Mother and child

Maternity and child welfare in Dublin, 1922–60

Lindsey Earner-Byrne

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To my mother,
Lesley (Earner) Byrne

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Abbreviations

AGF	Attorney General Files
CMO	County Medical Officer
CSSC	Catholic Social Service Conference
CSWB	Catholic Social Welfare Bureau
DDA	Dublin Diocesan Archives
ICPRS	Irish Catholic Protection and Rescue Society
IER	*Irish Ecclesiastical Record*
IESH	*Irish Economic and Social History*
IHA	*Irish Housewives Association*
IHS	*Irish Historical Studies*
IJMSc.	*Irish Journal of Medical Science*
IMA	Irish Medical Association
JCWSSW	Joint Committee of Women's Societies and Social Workers
JIFSMU	*Journal of the Irish Free State Medical Union*
JIMA	*Journal of the Irish Medical Association*
JMAÉ	*Journal of the Medical Association of Éire*
JSSISI	*Journal of the Statistical and Social Inquiry Society of Ireland*
JSSSI	*Journal of the Statistical and Social Society of Ireland*
MCS	Mother and child scheme
NAI	National Archives of Ireland
NLI	National Library of Ireland
RCSI, ML	Royal College of Surgeons Ireland, Mercer Library
Studies	*Studies: An Irish Quarterly Review of Letters, Philosophy and Science*
UCDA	University College Dublin Archives
WNHA	Women's National Health Association

Glossary of Irish words

An Bord Altranais	Nursing Board
Bean na hÉireann	The Women of Ireland *(journal)*
Bunreacht na hÉireann	Constitution of Ireland
Cumann na nGaedheal	Party of the Irish (political party)
Cumann na dTeachtaire	League of Women Delegates
Clann na Poblachta	Party of the Republic (political party)
Clann na Talmhan	Party of the Farmers (political party)
Dáil Éireann (Dáil)	Irish parliament
Fianna Fáil	Soldiers of Ireland (political party)
Ríocht na Midhe	*The Kingdom of Meath* (journal)
Saor an Leanbh	Save the Children
Saorstát Éireann	Irish Free State
Sinn Féin	Ourselves (political party)
Sláinte na nGaedheal	The Health of the Gaels
Taoiseach	Irish Prime Minister
Teach Ultáin	St Ultain's Hospital

Tables

Note: In all tables national and Ireland refers to the twenty-six counties of Ireland, unless otherwise stated.

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Introduction

> The family is the core of human society and the mother, we are told, is the heart of the family. By virtue of her position, she has the responsibility of caring in a special way for the physical, mental, moral, and spiritual and social wellbeing of the family. What then can be more important than to assist in the work of guarding a mother's health, by helping her to solve the problems and anxieties which are preventing her from getting the maximum benefit from the medical services offered to her during pregnancy?[1]

Motherhood is a complex issue involving the mechanics of pregnancy and childbirth and the life experience of mothering and rearing children. Hence both the social realities and the cultural perceptions of motherhood are essential to the experience of mothering.[2] Motherhood, like childbirth, 'stands uncomfortably at the junction of two worlds of nature and culture',[3] and during the first half of the twentieth century the issue of maternal welfare raised many other social questions from family privacy to state responsibility. During the first few decades after Irish Independence in 1922, many mothers found it necessary to negotiate both the limited official relief services and the network of informal welfare services available in order to secure the welfare of the family. This book is concerned with the myriad of motives, conflicts and priorities behind the social and medical services offered to Dublin mothers by voluntary and religious organisations and by local and central governments. The envisaged role and reality of Irish motherhood not only exposed inherent contradictions in the societal response to tradition and modernity, but also called into question the appropriate role of charity and raised the thorny issue of responsibility. Tensions concerning religious territory, the domain of charity and the spectre of state control played a part in the move towards the development of a comprehensive maternity service in Ireland between the years 1922 and 1960.

This book draws from a wealth of literature on Irish culture, society and politics that had helped to elucidate aspects of life in Ireland during the first half of the twentieth century. In the last decade the scope of research on women in Irish history has expanded beyond feminism and nationalism to incorporate every aspect of women's lives from 'the ecclesiastical construction of the ideal Irish woman'[4] to the impact on women's domestic lives of

running water.[5] The issue of maternity, however, has been conspicuously absent in the body of literature on Irish women.[6] Despite the centrality of the 'mothering experience' to women's lives, 'maternity' has not provided much allure for historians, primarily because it held little interest for contemporaries. Apart from the 'mother-and-child controversy' of 1951, the issue received little coverage. The controversy was ostensibly over the introduction of a free maternity scheme for all mothers, irrespective of income. In reality, however, it had more to do with political incompetence and disunity, religious and medical protectionism, and the dynamic of certain personalities. Although the controversy forms an essential part of the history of maternity policy, it also serves as a distraction in terms of maternity provision. Furthermore, despite the tendency of women's history to focus on the issue of female citizenship, there has been a reluctance to consider citizenship beyond political access to incorporate the notion of social citizenship. This study explores, through the issue of maternity welfare, the development of female 'social rights of citizenship' during the first forty years of Independence.[7]

Ireland is rarely considered in studies of welfare provision: welfare is commonly associated with industrialisation, modernisation and secularisation, and Ireland with agriculture, tradition and religion. In fact, it was the emphasis on tradition and the importance of religion that prompted initial welfare provision, and the history of Irish welfare policy is imbued with, and shaped by, the growing anxiety regarding the role of religion and tradition in modern Ireland. Work by Mel Cousins has opened the debate on the history of Irish welfare, but there has been nothing in the Irish context to rival the extensive study of women and welfare in other countries.[8]

While taking on board the warning against treating the development of welfare in any country as sui generis, this study analyses the particular cultural and social influences that impacted on the treatment of mothers in Ireland in general and Dublin in particular.[9] To this end, sources such as the papers of the two Roman Catholic Archbishops of Dublin, Dr Edward Byrne (1921–40) and Dr John Charles McQuaid (1940–72), have been invaluable in exposing the centrality of the Roman Catholic Church in the welfare and public health debates in relation to mothers during these years. The thousands of letters written by mothers to Dr Byrne have also afforded a rare insight into how mothers themselves viewed their position in society in terms of welfare provision. With the advantage of these sources, this work adds to a history that aims to provide not only a 'more complex picture of the totality of women's experiences',[10] but also an insight into the development of secular welfarism and social citizenship in modern Ireland.

In the 1920s and 1930s, the international preoccupation with state power and population development led to an increased emphasis on motherhood as a determining influence on national vitality and public health. In countries as different as France, Germany, Italy and Norway, feminists were declaring 'motherhood as a social function'.[11] In most Western European

countries the main impetus behind the interest in maternal welfare was an international concern about the declining birth rate, which had reached a low point in many countries by 1933.[12] Ireland was a demographic anomaly in Western Europe. As a gathering of the Irish Statistical and Social Inquiry Society was informed in 1935, 'In no respect is this country more strikingly dissimilar from others than in the manner in which the population is recruited. With the lowest marriage rate in the world and one of the highest fertility rates (births per marriage) the Saorstát achieves a more or less average birth rate.'[13] The Irish demographic challenge came in the guise of a low marriage rate, and high emigration and infant mortality rates.

In 1939, as a result of an examination of the 1936 census, the Minister for Finance, Séan MacEntee, reassured the cabinet that every other country in Europe except Germany exceeded the percentage decline in Ireland's birth rate of 4.9 between 1926 and 1936.[14] Although he believed that the main problem was emigration, he conceded that the situation could be counteracted by an improvement in the survival rate of Irish children.[15] While the Irish state flirted with the rhetoric of population panic, ultimately both the demographic reality and social outlook of the state leaned more to the issue of public health as an objective in its own right. For many contemporaries working in the area of social services, the increased investment in maternity and child welfare services was regarded as 'one of the most convincing signs of an awakening of public interest in public health'.[16] Although it was hoped that improved public health might lead to an increase in national vitality and a comparable decrease in emigration, that wish should not detract from the fact that the desire to improve the physical health of Irish citizens was genuine. Consequently, from the late 1930s until the mid-1950s Ireland sought to confront its population problem with a strategy of counteraction against the tolls of infectious diseases and maternal and infant mortality. The Irish mother, therefore, was not targeted by pronatalist policies as in other European countries; instead she was the focus of debates and policies relating to the development of public health and the preservation of the social and the moral order.[17]

Prior to the Second World War, preventive maternity care was the preserve of the local authorities: they negotiated deals with charities and instigated a network of protection for mothers and their children. They were, however, not obliged to do so. For that reason the first identifiable feature of Ireland's maternity services was that they developed in a piecemeal fashion, varying hugely from county to county. The geography of the maternity and child welfare services that developed between 1922 and 1960 is crucial to the examination of the impact and tenor of those services. The maternity and child welfare services grew up around the county medical officer system, thereby rendering the service dependent on local initiative and regional variations. If a county did not appoint a county medical officer, and it was not obligatory to do so, then services for that county depended almost wholly on chance and charity. Often maternity hospitals proved crucial to

the development of maternity and child welfare services in an area: the maternity hospital provided the core supervising antenatal clinics, referring patients to voluntary agencies for food and assistance, and arranging health visits.[18]

Dublin was exceptional in national terms, as it had the most comprehensive services for mothers and children, in both medical and welfare terms, and the most established network of charitable endeavour. Dublin was also well-endowed with three maternity hospitals, all of which were proactive in creating a canopy of integrated services for mothers, from medical attendance in hospital and at home to antenatal clinics and a referral system to maternity kitchens and other charitable facilities. Furthermore, despite its three voluntary maternity hospitals, Dublin had one of the worst infant mortality rates in the country for many years.[19] When central government was prompted into a more proactive response to maternity and child welfare in the early 1940s, it was primarily as a result of the soaring infant mortality rate in Dublin caused by the infectious disease gastro-enteritis and an awareness of the Beveridge Report (1942) in Britain.

From the beginning of the twentieth century, public health officials, medical experts and voluntary organisations drew attention to the connection between pregnancy and infant survival. Research into the impact of nutrition and antenatal care helped to broaden the contemporary understanding of pregnancy beyond childbirth. The more comprehensive view of pregnancy that emerged in the early twentieth century simultaneously expanded the social interpretation of maternity welfare. A mother's welfare began before the birth of her child and lasted well into the period of nursing. She was, therefore, entitled to medical care and nutritional and financial support. Nevertheless, the issue of assisting mothers to avail themselves of medical services and secure sufficient nutrition for themselves and their families was considerably more complicated than simple administration and organisation. The dilemma posed by the issue of maternity welfare drew in its train issues of religious and professional protectionism, money, morality and state power.

The first two chapters of this book chart the development of a maternity consciousness in public health terms and the social and moral complications that ensued. The nineteenth-century legacy of proselytism meant that the Roman Catholic Church was suspicious of, and hostile to, any Protestant or 'non-sectarian' organisations engaged in maternity and child welfare. Thus attention is also paid to the cultural association between morality and health, which did so much to complicate the development of a more comprehensive maternity and child welfare service in the succeeding years. Sectarian tensions undoubtedly limited the potential for co-operation between voluntary organisations and served as a distraction from the objective of infant protection. Nonetheless, the emphasis on moral supervision and religious-based charity, while restrictive and punitive, did also afford mothers room for negotiation. Chapter 3 explores the ways in which Catholic

mothers negotiated the various relief options open to them. There is ample evidence that Catholic mothers were not merely passive recipients of assistance and advice, but were frequently active agents securing charity in exchange for allegiance. It was this fear of religious bargaining and the desire to limit secular or state intervention into social welfare that precipitated Roman Catholic involvement in maternity welfare. From this juncture the issue of maternity and child welfare became a virtually exclusive dialogue between the Roman Catholic Church and the Irish state, to the detriment of other religious and lay groups previously active in that arena.

Chapters 4 and 5 examine the impact of the Second World War, the emergence of a welfare state in Britain, an increasingly vociferous medical profession in alliance with a more proactive Roman Catholic diocese under McQuaid. McQuaid believed in the 'informal but effective concordat' established in the nineteenth century between the Catholic Church and nationalist leaders.[20] Consequently, he fought to maintain an established working relationship, one in which the state sought to 'supplement not supplant' Catholic voluntary effort in the field of social service.[21] In pursuit of that goal, McQuaid was involved in a positive sense in the government's drive to promote breastfeeding and reduce gastro-enteritis. However, the Archbishop was also assisted and encouraged in a policy of Catholic supremacy, whereby co-operation between different religious voluntary organisations was eschewed in favour of competition and exclusion. An analysis of the working relationship between the Archbishop of Dublin and the Department of Local Government and Public Health during the early 1940s provides the background of the difficulties that emerged in the late 1940s and early 1950s, when the state took a more 'secular' approach to maternity care.

By the 1940s the issues of infant mortality and infectious disease raised the profile of maternal health, allowing the state to take a more interventionist stance then previously justifiable: infectious diseases were accepted as a communal concern, enabling the state to encroach on the privacy of the family. Until the introduction of the ill-fated Public Health Act of 1947 the Irish state had no coherent policy in relation to maternal health and welfare. The attempts to introduce a free service for all mothers and children, irrespective of income, resulted in the infamous 'mother-and-child controversy' of 1950–51. While Chapter 5 offers a detailed analysis of this controversy in a political, cultural and medical sense, Chapter 6 explores the impact of the controversy on the progress of maternity care and analyses the meaning of the compromise scheme introduced in 1953 to Dublin mothers.

The final chapter examines the services provided for the unmarried mother and her child. The Irish state proscribed birth control, and while the rhetoric concerning motherhood was relatively non-prescriptive, a mother was only considered 'legitimate' if she was married. The unmarried mother was, therefore, in a particularly invidious position. Nonetheless, almost 100,000 illegitimate births were recorded between 1920 and 1970. The fate of both

the mothers and the children was an indication of the social price that society was willing to pay for moral and cultural peace of mind. Frequently, these women faced detention in an institution, and their children died at between two and five times the rate of legitimate infants.[22] Many of the mothers fled to Britain rather than face the haphazard fate that awaited them and their children in Ireland. While the unmarried mother benefited from the mother-and-child scheme of 1953, she was virtually ignored by the Irish state, which operated a policy of stressing the moral aspect of the 'unmarried mother problem', thereby passing responsibility to the religious authorities. Neither Church nor State considered the single mother in terms of her citizenship; both institutions were concerned with the protection of her infant and the national disgrace caused by her propensity to emigrate, pregnant, to Britain. In the context of the wider debate on maternal welfare, the final section of this book completes an examination of maternity and child welfare with all its intricacies, including the role of religion, society, individuals and government.

Notes

1 M. Horne, 'An almoner's work in a maternity hospital', *Journal of the Irish Medical Association* (*JIMA*), 34:202 (Apr. 1954), 105.
2 J. Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900–1939* (London, 1980), p. 14.
3 A. Oakley, *Women Confined: Towards a Sociology of Childbirth* (Oxford, 1980), p. 7.
4 M. Valiulis 'Neither feminist nor flapper: the ecclesiastical construction of the ideal Irish woman', in M. O'Dowd and S. Wichert (eds), *Chattel, Servant or Citizen: Women's Status in Church, State and Society* (Belfast, 1995), pp. 168–78.
5 M. E. Daly, '"Turn on the tap": the state, Irish women and running water', in M. G. Valiulis and M. O'Dowd (eds), *Women and Irish History: Essays in Honour of Margaret MacCurtain* (Dublin, 1997), pp. 206–19.
6 There has been an attempt to deal with the issue of childbirth focusing on medical intervention and the development of different birthing practices. Caitríona Clear has looked at 'aspects of pregnancy and childbirth' and the issue of breastfeeding. See C. Clear, *Women of the House: Women's Household Work in Ireland 1922–1961: Discourses, Experiences, Memories* (Dublin, 2000); See also P. Kennedy (ed.), *Motherhood in Ireland: Creation and Context* (Cork, 2004), which, although not an historical study does contain certain chapters with historical dimensions.
7 H. Heclo, *Modern Social Policies in Britain and Sweden: From Relief to Income Maintenance* (London, 1974), p. 13.
8 M. Cousins, *The Birth of Social Welfare in Ireland, 1922–1952* (Dublin, 2003). See, for example, G. Bock and P. Thane (eds), *Maternity and Gender Policies: Women and the Rise of European Welfare States, 1880–1950* (London, 1991); Lewis, *The Politics of Motherhood*; J. Lewis (ed.), *Women's Welfare, Women's Rights* (London, 1983); S. Pedersen, *Family, Dependence, and the Origins of the Welfare State: Britain and France, 1914–1945* (New York, 1993); R. Fuchs, 'Morality and poverty: public welfare for mothers in Paris, 1870–1900', *French History,* 2:3 (Sept., 1988), 288–311; S. Michael, and S. Koven, 'Womanly duties: maternalist politics and the origins of the welfare

states in France, Germany, Great Britain and the United States, 1880–1920', *American History Review,* 4:95 (Oct. 1990), 1076–108.

9 Heclo, *Modern Social Policies in Britain and Sweden,* p. 14.

10 M. Ward, *The Missing Sex: Putting Women into Irish History* (Dublin, 1991), p. 18.

11 Bock and Thane, *Maternity and Gender Policies*, p. 8.

12 *Ibid*., p. 10.

13 R. C. Geary, 'The future population of Saorstát Éireann and some observations on population statistics', *Journal of the Statistical and Social Inquiry Society of Ireland* (*JSSISI*) 89 (1935–36), 20.

14 S. MacEntee, 'Some observations on the population problem in this country', 1939; NAI, Dept. Taoiseach, S9684.

15 *Ibid.*

16 Anon., 'Maternity and child welfare,' *The Lancet*, 1 (19 June 1927), 407.

17 During the 1930s there was a wave of 'panic pronatalism' in Franco Spain, France and, to a lesser degree, in Britain and Scandinavia: Bock and Thane, *Maternity and Gender Policies*, p. 50.

18 This was the case in Dublin, Cork, Limerick and Drogheda.

19 In 1921 the national infant mortality rate was 77 per 1,000 registered births and for the Dublin registration area 134, for Belfast 115 and for Limerick 113. See *Annual Report of the Registrar-General, 1921* (Dublin, 1922), pp. xix–xx.

20 Larkin cited in D. Miller, *Church, State and Nation in Ireland 1898–1921* (Dublin, 1973), p. 493.

21 James Staunton to Taoiseach, J. A. Costello, 10 October 1950, DDA, McQuaid Papers, AB8/B/XVIII.

22 In 1923, the Registrar-General noted that the illegitimate death rate was six times the legitimate death rate. In 1940 the recorded illegitimate death rate was four times the legitimate death rate. See *Annual Report of the Registrar-General, 1923*, p. xviii; *Annual Report of the Registrar-General, 1940* (Dublin, 1941), p. viii.

1

Maternity and child welfare pre-Independence

So the babies' clubs were started
in a real viceregal way
With a feast of cakes from Scotland and a mighty flood o' tay,
An' Mrs Aberdeen was there in
her disinfected best,
An' swallowed with her tay as
Many microbes as the rest.[1]

The framework legislation passed in relation to public health, prior to Irish Independence, provided the backbone and logic for the haphazard system that persisted in Ireland until its overhaul in the early 1950s. However, the debates generated by certain pieces of legislation, and the tailoring and omission of others, provide interesting insights into the public health culture that emerged in pre-Independence Ireland. The theory of Ireland's sui generis needs was well established prior to 1922. This facilitated the centrality of debates regarding the role of religion, the state, voluntarism and the sanctity of the family. The resistance to adapting all British initiatives to the Irish context without question had its roots in a colonial past but this attitude, fuelled by national pride and financial realities, persisted throughout the twentieth century with regard to the creation of a welfare state. Maternity and child welfare often provided the pretext for debate on issues quite apart from mothers and children, which related to deep-seated fears regarding the power lines in Irish society. The boundaries between the spiritual and the temporal, state and voluntary body, central and local government, doctor and midwife, and husband and wife were challenged by the most unadventurous of measures in maternal and infant protection.

Irish public health: the nineteenth-century legacy

The tradition of preventive public health care in Ireland, however *ad hoc*, dated back to the first half of the nineteenth century.[2] The level of poverty and the fear of infectious diseases spurred the development of an impressive

medical charities system based on the Dispensary Act of 1805[3] and the Fever Hospital Act of 1818.[4] Ronald Cassell noted that by 1841 'a year before the public health movement started in England, the theory that sickness caused poverty and that the state had to do something substantial about it was clearly formulated in Ireland'.[5] These developments were consolidated by the Medical Charities (Ireland) Act 1851,[6] which concentrated in the Irish Poor Law Commission 'medical relief and public health powers unprecedented in Ireland and unparalleled in the rest of the United Kingdom'.[7] Under the Act the Irish Poor Law Commission was empowered to regulate and define the role of the dispensary medical officers by insisting that they should be qualified in surgery, medicine and midwifery and should keep records. Between 1851 and 1872 the number of dispensary midwives employed in the country increased from 10 to 187.[8] Furthermore, the Medical Charities (Ireland) Act never mentioned the word 'destitute', and instead referred to the medical relief and care of 'poor persons', which facilitated a broader interpretation of entitlement.[9] Geary argues that the charities act removed the 'vestiges of paternalism and philanthropy' that clung to the dispensary system by making these institutions an 'integral part of the poor law system', and heralded the beginning of greater state involvement and increased centralisation.[10]

In 1925, the Department of Local Government and Public Health viewed the lack of definition of 'poor persons' in the 1851 act as an advantage because it allowed a 'liberal interpretation'.[11] Ruth Barrington also observed that the Irish poor law differed from the English version in the degree of emphasis on medical relief.[12] By 1862, the Poor Law (Ireland) Amendment Act legalised the admission into workhouse infirmaries of poor persons with non-contagious medical problems, facilitating, in effect, a conversion of the workhouse system into one of general hospitals. While this act legalised a growing trend, it ironically signalled the end of innovation in the public health care system in Ireland.[13] All other legislation affecting public health in the latter part of the nineteenth century, such as the Compulsory Vaccination (Ireland) Act (1885) and the Births and Deaths Registration (Ireland) Act (1864), originated in Britain.[14] Both were introduced despite opposition in Ireland from a section of the medical profession and the Catholic clergy respectively.[15] Even at this early stage in the development of a public health consciousness, the potential for a medico-religious alliance against state intervention was evident.

The vaccination and registration legislation reflected the trend towards prevention, regulation and control: the infectious nature of disease and the high rate of infant mortality encouraged contemporaries to approach public health from a communal as well as an individual perspective. Towards the end of the nineteenth century, public health policy continued to privilege the needs of the community over those of the individual. As a result, the language of legislation increasingly took on the 'syntax of compulsion'.[16] The Public Health (Ireland) Act of 1878 and the Local Government (Ireland)

Act of 1898 further established this approach, the former establishing new local authorities to administer preventive health services and certain curative services primarily for infectious disease. The 1898 Local Government Act established county councils and county borough councils which eventually became responsible for the administration of public health services, including tuberculosis services established under the tuberculosis acts, and the venereal disease scheme established under the Public Health (Prevention and Treatment of Disease) (Ireland) Act, 1917.[17]

Maternity and child welfare increasingly became the focus of public health legislation in the early twentieth century. Much of the legislation introduced was in keeping with the emerging regulation logic and was justified on the grounds of prevention: the prevention of maternal and infant mortality and morbidity. The Notification of Births Act, 1907, which enabled local authorities to require that all births be registered, and the compilation of statistics regarding mortality represented the first tentative steps in establishing maternity and child welfare services. This was only gradually extended to Ireland when Dublin embraced the legislation in 1910 after lobbying by public health campaigners and voluntary groups such as the Women's National Health Association (WNHA).[18] Dublin Corporation viewed the act's primary purpose as infant protection through the targeting of the poorer classes. It enabled health visitors, following the notification of a birth, to 'give advice … to mothers of the poorer classes on the feeding and rearing of infants'.[19] While it was acknowledged that the act was class-blind and that all births had to be notified, in practice the corporation's health visitors did not disturb the mothers of the middle and upper classes.[20] The Notification of Births Act, 1915, which was extended to Ireland, made the 1907 act compulsory and gave limited financial teeth to its good intentions.[21] It allowed for a 50 per cent recoupment of local authority spending on maternity and child welfare schemes to a maximum of £5,000 per annum.[22] These financial provisions only applied to urban districts in Ireland and did not oblige local authorities to set up maternity and child welfare schemes.[23] However, the powers afforded the Irish sanitary authorities were greater than those afforded their English counterparts, as the Irish legislation was not subject to amendments during the committee stage of the bill.[24]

Revealingly, the 1915 act allowed for the formation of urban committees on maternity and child welfare 'which shall include women'. This acknowledged the leading role played by women in public health and the widely held conviction that women were particularly suited to this form of work.[25] Irish women had already made inroads into maternal and child welfare. When reviewing the impact of the 1907 and 1915 acts, Lawson acknowledged the role of the Infant Aid Society in visiting Dublin mothers upon birth and the WNHA in establishing baby clubs for the propagation of mothercraft.[26] Margaret Ó hÓgartaigh argues that women physicians 'capitalised on the increasing interest in public welfare, and were active in the Babies' Clubs'.[27] What emerges from the work of Ó hÓgartaigh and Irene

Finn is a web of women active in the field of public health and welfare, mostly, though not exclusively, middle-class and Protestant, who populated committees, clubs, charities and hospitals and thus provided the network and precedence for later social feminists in Ireland.[28]

The Midwives (Ireland) Act, 1918, which was principally designed to regulate midwifery, also entitled any mother who did not qualify for free treatment under the medical charities system to the attention of skilled medical aid in the case of an emergency in connection with parturition.[29] Those working with necessitous mothers in Ireland were anxious that the midwives act should be extended to the country. The Lady Sanitary Officers in Dublin, who visited mothers under the Notification of Births Act, were active in the campaign to stamp out the practice of 'handy women'. The officers encouraged the centrality of maternity hospitals and promoted hospital births or births attended by hospital doctors and midwives. One Lady Sanitary Officer, Mrs E. Nally, feared that if the midwifery act were not extended to Ireland, the country would become 'the dumping ground for the inepts of Great Britain'.[30] The fear that legislation pertinent to mothers would not be translated appropriately to the Irish context was a constant theme in the pre-Independence years.

The early twentieth century witnessed an increase in social legislation that focused on welfare and health, thereby acknowledging the increasingly accepted link between these two aspects of life.[31] Between 1900 and 1921 Ireland benefited from the wave of liberal reforms in Britain, for example the Children's Act, 1908, the Old Age Pension Act, 1908 and the National Insurance Act, 1911.[32] The Old Age Pension Act was hugely popular in Ireland and caused official alarm owing to the enormous up-take: it appeared that a good many more Irish people lived to the age of seventy than the exchequer had calculated.[33] The National Insurance Act was also contentious: first, the medical benefit was not extended to Ireland and secondly, the maternity benefit, which was available to the wives of workers who qualified under the act, was altered to suit Irish conditions.[34] In theory, this act offered protection to working-class families against medical costs, the expense of childbirth and sanatorium treatment for tuberculosis.[35] However, the act was 'not designed for Irish conditions' as it was a health insurance system based on friendly societies, which hardly existed in Ireland.[36] Furthermore, the act was perceived in Ireland as a form of 'penal taxation'[37] and as a 'sudden and potentially catastrophic threat'[38] to the three voluntary maternity hospitals in Dublin city. The Rotunda,[39] the Coombe,[40] and the National Maternity Hospital[41] were powerful players in medical politics and public health policy. The hospitals objected to the fact that the thirty shillings maternity benefit would not be paid to mothers receiving hospital care. The logic for denying this payment to mothers receiving hospital care was based on the presumption that this care was generally provided free of charge. The hospitals feared that these women would opt for the money instead of hospital treatment, thus decimating the hospitals' client list.[42]

The hospitals also embellished their case by expressing a fear that such 'cash payments' would destroy the industry of private charity, thus establishing a formula for medical objections to state intervention in the arena of maternal welfare which was closely allied with religious (principally, though not exclusively, Roman Catholic) concerns.[43]

Henceforth, any threat to the medical profession's territory was married with a comparable risk to the benevolent instincts of charity. A compromise was found: mothers opting for hospital births would receive the maternity benefit subject to a deduction of five shillings which would be paid to the hospitals.[44] The issue of maternity benefit continued to be controversial even after its compromise introduction into Ireland. Irish women eagerly took advantage of this provision to such a degree that by the end of the first year there was considerable concern at the numbers availing themselves of the benefit. Barrington notes that by 1915 some 44,318 Irish mothers were in receipt of maternity benefit, which accounted for nearly half of all births.[45] However, those who entered the homes of the poor argued that the 'small maternity benefit of the insurance act scarcely ever reaches the mothers most in need of it. The wives of casual labourers – owing to the husband being in arrears with his contributions, due of course, in all cases to unemployment.'[46] There were also debates regarding the payment of the benefit which mirrored future debates regarding the payment of Children's Allowances (1944), with contemporaries arguing that the maternity benefit should be paid to the father in order to protect his domestic status as breadwinner and provider. This enraged Irish feminists, who commended the Women's Co-operative Guild[47] for fighting to have the benefit considered the 'property of mothers'.[48] Nonetheless, Irish feminists believed that the benefit was 'a first step in the right direction' and, crucially, they argued that it had 'drawn public attention to the grave needs of working-class mothers, and to a condition of affairs seriously affecting the future generations'.[49]

The Republican Maud Gonne drew attention to the near-starvation of many schoolgoing children and there was considerable disquiet that Ireland had not been included in the Provision of School Meals Act, 1906. However, when Gonne established the Ladies' School Dinner Committee she faced contemporary opposition on the grounds that children should be fed in the bosom of the family and that organised feeding of schoolchildren amounted to socialism.[50] A compromise, the Education (Provision of Meals) (Ireland) Act, 1914, allowed Irish Urban District Councils to make arrangements for the provision of meals for children attending national schools if children were unable to avail themselves of education as a result of hunger. The only public health legislation in relation to infant or child protection which was made mandatory in Ireland was the medical inspection of schoolchildren under the Public Health (Medical Treatment of Children) (Ireland) Act, 1919.[51] The fraught political climate in Ireland meant that the 1919 act was effectively shelved until after Independence. Indeed, in the wake of Independence the Minister for Local Government and Public Health, Séamus

A. Burke, appeared unsure of the act's relevance to Ireland:

> There was an English Act, and I assume it was drafted more with reference to the conditions in England than the conditions over here … The appointment of a medical inspector of schools would, I imagine, be an economic proposition for a big populous area like an English county, but might be altogether uneconomic for an area of the size of the average Irish county.[52]

When the issue of school medical inspections was tackled by an Irish administration in 1947, it brought with it the increasingly prominent anxiety regarding the sanctity of the family, the power of the state, and fears regarding socialism.

Infant protection: British wars and Irish babies

> [In 1912 there were] 156 tombstones for the Dublin babies who passed from the noise and crowding of the tenement house to the Kingdom of Heaven which is ever open to the little children. We ask, in all seriousness, is it not time our rulers took thought for this matter? What use to build Dreadnoughts and plan for regiments when children who, grown to full age, should man these are dying.[53]

The impact of war served to focus attention on infant mortality, which was considered an indicator both of national vitality and of the weaknesses in public health policy.[54] In Britain this awareness led to a series of investigative committees and reports, including the Inter-Departmental Committee on Physical Deterioration in 1904,[55] the National Conference of Infant Mortality in 1906 and 1908 and the Departmental Committee on Maternal Mortality in 1928.[56] These reports were heavily influenced by imperialist fears about the physical weakness of British subjects. The death tolls of the Crimean War (1853–54), the Boer Wars (1880–81, 1899–1902) and crucially, the Great War (1914–18) heightened contemporary awareness of the domestic battlefield against infant mortality. Public health, particularly the health of mothers and children, was increasingly regarded as a necessary form of national investment. The theory of counteraction and prevention emerged: in essence, the idea that began to infuse and enthuse public health activists was that infant lives could counteract the war losses and healthy citizens could prevent future military defeats. As Lawson argued, when extolling the virtues of the Notification of Births Act, 1915, 'The war is still with us, but the great loss of adult life caused thereby makes it the more incumbent on us to do what we can to protect the infant life we have.'[57] Dunwoody observes that the First World War brought the language, if not the reality, of social reform to Ireland. However, in providing the language it facilitated the debate, which ultimately led to significant pressure for change.[58] The war galvanised voluntary effort and witnessed a proliferation of local maternity and child welfare groups and initiatives.

In 1917 the Carnegie United Kingdom Trust sponsored investigations into maternity and infant welfare in the three Kingdoms.[59] The Irish report was compiled by Dr Edward Coey Bigger, the medical commissioner of the Local Government Board of Ireland and the Crown representative for Ireland on the General Medical Council.[60] Bigger's report was imbued with concern regarding population growth and 'imperialist preservation'.[61] He argued that infant protection was vital to national prosperity and national existence.[62]

Bigger proposed Dublin as the centre 'for the teaching of infant and child welfare work'.[63] He stressed the urgent need for mandatory legislation to provide for their welfare. Locating his argument in the realm of social investment, he wrote, 'No branch of public health work can affect so much at a moderate cost as that of maternity and infant welfare. Every mother, every infant and every child is of value to the country; we can no longer afford to waste their lives.'[64] Bigger isolated the tendency toward permissive legislation in Ireland, noting that it was insufficient to *permit* local authorities to provide for the care of mothers and children. He recommended 'repeated and systematic examination' of mothers during their pregnancy, thereby making the crucial connection between the supervision of pregnancy and the survival of the baby.[65]

Bigger's report was perspicacious in many respects, but most importantly for the future of maternity services, he identified a direct link between the mother's health, her surroundings and her child's survival. He prioritised ten factors which contributed to the death of infants, ranging from the care of the mother during her labour to the supervision of milk and food supplies.[66] All of these would become central to the maternity debate in the ensuing years; the first five dealt exclusively with the mother's health and her economic position and social surroundings.[67] Bigger argued that all social factors were interrelated and that 'poverty, by means of the influence which it exerts on the parents, the food and the environment of the infant, is a serious factor in the causation of infant mortality'.[68] Although Bigger considered the realities of impoverished motherhood, his primary focus was the infant. Imbued by the atmosphere of war, Bigger drew attention to the high infant-mortality rate in Dublin by placing the death rate in the context of war casualties:

> If the public can only be made to realise that the newly born infant has less chance of living till this time next year than his father who is fighting in France, surely something must be done, but we have a burden of apathy and ignorance to contend with, and these foes are so dangerous as they are insidious.[69]

The Weekly Irish Times made the same comparison, declaring that 'the death of Irish babies exceeds the casualties of war so far as Irish soldiers are concerned'. This it attributed to 'Ireland's neglect', noting that it was deeply unpopular even to suggest such communal negligence.[70] However, poignant

juxtapositions of infant corpses and military body bags did not lead to comprehensive provision for the protection of infant life. The Notification of Births Act, 1915 and the Midwives Act, 1918 marked the only legislative initiatives prompted by the raised awareness of war. Both were mandatory but involved the regulation of procedures and the fortification of professionalism rather than any brave new measures in the field of infant and maternal welfare.

Historians have argued that up until the late 1920s the high infant-mortality rate in Ireland was accepted with a curious mix of apathy and stoicism.[71] Concern was slow to emerge, owing primarily to a sense of fatalism and an underlying suspicion that debility was the cause. The notion of debility was frequently used to defend the high infant-mortality rate among illegitimate babies.[72] The Eugenics movement did not take hold in any major way in Catholic Ireland[73] Nonetheless, social commentators and doctors did indulge in eugenic semantics and it was often hinted that a belief in the 'survival of the fittest' was a reason for the tardy response of many in positions of responsibility. Furthermore, some of the leading public health campaigners were associated with the eugenic movement, for example Lady Aberdeen and Dr Marion Andrews of the WNHA.[74] It was, however, the fatalistic attitude, resultant, in part, from the long-standing history of high mortality rates among the poorer sections of Irish society, which lead to the conviction that these deaths were inevitable. Prunty noted that in the fight against tuberculosis 'the biggest obstacle was fatalism', and this defeatism was apparent generally when it came to confronting the social problems of slum living.[75]

The notable exception was the WNHA, which worked tirelessly to counteract the latent apathy regarding public health.[76] It was a pioneering public health organisation established by Countess Aberdeen, the wife of the Lord Lieutenant of Ireland, in 1907 in response to the appalling social conditions she witnessed in Dublin.[77] By 1911 the WNHA had 155 branches and almost 18,000 members.[78] The organisation sought to educate and energise the public in relation to health and welfare. Its activists focused on subjects particularly relevant to the poor: tuberculosis, clean milk, the implications of poor hygiene, and maternal and child welfare.[79] They were instrumental in raising awareness regarding tuberculosis and instigating the campaign for school meals.[80] Although the organisation operated nationwide, Dublin was the focus of initial campaigns to establish clubs for infant welfare. On extension of the 1915 Notification Act the WNHA began negotiations with Dublin Corporation and secured the first grant to establish baby clubs in the city in 1916.[81] The clubs were created with the intention of fostering co-operation between official and voluntary bodies.[82] In the long run this was perhaps the most beneficial aspect of the association's work for Dublin mothers, as they encouraged the authorities to enter the field of maternity services, a process which became irreversible. In 1927 a model child care centre was established at Lord Edward's Street with