

THE BRIDGWATER INFANT WELFARE CENTRE, 1922–1939: FROM AN AUTHORITARIAN CONCERN WITH ‘WELFARE MOTHERS’ TO A MORE INCLUSIVE COMMUNITY HEALTH PROJECT?*

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The infant welfare movement in Britain has received considerable scholarly attention but continues to generate controversy and debate. Many of the services began with nineteenth-century voluntary initiative but were later developed by local authorities. Critics have drawn attention to the limitations of such provision; arguing that it was predicated on unattractive assumptions about class and gender roles. Under this interpretation working-class mothers were viewed with suspicion and targeted for advice aimed at inculcating middle-class standards of childcare and housekeeping. This paper accepts that there was an authoritarian character to much of the early welfare work but suggests that over time this gave way to more inclusive approaches that sought to provide clients with the services that met their real rather than assumed needs. This paper reviews the recent historiography, develops an overview of national trends, and then takes a detailed look at the Bridgwater Infant Welfare Centre. The case study benefits from unusually comprehensive records and, by drawing on evidence from a small Somerset town, adds to our understanding of infant welfare work that has previously been developed from research on major urban centres.

Introduction

The infant welfare movement in Britain has received considerable scholarly attention but continues to generate controversy and debate. It is generally agreed that services for babies and children increased in scale and scope in the early decades of the twentieth century (Hendrick 1994; Ham 2004: 8–9). Yet, efforts to understand the multiple and even conflicting motivations of the reformers and service-providers have resulted in any number of competing interpretations. These apply to the developing infant welfare movement and the growth of state welfare more generally (Harris 2004: 15–27). The expansion of statutory and voluntary sector effort is usually presented as entirely good for professional staff and other interested parties; while the benefits accruing to service

users appear more uncertain. This is because commentators have strongly linked any improvement in the quality of care provided to working-class families with an intention to impose social control from above (Hendrick 2003: 1–2). This made any engagement with the services a complex calculation of costs and benefits, although coercion in various forms served to undermine client choices (Lewis 1980; Lewis 1984: 38–40; Lewis 1991: 40). Feminist writers have been particularly concerned about the way motherhood was appropriated as an imperial project that saw the language of colonialism applied as much to working-class communities as overseas territories (Davin 1978).

Alternative interpretations have placed more emphasis on the expansion of health and welfare services and the apparent improvements in health, measured by falling infant mortality rates, which followed their development (Marland 1993; Marks 1996: 167–194; Welshman 2000: 47–8; Chinn 1988: 136–7; Baly 1995: 238–40). In a strong critique of feminist texts highlighting the control rather than care functions of the infant welfare movement Dwork argues that ‘war is good for babies and other young children’, precisely because it stimulated specialist services that were used by, and useful to, their intended clients. She further argues that these services offered much better care, and were much less concerned with control, than critics have suggested (Dwork 1987: 226–30). More recent interpretations have been less pre-occupied with the care and control paradox, arguing that the same services could serve a variety of agendas for their providers and clients. Niemi, for example, notes the authoritarian style of early infant welfare activities in Birmingham and their limited success in the Edwardian slums. Yet after World War One, very similar measures were extended to working-class and even lower middle-class women living in the suburbs and new council estates. Here they were more enthusiastically received, partly because the new clients were able to negotiate the terms of their use (Niemi 2007: 61–111).

There were several components to evolving infant welfare services. The two best-known and most universal services, that in many places provided the bedrock for any additional provision, were the local authority health visitors and the infant welfare centres [IWCs] they worked in and from. Health visitors have received much criticism in the literature, as many contemporary as well as historical commentators see their unannounced visits to the home as invariably intrusive (Dyhouse 1979; Lewis 1984: 38–40; Ross 1993: 204–9). This was especially true in the early days when Edwardian staff and clients were relatively unfamiliar with the work; but there was a persistent concern that the health visitors visited homes to make official assessments of the standards of housekeeping and childcare and offer un-solicited advice about their improvement (Vincent 1991: 34–5). The IWCs, developed slightly later, attended on a voluntary basis, and offering a variety of goods and services as well as advice, have been reviewed more positively although they were staffed by the same health visitors whose activities and attitudes caused such concern to critics (Lewis 1991: 40).

Health visiting and IWCs had their origins in nineteenth-century voluntary sector activity but were increasingly developed as municipal services (Davies 1988; Marland 1993; Smith 1995; Baly 1995: 108–9). These measures were encouraged by the Edwardian Liberal Welfare reforms and given shape by the 1918 Maternity and Child Welfare Act. By the inter-war period local authorities had acquired a number of permissive powers that allowed them, if they chose, to systematically address the problem of infant health. Self-consciously progressive councils certainly developed these services, and under

pressure from the Ministry of Health after 1919, most areas had some level of provision (Peretz 1992: 257–280). The problem was that varying amounts of attention and resources were committed to infant welfare projects. This inevitability led to different models of service-provision and mixed standards of care (Peretz 1995).

Efforts to standardise infant welfare provision

Infant welfare services developed by the statutory and voluntary sectors came under scrutiny from central government in the 1930s. The Ministry of Health appreciated that services aimed at mothers and babies had been started by many different actors, and, following different traditions, had developed a variety of policies and practices. These impacted not just on the scale and scope of operations but also on the relationships between service providers, the division of labour between professional staff and volunteers, and the terms of engagement for clients. Officials from the Ministry seemed keen to both standardise and develop provision, while recognising the peculiar local circumstances that tended to encourage or retard progress. Two points attracted particular comment when services were evaluated as part of the public health surveys of each county and county borough council following the 1929 Local Government Act. These were the appointment of female medical officers to staff the centres and encourage the development of ante and post natal care for women as well as infant health services. The second issue that concerned the Ministry was the proper role of volunteers. Voluntary workers had been crucial in establishing the ‘schools for mothers’ and ‘baby welcomes’ that pre-dated the municipal IWCs and remained an essential part of the staffing arrangements; yet they could also be off-putting to the intended clients of the services (Lewis 1984: 38) and interfere with the developing medical work of the clinics.

Official Ministry of Health approval seems to have been reserved for comprehensive maternity and infant welfare schemes providing routine ante and post natal care for women, as well as clinics for well-babies and arrangements to refer sick children and women with complicated pregnancies to specialist doctors and treatment facilities. This interpretation differs from Peretz’s view that the Ministry wanted municipal schemes restricted to protect and encourage voluntary effort (Peretz 1995), although it was clear that comprehensive provision was only possible in major urban centres, especially where there was a strong commitment from the social, economic and political elite of the city to health as a symbol of municipal progress and civic pride. These concerns, and strong leadership by impressive Medical Officers of Health, explain the quality of services achieved in Manchester (Pickstone 1985) and at a slightly later date in Birmingham (Niemi 2007: 1–24). Elsewhere, other factors were important. In London the role of the leading teaching hospitals was vital (Marks 1996), but there was also a clear commitment to the socialist politics (Stewart 1997) that formed the backdrop to pioneering developments in cities such as Bradford (Dale and Mills 2007: 114).

Municipal enterprise that celebrated collectivist principles presented itself as a definite alternative to the patchy provision and patronising attitudes that critics associated with voluntary sector activity (Stewart 1997). In some areas, such as Bradford, the initial involvement of the voluntary sector in the provision of ‘baby welcomes’ (Bradford Council of Social Service 1923: 39–40) was so embarrassing that later official histories

simply ignored it when recounting municipal efforts to expand institutional and community health services (Firth 2001). At a national level, officials from the Ministry of Health acknowledged that the voluntary sector had played a vital role in establishing services, and in the depressed economic conditions of the early 1930s would continue to be an important source of staff and funds, but seemed keen to curtail volunteer-led initiatives. Towns like Halifax, where the Medical Officer of Health [MOH] had developed his own Public Health Union in the Edwardian period (Halifax Local Studies Centre HAL 614:Halifax MOH Report 1907: 87–90) to recruit volunteers to support, but be subordinate to his professional staff, received more favourable assessments from visiting Ministry officials than local authorities which allowed volunteers a leading role in the provision of services into the 1930s.

An extreme example of this was found in Exeter, where local ladies managed a number of infant welfare clinics through a series of committees that had guaranteed representation on the city council's own maternity and child welfare committee. Dr Allan C. Parsons, who conducted the Exeter public health survey in 1930, could not understand why a prosperous city like Exeter, apparently in a good position to develop the comprehensive range of municipal services encouraged by the Ministry, allowed and positively encouraged this state of affairs. Parsons thought the influence of the volunteers embarrassed the MOH, and was positively detrimental to infant welfare activities. Parsons was especially concerned that the voluntary workers had built a lavish new IWC that was admirably suited to their own activities, but seemed designed to prevent rather than facilitate consultations with the doctor (NA, MH 66/608: Exeter PH survey 1930: 32, and 61–2).

The situation in Exeter may usefully be contrasted with that existing in Plymouth, where Parsons found an impressive array of municipal services firmly under the control of the MOH and his department; though in the interests of economy he pondered over the merits of using paid council clerks to do clinic tasks, such as selling milk, more normally left in the hands of volunteers (NA, MH66/818: Plymouth PH survey 1930: 34–5). Parsons is an interesting commentator because he was also responsible for the surveys of the administrative counties of Cornwall, Devon and Somerset. This allows a comparative analysis similar to that which Peretz used to such good effect when contrasting infant welfare provision in Oxford and Oxfordshire (Peretz 1995). Peretz was highly critical of the limited provision, and the unattractive terms on which it was grudgingly offered to clients, in prosperous Oxford; a city which, like Exeter, suffered from a weak tradition of public health improvement and the interference of powerful lay groups. The situation in Oxfordshire was more complicated as services to a dispersed rural community always risked being more expensive and less comprehensive than equivalent provision in towns simply because of the difficulties of transport and communication (Peretz 1990, 1992 and 1995).

When surveying rural areas, Parsons did not expect to find all the services routinely provided by urban county boroughs, but he was nonetheless disappointed by the minimal level of progress he found in Cornwall, and to an extent in Devon. Cornish infant welfare work was left entirely in the hands of voluntary bodies, without even direct financial assistance from the council, and Parson's colleague Dr Carol Sims found the work under-developed in every way (NA, MH 66/30: Cornwall PH survey 1931: 85 and supplementary report: 7–8). In Devon there were 26 IWCs run by a variety of statutory

and voluntary agencies; many received financial assistance from the county council but only three were under its direct control (NA, MH 66/58: Devon PH survey 1931: 24). Sims found the infant welfare work considerably better in Devon than Cornwall, noting the ubiquitous voluntary workers were ‘competent and keen’, but medical services were limited and little had been done in respect of ante natal care, possibly because few women medical officers were employed (NA, MH 66/58: Devon PH survey 1931 supplementary report: 8–9).

Superficially the neighbouring county of Somerset faced very similar difficulties in terms of a dispersed rural population relatively inaccessible to a centralised health department, but the local authority had a reputation for making the most of limited resources and developing innovative solutions to problems (Chester and Dale 2007). It is also true that the Somerset County Council [SCC] committed more resources to public health (Cornwall PH Survey 1931:13–14 for comparative figures), and by offering more generous salaries attracted the services of outstanding staff such as William George Savage, County MOH 1909–1937. Parsons was impressed by Savage’s work in developing and coordinating the health services in Somerset, especially in the field of health propaganda and health education (NA, MH 66/210: Somerset PH survey 1931).

Dr Savage was reported to keep in ‘close touch’ with the 15 IWCs run by voluntary groups in association with district nurses, and the county council’s own infant welfare centre in Bridgwater. The early 1930s saw Savage developing ‘flying clinics’ to fill gaps in provision, while the county-wide activities of the woman health propaganda officer fulfilled a similar function. Parsons’ colleague, Miss Colles, was particularly complimentary about the health visiting service in Somerset, where 16 full-time staff and 165 women, combining duties as district nurse-midwives and health visitors, managed responsibilities for the infant welfare, school nursing and public health work. Volunteers were also vital, but, instead of competing with health department staff for the leadership of key projects, voluntary groups showed a willingness to lay the ground work for later action by the local authority, which they then supported.

Cooperation between the statutory and voluntary sectors was facilitated by influential figures like Norah Cooke-Hurle (née Fry). She had married Joseph Cooke-Hurle when he was the chairman of SCC, and after his death combined voluntary work with membership of the SCC as a councillor and then alderman (Norah Fry papers). When the SCC set up its only IWC in Bridgwater it is noteworthy that she and Dr Savage were active members of the original committee that first met on the 24th October 1921. The more routine work was left in the hands of a committee of Bridgwater ladies. Full biographical details are unavailable but apart from an occasional doctor’s or vicar’s wife they appear to have been the wives of local councillors serving Bridgwater Corporation (Bridgwater directories 1919–1951). A Mr Deacon, later Mayor of Bridgwater 1926–28, acted as chairman for 18 years.

It is not entirely clear why Bridgwater was the chosen location for the IWC, or indeed why it was the only such SCC facility. The activism of Mrs Cooke-Hurle was certainly an important factor and so was a debate about the future of Somerset County Council. Somerset had no clear administrative centre and its only county borough, Bath, was inconveniently located and had poor transport links with other Somerset towns. These were administered through six non county boroughs, 16 urban and 17 rural district councils. The SCC itself met in a number of locations and maintained a variety of

offices, with the chief officers and major departments based at Weston-super-Mare. The 1920s saw a prolonged campaign to concentrate activities, with Bridgwater councillors making much of the town's central location. Although Taunton was eventually developed as the SCC headquarters (*Somerset County Gazette*, 7 January 1928: 8), Bridgwater had already secured support for its IWC. This was possibly designed as an experimental clinic to serve as a model for other towns but restrictions on public expenditure discouraged such investment and by the 1930s there was a new emphasis on mobile facilities that better served scattered communities. Although a SCC venture, the IWC remained largely a Bridgwater affair with clients, staff and committee members drawn from the town. Since Bridgwater was some distance from the administrative offices of the county council, based in Weston-super-Mare and in the process of moving to Taunton, the IWC committee kept its own independent records. This is quite unusual as most references to infant welfare activities are derived from summaries presented in the annual reports of medical officers of health or written into the minutes of maternity and infant welfare committees of different councils.

Inside the Bridgwater Infant Welfare Centre

It was not unusual for a committee of ladies to run an IWC, but in Bridgwater the volunteers were expected to take a 'hands on' role in relation to the work and keep in close contact with the SCC health department and its staff. The commitment of time given to the project, and the expertise built up in this service, perhaps makes it more useful to think of the women involved as 'lay professionals' rather than simply volunteers (Dale 2006: 154–78). They certainly took their work very seriously and looked to a medical model of care to legitimate and support their activities. Yet, as voluntary workers, they also reached out to their community contacts, as well as client groups, to facilitate the work of the IWC.

The initial arrangements for the IWC were given careful thought, and were also subject to Ministry of Health approval (Somerset County Records Office: A/AJT,1: Minutes of the Bridgwater Infant Welfare Committee (hereafter IWC) 24 October 1921). The IWC was based in rooms belonging to the Bridgwater Girls' Association which were conveniently located in Castle Street where the Bridgwater District Nursing Association had premises. It was decided that the nurses would be welcome at the IWC at any time, and pupil nurses could attend the centre for training purposes. The chosen rooms proved unsuitable for IWC purposes, prompting a move to St Mary's Parish Hall, but the close links with the district nurses and the Mary Stanley Home County Training Home for nurses were maintained. The IWC always opened for two hours a week, Tuesdays 2.30–4.30 pm, with brief holiday closures in the summer and at Christmas. It was agreed that the IWC would cater for all children up to five years of age and provide services for expectant mothers. Dr Savage agreed to provide all necessary equipment and forms, and efforts were made to find a female doctor to provide medical consultations at alternate sessions.

The importance of this point was stressed by the Ministry of Health, with officials making the opening of the IWC conditional on a suitable appointment. This proved unexpectedly difficult. There was no qualified woman practitioner in Bridgwater, and when Dr Alice Cameron from Taunton said she was unavailable a complicated and

expensive contract had to be agreed with a Dr Lily Baker from Bristol which the Ministry of Health only approved as an interim arrangement (IWC minutes 31 January 1922). In addition to medical care the centre was designed to provide health lectures and sell items such as virol and cod liver oil at cost price. There were no arrangements to stock drugs; instead local chemists were requested to fill prescriptions from the medical officer as cheaply as possible.

As the IWC evolved its main functions became clearer as volunteers took charge of different activities. The 'teas' were a major undertaking and there was also an old clothes stall. At an early date it was agreed that any profits from sales of goods would be transferred to a fund for necessitous cases and fund-raising was organised to support this and other IWC activities. Early attendances at the IWC had pleased the committee but there was concern that some of the mothers were avoiding the formal programme of lectures. A carrot and stick policy was adopted to encourage attendance. On occasion regular attendees were rewarded with 'treats' or gifts (IWC minutes 4 December 1922, and 16 December 1925) but printed rules designed to enforce attendance were also popular with committee members (IWC minutes 5 July 1923, and 16 January 1924). Under both schemes absences were carefully noted by staff and volunteers, with mothers needing permission from either the superintendent or health visitor to miss a lecture; other sessions being run on a more voluntary basis. Toddlers were sent birthday cards to remind their mothers that they were still welcome at the IWC (IWC minutes 24 March 1924) and special groups were arranged for them.

Lack of funds tended to curtail the work of the centre in the early days with the committee noting that no further contributions could be made towards the hospital treatment of 'baby L' (IWC minutes 5 July 1923). The distribution of free milk was discussed at length but never became a practical policy (IWC minutes 16 December 1925). The thrift club attracted a lot of committee support, though mothers were less enthusiastic prompting a number of lectures and announcements on the subject, and the whole scheme went into decline when it was found the interest rate used to tempt the mothers was seriously depleting IWC funds (IWC minutes 24 March, 23 May, and 5 November 1924, also 7 January 1925). Despite the initial interest in providing appropriate medical care it seems that ante-natal work took time to develop and it was the health visitor, Miss Goddard, who finally took the initiative and raised the matter with Dr Baker and Dr Savage (IWC minutes 23 May 1924).

To this point the main focus of the work had been well babies. In 1926 a competition was held for babies attending the IWC. This attracted 35 entrants and was judged by Dr Allen, the Taunton MOH. He placed 9 babies in a first class with honours category, while 13 were first class and the rest second. All the babies received commemorative certificates and the 9 winning babies were professionally photographed. These were presented by the lady mayoress after the usual February lecture (IWC minutes 3 February 1926). Such events were designed to promote positive images of healthy babies, reward attendance at the IWC and interest the wider public in the work. This was becoming more professional and more medicalised as hours were extended, Friday sessions were introduced, and services expanded.

In 1927 the clinic was reorganised. A proper doctor's room was established, staffed by a doctor and a nurse. Methods of recording were improved with the introduction of case sheets and new arrangements for weighing babies. Infant weighing commenced at

2.15pm, with medical consultations starting at 2.30pm. Patients arriving after 3.45pm were not seen unless the nurse judged the case to be an urgent one and infant weighing ceased at 4pm. This routine formed the basis for the future development of the IWC, but once the details were agreed less information was recorded in the minute book, which is blank for nearly 2 years from January 1927 apart from a note of a meeting about the 1928 AGM in January of that year. In December 1928, Miss Soper resigned after long service as IWC superintendent and Mrs Alexander was asked to accept the post of superintendent-nurse and her baby weighing role was passed to nurse Gillard (IWC minutes 12 December 1928). Over the next two years very little is recorded apart from a note that the committee were seeking more suitable premises and consulting Dr Savage about the future of the IWC.

The IWC was undergoing modest changes and there were more obvious efforts to ask the mothers what they wanted from the service, although a plan to ask them if they wanted the opportunity to buy 'grade A milk' for toddlers at the centre was frustrated through lack of funds (IWC minutes 11 July, and 20 October 1930). A range of fund raising efforts were considered, but these were deferred while attention was given to finding a new nurse-superintendent to replace Mrs Alexander (IWC minutes 20 January 1931). There were also resignations amongst the volunteers with 'teas', the toddlers' group, and the wool stall changing hands in 1932. Mrs Light became the new treasurer but the superintendent post remained vacant. The administration of the IWC continued to be debated but no definite decisions were taken as a wide-ranging consultation with Dr Savage was planned (IWC minutes 7 November 1932). Dr Savage expressed the hope that a new superintendent would be found who would be interested in developing the educational side of the work with lectures, poster displays and less formal talks with the mothers.

There are signs that work at the IWC had encountered a number of difficulties in the early 1930s and the appointment of a new superintendent, Mrs Warry, was seen as an important step to restoring normal routines and then developing the work. Interestingly, after a period of personnel change, Mrs Warry was 'assured of the loyal support of the committee' (IWC minutes 24 April 1933). Mrs Warry suggested a number of improvements. Her request to move the IWC into the Mary Stanley Home had to be declined due to lack of space (IWC minutes 29 May 1933) but her ideas for making the centre more attractive to mothers and toddlers were adopted. Mrs Warry suggested that 'it would be nicer if the mothers could be given their tea at a table which could be covered with a cloth' and also mentioned 'that a little wireless or gramophone would brighten the tea-time' (IWC minutes 24 April 1933). Two of the mothers agreed to wash up tea things as there was no longer money to pay the caretaker.

A plan to interest fathers in the work of the IWC was considered. Nurse Gillard suggested a club night when parents would attend without children. 'Its object would be to stimulate the interest fathers are already showing and to arouse it where it does not exist'. Mrs Warry was asked to find a room and to try to have one meeting before the summer vacation (IWC minutes 29 May 1933) but it was later reported that the idea of a fathers' club had not been enthusiastically received by the mothers. The plan was therefore shelved, with the aim of conserving funds and concentrating on core activities, although fathers were specially invited to the annual Christmas treat (IWC minutes 15 November 1933). There had also been plans to extend the work of the toddlers' group.

A decision was made to provide 'rusks' instead of cake at the toddlers' tea and, as an inducement to encourage attendance in the toddlers' annexe, this was offered free for a period of three months (IWC minutes 15 November 1933). This work was however hampered by the extreme cold in the annexe, which led to an appeal to the SCC to pay for the hire of a stove during the winter months (IWC minutes 30 January 1934).

The February 1935 IWC committee meeting noted that Mrs Warry had unexpectedly resigned as superintendent. This immediately led to a rolling back of her improvements, together with evidence of a more authoritarian attitude towards the mothers. The previous quarterly meeting had already shown an unusual interest in tightening procedures. New rules for attendance at lectures were formulated and the lecture committee was tasked with 'discipline during lectures' (IWC minutes 19 September 1934). The February 1935 meeting was even more critical of the mothers. It was suggested 'that the white tablecloths recently introduced be used only on special occasions as the mothers did not really appreciate them and the laundry of the same was an extra expense'. Arrangements were also put in place to ensure 'volunteer mothers' were found for the washing up while cakes for mothers were restricted to 'plain fairy cake only' (IWC minutes 10 February 1936).

The IWC seems to have entered another chaotic phase in its existence and amidst a multitude of personnel changes very little is recorded in the minute book between February 1936 and November 1937 apart from pasted copies of the reports of the annual meetings cut from the local paper. These remained optimistic about current and future work. In 1937, the committee was reconstituted and the IWC moved into new premises in a purpose built health centre that was provided by SCC. This had some similarities with pioneer centres in London (Beach 2000: 203-230), but was conceived and run on a fairly modest scale. The move to the health centre created some problems for the organisation and management of the IWC and after a series of resignations, from long-standing committee members and the chairman Mr Deacon, there was a feeling of instability as routine IWC activities competed for space with developing Red Cross and civil defence work, 1938-1940.

Mrs Cooke-Hurle took on a more prominent leadership role at this time, and the medical work of the centre was strengthened with the allocation of a budget for drugs and arrangements to extend services to evacuee children. The social side of the IWC was kept up with unusually large Christmas parties, supported by the Mayor and Mayoress, held in January 1940 and 1941 (IWC minutes 11 July 1941). There was still a clear role

Table 1: Report from Nurse Carpenter on year's work to 1 May 1942.

Children on visiting list	1496
Visits paid by health visitors	5050
Mothers attending during the year	420
Children attending during the year	501
Total attendances (mothers)	1536
Total attendances (children)	3433
New babies attending for the first time	301
Medical consultations (children)	1032
Medical consultations (mothers)	320
Medical consultations (ante-natal)	39

for the committee and the volunteers, especially in relation to the sale of food and milk, but it was Nurse Carpenter who took responsibility for reporting on the infant welfare activities. In common with IWCs in other places, she concentrated on the number of children attending, the number of visits they paid to the clinics and the number of home visits made by the nurses.

Nurse Carpenter also mentioned the nurses' other health centre work which in addition to the twice weekly infant welfare clinics included a weekly clinic for venereal diseases, fortnightly dental clinics, a monthly immunisation session and a clinic run by the county oculist six times a year. As anticipated the move to the health centre had encouraged a more inclusive approach with new groups of patients (in terms of age, sex and social class) brought within the scope of the work. Also in accordance with the policy of the Ministry of Health, the professional staff of the SCC health department were more in evidence, while the volunteers withdrew to a largely supportive role. Yet it is not clear that this was a deliberate strategy. The Bridgwater clinic was not embarrassed by its volunteers as they chose to work as 'lay professionals' under the umbrella of the health department, and unlike the MOH in Exeter, Savage had no cause to be concerned by independent voluntary action that disrupted the core functions of the clinic. Indeed, despite moments when an authoritarian tone crept in, it seems that voluntary sector support was helpful in providing supplementary activities like teas and sales of work that encouraged mothers to attend the IWC. The multiple contacts existing between the statutory and voluntary sectors also encouraged public interest in the work; a vital but often over-looked part of any IWC's activities.

Reaching out to a wider community

Early attendances at the Bridgwater IWC had pleased the committee but while its target group was new mothers from the poorer parts of town the IWC wanted to reach a wider public. This helped spread the key messages from the infant welfare campaign to new audiences, and drew in much needed financial and practical support. Fund raising became an important way of reaching out to the wider community. The IWC flag days were important ways of raising the profile of the work, with local press coverage reinforcing the impact of the actual event, as well as attracting donations and subscriptions. The first flag day raised more than £30 from sales of cakes, flags and small donations; a not insignificant sum when read alongside the accounts for 1922–1939. A fund raising activity that became part of the tradition of the Bridgwater IWC was the making and sale of golliwogs. This may be read as the kind of oppressive colonialism that Davin and others have associated with the infant welfare movement but in Bridgwater it may have been a conscious celebration of the town's historic role in leading opposition to the slave trade, and more prosaically the toys were easy and cheap to make and sold well.

Although the mothers attending the centre were drawn from the poorer sections of the community, and attention was paid to necessitous cases and providing clinic mothers with free entry to activities wherever possible, the IWC reached out to the whole community to promote infant welfare work and attract funds. On one level there was a straightforward celebration of healthy babies and happy families, with the committee organising a 'parade of perambulators' at local hospital fetes (IWC minutes 19 March 1923). The local community was also encouraged to support and feel involved with the

IWC. Flag days always targeted local factories (IWC minutes 21 and 27 November, and 4 December 1922), and local school children were encouraged to make goods for use and sale. These projects were sometimes designed to reinforce health and hygiene messages, with children asked to help make covers for milk jugs (IWC minutes 24 March 1924). Girls and boys from elementary and other schools, and youth groups, also made clothes and toys for children attending the IWC (IWC minutes 9 January and 29 May 1933). The Girl Guides acted as helpers at the rummage sales (IWC minutes 5 November 1924) and a series of children's concerts provided community entertainment as well as fundraising opportunities (IWC minutes 3 February 1926). Infant and child welfare exhibitions were held and special arrangements were made to encourage older school girls to attend (IWC minutes 10 September 1926). Cookery demonstrations also boosted funds with an unusually healthy balance sheet of £42-10-6d reported to the January 1928 committee meeting after a series of public events.

The main event of the year was the annual public meeting. This was advertised and reported in local churches as well as the local press (IWC minutes 7 January 1925). The format was usually a 'health talk' from a visiting speaker, a tea and some light entertainment. As many as 500 invitations were printed annually and it was usual to see reports of a packed hall for the meeting. People attending were asked to buy tickets and provide a small item for sale. The tea was originally planned as a novelty event with an 'American tea' in 1926 and 'pancakes' when the event coincided with Shrove Tuesday in 1928. As the IWC work became better-established, and more professional, the event was used as a health propaganda tool with a 'vitamin tea' in 1927. In later years emphasis switched from the tea to the lecture with presentations given by officials from the Ministry of Health, various MOHs, and SCC staff, including the woman health propaganda officer and the county psychologist, until the wartime AGMs became purely business affairs.

Public events were often explicitly linked to IWC funding issues, but there was also a willingness to work to support other local health and welfare charities and civic activities. In 1930 the IWC funds were overdrawn and attention turned to fund-raising activities, including ideas for the screening of a cinema film on infant welfare work, a flag and golliwog day, school concerts and a whist drive (IWC minutes 20 October 1930). It was later decided to concentrate efforts on the annual meeting and the spring golliwog day (IWC minutes 20 January 1931). In 1933 the annual golliwog day raised more than £37 after expenses (IWC minutes 24 April 1933). The same year saw the IWC committee participating in 'Bridgwater week' at the request of the town clerk by holding three competitions for best decorated perambulator, a toddlers' mannequin parade for children dressed in sun-bathing suit and hat, and a toddlers' parade of nursery rhyme characters (IWC minutes 29 May 1933). The town council publicity committee later thanked the IWC for 'one of the most attractive and beneficial items during the week's programme' (IWC minutes 15 November 1933).

Discussion

Evidence from the Bridgwater IWC tends to confirm the oft-reported limitations of the mixed economy of care operating in the inter-war period. Despite the best efforts of the staff and volunteers, supported by influential actors in the statutory and voluntary

sectors, the limitations of the service are all too obvious. The IWC was housed in unsuitable premises for most of the period 1922–39, and there are many contemporary references to the way this, and acute funding crises, served to curtail the scope of the work. Yet, there is also evidence of some successes. Women and children attended the centre in large numbers, and evidence of repeat visits suggests they found some of its services useful. The sale of food and goods was certainly carefully tailored to client-demand, and the social side of the centre was well-developed. The provision of medical care by a suitably qualified woman doctor was also a noticeable first for the town, and provided a foundation for improved medical services that were eventually developed through the progressive vehicle of a proper health centre.

This positive assessment of some aspects of the work of the IWC is not meant to detract attention away from its obvious failings, but aims to correct a misleading impression given by some strands of the historiography that infant welfare work was all about social control. The Edwardian health and welfare reforms are usually associated with the Boer war and the needs of the ‘productionist state’ concerned with national efficiency at home and international economic and military competition. Yet, as Pickstone demonstrates, those same services, including IWCs, could equally address ‘communitarian’ and ‘consumerist’ agendas, as the clinic set up to monitor the quality of the population was also a place to voluntarily go for help and advice, take tea with other mothers and/or purchase infant food and baby clothes (Pickstone 2000: 1–19).

This idea of multiple functions has usefully been deployed as an explanation for the increasing use and growing popularity of local authority maternity and child welfare services in the inter-war period. It seems important that the Bridgwater IWC was established in 1921 and had no earlier history. Hendrick certainly argues that the first phase of infant welfare movement was over by 1908 and it became part of the social services system (Hendrick 2003: 63). This suggests some of the more controversial attitudes associated with the early infant welfare movement may have been left behind, though that did not necessarily imply that the financial and organisational resources required to improve standards of care were in place.

Interestingly while the Bridgwater IWC minutes mention the poverty of at least some of the mothers and children attending there is no overt discussion of the poor, in the sense of neglectful, mothering that commentators like Jane Lewis draw attention to (Lewis 1984: 38). Nor is there any sign of the eugenic language that made Peretz so concerned about the orientation and purpose of services in Oxford (Peretz 1995). Yet, what is also missing from the Bridgwater discussions is sustained pressure for better services from staff, volunteers or client groups. This was certainly a noticeable feature of some infant welfare campaigns, being most obvious in places where the professional staff were committed to state provision, where voluntary groups had a limited voice and staff and/or volunteers were prepared to engage with and work alongside client aspirations (Peretz 1995, Vincent 1991: 34–5). Yet in Bridgwater better, and more inclusive, services finally emerged in the form of a purpose-built health centre. Earlier Bridgwater IWC initiatives, such as the determination to treat unmarried mothers on the same basis as married women (IWC minutes 25 November 1921), and engage fathers with the work of the clinic, may be contrasted with infant welfare programmes in other places that appear designed to reinforce social and economic norms and traditional gender roles (Niemi 2007: 64–7 and 98–9).

In some respects it seems that committee members were pursuing a more progressive agenda than the clients were comfortable with, such as when the mothers registered opposition to the plan to involve fathers. Thus, when considering tension between service-users, voluntary workers and professional staff it is perhaps erroneous to assume that service-users invariably wanted more than providers were willing or able to provide. In smaller communities shared values, and a common understanding of what could be afforded were a distinct possibility, and in this sense it is interesting to look at the way that the IWC drew support for its work from a wide cross-section of the community. The problem was that inclusive rhetoric and broad-based contributions to the cost of services was no guarantee of democratic accountability or a voice for service-users (Harris 2004: 230–1). This left the leadership of the IWC in the hands of a fairly narrow group of people, who were apt to register their frustrations about service-development, or lack of it, by criticising each other and the service-users. Isolated efforts to improve discipline and exert control over the mothers were certainly evident at times of crisis, but were arguably not the defining aim of the IWC. Instead there seems to have been a genuine desire to provide a community facility that could serve a variety of purposes for a variety of groups.

Notes

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