover, the doctor can, if he so desires, put a stop to practice by unqualified women in his district, and thus free the competent midwife from a very unfair competitor. A condition to be imposed on the midwife would be that in advising the calling in of medical aid for a patient, she must in all cases fill in on the requisite form the name of the medical man who is the recognised medical attendant of the patient.

I think it is probable that the payment of the fees on the scale laid down by the Local Government Board to doctors called in by midwives in emergency cases will lead to an increase in the practice of certified midwives, for the doctor will realise that in many cases he will obtain a higher fee when called in by a midwife than if he was himself engaged for the confinement, and he will, therefore, be inclined to refer a larger proportion of cases to the midwife.

T. EUSTACE HILL.

County Health Department,  
Shire Hall, Durham,  
14th January 1919.

*Note (Jan. 1920).*—At a later meeting the scheme for the County Trained Midwifery Service was passed by the County Council. At the suggestion of the Medical Officer it was agreed



that where a whole-time midwife was appointed by a Nursing Association with the approval of the County Council, any deficit incurred should be met by the County Council, provided that the same fee for midwifery was charged as under the County scheme. Also, in respect of nurse-midwives appointed under similar approval, the Council would pay a grant of £30 per annum or 10s. 6d. a case, whichever were the greater, similar provision being made as above in respect of the fee charged.

The scheme has been approved by the Ministry of Health.

## APPENDIX VI(B)

### SCHEME OF PAYMENTS AND PENSIONS FOR MIDWIVES IN HERTFORDSHIRE

.....NURSING ASSOCIATION.  
(Affiliated to the Hertfordshire County Nursing Association.)

MEMORANDUM OF AN AGREEMENT made the  
day of                      one thousand nine hundred and  
BETWEEN                                      of                                      in the  
County of                                      (hereinafter called "the Nurse") of the  
one part and the                                      NURSING ASSOCIATION (here-  
inafter called "the Association") by                                      Secretary  
of the                                      Association of the other part whereby it  
is agreed as follows:—

#### THE NURSE AGREES WITH THE ASSOCIATION.

1. That she will at all times punctually observe and carry out all the Rules and Regulations of the Association for the time being in force.
2. That she will always see that the directions of the medical man in charge of the respective cases are carried out, and further, that she will be responsible to the Committee for the proper nursing and prescribed treatment of every case attended by her.
3. That she will faithfully carry out the duties of Village Nurse, Midwife, School Nurse, Tuberculosis Nurse and Health Visitor.
4. That she will be responsible to the Committee for all appliances and garments lent to patients being returned in good order.

5. In consideration of the Association taking the Nurse into their employment the Nurse agrees that she will not without the consent in writing of the Association under the hand of their Secretary for a period of five years after she has left the service of the Association act as Village Nurse, Tuberculosis Nurse, District Nurse, Health Visitor, School Nurse, Midwife, or Maternity Nurse within the district of \_\_\_\_\_ or within five miles therefrom.

THE ASSOCIATION AGREES WITH THE NURSE.

1. To give her an annual salary of £ \_\_\_\_\_ rising by annual increments of £ \_\_\_\_\_ to a maximum salary of £ \_\_\_\_\_ and an allowance of \_\_\_\_\_ per week for board, lodgings, and laundry, and to pay £5 per annum for uniform in accordance with the terms set out in the Schedule [see Grade \_\_\_\_\_ Class \_\_\_\_\_] and to pay her travelling expenses (if any) in connection with her duties as Nurse.

2. To allow her one calendar month's holiday in the year, and to be off duty from 2 p.m. on Saturday till 10 a.m. on Monday once a month with the exception of the month of holiday, provided the cases allow of her absence.

3. In the event of illness to allow her for one month her full salary, and after the expiration of that time, should the illness continue, her case will be considered by the Committee as to whether the whole or any part of her salary should be paid for any and if so what longer period. She is to receive in addition any benefit due to her under the Insurance Act.

PROVIDED ALWAYS:

That if the Nurse is guilty of misconduct or neglect of duty she may immediately be suspended by the Chairman or Hon. Secretary of the Committee, and the Committee, if satisfied of such neglect or misconduct, may summarily dismiss the Nurse, and she shall forthwith leave the Association.

That this engagement may be determined by one calendar month's previous notice in writing on either side expiring at any time or in the event of misconduct on the part of the Nurse at any time without notice.

AS WITNESS the hands of the said parties hereto  
the day and year above-mentioned.

WITNESS to the signature of the above-mentioned.

WITNESS to the signature of the above-mentioned.

6d. Stamp.

## HERTFORDSHIRE COUNTY NURSING ASSOCIATION.

MEMORANDUM OF A SCHEME passed at a Meeting of the General County Committee held at 20 Arlington Street on Thursday, 3rd October 1918, for equalising and putting on an increasing scale the salaries of Queen's Nurses, Midwives, and Village Nurse-Midwives employed by Associations affiliated to the County Nursing Association.

## THE NURSES ARE DIVIDED INTO FOUR GRADES.

These Grades are again divided in Classes :—

## GRADE I.—VILLAGE NURSE-MIDWIVES (THREE CLASSES).

- (A) Population under 1000.  
 (B) Ditto, over 1000 and under 2000.  
 (C) Ditto, over 2000 and under 3000.

## GRADE II.—MIDWIVES WORKING IN ASSOCIATIONS EMPLOYING QUEEN'S NURSES.

- (A) Population under 3000.  
 (B) Ditto, over 5000.

## GRADE III.—QUEEN'S NURSES.

- (A) Population under 3000.  
 (B) Ditto, over 3000 and under 5000.  
 (C) Ditto, over 5000.

## GRADE IV.—THE STAFF OF THE TRAINING HOME AT WATFORD.

The Matron and Three Staff Nurses.

## SCHEDULES OF SALARIES AND ALLOWANCES.

## Village Nurse-Midwives.

## GRADE I.—CLASS A.—POPULATION UNDER 1000.

|   |       |   |       |
|---|-------|---|-------|
| Salary—minimum                                      | £20 0 | rising by annual increment of £2, 10s. to—maximum | £30 0 |
| Board, Lodging and Laundry Allowance at £1 per week | 52 0  |   | 52 0  |
| Uniform   | 5 0   |   | 5 0   |
|   | 77 0  |   | 87 0  |
| War Bonus, £1 per month                             | 12 0  | Five years' service                               | 12 0  |
|   | £89 0 |   | £99 0 |

N.B.—The Nurse under agreement to County Nursing Association for her training to be at the minimum for the first 2½ years, and then to receive increment of £7, 10s.

## GRADE I.—CLASS B.—POPULATION OVER 1000 AND UNDER 2000.

|   |       |                              |        |
|---|-------|------------------------------|--------|
| Salary—minimum                                      | £25 0 | rising £2, 10s. per annum to |        |
|   |       | —maximum of                  | £40 0  |
| Board, Lodging and Laundry Allowance at £1 per week | 52 0  |                              | 52 0   |
| Uniform £5  | 5 0   |                              | 5 0    |
|   | 52 0  |                              | 97 0   |
| War Bonus, £1 per month                             | 12 0  | Six years' service           | 12 0   |
|   | £94 0 |                              | £109 0 |

N.B.—The Nurse under agreement to County Nursing Association to start at minimum salary, £20, for first 2½ years, and then to receive increment of £10.

## GRADE I.—CLASS C.—POPULATION OVER 2000 AND UNDER 3000.

|   |         |                              |         |
|---|---------|------------------------------|---------|
| Salary—minimum  | £30 0   | rising by £2, 10s. per annum |         |
|   |         | to—maximum                   | £45 0   |
| Board, Lodging, and Laundry allowance at £1, 3s. per week | 59 16   |                              | 59 16   |
| Uniform   | 5 0     |                              | 5 0     |
|   | 94 16   |                              | 109 16  |
| War Bonus, £1 per month                                   | 12 0    | Six years' service           | 12 0    |
|   | £106 16 |                              | £121 16 |

N.B.—The Nurse under agreement to County Nursing Association to start at minimum salary, £20, for first 2½ years, and then to receive increment of £12.

## Midwives working in Associations employing Queen's Nurses.

## GRADE II.—CLASS A.—POPULATION UNDER 5000.

|   |         |                               |         |
|---|---------|-------------------------------|---------|
| Salary—minimum  | £30 0   | rising by annual increment of |         |
|   |         | £3 for six years, and one     |         |
|   |         | year £2 to—maximum            | £50 0   |
| Uniform   | 5 0     |                               | 5 0     |
| Allowance of £1, 3s. per week for Board, Lodging, and Laundry | 59 16   |                               | 59 16   |
|   | 94 16   |                               | 114 16  |
| War Bonus, £1 per month                                       | 12 0    | Seven years' service          | 12 0    |
|   | £106 16 |                               | £126 16 |

N.B.—If more than one Nurse living in the house, the allowance to be reduced to £1 per week each. The Nurse under agreement to County Nursing Association for her training to start at minimum salary of £20 for first 2½ years, and then to receive increment of £12.

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### GRADE II.—CLASS B.—POPULATION OVER 5000.

|   |                |   |                |
|---|----------------|---|----------------|
| Salary—minimum  | £40 0          | rising by annual increment<br>of £3 for six years, and £2<br>for one year | £60 0          |
| Uniform   | 5 0            |   | 5 0            |
| Allowance of £1, 3s. per week<br>for Board, Lodging, and<br>Washing | 59 16          |   | 59 16          |
|   | <u>104 16</u>  |   | <u>124 16</u>  |
| War Bonus, £1 per month   | 12 0           | Seven years' service  | 12 0           |
|   | <u>£116 16</u> |   | <u>£136 16</u> |

N.B.—If more than one Nurse living in the house, the allowance to be reduced to £1 per week each. The Nurse under agreement to County Nursing Association to start at minimum salary of £20 for first 2½ years, and then to receive an increment of £15 first year and £5 second, bringing total to £40, after to rise £3 per annum to £60.

### Queen's Nurses.

#### GRADE III.—CLASS A.—POPULATION UNDER 3000.

|   |                |                                       |                |
|---|----------------|---------------------------------------|----------------|
| Salary—minimum  | £40 0          | rising by £5 per annum to—<br>maximum | £55 0          |
| Allowance for Board, Lodg-<br>ings, and Laundry, of<br>£1, 3s. per week | 59 16          |                                       | 59 16          |
| Uniform   | 5 0            |                                       | 5 0            |
|   | <u>104 16</u>  | Three years' service                  | 119 16         |
| War Bonus, £1 per month   | 12 0           |                                       | 12 0           |
|   | <u>£116 16</u> |                                       | <u>£131 16</u> |

#### GRADE III.—CLASS B.—POPULATION OVER 3000 AND UNDER 5000.

|   |                |   |                |
|---|----------------|---|----------------|
| Salary—minimum  | £45 0          | rising by annual increment<br>£5 to—maximum | £70 0          |
| Allowance for Board, Lodg-<br>ings, and Laundry, at<br>£1, 3s. per week | 59 16          |   | 59 16          |
| Uniform   | 5 0            |   | 5 0            |
|   | <u>109 16</u>  | Five years' service                         | 134 16         |
| War Bonus, £1 per month   | 12 0           |   | 12 0           |
|   | <u>£121 16</u> |   | <u>£146 16</u> |

N.B.—If more than one Nurse living in the house, the allowance to be reduced to £1 per week.

## GRADE III.—CLASS C.—POPULATION OVER 5000.

|  |         |                            |         |
|--|---------|----------------------------|---------|
| Salary—minimum   | £50 0   | rising by £5 per annum to— |         |
| Allowance for Board, Lodging, and Laundry, at £1, 3s. per week | 59 16   | maximum                    | £80 0   |
| Uniform  | 5 0     |                            | 5 0     |
|  | 114 16  | Seven years' service       | 144 16  |
| War Bonus, £1 per month  | 12 0    |                            | 12 0    |
|  | £126 16 |                            | £156 16 |

N.B.—If more than one Nurse living in the house the allowance to be reduced to £1 per week.

## GRADE IV.—WATFORD TRAINING HOME.

|  |       |   |        |
|--|-------|---|--------|
| Matron's Salary—minimum<br>(All found in Home) | £75 0 | rising by annual increment,<br>£10 first two years and £5<br>after to five years' service | £110 0 |
| Staff Nurse's Salary<br>(All found)            | 50 0  | rising by annual increments<br>of £5 to<br>(Seven years' service)                         | 85 0   |

N.B.—Allowance to be given during holidays for Board and Laundry, £1 per week.

Uniform allowance of £5.

Pupils' allowance to be 10s. a month.

1. All Village Nurse-Midwives while under agreement to the County Nursing Association for their training to receive a uniform salary of £20 and allowances according to scale of Grade and Class and Population in which they are employed, i.e., if practising as midwife in a town under an Association employing a Queen's Nurse, or acting as Village Nurse-Midwife in a single district. At the termination of this 2½ years' service the increment will vary according to the Grade or Class of Population as set forth in the Schedule.

2. The War Bonus of £1 per month to be given to all Nurses working in affiliated Associations from 1st October 1918. Such bonus to remain in force for the period of the war and for six months after.

3. The first annual increment to be given as from April 1919, to all Queen's Nurses, Midwives, and Village Nurse-Midwives who are out of agreement to the County Nursing Association.

4. Should a Nurse move from one Association to another in the County she should receive salary in accordance with the number of years she has served in the County Association, and not have to start again at the minimum.

5. The Nurses will continue to receive their premiums paid on the policies under the Pensions Scheme without relation to the increased salaries.

6. It is suggested that instead of actually giving the Nurses £5 for uniform, they should submit the bills for payment by the Committee provided they did not exceed £5 in any one year.

Further, there is a Pension Scheme for Midwives given below which makes the salary of greater value.

The deficit on the workings of certain Associations, whose

local conditions render it impossible to maintain the nurse-midwife there, are paid by the Hertfordshire County Council, in order that the provision of midwifery may be assured in those areas.

#### SCHEME FOR PENSIONS FOR NURSES AND MIDWIVES.

At a Meeting of the General County Committee held on Thursday, May 10th, 1917, at St. Albans, the following resolution was passed unanimously :—

“That this Committee is in favour of the Scheme for providing Pensions for Nurses employed by the County Association and its Affiliated Associations as submitted to this Meeting.”

There were 17 representatives of Local Associations present, and 13 who were unable to attend had already signified their approval of the Scheme by letter. Fourteen other members of the County Committee were also present and approved the Scheme, and several wrote expressing their regret at being unable to come, but giving it their cordial support and sympathy.

The Scheme suggested to the Meeting was explained by Sir Charles Longmore, and is as follows :—

The Executive Committee have had under consideration a Scheme for Pensions for Nurses, suggested to them by the County Superintendent; an extract from her memorandum is as follows :—

(1) “For some years past (even before the war) it has been increasingly difficult to obtain Nurses for district work, either the full trained Queen’s Nurses or the Village Nurse-Midwives. What happens is they do the term of years they are bound for by agreement and then leave to take up private nursing or to obtain posts as health visitors. The average stay of district nurses in Hertfordshire during the past ten years has been : Queen’s Nurses, one year and one month ; Village Nurses two years and five months.

(2) “The salaries of these women are not as good as domestic servants, yet they are asked to undertake work that requires skill and involves the lives of both mothers and infants, entirely relying upon their own knowledge as to when it is necessary to send for a doctor and being ready to act with promptness till he arrives; this is a heavy responsibility, and women so employed should receive adequate pay. The minimum salary of a Queen’s Nurse is £35, rising to £40 and all found, or £100 rising to £105 inclusive. The Village Nurse £15 and maximum £25 to £30, or £75 to £80 inclusive, when

out of agreement. I know these salaries are higher than in most counties, but the Nurse has to buy her own clothes, boots, etc., pay the expenses of a holiday and sundry small items; there can be very little, if any, left to save for her old age. Also in many cases I have known the Nurse has a mother or some other relative to help. Since the war most of the Nurses' salaries have been raised to meet the increased cost of living, but this does not make them really better off."

(3) "It is on account of this low pay that the best women do not take up the work and also because there is no future in it. If they were certain of a pension as in the Post Office, or School Teaching Profession, I feel sure women would come forward and do the work and stay in their districts."

(4) "Again, because of the low pay Nurses make little or no attempt to save; but if their employment carried a pension they would be encouraged to try and save in order to increase that Pension."

The Committee have gone very carefully into the question, and are of opinion that it is desirable in the interests of the District Nursing of the future that a Pension in some form should be provided for the Nurses in order to maintain the supply, and if possible to keep the better and more educated class of women practising as midwives. With this end in view, they beg to submit the following proposals for the consideration of your Local Nursing Association's Committee:—

(1) That all Nurses employed by the County Nursing Association and its Affiliated Associations should have a Pension of £15 per annum, payable at 60. The County Association to pay half and the Local Associations pay the other half. This would mean an annual payment of £3, 9s. 6d. for each Nurse for each Local Association. The estimated cost of the whole Scheme for the first year is £523, 16s. 0d. The County Association will find £261, 18s. 0d., and the Local Associations the remainder. This is in practical figures an addition of £6, 10s. per annum in salary for every Nurse. The sum would, of course, vary with the number and ages of the Nurses to be insured each year.

(2) That every Nurse must give one year's satisfactory service in the County before a policy is taken out in her name.

(3) The Pension Scheme to be carried out through the Royal National Pensions' Fund for Nurses. The Premiums will be paid wholly by the two Committees so long as the Nurse works in the County; though the Policy will be assigned to the Nurse after five years' service, but she will not be able to obtain the surrender value for a further period of 12 months after leaving the County. If she wishes she can continue



## 302 THE CHILD WELFARE MOVEMENT

paying the Premium herself. Nurses coming into the County will be insured at the end of their first year provided they are satisfactory and likely to remain.

(4) The Committee may assign a Nurse her policy or its surrender value before the five years are complete should special circumstances render it desirable.

We appeal to the people of the County to help us to carry out this Scheme for the benefit of women who devote their lives to work which is of such vital importance to the nation at the present time. We know it may be urged this is not the time to ask for money for such an object; but the need is urgent if midwives are to be kept at their valuable calling and not leave to take up less responsible and more highly paid work elsewhere, and the question is one, therefore, which calls for some immediate action.

(Signed) ALICE SALISBURY,  
*President and Chairman of the Executive Committee.*

## APPENDIX VII

### HOUSING AND SANITARY CONDITIONS IN RELATION TO MORTALITY RATES IN BIRMINGHAM

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#### THE HOUSING QUESTION.

EXTRACT FROM THE ANNUAL REPORT OF THE MEDICAL OFFICER OF HEALTH, 1918.

My object in submitting certain recommendations now rather than waiting till a later date is twofold :—

(1) If what I consider necessary is to be accomplished, the work of getting additional local Parliamentary powers should be commenced soon, and

(2) the Government by their Housing and Town Planning Bill of 1919 propose to give to local authorities power to carry out schemes under Parts I. and II. of the Act of 1890, which schemes may be included with those for which financial assistance from the Treasury may be obtained. It is true that the wording of the Section of the Act is not very definite, but apparently the Government desire that all schemes for which this assistance is eligible shall be submitted within a short period, and that they shall be carried out within three years. They have, however, made indefinite provision for an extension of time, and it is because of the possibility of getting this extension that I think Birmingham ought to be able to say quite definitely what the Corporation propose to do with the central area of the City, and make an effort now to get the scheme for dealing with that area brought within the provisions of the Act for financial assistance.

The steps which have already been taken by Birmingham in regard to the housing question may be put very shortly, as follows :—

1. The main, and indeed from a health point of view the

only, object in our obtaining the great extension of the city in 1911 was to enable the city to be spread over an area much larger than had ever been contemplated previously, and thereby thin out the central area.

2. It was recognised that to enable this to be done properly town planning was essential, and the Housing Committee of that day contemplated not the restricted town planning as we know it now, but town planning of the built-on area of the city, as well as the unbuilt-on portions.

3. It has been pretty generally recognised that housing schemes in the central areas of towns have been so expensive in the past as to be impracticable as a substantial means of re-housing people.

My present contention is, therefore, that before any attempt is made to deal with the central areas it is absolutely essential that either by local legislation or by an alteration of the general law suitable powers shall be obtained from Parliament to town plan the central area. I recognise at once that the proposition of dealing with this central area is one of great magnitude and one of great cost, and, therefore, reasons must be given sufficient to warrant the enormous expenditure that will be involved.

The only reason which in my judgment calls for this action is the improvement of the health of the people. There can be no doubt that the conditions under which a large number of the people of Birmingham have to live are unwholesome. They give rise to ill-health and high mortality; they give rise to loss of self-respect and all that follows such loss of self-respect, viz., thriftlessness, drunkenness, dirt, poverty, and crime.

The real problem to be dealt with is the question of the back-to-back courtyard house, whose chief defect, in addition to its lack of size, its dampness, and its dilapidation, is that it is not self-contained. There is no water supply inside the dwelling-house, no adequate provision for discharging slop water, and the only sanitary convenience is often some distance from the house and usually common to two or more dwelling-houses. This convenience is frequently in a revolting condition, because of its common user. There is no bath or means of having a bath in any of the houses. These houses are in many cases surrounded by metal or other works giving off smoke and dust, so that it is impossible for an occupant to keep himself clean or to cultivate any green thing in the neighbourhood of his house. The whole outlook from these houses is sullied by soot-besmirched buildings in a soot-laden atmosphere.

It is impossible to imagine a rising generation of young people being able to improve in health or self-respect even if the best

of educational facilities are provided, when everything they come in contact with is sullied by dirtiness and squalor.

IN MY OPINION THERE IS ONLY ONE REMEDY, VIZ., THE REPLACEMENT OF THESE SLUMS BY DECENT HOUSES IN A PLEASANT ENVIRONMENT.

It is often said that you cannot reform the slum dweller. This I feel strongly, if accepted, would be a libel of the worst type if applied generally to Birmingham. The majority of people in these courtyard houses would be decent, clean people if they had a chance of being clean. There is, of course, a small group who are thriftless and criminal, but such a group is found in all ranks of society. On the whole, therefore, I am quite certain that it is safe to spend money freely on our slums, because the people will not only benefit enormously in health, but they will appreciate the improvement very highly and respond to it.

In 1913 there were 43,366 back-to-back houses in Birmingham, with an estimated population of nearly 200,000 persons (a population as large as the whole town of Cardiff or Bolton), which may be said to be living under slum conditions. The unhealthiness of the dwellers in this type of house is indicated graphically in the following maps:—

Map No. 1 shows in colours the wards in the city of Birmingham where the percentage of houses of the back-to-back type is greatest. The darkest area shows where more than 50 per cent. of all the dwellings are of the back-to-back type. The second darkest colour represents wards having from 20 to 50 per cent. of back-to-back houses. The third group shows wards with from 10 to 20 per cent. of back-to-back houses, and the fourth group shows wards with less than 10 per cent. of back-to-back houses.

Map No. 2 shows the distribution of the death-rate of the city during the five years 1914-1918.

Map No. 3 shows the distribution of infant mortality rates in the same five-year period.

Map No 4 shows the distribution of mortality from Measles.

Map No. 5 shows the distribution of mortality from Bronchitis and Pneumonia.

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Map No. 7 shows the distribution of deaths from infantile summer Diarrhoea.

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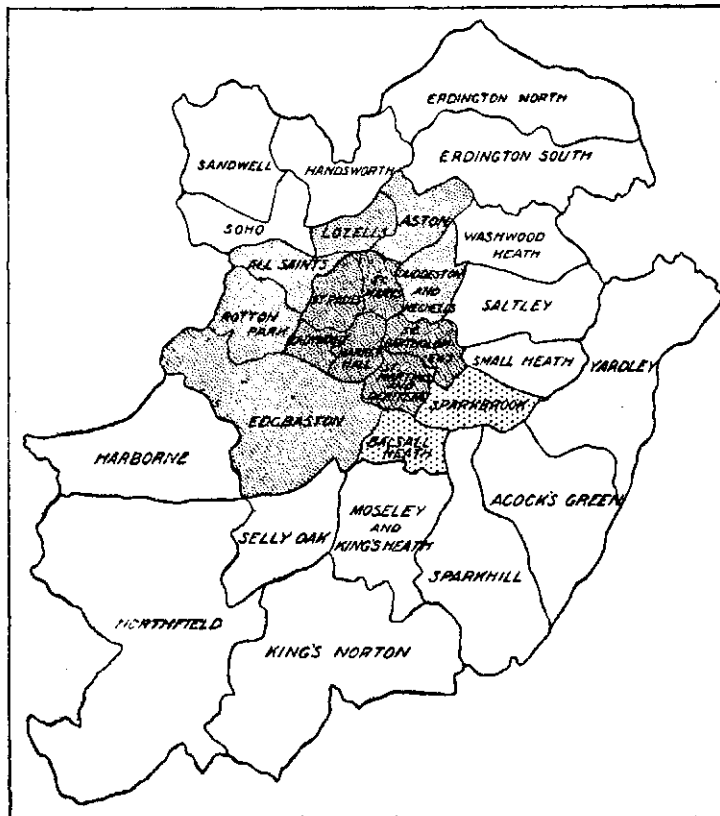
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Map No. 6 shows the distribution of deaths from Phthisis.

Map No. 7 shows the distribution of deaths from infantile summer Diarrhoea.

## BACK-TO-BACK HOUSES.

No. 1.



## PERCENTAGE OF BACK-TO-BACK HOUSES.

61-78 per cent.

27-47 " "

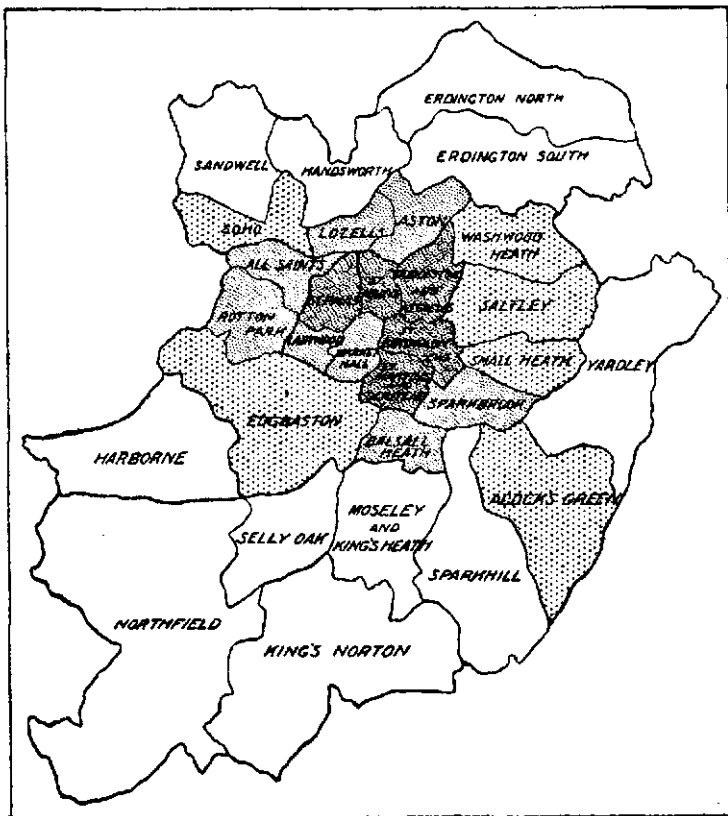
16-19 " "

0-15 " "



## TOTAL DEATH-RATE.

No. 2



## TOTAL DEATH-RATE 1914-1918.

19.6-22.6 per 1,000.

18.0-17.6 " "

11.4-12.4 " "

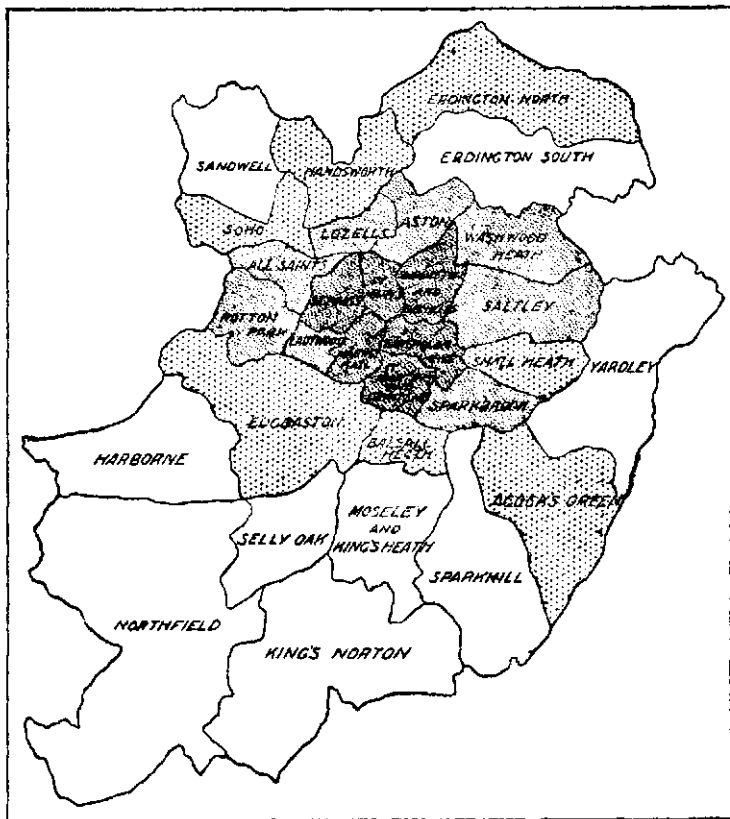
8.6-10.9 " "





## INFANT MORTALITY

No. 3.



INFANT MORTALITY RATE 1914-1918.

134-171 per 1,000 births

94-128 " "

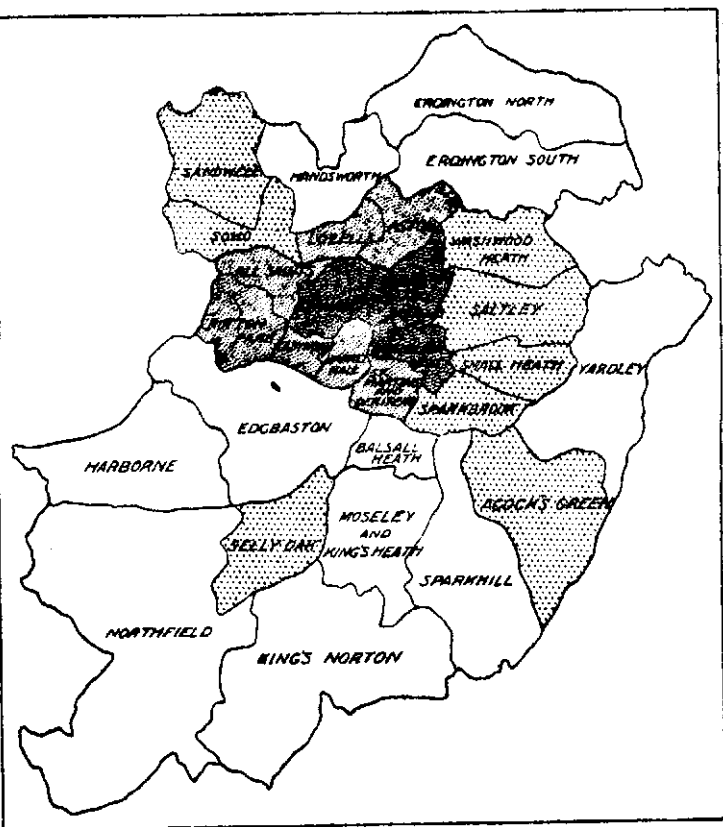
60-85 " "

60-75 " "



## MEASLES.

No. 4.



MEASLES DEATH-RATE 1914-1918.

0.68-0.72

0.29-0.48

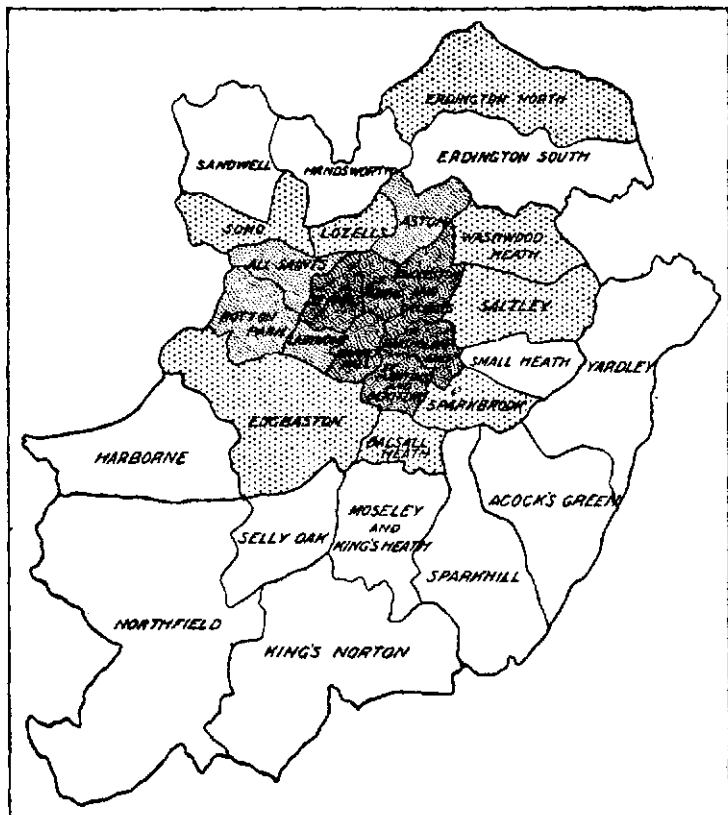
0.14-0.25

0.00-0.12



## BRONCHITIS AND PNEUMONIA.

No. 5.



BRONCHITIS AND PNEUMONIA DEATH-RATE 1914-1916.

4.63-4.78



3.61-3.12



1.64-2.00

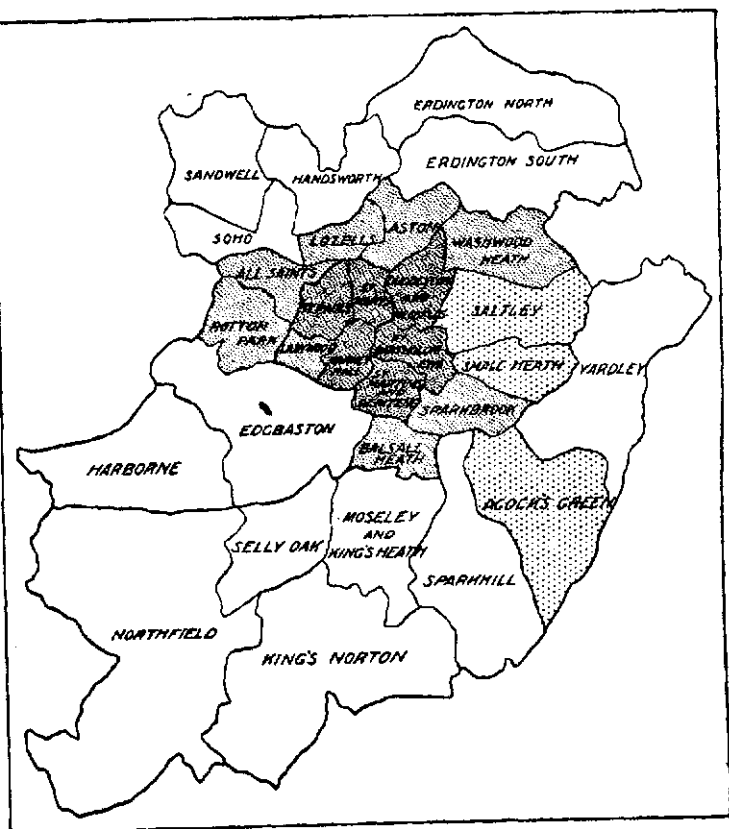


1.19-1.62



## PHTHISIS.

No. 6.



PHTHISIS DEATH-RATE 1914-1918.

1.65-2.68 per 1,000.

1.17-1.42 " "

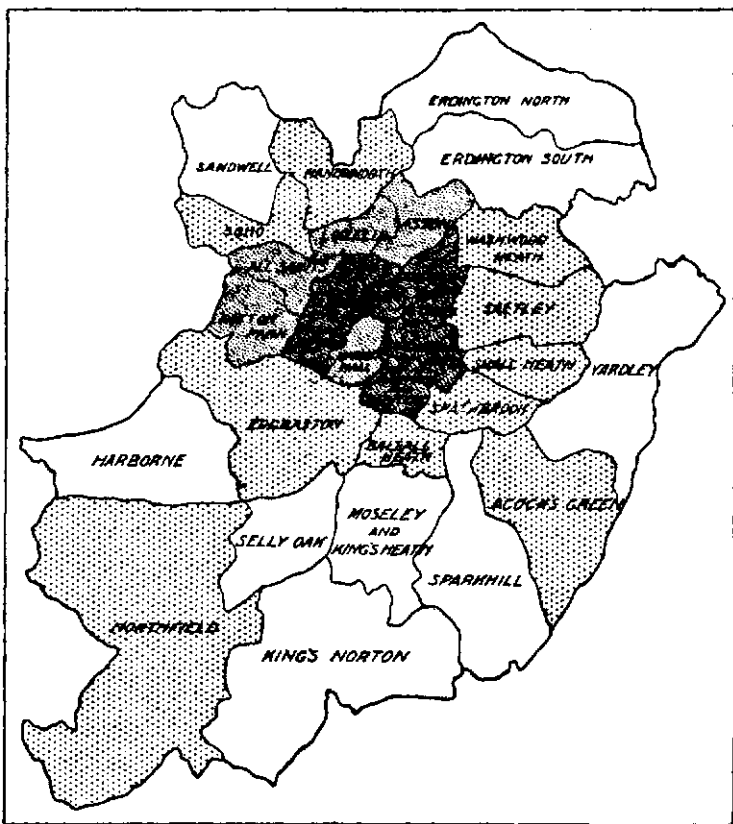
1.03-1.04 " "

0.67-0.89 " "



## DIARRHŒA AND ENTERITIS

No 7



## DIARRHŒA AND ENTERITIS MORTALITY.

(DEATHS UNDER 2 YEARS PER 1,000 BIRTHS.)

20-57 per 1,000 births.

10-20

11-16

3-6

"

"

"



Many more such maps might be made to show the high incidence of mortality in the central slum areas. Detailed statistics have been given in the annual reports on the health of Birmingham for each of the years 1914-1918, and may be consulted for confirmation of the general impression given from the maps. The more one looks into the subject the more one is impressed with the need which exists for a radical change in the conditions under which these people are housed.

The problem of dealing adequately with the slums of Birmingham is, as has already been said, one of even greater magnitude and complexity than the very large question of making provision for new dwellings, which is on hand at the present time. If it is agreed that the courtyard back-to-back houses shall be done away with, and the remainder of the small house property brought up to a fair standard of accommodation and comfort, and be made self-contained, then there arises the question which I am most anxious should be dealt with almost at once, viz., that of the environment of these houses in the central area.

In my opinion it is impossible to provide clean and bright surroundings so long as the present custom exists of permitting works to exist alongside of dwellings, and that to merely replace existing houses by new ones would not adequately remedy the conditions which we wish to improve. I feel strongly, therefore, that power to town-plan the old area of Birmingham is needed, so as to enable the city to be divided into areas somewhat on the following lines :—

#### 1. A BUSINESS CENTRE

should be defined in which few, if any, restrictions are necessary, other than those already existing under the Building Regulations.

#### 2. Areas in which

#### FACTORIES AND WORKSHOPS

will have every possible facility which the city can provide, and in which no dwelling-house, other than a caretaker's house, shall be built without the consent of the Corporation. I believe in the past that sufficient attention has not been given to facilitating the trade interests of the city, and that it will be greatly to the advantage of Birmingham if manufacturers are given facilities in the direction of motive power and transit. Birmingham largely depends on its metallurgical works. Nearly all these works require heating furnaces of various kinds, and each of these gives off its quota of soot. I look forward to the time

when a large number of these heating furnaces will be worked by cheap varieties of gas rather than coal, and by collecting works of this character into groups I think such a supply may be possible, while it would be impossible were they scattered. Similarly, electricity for power purposes might also be distributed cheaper in works areas than throughout the whole of the town. The selection of these areas need not be so difficult a matter as it would appear to be at first sight. They will indicate themselves largely by the contour lines and by the existing lines of railway and canal.

It will be noted that no suggestion is made for the compulsory removal of works to these areas. I am convinced that it would be unwise to attempt any such removal, but I am of opinion that, having defined these areas and provided such facilities as I have indicated, it will happen in course of time that the residential areas will be freed from most of the existing works.

### 3. RESIDENTIAL AREAS.

I would suggest that these be defined as areas in which it will be illegal for any new works to be built, or any enlargement of works to be erected, without the consent of the Corporation. I can imagine that in the case of a good many industries which produce no smoke or dust or noise little or no objection may be raised to their continuing in a residential area if the owner so desires.

The advantage of obtaining such powers before proceeding to reconstruct the slum area of Birmingham must be obvious. Having defined these areas it will be possible to commence reconstruction in the areas which are to be permanently residential in character, and to do the work in such a way as to secure in these areas pleasant surroundings and the amenities necessary for a wholesome life, such as playgrounds, open spaces, tree-planted streets, etc. etc. We should then know definitely that any expenditure on such areas will be of permanent value.

In my opinion the chief feature which we must pay attention to in obtaining town planning for the old city is this question of mapping out areas. Few road alterations need be contemplated, for Birmingham is one of the few large cities without a single narrow residential road. The question of main roads need not be dealt with in a town plan, because already these can and have been dealt with. There are, however, a good many areas where the building sites are unnecessarily deep and may cause difficulty. In such cases, however, there are many methods which can be applied, such as providing cross streets or cross streets with playgrounds.

If town planning powers are obtained at an early date to deal with the central areas, I think it will be possible to deal with the residential portions gradually, and to get some of the work done by the owners of the property, who would have a very definite assurance that such districts will not be spoiled in the future, and that any money expended, will be expended with a knowledge that the work being done was part of our definite scheme. Further, I feel that it may be impossible for the city without outside financial help to adequately tackle the very difficult problem of reconstructing the central areas, and that if this is to be done and the health of the people brought up to the best possible state, financial help should be obtained. To obtain this financial help it will be necessary to provide a good scheme. We should be much more likely to be successful in this respect if we went to the Ministry of Health with such a scheme as I am outlining.

It is obviously premature on my part to discuss the type of housing required for these areas. I hope, however, that it will not be lower than that foreshadowed in the "Manual"<sup>1</sup> on Housing, because what is to be kept in mind is not only the type of house which can be lived in by these people, but the kind of house which is going to prevent damage to their health. In any existing area there will be some houses which will not require to be dealt with, and there will be a good many others which need not be pulled down if properly amended.

I would like to make one further observation in this respect. It is that I very strongly advise that block buildings (flats) should not under any conditions be contemplated as a substitute for the back-to-back courtyard houses, as I believe that such in time will become even more unwholesome than the courtyard cottage.

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<sup>1</sup> Issued by the Local Government Board.



## APPENDIX VIII

### EXTRACTS FROM THE MINISTRY OF HEALTH CIRCULAR ON MEASLES AND GERMAN MEASLES

CIRCULAR 35.

*County Councils and Sanitary Authorities.*

MINISTRY OF HEALTH,  
WHITEHALL, S.W.1,  
28th November 1919.

#### MEASLES AND GERMAN MEASLES.

SIR,—I am directed by the Ministry of Health to state that the large numbers of deaths which occur annually from measles, and the disabilities and impairment of health which are the after-result of this disease in so many cases make it, in the view of the Ministry, extremely important that all practical measures for combating the mortality from measles should be extended and developed as much as possible.

The Ministry have therefore considered it desirable to review the whole position, including the working and results of the present notification arrangements which were made obligatory by the Local Government Board Order of 27th November 1915 (Notification and Treatment of Measles and German Measles). The Ministry have given careful consideration to various criticisms which have reached them as to the ineffectiveness of that Order, and have come to the conclusion that its continuance on present lines is not the best method of dealing with the problem.

A new Order (copies enclosed) has, therefore, been made which rescinds the former Order as from 31st December next, and I am to request that the rescission of the Regulations may be brought to the notice of all medical practitioners and made known by every practicable means throughout the district of the Authority. In bringing the new Order to the notice of local health authorities the Ministry wish it to be understood that it is in no sense their intention to impose any check on the action which such authorities can take to combat the mortality from measles. On the contrary, the withdrawal of the Notification Order in its present form still leaves local authorities free

to organise various forms of combating and preventing the spread of the disease immediately on receiving information respecting cases of measles occurring in their districts from the many different local sources of information now available. Such information should enable appropriate action to be taken not less speedily in regard to cases of measles than has been possible when knowledge of the incidence of the disease has depended solely on notification.

*Section I.—Practical Measures.*

Apart from any information which may in particular localities continue to be obtained from some form of notification of measles, it is important that the medical officer of health in all districts should utilise to the full the various opportunities which are available to him to learn of the occurrence of measles arising in his district and to follow its epidemic variations. This information can be obtained principally through the reports of Health Visitors, School Nurses and the School Attendance Officer, while parents and guardians should also be encouraged to report cases to the office of the Local Sanitary Authority.

1. *Instruction of Parents and Guardians.*—Formal and informal lectures by the medical officer of health or medical practitioners to those most likely to influence the public attitude to measles; instruction imparted at the Infant Welfare Centre, and other propaganda work, such as the distribution of posters, pamphlets, etc., on the disease all prove useful in instructing the public concerning measles. The practical advice of the health visitor or nurse, exemplified in a particular case in the home, will educate the parent and spread practical working knowledge more satisfactorily than any other method.

2. *Health Visiting.*—It should be a general instruction to Health Visitors to whom measles work is assigned that, on learning of the occurrence of a case of measles in their particular district, a visit should be made promptly to the home of the sufferer. The Health Visitor advises the parents or persons in charge as to the infectious nature of the disease and the precautions to be taken, and gives elementary instructions as to nursing where this is required. She makes inquiries as to the existence of previous cases, or of other cases of the disease, and as to whether the School Authorities have been informed. She reports on her visit to the medical officer of health; doing so immediately, if she finds conditions of environment which seem to call for action by the public health authority, or if the case is obviously one in which steps should be taken at once to secure medical treatment and nursing. If she receives no other

instructions she continues her visits as required until the child is convalescent. On receipt of her report, the medical officer of health decides whether it is necessary for him to communicate with the medical attendant, if any, or to make a personal visit to the house, and whether nursing or other assistance is required, and in what way it can be supplied.

It is not necessary, as a rule, to appoint Health Visitors solely for measles visiting. It is convenient that Health Visitors engaged in Maternity and Child Welfare visiting should also undertake the visiting of cases of measles. In periods of severe epidemics of measles it may be necessary for a local authority to employ the whole resources of its health visiting staff in measles visiting. In such times of stress, if the staff available is insufficient to allow of visits to all cases, such action should be confined to children under five years of age.

3. *Nursing Provision.*—This is of the first importance in preventing mortality and disablement resulting from measles. The services of nurses are not perpetually required, but it is essential that sanitary authorities should have a call on the services of nurses for home nursing whenever the need for utilising them arises.

Arrangements may be made for engaging the nurses of a District Nursing Association, or by employing the nurses of the sanitary authorities' isolation hospital staff. Often local authorities of contiguous districts can usefully combine with the object of providing nurses who can serve a large number of smaller urban districts and rural districts, and who can be dispatched to the seat of outbreaks of measles as required. The various component authorities combining for this purpose contribute to the cost in proportion to their populations or otherwise. Another, and in some cases a more efficient and economical arrangement, is for the County Council to provide a staff of nurses for the visiting and nursing of measles and other infectious diseases, such as whooping-cough, poliomyelitis, epidemic diarrhoea and ophthalmia neonatorum in children under five years of age throughout the county. This provision can be made by County Councils exercising their powers under the Maternity and Child Welfare Act, 1918. The direct employment of these nurses by the County Council for the benefit of the whole administrative county simplifies the financial arrangements, since the County can be rated equally for the salaries, and no charge need be made for their services to the particular local authorities who use them.

With regard to Health Visitors and nurses undertaking visits to the homes of cases of measles while engaged also on other branches of work, the Ministry are advised that subject to the

taking of simple precautions, on the advice of the medical officer of health, there is little or no risk of the conveyance of infection from house to house.

It is, naturally, of the utmost importance that health visitors and nurses employed by the local authorities in visiting and nursing cases of measles should not only be fully acquainted with the principles which govern the work, but should know how in practice to make the best of unsatisfactory conditions of environment in the interest of the sick child and the family.

4. *Medical Assistance.*—The health visitor should be instructed to advise the calling in of a doctor in all cases of measles. Medical assistance may be provided for necessitous cases at the expense of the sanitary authority, on the advice of the medical officer of health.

5. *Institutional Treatment.*—Although the majority of cases must necessarily be treated at home, yet cases occur where, for one or another reason, hospital treatment is specially desirable, and provision should be made for such cases. Institutional treatment in measles is specially valuable for severe or necessitous cases coming from bad home surroundings, whose prospect of recovery may be improved by hospital treatment; and on account of the provision made in the institutions for the prevention of complications and sequelæ of the disease.

The Local Government Board in 1911, issued orders enabling the managers of the Metropolitan Asylums Board to receive patients suffering from measles into their hospitals under certain conditions. At present, admission is restricted to very severe cases, and to children of the poorest class, who cannot receive proper attention at their homes. The cases are recommended for admission by medical officers of health and poor law medical officers. In certain large urban centres in England and Wales, some hospital provision for necessitous cases has been made, but the provision is generally inadequate for the needs of the population. In other cases it is entirely lacking. The provision of numerous small wards, containing only a few patients, which allow of successive cleansing of each ward, together with prompt isolation of a case of bronchial pneumonia, are calculated to secure favourable results in hospital treatment. The adoption of such measures in France has proved efficacious in checking mortality from the disease.

6. *Convalescent Home Treatment.*—For children who have recently passed through an attack of measles a certain period of treatment in a convalescent home is often specially important for complete recovery.

It is desirable, therefore, that local authorities should, either themselves or through a voluntary agency, arrange for beds in

convalescent homes for children convalescent from measles. The selection of suitable cases can be entrusted to the medical officer of health.

7. *After-Care*.—The health visitor should keep under review children who have recently suffered from measles. The disease is often followed by a more or less prolonged period of ill-health which can be ameliorated by good home conditions, suitable food, fresh air, and so forth. Special medical observation of these cases, e.g., at the Child Welfare Centre, or at a School Clinic, seems desirable for some months in order that if sequelæ arise the child may promptly receive the benefit of expert advice.

8. *Measles in Institutions*.—The risks of measles should always be kept in mind in connection with day nurseries, crèches and other institutions for children. The authorities of such institutions should consult the medical officer of health, or the medical officer in attendance at the institution on all cases of suspected infectious disease arising in the institution at ordinary times, and with regard to all children presenting themselves for admission during the prevalence of a measles epidemic.

#### *Section 2.—Grants for Measles Work.*

In aid of the provision for maternity and child welfare, the complete regulations for which are set forth in the Local Government Board's circular of 9th August 1918 (M. & C. W. 4), and the Ministry's circular of 15th July 1919 (Circular No. 5 M. & C. W. 11), grants not exceeding one-half of approved net expenditure are payable by the Ministry during each financial year, commencing on 1st April, in respect of the following services for measles in the case of children under 5 years of age:—

- (1) The salaries and expenses of Health Visitors engaged in Maternity and Child Welfare work (including the home visiting of cases of measles).
- (2) Home nursing of cases of measles.
- (3) The provision of hospital beds for measles occurring in children under 5 years of age, either permanent or temporary in character, provided either at a hospital for infectious diseases, or in a separate institution. If this provision is made at a local authority's hospital for infectious diseases it must be arranged so as not to interfere with the accommodation for other infectious diseases which are usually admitted to hospital.
- (4) The provision of accommodation in convalescent homes for children under 5 years of age.

It is desirable that Local Authorities should, either themselves or through a voluntary agency, arrange for beds in convalescent

homes to be available for children requiring such treatment after measles. As a general rule grants will be paid in the case of voluntary agencies providing convalescent homes for this purpose only in respect of accommodation provided in connection with a local authority's scheme and approved by the local authority and the Ministry.

When reason is shown, the Ministry are prepared to consider a local Order which would require compulsory notification for all cases of measles occurring in the district, not merely the first cases, as in the Order of 1915.

I am, Sir,

Your obedient Servant,

ROBERT L. MORANT,

*Secretary.*

*To the Town Clerk or  
The Clerk to the Council.*

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