10. A. Hill, 'Women health visitors', *Journal of the Sanitary Institute*, **XVII** (1902), 188.
11. S.M. Archer, *Infant mortality in Batley 1890–1914. 'Destruction of the Innocents'*, (unpublished research component for the Diploma in Local History, Trinity and All Saints College, Leeds, 1988), 8–9, 14.
12. A.M.N. Pringle, *Annual report of the medical officer of health and the school medical officer for the year 1909*, County Borough of Ipswich, (Ipswich, 1910), 39–40. I am grateful to Open University Research student Eric Hall for drawing my attention to this source. From figures given in *Medical Officer of Health Report on infant and child mortality: a Supplement to the 42nd Report of the Local Government Board 1912–13*, British Parliamentary Papers (1913), **XXXII**, 118+, it is possible to produce estimates of the number of visits made by health visitors in a large number of towns in the early years of the 1910s. Some examples are: Aberdare, 1,668 plus re-visits; Acton (1912) 1,033 first visits, 258 revisits 'in some cases fortnightly' (75 per cent of all births); Aldershot, 626 first visits (68 per cent of all births) 'average re-visits being 3–4'; Ashton-under-Lyne, 773 first visits (75 per cent of all births) 're-visits being made to all the cases'.
13. By 1930 there were 2,331 full-time equivalent health visitors in England, of whom 1,810 were maintained by local authorities and 521 by voluntary organisations. Earlier, in 1922, some 346 antenatal clinics were maintained by local authorities as against 218 by the voluntary sector. B. Harris, *The origins of the British welfare state: society, state and social welfare in England and Wales 1800–1945* (London, 2004), Table 15.5.
14. C. Davies, 'Making history: the early days of the HVA', *Health Visitor*, **60** (1987), 146.
15. Miss Ashwell, 'Some notes on work as Officer of the Chesterfield Infant Life Protection Society', *Journal of the Sanitary Institute*, **XX** (1900), 86–8.
16. Ashwell, 'Some notes on', 87
17. Ashwell, 'Some notes on', 88. Incidentally, 3½d. was the cost of a quart (2.2 litres) of milk in Sheffield in 1906, City of Sheffield, 'Special Committee', 12.
18. Galley, 'Social intervention', 35–6.
19. See, for instance, *Medical Officer of Health Report 1912–13,* 118+ which gives information on welfare programmes, including those provided by voluntary agencies, in many of the 241 towns of England and Wales covered.

HEALTH VISITORS: HOW MUCH DIFFERENCE DID THEY MAKE? —A REPLY TO MICHAEL DRAKE

Chris Galley

Anyone who ends the first paragraph of an article by suggesting that, 'a number of tentative conclusions about the nature of infant mortality decline' will be made, 'in an attempt to stimulate further debate' deserves to be challenged, and it is therefore not surprising to discover that Michael Drake disagrees with some of my conclusions.[1] Drake makes the point that by not providing a quantitative assessment of the work done by the health visitors I have failed to give an account of their true worth. Using evidence from Edwardian Sheffield he demonstrates that the amount of work undertaken by the health visitors was indeed impressive and he then proceeds to assess the effectiveness of social intervention by posing three questions: (1) what changes in behaviour were being attempted; (2) how speedily could such changes be effected; (3) were the number of health visitors sufficient for the task? Drake's Table 1 shows that in Sheffield the health visitors were mainly concerned with the health of the child, infant feeding, nursing, mothers' occupation, whether

or not the house was dirty and whether a separate cot was used. He admits that most of these proved to be of little consequence in influencing the infant mortality rate and he concludes that the main thrust of the health visitors' work focussed on infant feeding, cleanliness and presumably the prevention of infant diarrhoea. Drake's critique is to be welcomed for providing these additional data about health visiting and for pointing out the enormous amount of work carried out by the health visitors. Here there is little to take issue with. Where we differ is in our assessment of the effectiveness of health visiting in the first decade of the twentieth century. Drake's evidence may be useful in answering each of his above three questions, but it does not address the more important underlying question concerning the effectiveness of these visits. Most official information about health visiting is biased; it is good at revealing the advice given, but less so on how that advice was received and acted upon. In this short reply I wish to explore some of the reasons for the apparent paradox that while health visitors undoubtedly dispensed sensible advice, they appeared to have made little impact on infant mortality rates.[2]

I have little to add about health visiting in Sheffield, but the other town examined in my original article, Birmingham, provides further interesting evidence. Here female health visitors were appointed in 1899 and most of their initial duties were concerned with improving domestic hygiene. According to the medical officer of health,

> Their mission being to visit the houses of the poor, with the object of helping the tenants to make their homes as healthy and as comfortable as possible, having regard to their construction.
>
> The directions given to the Visitors were as follows:—
>
> To visit from house to house in such localities as the Medical Officer of Health shall direct.
>
> To carry with them disinfectant powder and use it when required.
>
> To direct the attention of those they visit to the evils of bad smells, want of fresh air, and dirty conditions of all kinds.
>
> *To give hints to mothers on the feeding and clothing of their children,* and to use their influence in getting children sent regularly to school.
>
> In cases of sickness, to assist in promoting the comfort of the invalid by advice and personal help.
>
> To urge, on all possible occasions, the importance of cleanliness, thrift, and temperance.
>
> They must note—
>
> (1) The general sanitary condition of the house.
>
> (a) The number of rooms and of occupants.
>
> (b) The existence of bad smells, and whether they arise from deficient ventilation, from bad drainage, or from accumulations of filth.
>
> (c) The state of the walls and floors: whether dirty from the tenant's or landlord's neglect, or in need of repair.
>
> (2) The general mode of living, particularly with regard to personal and

domestic cleanliness.

(3) *The feeding and clothing of children, especially of those under two years old. Whether the baby is nursed by the mother or fed by hand; if the latter, what it is fed upon.*

(4) Any cases of illness in the house—

(a) Nature of the disease

(b) Whether there is a medical man in attendance.

(c) How far the necessary sanitary precautions are being carried out.[3]

The sections dealing with infant welfare have been italicised and are shown to be only a fraction of the health visitor's overall workload. Drake suggests that health visitors could undertake between 2,000 and 4,000 visits per year, which implies that between 7.6 and 15.2 visits were made each day (assuming that the visitor worked for 5½ days per week for about 48 weeks per year).[4] This means that on average the maximum time allowed for each visit would have been somewhere between 30 minutes and one hour, although this estimate does not take into account any illnesses, training, administration, travelling time or visits made when no one was at home. Given the health visitors considerable responsibilities and the problems of forging positive relationships under such time constraints it is likely that many visits were short, formal and in some cases perfunctory. It is therefore not surprising that health visiting made little immediate impact on the infant mortality rate and that it took time before it became effective.

During the first decade of the twentieth century, as infant health assumed greater importance, health visitors began to focus more of their efforts on the prevention of infant mortality.[5] In 1908 Dr Jessie Duncan was appointed to work alongside two health visitors in St George's and St Stephen's, districts of Birmingham that suffered some of the highest rates of infant mortality in the city.[6] This scheme appears to have been well thought out and it was managed efficiently,

> The children born in the district are visited as soon after birth as convenient, usually about the end of the first week. At this visit directions are given as to the care of the child, and information is obtained regarding the mother's employment, previous history, husband's wages, etc.
> Visits are then paid by the Health Visitors (one visitor for each ward) every week for the first five weeks and every month afterwards. If at any of these visits the baby is found to be unsatisfactory in any way it is reported to me (i.e. Duncan), so that I may visit, and, if necessary, take over the case altogether. The unhealthy and ailing children are subsequently visited by me very frequently, according to the condition of the child.[7]

Duncan noted that her visits were welcomed: indeed in those 'better class' households, which were excluded from visiting, mothers often 'expressed their disappointment' when the visitors did not call.[8] Infant consultations were also held and here Duncan believed that mothers were more receptive to the advice

Table 1 The relationship between mother's employment status, father's income and infant mortality: St George's and St Stephen's Birmingham, 1909

Mother's employment status	Father out of work or earning less than £1 per week	Father earning £1 per week or over
Employed in factory	235	146
Employed at home	176	120
Total employed	217	137
Not employed	199	154
Total	211	146

Source: Duncan, 'Report on infant mortality', 12.

being dispensed. Given such evidence, it is difficult to imagine how health visiting could have been better administered in this period. However, whilst infant mortality rates declined in St George's and St Stephen's, no doubt in part due to the good work of the health visitors, they also declined in other working-class districts in the city and the rate of decline in those middle class districts where there was no health visiting was even higher.[9] The reasons why infant mortality rates remained stubbornly high in these two districts can be linked to the social condition of the population. Duncan's initial remit had been to investigate the relationship between women's employment and infant mortality, but during the course of her research she discovered a more powerful relationship at work—that between poverty and infant mortality (Table 1).[10] Thus, while the advice meted out by the health visitors to prevent infant deaths may have appeared appropriate, it proved difficult to implement in those poor households which inevitably had to endure the worst environmental conditions.[11] There was also the additional problem that some mothers were reluctant to take on the advice given by the health visitors. As late as 1933 the Medical Officer of Health was expressing concern about the high level of infant mortality in Birmingham on the canal boats. He quotes an illuminating example of the difficulty of putting health messages across,

> Very few of the babies are breast-fed and the artificial food chosen is almost without exception Nestles condensed milk. It appears to be a custom, and one mother boasts of having reared sixteen children on it, with the help of a long tube feeding bottle, still in use.[12]

The health visitors appeared to have been powerless to influence many of the underlying problems associated with poverty. Consequently, and precisely as Drake infers, it was the better-educated middle classes who were able to make the most of the various messages relayed by the infant welfare movement even though these messages were not directly addressed at them.[13]

During the very hot summer of 1911 the health visitors faced their severest test when a severe outbreak of infantile diarrhoea occurred. The measures that were enacted were sensible: the seriousness of the disease was emphasised at every

opportunity, house-to-house visiting was instituted (including those homes with children aged over one), special meetings of mothers were held in courts and yards, warnings were given about a lack of cleanliness, long-tubed bottles, comforters and the care of milk and all those who were ailing were visited frequently and sometimes daily.[14] Yet, in spite of all the health visitors' efforts, infant mortality rates soared to over 200 per 1,000 live births in many working-class areas.[15] Clearly, while the measures advocated by the health visitors were in themselves capable of preventing infantile diarrhoea, their application proved wanting and consequently many infants died. Writing in 1912 the medical officer of health commented that the various infant health measures introduced in the city had achieved only 'slow results' and he felt that the health visitors were 'overburdened'.[16] He also recommended that Duncan be moved from St George's and St Stephen's to undertake more general infant health work throughout the city. In spite of this setback Birmingham persisted with its health visitor scheme, but there was now a realisation that more health visitors were needed if the problem was to be dealt with successfully. Four visitors had been employed in 1899 and this number had been increased to eight in 1900 and 17 in 1910. However, by 1916 49 health visitors were employed together with another 23 women, who worked in other types of visiting or voluntary centres and also dispensed infant welfare advice where appropriate. Thus, by the middle of the First World War, a total of 72 female health workers were employed throughout the city and these were backed up by a range of both official and voluntary bodies actively promoting infant welfare.[17]

Given the number of health visitors employed during the first decade of the twentieth century, the tasks they were required to perform and the problems they had to overcome it is not surprising to discover that in Birmingham at least, they appeared to make little impact on the infant mortality rate. The increased attention and more enlightened attitudes shown towards infants, including the employment of health visitors, did have an impact, but that impact was often indirect. There is much contemporary evidence about the indirect benefits of social intervention with many leading contemporary authorities, such as George Newman and Arthur Newsholme, believing that this played a part in the overall decline of infant mortality. George McCleary, medical officer of health for Battersea and a major force behind the first national conference on infant mortality in 1906, writing from the perspective of the 1930s, is worth quoting on this subject. He detailed the nature of various infant welfare initiatives and then went on to argue,

> From the beginning of the present century [20th] there was a steady growth in the public interest in infant welfare not only in the towns in which new measures had been adopted, but, and largely owing to the influences of those measures, all over the country. The growing interest was soon followed by a growing appreciation among all classes of the conditions necessary for infant nurture. Infant welfare was in the air.[18]

More pertinently, at least as far as this discussion is concerned, in the same paragraph he then writes,

> Where the success of a movement depends on the growth of an enlightened public opinion, its progress cannot be estimated merely by the mechanical process of counting the ameliorative agencies in operation.[19]

In conclusion, my reading of the Birmingham sources would be that this town appears to fit well with McCleary's view of infant mortality decline. Referring back to the three questions posed by Drake, my answers are that in Birmingham: (1) the advice given by the health visitors appears to have been appropriate; (2) that advice took time before it became fully assimilated and effective; and (3) more health visitors than were employed before 1914 were needed to make a difference. Of course, other towns may have been different—there is a wealth of local source material on this subject in record offices throughout the country—and alternative analyses are to be welcomed.

NOTES

1. C. Galley, ' Social intervention and the decline of infant mortality: Birmingham and Sheffield, *c*. 1870–1914', *Local Population Studies*, **73** (2004), 29; M. Drake, 'Surely they made a difference? Health visitors and infant mortality in the 1900s', *Local Population Studies*, **76** (2006), 63–9.
2. The most important evidence to support this assertion is that infant mortality rates declined throughout the whole of England and Wales after 1900, including the large number of areas where no health visitors were employed: Galley, 'Social intervention', 40–4; see also A. Reid, 'Health visitors and child health: did health visitors have an impact?' *Annales de Démographie Historique* (2001), 119–20.
3. *Annual report of the Medical Officer of Health for Birmingham, 1899* (Birmingham, 1900), 34.
4. The hours worked by health visitors are given in F.J. Greenwood, 'Women as sanitary inspectors and health visitors' in E.J. Morley, ed., *Women workers in seven professions* (Routledge, 1914), 228.
5. As was the case in Sheffield, the health visitors emphasised the importance of improving the home environment, personal cleanliness and infant feeding: J. Robertson, *Special report of the medical officer of health of the city of Birmingham* (Birmingham, 1904).
6. J. Robinson, *City of Birmingham Health Department report on industrial employment of married women and infantile mortality* (Birmingham, 1910).
7. J. Duncan, *City of Birmingham Health Department report on infant mortality in St George's and St Stephen's wards* (Birmingham, 1911), 3.
8. Duncan, *Infant mortality 1911*, 4.
9. Galley, 'Social intervention', 35–7. The infant mortality rate declined by 18.1 per cent in St Stephen's and St George's between 1907 and 1910. This compares with 11.5 per cent in the city as a whole. If the 18 wards of Birmingham are ranked according to this figure then St Stephen's is fifth and St George's twelfth. The greatest decline, 26 per cent, occurred in middle class Edgbaston and Harborne, see *Annual report of the Medical Officer of Health for Birmingham, 1910* (Birmingham, 1911), 18.
10. As far as the relationship between female employment and infant mortality was concerned, Robinson, *industrial employment of married women*, 21 argued that the effects were 'somewhat indefinite' since while employment prevented breastfeeding it also alleviated poverty and it was difficult to say which was the 'greater of two evils'.
11. Likewise, using health visitor records from Derbyshire, 1917–1922, Reid, 'Health visitors', 132 concluded, 'it appears that health visitors were often stymied in their efforts to do good by the poor conditions mothers were living in which inhibited them from carrying out the advice'.
12. *Annual report of the Medical Officer of Health for Birmingham, 1933* (Birmingham, 1934), 137. There was also the problem that in some instances the health visitors' advice was misunderstood: see G. McCleary, *The early history of the infant welfare movement* (H.K. Lewis, 1933), 125; Galley, 'Social intervention', 44. This may partly explain why Britain diverged from the Scandinavian examples quoted by Drake in footnote 8, where the infant health messages appeared to have been readily

assimilated.

13. Drake. 'Surely they made a difference', 66–7.
14. J. Duncan, *City of Birmingham Public Health and Housing Department report on infant mortality in St George's and St Stephen's wards* (Birmingham, 1912), 6. Leaflets dealing with the prevention of diarrhoea were distributed freely, but such printed advice was felt to be 'almost useless unless the instructions are gone over and explained to the women'.
15. Galley, 'Social intervention', 35.
16. Duncan, *Infant mortality 1912*, 3–4.
17. J. Robertson, *Report of the Medical Officer of Health on maternity and child welfare during 1916* (Birmingham, 1916), 2.
18. McCleary, *Infant welfare movement*, 149.
19. McCleary, *Infant welfare movement*, 149.