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Reports on

Maternal Mortality and the Maternity Services

and

Women in Industry

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Report on
MATERNAL MORTALITY
AND THE
MATERNITY SERVICES

I—RATE OF MATERNAL MORTALITY

It is clear from the growing interest in maternal mortality that the public generally is beginning to realise two facts: (1) the maternal mortality rate is very *high*, and has persisted at a high level for many years; (2) maternal mortality is largely *preventable*.

Since 1911, the risks of life have been reduced for every section of the community, except for mothers at childbirth. The general death-rate has fallen from 14·6 per 1,000 in 1911 to 12·3 in 1933; the infant death-rate from 130 per 1,000 births to 64; the tuberculosis death-rate from 1,646 per million (this was the average rate for the period 1901–10) to 799. But the maternal death-rate from puerperal causes, which was 3·87 per 1,000 live births in 1911, was 4·51 in 1933. There were fewer maternal deaths than in 1911, but the death-rate was higher since the number of births had fallen from 881,138 in 1911 to 580,413 in 1933, and the death-rate is calculated on the basis of live births registered.

The falling birth-rate means a larger proportion of first confinements, which are known to be the most dangerous. Therefore, it is sometimes argued, the high maternal death-rate is not so alarming as the figures might suggest. But no explanation on these lines can conceal the fact of our failure to lessen the risks of motherhood.

England and Wales

The following table gives the figures for maternal mortality and infant mortality since 1911 and shows the upward trend of the *total puerperal mortality rate*:—

Year	Deaths of Women classed to Pregnancy and Child-bearing				Deaths of Women not classed to Pregnancy and Child-bearing, but returned as associated therewith		Infant Mortality Rate per 1,000 births	
	No.	Rates per 1,000 live births registered			No.	Rate per 1,000 live births registered	Under 4 weeks	Under 12 months
		Puerperal Sepsis	Other puerperal causes	Total puerperal mortality.				
1911	3,413	1·43	2·44	3·87	909	1·04	40	130
1912	3,473	1·39	2·59	3·98	848	0·97	38	95
1913	3,492	1·26	2·70	3·96	803	0·91	39	108
1914	3,667	1·55	2·62	4·17	831	0·95	39	105
1915	3,408	1·47	2·71	4·18	881	1·09	38	110
1916	3,239	1·38	2·74	4·12	739	0·94	37	91
1917	2,598	1·31	2·58	3·89	638	0·95	37	96
1918	2,509	1·28	2·51	3·79	2,529	3·81	36	97
1919	3,028	1·67	2·70	4·37	1,337	1·93	40	89
1920	4,144	1·81	2·52	4·33	1,086	1·13	35	80
1921	3,322	1·38	2·54	3·92	925	1·09	35	83
1922	2,971	1·39	2·44	3·81	1,051	1·35	34	77
1923	2,892	1.30	2·52	3·82	764	1·01	32	69
1924	2,847	1·39	2·51	3·90	849	1·16	33	75
1925	2,900	1·56	2·52	4·08	759	1·07	32	75
1926	2,860	1·60	2·52	4·12	709	1·02	32	70
1927	2,690	1·57	2·54	4·11	861	1·32	32	70
1928	2,920	1·79	2·63	4·42	790	1·20	31	65
1929	2,787	1·80	2·53	4·33	960	1·49	33	74
1930	2,854	1·92	2·48	4·40	774	1·19	31	60
1931	2,601	1·66	2·45	4·11	911	1·44	32	66
1932	2,587	1·61	2·60	4·21	713	1·16	32	65
1933	2,618	1·83	2·68	4·51	828	1·43	32	64

The maternal deaths are not distributed evenly throughout the country. Some counties and boroughs have rates well below the average for the whole country. The North, generally, has higher rates than the South. The highest rates over a number of years have been found in certain industrial areas, *e.g.*, Lancashire and Yorkshire; certain mining areas, *e.g.*, South Wales; and certain sparsely populated areas, *e.g.*, North Wales and Cumberland.

Scotland

The Scottish figures, too, have remained almost stationary for many years :—

Year	Maternal Mortality Rate, per 1,000 births	Year	Maternal Mortality Rate, per 1,000 births
1905–14 (annual average) ..	5·6	1927	6·4
1905–24 (annual average) ..	6·2	1928	7·0
1924	5·8	1929	6·9
1925	6·2	1930	6·9
1926	6·4	1931	5·9
		1932	6·3
		1933	5·9

The infant death-rate fell from 124·5 per 1,000 births in 1915 to 81 in 1933. Both the maternal and infant death-rates are higher than for England and Wales. The Scottish figures for maternal deaths are compiled on a different basis and include some which would not in the returns for England and Wales be classed to puerperal causes. But when this fact is allowed for it still appears that the risks of motherhood are greater in Scotland than in England, and that there is a high rate in the rural areas of Scotland, which are thinly populated, as well as in the industrial areas.

Social Effects

The women who die are mostly in their prime. Their loss is a serious waste from the point of view of the community, as well as a tragedy for the thousands of homes which are deprived of homemaker, wife and mother. It is important to remember that pregnancy and childbirth are physiological, not pathological conditions; and that they should result in a healthy baby, and a mother restored to full health at the end of the " puerperium "—that is, the period necessary for the body's recovery from the strains of pregnancy and the fatigue of labour. We cannot therefore separate the question of maternal deaths from two other closely associated questions—the welfare of the babies and the health of the mothers who survive childbirth.

Infant Mortality

The table on page 4 shows that the reduction in infant mortality has been in the main among infants over four weeks old. The death-rate among babies in the first four weeks and especially in the first few days of life is very little below what it was twenty years ago. The stillbirth rate also continues stationary. Our failure to protect the mothers in pregnancy and at childbirth is reflected in the high death-rate of children in their earliest days, when their well-being depends so intimately on the health of their mothers.

Maternal Morbidity

And what of the health of the mothers who survive childbirth ? On this question there is little or no statistical information, but it is known that there is a very high percentage of mothers whose health is damaged by childbirth. The woman who says : " I have never felt well since my first (or my last) baby was born " can be counted by the thousand, and there is no doubt that the problem of maternal morbidity is as grave a problem as that of maternal mortality though its existence is not so dramatically apparent, and too many mothers accept as normal and inevitable the ill-health which follows childbirth, and do not trouble to seek medical advice.

A very large proportion of the women who pass through the gynæcological wards of hospitals come there because of the effects of child-bearing. In a follow-up of 2,000 mothers who had attended an ante-natal clinic in Edinburgh, 30 per cent. were found to be suffering from various complaints and disabilities which required treatment. If the percentage were the same throughout the country, it means that for every mother who dies there are sixty-five others who suffer some impairment of health as a result of pregnancy and childbirth.

International Position

The question of maternal health has given concern to the Health authorities in many countries and the Health Section of the League of Nations. It is very difficult to make comparisons with other countries, because even where the deaths are classified on a method agreed to internationally, there are differences in regard to medical certification and

the method of calculating mortality rates. When we allow for these differences certain very general conclusions seem to be indicated : where conditions of life are good, and skilled medical care available, the rates tend to be low ; where conditions of life are poor, or where there is difficulty in obtaining skilled medical care, *e.g.*, in mountainous and sparsely populated countries, rates are high.

II—CAUSES OF MATERNAL MORTALITY

The causes of maternal mortality are complex, but may be classified generally as " medical " and " social." There has been considerable investigation of the medical aspects of the problem, notably by the Departmental Committee on Maternal Mortality and Morbidity which sat from 1928 to 1932.

(A) Medical

The main causes of deaths classed to pregnancy and child-bearing in the Registrar-General's report for 1933 are as follows :—

Total Puerperal Deaths	2,618		
Puerperal Sepsis	1,061	40	per cent.
Puerperal Convulsions (eclampsia)	373	14·2	,, ,,
Puerperal Hæmorrhage	269	10·2	,, ,,
Other accidents of childbirth ..	211	8	,, ,,

There are other causes, but these are the chief. 804, or 30·7 per cent. of the cases of puerperal sepsis were of sepsis fo lowing childbirth. 257 were of sepsis following abortion, and if to these are added 121 cases from non-septic abortion there is a total due to abortion of 378 or 14·4 per cent.

The relative importance of the main causes of maternal deaths indicated by these figures is confirmed by the Report of the Departmental Committee and various other reports. *Puerperal sepsis* (which is due to infection conveyed to the mother from an outside course, frequently her attendant) is the chief cause, and is followed by *convulsions* and other *toxæmias*, *hæmorrhage*, and *accidents of childbirth* as the next important causes.

Preventable Deaths

Medical evidence shows that a very large proportion of these deaths could be avoided. A Report on Maternal

Mortality, published by the Health Section of the League of Nations, 1931, says :—

> " Puerperal fever (sepsis) leads to more deaths than any other complication of childbearing ; but it is one of the causes which it is most easy to prevent by observing antiseptic principles, the favourable results of which have been strikingly demonstrated since their introduction."

About puerperal convulsions, the Report of the Departmental Committee, 1932, states :—

> " No fact in connection with the prevention of maternal mortality has become better established in recent years than that . . . eclampsia is almost entirely a preventable disease."

Its prevention depends on early diagnosis and treatment—that is, on efficient ante-natal care. Such care would also make possible the early detection and treatment of other conditions likely to cause difficult labour.

The Departmental Committee made a special inquiry into 3,432 of the maternal deaths which were reported to them. They found that in 45·9 per cent. there was " a primary avoidable factor," *i.e.*, a particular circumstance which could have been prevented, and to which the fatal result could ultimately be traced. They fixed responsibility as follows :—

(a) Lack, or failure, of ante-natal care ..	15·3 per cent.
(b) Error of judgment	19·1 ,, ,,
(c) Lack of facilities	3·7 ,, ,,
(d) Negligence on part of patient ..	7·7 ,, ,,

The Committee expressed the view that with fuller information about some of the cases they would probably have found the percentage of avoidable deaths to be higher than 45·9 per cent., and their conclusion was that *at least half of the maternal deaths which occur every year could be avoided*—a conclusion which no one to-day attempts to challenge.

(B) Social

It is more difficult to assess the influence of various social factors on maternal health.

Employment of Women

The employment of women may have a direct or indirect effect. Fuller investigation is necessary to establish whether any forms of employment are definitely harmful, *e.g.*, by causing displacement of the womb or a weakening of the abdominal muscles, effects which may remain unnoticed

until the time of pregnancy or childbirth. There is no evidence that the more usual forms of industrial employment are injurious to the health of the mother. Dame Janet Campbell, in a Report on High Maternal Mortality in Certain Areas, 1932, said :—

> " The employment of married women is discussed in some detail in the West Riding Report. It does not itself adversely affect childbearing so far as the actual work is concerned, but industrial work combined with household duties often imposes too great a strain upon physical strength, leaves little opportunity for prenatal supervision or care, and may lead a woman to attempt to terminate an unwanted pregnancy from sheer inability to cope with the claims of a growing family while continuing her employment."

In an earlier report Dame Janet Campbell stated :—

> " Outside employment is often less arduous than much of the household work ordinarily done by the mother of the family, and relief when necessary from heavy housework seems of greater practical importance than the restriction of paid employment."

Housing

Certain conditions associated with poverty, *e.g.*, *bad housing* and *overcrowding*, do not appear to have any adverse effect when everything is normal, but when there is any complication requiring operative measures, insanitary housing conditions greatly add to the risks, and the lack of privacy and quiet in an overcrowded house must retard the recovery of the mother even when the confinement has been normal.

Nutrition

The importance of good environment and good nutrition for healthy motherhood has been stressed by many authorities, *e.g.*, the Report of the Health Section of the League of Nations on Maternal Welfare, 1931, states :—

> " The circumstances under which a woman lives, the state of her health and nutrition during childhood and adolescence, her daily life and occupation, may all exercise some, though often a remote, effect upon her health during pregnancy and childbirth. Any conditions which prevent the full physiological development of the growing girl may have an injurious effect from the obstetric point of view. Malnutrition, for example, whether due to insufficient or unsuitable food, to lack of exercise and fresh air, or to unsatisfactory hygiene, may cause stunted growth and general

physical weakness. Rickets in childhood is one of the causes of bony deformity, including pelvic contraction which may give rise to difficult labour in later life."

The Report on High Maternal Mortality in Certain Areas, 1932, pointed out that :—

> " Anæmia and malnutrition not only tend to unfit a woman for the strain of child-bearing, but lower her resistance to septic infection and may predispose to disease during pregnancy."

The Report of the Departmental Committee on Maternal Mortality, 1932, says :—

> " We cannot expect a low maternal mortality rate unless the women subjected to the strain and stress of the physiological function of childbirth are themselves healthy and physically fit to undergo it. Such a proposition is obviously a truism, but, unfortunately, it is a truism which is widely unappreciated, and it exerts a profound influence on the whole problem of maternal mortality. An illustration occurs in the defective rearing of children which produces rickets in infancy, affecting the bones during the period of most rapid growth up to the end of the second or third year, and causes the rickety pelvis which constitutes one of the most serious complications of childbirth. Another disease which may profoundly affect the build of the child's body and its subsequent health is tuberculosis, whether in childhood or in adolescent womanhood. Anæmia in young women is detrimental to the function of motherhood ; so is rheumatic fever ; so is venereal disease. Malnutrition and dental decay are obviously injurious and the psycho-neuroses of urbanised life play their part in predisposing the pregnant woman unfavourably."

Rickets

There is abundant evidence that *rickets* in childhood is one of the most frequent causes of pelvic contractions which lead to difficult labour. Rickets is a deficiency disease, the result of poverty and bad living conditions, and while its incidence has decreased in the past twenty years the improvement has not yet had time to affect the women who at present are bearing children. There have been disquieting suggestions in recent reports of one or two Medical Officers that rickets may probably be on the increase, and if this be true then the bad results will be seen when the little girls of to-day reach the age of motherhood.

It is significant that among the reasons given by the Departmental Committee for the low maternal mortality rate in Holland and the Scandinavian countries is the comparatively good nutrition and the rarity of pelvic deformity among the women.

Social Circumstances

We know very little about the social circumstances of the mothers who die at childbirth, but the maternal deaths which have been the subject of special inquiries have been classified as follows :—

	Departmental Committee Interim Report, 1930 (2,000 cases)	Ministry of Health, 1933 2,148 deaths
Well-to-do / Comfortable	1,256	68 / 956
Poor	439	866
Destitute	120	24
No information	185	234

These figures are the basis for the statement often made that more well-to-do mothers die than poor mothers, and that maternal welfare is not a question of poverty. But the classification is of very little value (the Departmental Committee admits that it is not satisfactory) since there is no objective definition of " comfortable " and " poor," and doctors in making reports will be influenced by standards in their area and by their own social outlook. A woman who might seem " comfortable " to a general practitioner in a South Wales mining valley might be considered " poor " by a fashionable Mayfair doctor.

It is known of course that the maternal deaths include women who on any reckoning would be classed as " comfortable." Wealth can command expensive medical attendance, which is not necessarily skilled medical attendance ; infection can be conveyed to a wealthy woman as to a poor woman, and in this class of practice it is stated that there is a tendency to unnecessary operative interference which increases the danger of infection.

The Handicap of Poverty

In spite of what may seem to be evidence to the contrary, we are convinced that poverty is a definite handicap to the mother during pregnancy and at childbirth. The power of recovery from pain and exhaustion, and of resistance to infection, are bound to be weakened by poor nutrition and by mental anxiety before and during pregnancy, either of which the poor mother can scarcely avoid. The following is

a comment from the Report on High Maternal Mortality in Certain Areas, 1932.

> "The exceptionally bad housing conditions, together with unemployment, poverty and a low standard of living, have probably debased the general health. Under such conditions it is the women who suffer most ; their capacity to resist infection or physical strain is likely to be below the average, and perhaps also their liability to toxæmic conditions is increased."

Some Medical Officers have definitely associated the increase of maternal deaths with poverty and unemployment :—

> "The maternal mortality rate increased from 1·95 to 5·43 per thousand births. I attribute a considerable proportion of these deaths to poor nutrition on the part of the mother . . ."
>
> (Report M.O.H., Smethwick, 1932.)

> "With regard to the sharp rise in the maternal mortality rate for 1933, affecting both the County of Middlesex and the country at large, two additional factors may have contributed. Widespread poverty, consequent upon the national industrial depression, may prejudicially have affected the nutritional level of the female population."
>
> (Report M.O.H., Middlesex, 1933.)

But the problem is not only to prevent maternal mortality, but to safeguard maternal health. Emphasis on maternal mortality has tended to obscure the equally serious problem of maternal morbidity, and in connection with the latter question we believe nutrition to be of supreme importance. While maternal deaths generally cannot be attributed to bad nutrition we believe that a very great deal of the damaged health associated with pregnancy and childbirth can be attributed to that cause.

The Report on High Maternal Mortality in Certain Areas, 1932, says :—

> "It is likely that nutrition plays a more important part in maternal morbidity than is generally realised. Some degree of malnutrition is probably fairly widespread among women in these towns."

Again with special reference to certain areas where wages are low and the general standard of living poor, the Report states :—

> "It is not possible to say whether this has led directly to any increase in the maternal death-rate, but morbidity has been affected rather than mortality."

Referring to the poor results obtained in midwifery, Sir George Newman in *The State of the Public Health*, 1933,

points out that a factor is the neglect of the nutrition of the mother during pregnancy, and particularly her diet, and continues :—

> "She should become accustomed to a diet which includes ample milk (two pints a day), cheese, butter, eggs, fish, liver, fruit and fresh vegetables, which will supply her body with the essential elements, salts and vitamins."

Such a diet is beyond the reach of a very large proportion of expectant mothers, and where the diet falls seriously short in essential elements of this necessary standard the mother's fitness to come through the strain of childbearing without ill effect must be impaired.

III—EXISTING MATERNITY SERVICES

This summary of the facts about maternal morbidity points to two necessary conditions for healthy motherhood : (a) good environment and good nutrition, and (b) efficient care before, at, and after childbirth.

It is outside the scope of this report to deal with the measures necessary to ensure an adequate standard of living for every family, which ultimately is the only sure basis of health. Here we are concerned with the provision of proper medical and nursing care for all mothers. There is abundant evidence that where such care is available the maternal death-rate is greatly reduced, *e.g.*, the East End Maternity Hospital dealt with 17,525 confinements from 1921–28, and the death rate was 0·68 per 1,000, *less than one-sixth of the rate for the country as a whole.*

Laws affecting Maternal Welfare

Certain aspects of maternal welfare are provided for by Acts of Parliament, *e.g.* :—

> Public Health Acts (England and Wales, and Scotland) ; Factory and Workshops Act, 1901 (which forbids the employment of a woman for four weeks after childbirth) ; National Health Insurance Acts (which provide maternity benefit to insured women and the wives of insured men) ; Notification of Births Act, 1907 (England and Wales) and 1915 (Scotland) ; Midwives Acts (England and Wales, and Scotland) ; Maternity and Child Welfare Act, 1918 (England and Wales).

Powers of Local Authorities

Under these Acts, and particularly the Maternity and Child Welfare Act (England and Wales) and the Notifica-

tion of Births Act (Scotland), Local Authorities* have extensive powers for the care of mothers and infants, but they are not compelled to use them :—

(1) The appointment of Health Visitors, whose duties include attendance at Ante-natal and Post-natal Centres, and the visiting of expectant mothers.
(2) The establishment of Ante-natal Clinics for expectant mothers, and of Post-natal Clinics which mothers can attend immediately after confinement.
(3) Assistance to Midwives :—
  (a) The provision of sterilised maternity outfits free or at cost price.
  (b) A subsidy to enable a midwife to practise in a district which would otherwise not support her.
  (c) The appointment, where necessary, of municipal midwives.
  (d) The payment of part fees to a midwife when the patient cannot afford the full fee.
  (e) " Refresher " courses for practising midwives.
(4) Maternity Homes or beds in a Maternity Hospital for :—
  (a) Complicated cases.
  (b) Patients whose home circumstances are unsuitable for a confinement at home.
  (c) Ante-natal observation.
  (d) The treatment of puerperal sepsis.
(5) Home Helps.
(6) The provision of milk or food during the last three months of pregnancy and during lactation.
(7) Complicated Midwifery :—
  (a) The fees of doctors called in by midwives for an " emergency " in connection with a confinement must be paid, if necessary, in whole or in part.
  (b) The fee of a consultant called in by a doctor for a complicated midwifery case or for puerperal infection.
  (c) Skilled nursing for patients confined at home.
  (d) Bacteriological examination in cases of puerperal infection.
(8) Convalescent Home Treatment for mothers after confinement.
(9) District Nursing Associations. Payments can be made for midwifery and maternity nursing, or for the nursing of puerperal fever. Assistance can also be given towards the establishment of new Nursing Associations in areas where a midwife is required.
(10) Post-natal and gynæcological clinics where advice and treatment may be given, and, in certain circumstances, information on birth control.
(11) Education on Health matters, by lectures, literature, &c.

* A useful summary of the extent to which Local Authorities make use of the powers (Nos. (1) to (9)) has been published by the Maternal Mortality Committee, whose secretary is Miss Gertrude Tuckwell, and which has done invaluable propaganda and publicity work on the question of maternal health.

How far do existing arrangements secure proper care during pregnancy, at childbirth and afterwards ?

(1) Ante-Natal Care

The first essential for safety at child-birth is efficient ante-natal supervision, which may be given by the doctor or midwife booked by the mother, at an hospital where she may have booked, or to which she may have been referred by her doctor because of some abnormal condition, or at an ante-natal clinic.

Success depends on the time at which the mother seeks advice, and on the skill of her advisers. Many doctors have neither the competence nor the time necessary to carry out proper ante-natal examination, and they are often unwilling to refer their cases to the municipal ante-natal clinic.

An increasing number of mothers attend the clinics provided by the Local Authorities (in some cases by voluntary organisations). In 1933, 42 per cent. of the mothers in England and Wales and 32 per cent. in Scotland attended these clinics. The number of clinics is inadequate ; even in boroughs and urban areas we have not brought a clinic within the reach of every expectant mother. In some areas the clinics are not used sufficiently, and while this is sometimes due, unfortunately, to the indifference of the mothers, the responsibility in many cases lies elsewhere.

Replies to a recent inquiry through the Women's Sections of the Labour Party about maternity services are instructive. All the replies show appreciation of the extreme importance of ante-natal care, many speak well of the local clinics and there is frequent mention of the fine work of women doctors and nurses. But the reason why, in other districts, the clinics are not well attended should be noted :—

(1) Health Committee makes no real effort to tell mothers of the clinic : insufficient Health Visitors.
(2) Women resent the patronising attitude of some of the doctors " who seem to think working women don't know the meaning of words " ; women dislike the atmosphere of clinics at some voluntary hospitals which impress upon patients that they are receiving " charity."
(3) Women would attend if there were a woman doctor.
(4) Local midwives and doctors oppose the clinics.

(5) Clinics are often depressing buildings ; waiting-room uncomfortable and bare with hard forms ; no privacy for interviewing doctor ; no opportunity to rest for a short time after a painful examination ; no couch in doctor's room.

(6) Clinics are too far away for mothers who cannot afford 'bus and tram fares.

(7) There is often long waiting ; a woman may have to wait for two hours or more before seeing the doctor.

It is not surprising in such circumstances that mothers are unwilling to make use of the clinics.

(2) Care at Childbirth

The majority of confinements take place at home, under a variety of conditions. There may be a doctor and qualified nurse in attendance, much more often a doctor and "handywoman," or there may be a midwife only.

The "handywoman" is usually a neighbour or friend who looks after the house and nurses the mother as well. She is untrained, lacks knowledge of proper antiseptic methods, and is often a source of infection. The preference of some doctors for the "handywoman" is a real danger. She is preferred just because she is less knowledgeable and less likely to criticise their methods than a qualified nurse.

Many doctors, from lack of interest or of proper training, are inefficient in midwifery. Some are impatient of the demands it makes upon their time, and resort too hastily to instrumental interference, with consequent risks to the mother. When a complication occurs the doctor may not have the necessary experience to take the right decision, and often there is no specialist obstetrician whose advice he can seek.

The midwife is able to deal with a normal case, but she is compelled to call a doctor when there is any abnormality. The mother's safety depends on the competence of the midwife to decide when this is necessary.

In rural areas the district nurse acts as midwife or maternity nurse, but she is often unable to give sufficient nursing care to the mother because she is overworked or has too big an area.

Hospitals

An increasing number of mothers prefer to have their babies in hospital, but emergency cases sent by doctors form a large proportion of hospital cases.

While many hospitals, both municipal and voluntary, are well-planned, well-staffed, and well-equipped, the inquiry through the Women's Sections of the Labour Party, to which reference has already been made, reveals that in many areas the confidence of mothers in the hospitals is shaken by defects in the organisation and management of local hospitals. Apart from the statement from many areas that there is a shortage of maternity beds, the following criticisms are made :—

(1) Hospitals badly-planned and situated—often being in old, inconvenient private houses.
(2) Lack of accommodation for the various types of cases so that potentially infective cases are not properly isolated.
(3) Frequency of sepsis epidemics at certain hospitals creates mistrust.
(4) No specialist immediately available in emergency, only a young doctor, in residence for six months to gain experience.
(5) Inadequate nursing staff ; atmosphere of strain and overwork and brusqueness of staff upset patients, who in a special way need sympathetic attention.
(6) Mothers left in reception room, on arrival, for as long as half-an-hour, without attention, when labour has begun.
(7) Mothers left unattended for a considerable period in labour ward just when it is important for a sympathetic attendant to be near.
(8) Staff made up largely of unqualified assistant nurses—to reduce salary costs.
(9) Some hospitals persistently overbook, so that wards are overcrowded, or a mother who has booked is turned away at the last minute.
(10) Booking at some hospitals is done through the porter.
(11) Mothers are sent home too soon, because of overbooking and pressure on available accommodation.

Private Maternity Homes, run for profit, must be registered with the Local Health Authority. The payment of substantial nursing home fees does not guarantee skilled care.

(3) Post-Natal Care

The third essential for the safety of the mother is efficient care after confinement ; without it, the advantages of care during pregnancy and at childbirth may to some extent be

lost. It takes some time for the body to recover from the strain of pregnancy and labour, but for most working-class mothers medical and nursing care come to an end too soon. If she goes to hospital, the mother is often sent home as early as the ninth or tenth day, and if she is at home the daily visit of doctor or midwife ceases then, and the mother is left with all her housework to do, and the care of the baby as well. She should have medical supervision and rest from housework for a much longer period.

General Criticisms

The present position, briefly, is that many mothers do not receive the care and supervision necessary before, at, and after childbirth. The reason in some cases is the unwillingness of the mother herself to seek advice. But in many cases there are serious defects in the services available for her.

(1) Legislation dealing with maternity services is in the main permissive, and many Local Authorities fail to make use of their powers.

During the period of the Labour Government all Health Authorities were requested (Scotland, September, 1929 ; England and Wales, December, 1930) to submit schemes for the provision of maternity services to the full extent of their powers. Some Authorities complied with these requests. But the disastrous economy campaign of the autumn of 1931 checked further advance, and since then there has been no effective urge from the Minister of Health to bring Health Authorities up to the highest standard.

The Block Grant system, introduced by the Conservative Local Government Act, 1929, has hampered the development by Local Authorities of their Maternity services, and in some of the poorer areas has prevented any advance.

(2) Lack of co-operation between the agencies concerned with maternal welfare.

The private doctor, midwife, and ante-natal clinic are often competing instead of co-operating units in the maternity service. Doctors and midwives feel that the local authority is encroaching upon their province and their livelihood, and there is an unwillingness to co-operate. On the other hand, the ante-natal clinic in many areas does not make its records available to the doctors and midwives who have been booked by the mothers. It is desirable in the mother's interest that the doctor or midwife who will conduct a confinement should be in close touch with the mother during pregnancy, but too often professional prejudice or administrative aloofness stand in the way.

(3) Inefficiency or lack of experience of many doctors and midwives.

The training of the average doctor in midwifery is inadequate. When he qualifies he may not actually have carried through the twenty personal deliveries he is supposed to have performed, and may never have seen a complicated case.

The training of the midwife was extended in 1926 from six to twelve months, but many practising midwives have had no training in modern methods. In many industrial areas the midwife's lot is very difficult ; she is unable to earn a decent livelihood and her own financial anxieties are an inducement to book too many cases—a circumstance which makes the best standard of work impossible.

The Departmental Committee on Maternal Mortality pointed out that one of the reasons for the low maternal mortality rate in Holland is the higher standard of midwifery work due to a much more thorough training of both doctor and midwife.

IV—WORK TO BE DONE

The preventable maternal deaths and ill-health which we record to-day are a reproach to the nation, and we must demand as a matter of urgency whatever action is necessary by Parliament, Local Authorities, medical profession and midwives to remove that reproach.

Legislation

We should press for the following measures :—

(1) An amendment of the **National Health Insurance Act** to secure the right to cash maternity benefit of the wives of men who, as a result of the Act of 1932, are " out of benefit " because of prolonged unemployment.

(2) The ratification of the **Washington Maternity Convention** which would entitle an expectant mother to remain away from work for six weeks before childbirth, and would prevent her returning to work for six weeks after childbirth, and would provide adequate benefit for twelve weeks.

(3) Legislation to **enforce upon Local Authorities the duty of carrying out all their powers** for the care of maternity.

While we are demanding legislation to compel the backward Authorities to do their duty and seeking an assurance from the Government that it will sanction whatever capital expenditure is necessary, we must continue to exert pressure on the Local Authorities.

Local Authorities

A maternity scheme based on the full use of existing powers would include the following :—

(a) Sufficient ante-natal clinics in boroughs, urban and populous rural districts to enable every expectant mother to seek advice.

The large overcrowded clinic must be abolished and long journeys avoided ; appointments should be arranged to prevent long waiting ; proper records should be kept. The clinic should be attractive and comfortable ; sufficient dressing-room accommodation provided, and a separate consulting room adequately equipped. A qualified midwife (who might be one of the Health Visitors for the area) should be in attendance to advise mothers on hygiene and preparations for the baby.

Every Health Authority should also have **consultative clinics,** associated where possible with its Maternity Hospital, to which abnormal cases should be referred and which would provide treatment and arrange where necessary for admission to hospital.

(b) An adequate staff of Health Visitors to visit mothers, to advise them and encourage their regular attendance at the clinic, and after confinement to see that there is proper supervision for six weeks.

(c) A Public Midwifery Service.—The appointment by every authority of a staff of salaried midwives is the only method of ensuring skilled attention for all mothers and of raising standards of midwifery practice. The other alternatives at present possible—payment of fees in necessitous cases or subsidies to private midwives—should be discarded in favour of a scheme which gives the Health Authority control over a staff of midwives.

Adequate salaries, pensions and conditions of work should be guaranteed, an age limit fixed, a limit placed on the number of cases each midwife undertakes ; and willingness to attend " refresher courses " (the cost being borne by the Authority) should be a condition of appointment. The staff at first should be recruited from practising midwives whose standards of work are good.

The staff should be closely associated with the clinic and hospital services and should be sufficient to enable the Local Authority to provide a skilled midwife to mothers who want a midwife, and also to those who book a doctor but cannot afford a nurse's fee.

(d) Sterilised maternity outfits for the use of doctors and midwives in all necessitous cases because the mother's life may be endangered in an emergency for lack of suitable materials.

(e) Sufficient maternity beds in hospitals or homes under the Local Health Authority for all women whose confinements are likely to be difficult, or whose home circumstances make confinement at home inadvisable, or who desire to go to hospital. Every Authority should make adequate provision within its own area so that emergency cases will not have long distances to travel. Beds should be provided either in a maternity hospital (which should not be a large unit) or in a maternity block in the Health Authority's General Hospital. More adequate provision for normal cases could be met by maternity homes, which in some cases might be jointly owned by adjacent Authorities.

The maternity hospital or block should be adequately staffed and equipped. Accommodation should consist of single-bedded ante-natal and labour wards, small lying-in wards, up-to-date laboratory accommodation, &c. Cases of infection should be provided for in a

completely detached isolation block or isolation hospital. Cases of abortion should not be admitted to a maternity hospital or ward.

Every hospital should have a competent official in charge of bookings which should be carefully arranged to allow for the fact that one can never be exactly sure when a baby will arrive. Patients should be accepted for up to 80 per cent. of the total number of beds. No mother should be sent home before the fifteenth day.

A specialist obstetrician should be in charge of every maternity ward or hospital, and no hospital should at any time be dependent on a house surgeon without experience.

All hospitals should be staffed by fully qualified midwives and a limit placed on the proportion of pupil assistants to qualified midwives in hospitals which train midwives.

(f) Free Ambulance Service for the transport of all cases to maternity hospitals.

(g) Sufficient post-natal clinics to ensure the supervision of all mothers for a period of six weeks after childbirth. If a mother who has been confined at home cannot afford to pay a doctor's fee for visits beyond the customary nine or ten days, she should be urged to come to the post-natal clinic for examination at four weeks and six weeks. If she is unable to attend the clinic medical care should be provided at home. Treatment for any disability should be provided for as long as the mother requires it.

(h) Qualified Medical Staff.—Local Authorities should appoint for maternity work only doctors who have special qualifications in midwifery, and should appoint a good proportion of women doctors. Specially qualified doctors should be in charge of ante-natal and post-natal clinics and specialist obstetricians (who would be available as consultants for doctors in the area) in charge of consultative clinics and maternity wards and hospitals.

(i) A staff of Home Helps who would be available at any time from six weeks before till six weeks after childbirth—or for longer on the advice of the Health Visitor. The Health Visitor should inform every mother of the existence of this service and supply her with a list of Home Helps on request.

The Home Helps should be guaranteed an adequate wage by the Local Authority and care should be taken to enrol suitable women who will have the confidence of the mothers, because most mothers will hesitate to ask for a Home Help unless they feel she understands their difficulties and will know the reason for the chipped crockery, the worn linoleum, the threadbare towels and sheets, and the poor shabby garments to which poverty or unemployment have reduced her household.

(j) Provision of Food and Milk for all mothers who show signs of undernourishment or whose income is insufficient to provide a nutritious and well-balanced diet, not only in the last three months of pregnancy, but from first attendance at the clinic.

(k) Co-operation of Doctors and Midwives with the services of the Local Authority. Every Authority should make an effort to secure such co-operation, the immediate purpose being (a) to encourage doctors and midwives to refer booked patients to the ante-natal and

post-natal clinics, the clinic records in return being available to doctor or midwife ; (b) to enable the Medical Officer to prepare a panel of doctors with special experience in midwifery who could be called on in emergencies by midwives ; and (c) to urge the doctors to refuse the attendance of a " handywoman " and to apply where necessary for the services of a maternity nurse from the Local Authority.

(l) Regular Educational Work.—Local Authorities should plan educational campaigns to emphasise the importance of efficient maternity services.

All these proposals could be carried out by Local Authorities under their present powers. Where they have been in operation for some time we see the results in a low maternal death-rate. The rate in Bermondsey, for example, is 2·5 per 1,000. It is a borough with widespread poverty, but motherhood is safer there than in many wealthier areas because Bermondsey has a splendid service of ante-natal clinics, health visitors and municipal midwives.

Rochdale has recently provided us with another striking example of how a Local Authority by a determined use of its powers can save the lives of mothers. For many years it had been a " black " area with a very high death-rate. In 1931, a campaign for publicity and education was undertaken, the co-operation of women's organisation was secured and the support of doctors and midwives. The death-rate of mothers, which had been 8·90 from 1929-31, has been reduced to 2·99 for the period 1932-34.

Rural Areas

Rural areas present special problems—*e.g.*, parts of Wales and the Highlands and islands of Scotland—to mention the most difficult—which are sparsely populated and have poor transport facilities. In such areas the provision of ante-natal, natal, and post-natal care must come by different methods. Obviously an ante-natal clinic cannot be brought within the reach of every isolated cottage. The County Councils should be urged to arrange with rural doctors for ante-natal and post-natal attention at home, and should accept responsibility for the payment of fees. Transport and telephone services should be provided for all midwives and nurses, and also for doctors summoned to confinement. It is unfair both to mother and doctor that a complicated case should be tackled by a doctor who has

himself had to drive a car over many miles of bad road in any weather—a common enough occurrence in the countryside.

The County Council should have a number of local maternity homes, as a central hospital cannot meet the needs of a scattered population. Mothers in isolated places should be encouraged to come to the maternity home for confinement in view of the great risks from unforeseen accidents when proper facilities for treatment are not at hand. Where any abnormality requiring specialist attention is detected during pregnancy, the County Council should arrange where necessary to meet the travelling expenses of the mother (and a friend to accompany her if she desires) to see a consultant at the nearest centre.

The County Councils should appoint an adequate number of district nurses and midwives under its direct control and should also make provision for Home Helps. Those who know conditions in rural areas, where the expectant mother has often no near neighbour, know her harassing anxiety about the care of her young children and her housework while she is laid aside. It would often be easier to persuade her to go to hospital for her own greater safety if she could rely on the services of a Home Help for a few weeks.

The Use of Anæsthetics

We cannot express an opinion on the purely medical aspects of anæsthetics. But we believe that anæsthetics should be available for any mother who is threatened with exhaustion from excessive pain, and that the Local Authority should meet the fees of a doctor called by a midwife to administer an anæsthetic in such a case.

The Training of the Doctor

We must aim at making midwifery a specialist branch of medical work, a suggestion which would probably be welcomed by many doctors. Dr. Harold Waller said in a recent address :—

> " There is the unquestioned fact that midwifery makes no appeal to a considerable proportion of those who enrol themselves in the medical profession—just as it makes no appeal to many who join the nursing profession . . . there are many who openly and heartily dislike it, and who, from the moment the qualifying

examination is over, do their best to arrange their lives so that in no circumstances can they be called upon to practise it."

Medical schools should organise post-graduate courses for young graduates who have a liking for midwifery and desire to specialise in it, and if Health Authorities were to make the possession of such an additional qualification a condition of appointment to maternity work, we believe that a sufficient number of young doctors of the right type would specialise in this work.

It is important that hospitals approved for grant as teaching schools for midwifery shall not be allowed to prohibit women students, and women doctors should be encouraged to specialise in midwifery.

In view of the need for extended facilities for training in midwifery, municipal maternity hospitals and wards should be made available for this purpose. To secure the co-operation of the mothers the local authority must be able to assure them that the students are closely supervised by a skilled obstetrician and that a qualified midwife shall always be in attendance.

Training of Midwives

It is desirable that candidates for the certificate of the Central Midwives' Board should have some general nursing training—one or two years—before entering upon special midwifery training. The latter should be a two-year course of theoretical and practical training under the supervision of qualified teachers and doctors with special midwifery qualifications.

Preference should be given at training schools to those who intend to practise as midwives or to undertake maternity nursing or to become Health Visitors in the maternity service. Their opportunities are limited to-day by the large number of pupil-midwives who do not mean to do maternity work, but who wish an additional qualification, and by the desire of some hospitals to accept a large number of pupils as a cheap method of staffing. It is desirable to reduce the number of training schools and to concentrate on securing greater efficiency of those which are recognised.

Inquiry into Maternal Deaths

In order to ascertain how far we may hope to reduce maternal deaths to an even lower figure than existing

evidence suggests, we think that there should be compulsory notification to the Medical Officer of Health of every maternal death in his area and an inquiry by the Medical Officer into all the circumstances of every death reported to him.

V—TOWARDS A STATE MATERNITY SERVICE

The Labour Party has accepted the principle of a State Health Service and a complete scheme for the care of maternity would form an integral part of such a service. We believe that a maternity service of the highest efficiency will not be achieved until all its units—doctors, midwives, advisory clinics, hospitals, &c.—are working together under single control, and midwifery is established as a specialist department of the Health Service.

A complete National Maternity Service cannot be achieved at one step. We have described some of the steps towards it. Progress generally should be along the following lines :—

(a) To establish local maternity services, as described above, to the fullest extent possible under existing legislation.

(b) To insist that all future development and extension of maternity services should be under the direct control of the Local Health Authorities.

Voluntary Maternity Hospitals, and Nursing Associations responsible for midwives and district nurses, are supported to-day partly by charitable donations and largely by workers' contributions which in many cases are deducted by agreement from their weekly wages. But the voluntary body is not subject to public control.

Local Authorities should employ midwives and district nurses as part of their Public Health Service rather than leave the responsibility to voluntary organisations.

In areas where adequate maternity hospital accommodation cannot be provided except through existing voluntary hospitals grants from public funds should be made only on condition that the maternity accommodation becomes part of the local maternity service under the control of the Medical Officer of Health.

(c) To secure legislation which will ensure that maternity hospitals and homes shall conform to adequate standards with regard to staffing, equipment and organisation.

The recent inquiry into the death of a mother who was a booked patient at a voluntary hospital in Manchester has directed attention to the irresponsible position of the voluntary

organisation and to the need for ensuring that there shall be some degree of public control over every agency responsible for maternal welfare.

(d) To make midwifery a specialist service confined to doctors with special training and qualifications as has been proposed above. To secure a more thorough training of midwives and to prevent unqualified persons from acting as private maternity nurses.

(e) To institute a system of **free medical and nursing care for expectant mothers until at least six weeks after childbirth for all wives of insured men, all insured women and those whose income is below the insurance limit though they are not insured.**

Such a measure would enable the Local Authority to build up its own specialist midwifery staff of midwives and obstetricians ; mothers would be allowed a choice of doctor from this staff as well as the services of a qualified midwife.

Work for Women's Organisations

We do not share the view sometimes expressed that increased public discussion of maternal mortality has led to increased fear among mothers ; nor do we share the misgivings expressed by certain medical men (*e.g.*, in recent correspondence in the medical Press) about the wisdom of publicity. The trouble is that many mothers to-day understand what good midwifery implies, and are able to criticise the methods of certain hospitals and doctors who have been too long safe from criticism.

Organised working women in the Labour, Co-operative and Trade Union Movements have played a very important part in educating mothers in every aspect of maternal welfare ; they have led the fight for the provision of maternity services ; and in the growing public interest in maternal welfare they see the fruit of their propaganda work.

But they cannot be content until the unnecessary toll of life and health which child-bearing takes of our mothers to-day is eliminated. They must review their own local services, not only as a matter of statistics—so many clinics, hospital beds, Health Visitors, &c.—but from the point of view of their *quality*. It is not enough to provide services : we must see that what we provide is of the highest standard.

Unnecessary deaths and preventable ill-health are a reflection not only on the quantity of services we provide but on their *quality*.

The Conference is asked to adopt this report and to pledge itself to work for the proposals it outlines—remembering that they represent not the end, but the beginning of the State Maternity Service at which we aim.

WOMEN IN INDUSTRY

I—PRE-WAR AND PRESENT-DAY NUMBERS

A survey of pre-war and present-day figures shows that in Great Britain at the 1911 census 5,423,944 women were gainfully employed; at the census of 1931 there were 6,265,100, an increase of 841,156.

Prior to 1914 few women were engaged in occupations formerly confined to men, but a change took place during the war period when there was an increase of one and a-quarter million in the number of employed women. In many occupations these women replaced men, and a large number were married women who gave up industrial work when their menfolk were demobilised.

Trade Unions attempted to safeguard the men's position and secured agreements with Employers' Associations, or through the Treasury Agreement, for the reinstatement of men after the war. Although the Unions honoured the agreement, in fact many men never returned to work.

Women had established themselves and their number has increased steadily. The most reliable figures for the purpose of comparison appear to be for the period 1923 to 1934. The former year was immediately after the post-war slump, when drastic changes in methods of production and mechanisation were speeded up.

A very interesting and significant survey* has been published by the Ministry of Labour of changes in the last eleven years in the number of persons employed in the various industries, and the distribution of male and female labour in them. One fact which the survey reveals very clearly is that the industries in which employment has declined during the period 1923-1934 are industries in which the workers are predominantly male, while the expanding industries are those which give employment to growing

* The survey related to work covered by insurance and excluded persons working for public authorities and statutory companies, and servants, teachers, railway servants, agricultural workers, domestic servants, banking and insurance.

numbers of women. This does not necessarily mean that more women than men are finding opportunities of employment or—to put the point properly—that women are finding employment at the expense of men; but what it does show is that the new and expanding industries are providing employment more for women than for men.

From 1923 to 1934 the employment of women has expanded to a greater extent than the employment of men. Over the whole period of eleven years it is shown that the number of males in employment increased by 6·3 per cent. while the number of women and girls increased by nearly 18 per cent. Of the total number of insured workpeople, aged 16 to 64, in employment, the proportion of women and girls was 27·4 per cent. in 1923; 28·5 per cent. in 1929; 30·3 per cent. in 1932; and 29·4 per cent. in 1934. In actual numbers, 483,440 women and girls were taken into industry, and 455,430 males, during these eleven years.

The survey gives figures which show that in many trades less employment is being provided for men and more for women, particularly in the following groups of industries: light engineering, electrical apparatus, ready-to-wear garments, hosiery, silk, artificial silk, bread, biscuits and confectionery, cardboard box and chemical industries, musical instruments, explosives, oil, glue, wire, hand-tools, leather goods, wood boxes, railway carriage, and miscellaneous. In this group the number of males employed fell by more than 106,000—from 808,430 in 1923 to 702,240 in 1934; whereas the number of women employed increased by more than 30,000—from 286,180 in 1923 to 316,980 in 1934. And of this increase of women in employment, more than half was in the tailoring trades, in which the number of women and girls increased by practically 15,000.

A total increase numerically of 600,000 is shown in the distributive trades, 200,000 being women.

With the following exceptions women are employed to-day in every branch of industry or commerce—mining (underground), quarrying, boilermaking, heavy engineering, blacksmiths, foundry work, iron and steel, building trades, and blast furnaces.

The development of mechanisation and the use of the automatic machine in the new industries means not only the increase of employment of women, but also that in many

areas young boys and girls find it comparatively easy to obtain employment at 14, but almost impossible to retain employment on reaching the age of 18. Indeed, under Part I of the new Unemployment Insurance Act, 864,688 books have been issued to employed boys and girls under 16 years of age. Out of this total 480,455 are boys and 384,233 are girls.

Juvenile employment has a direct bearing on adult employment and unemployment—whether of men or women. It has been found, for example, that the risk of unemployment amongst young persons engaged in the distributive trades shows a marked increase as approach is made to adult years ; the risk jumps fourfold three or four years from the time of leaving school. In other words, the services of young boys and girls are used for a few years after they leave school, but when the time comes for an advance to adult wages, they are dismissed, in many cases without any sort of proper training and with no prospect of a career, to make room for another generation of cheap youngsters straight from school.

II—WAGES AND HOURS OF WORK

There are three main methods of regulation of women's wages :—

(1) Trade Boards.

(2) Joint Industrial Councils.

(3) Collective Bargaining : that is, direct negotiation between the Trade Unions and the Employers' Organisations.

There is a fourth group of women's industries in which wages are so far practically completely unregulated, so that the subject can be divided into four main headings :—

(1) Trade Boards

The minimum hourly time-rates for women in Trade Board trades vary from 5¼d. to 10¼d. ; the great majority are 7d.

Most of the rates mentioned are time-rates based upon a 48-hour week. The majority of the girls and women employed in Trade Board trades are piece workers and invariably Boards fix slightly higher rates for workers employed on piece. All rates are on an hourly basis and workers are

paid only for actual hours worked. More than half the Boards have rates for "special classes" ; for example, *Learners' rates* are based upon either age or experience, according to the nature of the trade ; alternatively, learners can be employed as piece workers governed by the adult piece-rate price and receive wages only for the hours actually worked.

There are approximately 92,000 establishments on the Trade Boards list, and the number of inspectors at the disposal of the Boards is only 62. This fact is a reminder of the need for Trade Union organisation and for vigilance on the part of the Unions.

Over a period of years a great deal of criticism had been directed against the Boards, which culminated in an inquiry by the Trades Union Congress in 1930.

It will be seen at a glance that it is a practical impossibility for adequate inspection and enforcement to take place with the small number of inspectors at the disposal of the Boards ; at a generous estimate only a small percentage of the establishments on the list can be visited in a year, and less than a quarter of the wages can be examined.

It is in relation to the possible effect of Trade Boards on Trade Union organisation that the most serious criticism is directed against the Boards. It is alleged that the Boards weaken Trade Union membership. Difficult though it is to form any exact estimate of the effects of Trade Boards on Trade Union organisation, the T.U.C. Committee were unable to dismiss the body of criticism directed against the Boards in this connection. Large numbers of workers argue that because their wages are protected by a Trade Board there is no need for Trade Union organisation, and many employers encourage this view. Whether these workers would appreciate the need for organisation were the Trade Boards withdrawn it is impossible to say ; they would possibly find some other reason for not joining a Trade Union. *Experience over a lengthy period of years proves that without adequate Trade Union organisation evasions and infringements of the Acts take place.*

The T.U.C. Committee arrived at the conclusion, since endorsed by Congress, that for varying reasons existing Trade Boards must for the time being continue, and it was decided it would be well if the Unions concerned in each

Board met periodically to consider whether the circumstances of the trade warranted the continuation of the Board, or whether the workers' interests might be better served by the operation of normal Trade Union methods or some other form of negotiating machinery with or without legal enforcement of wages.

The Trade Union Movement is watching with interest the development of the negotiating machinery presently operating in the cotton industry, and it may be that other Unions in the course of time may welcome the extension of such machinery to sections of workers at present covered by Trade Boards.

Many Unions have agreements or other arrangements either individually or collectively with employers' associations for the payment of rates above the minimum: for example, laundry, ready-made and wholesale bespoke tailoring, and retail bespoke tailoring; and it cannot be too strongly emphasised that there is great scope for Trade Union activity in Trade Board trades in securing rates of pay higher than the minimum, payment for holidays, better control by the workers of speeding up processes and piece prices.

(2) Joint Industrial Councils

In a number of industries women's wages are regulated by Joint Industrial Councils, for example, cocoa and chocolate, sugar confectionery and jam, and municipal workers in non-trading services.

The minimum time-rates vary from 7d. per hour to 9¼d. per hour; piece-rates are fixed so as to yield 25 per cent. above the time-rates.

Some Joint Industrial Councils have introduced a shorter working week. For instance, a forty-hour week has been established in the match industry, forty-four in some sugar confectionery firms, and in the municipal services the women cleaners and lavatory attendants have a week varying from forty-eight to thirty-four, or even less. This reduction of hours has in the main only taken place where the weekly pay has been maintained.

In addition to a reduction of hours, holidays with pay have been agreed in a good many cases, varying from two weeks with pay to one week, or Bank Holidays only.

(3) Trade Union Agreements

The main groups of such trades are engineering and allied industries, silk and artificial silk, biscuits, canteen workers, brewery workers, textiles, metallic capsules, drug and fine chemicals, and fancy leather.

In addition to these main groups, there are also cases where agreements are in operation in Trade Board trades, already referred to, whereby considerably higher rates are paid and payment for holidays secured.

The wages in the trades covered by agreements vary mainly according to the strength of Trade Union organisation. In the great engineering group the time-rate varies from 24s. to 28s. a week, piecework basis 25 per cent. above the time-rates, for a working week of forty-seven hours.

Silk rates vary from 29s. to 35s.; artificial silk from 25s. to 32s., for forty-eight hours.

(4) Unorganised and Unregulated Trades

It is impossible to give an accurate picture of the wages and conditions of work in occupations which are not covered by Trade Boards, Industrial Councils or Trade Union agreements, and where the workers are not organised. These include bakelite, cellulose paint spraying, fancy leather goods, wireless, including battery service, gramophone, wire mattresses, vacuum cleaners, silk stockings (unregulated in the South), catering, toilet accessories.

In many of these trades wages are lower and hours worked are longer than in trades which are organised or where wages are regulated by Trade Boards or otherwise. In addition, there is no control of speeding up or of the various methods of payment by results which in organised and regulated trades can to a certain extent be controlled by agreement with the firm. There is also continual petty tyranny under which the dismissal and engagement of workers becomes a completely haphazard process.

Scandalous conditions exist in the catering trade which is almost entirely unorganised, and in the distributive trades which, outside the Co-operative Societies and a few private and multiple firms, are also unorganised. Information, for example, from the confectionery, drapery, grocery and boot and shoe trades shows that wages ranging from 7s. 6d. to 10s. per week are frequently paid. Distributive

workers over the age of 18 years are still entirely unprotected by any statutory limitation of working hours. The consequence is that, as with men, women employed in distribution are too often worked long hours with no payment whatsoever for overtime. Indeed, cases have been exposed where the total weekly hours worked have amounted to 80 and 90 per week and where Sunday labour is an accepted feature of the employment.

Promotion of Women

A point to be noted in any survey of the conditions of women's employment is the tendency to confine women almost entirely to routine work and to exclude them from posts of higher rank and responsibility, technical or professional, so that there are few prospects of promotion for the women who remain in industry. Experience among women who are promoted to certain of the higher-paid posts in various occupations often reveals that such women are even more exploited than their poorer wage-earning sisters, who more often are wise enough to be organised.

III—SOCIAL INSURANCE

National Health Insurance and Old Age Pensions

The main condition for National Health Insurance and Old Age Pensions is the same for men and women. Insurance is payable by employed persons between the ages of 16 and 65 in all occupations classified as manual, irrespective of earnings. In non-manual occupations a salary limit of £250 operates.

A contribution of 9d. is payable by insured men which is allocated as follows: N.H.I., 4½d.; O.A.P., 4½d. The women's contribution is 6d., which is allocated: N.H.I., 4d.; O.A.P., 2d.

From the inception of National Health Insurance in 1911, the liabilities arising from men's and women's claims have been assessed separately. The level of women's claims has been shown in actuarial reports to be higher than that of the men.

The system of separating the risks of men and women was carried a step further in the 1932 Act when a reduction was made in the benefits payable to married women on the grounds that their claims exceeded those of single men.

At the present time male contributors receive benefit at the rate of 15s. per week, on a contribution of 4½d.; single women receive 12s. per week on a contribution of 4d.; married women receive 10s. per week on a contribution of 4d. Disablement benefits show a similar differentiation.

This policy of differentiation between men's and women's sickness risks would be more readily understood if it could be shown that the risk among all sections of male workers are lower than the risks among all sections of female workers. In point of fact, the risks of certain groups of male workers exceed the risks of either single or married women, but these abnormal risks are accepted as a part of the general liability on the male side.

In considering the heavy claims of married women, it is impossible to ignore childbirth and the sickness and disablement which unfortunately must be associated with childbirth at the present time. Figures covering the whole subject are not available, but statistics collected by some of the cotton Unions immediately prior to the 1932 Act are sufficiently revealing. As the result of a test carried out among their married women members, it was shown that out of 5,724 weeks of incapacity, 3,625 weeks were due to childbirth.

The effect of separating men's and women's funds can be seen also in the additional benefits paid by the Approved Societies from their declared surpluses. On the last valuation, 88 per cent. of insured men benefited from surpluses, but only 38 per cent. of insured women were brought in.

On the Old Age Pension side, the contribution of 2d. per week, payable by the insured woman, effects an insurance only for her own old age. It is asserted that the contribution is assessed at a higher rate than is necessary to cover the benefits received in her own right, on the grounds that she should be prepared to contribute towards the benefits which she may receive as a future widow, mother of fatherless children or wife of an insured man.

Unemployment Insurance

Under the Unemployment Insurance scheme a contribution of 10d. is payable by men and 9d. per week by women. Benefits are payable as follows:—

Men, 17s. per week; women, 15s. per week. In addition dependants' benefit is payable in certain cases.

Payments are made into a common fund and there is no separation of risks, such as exists under Health Insurance. The Ministry of Labour gives the figures of insured unemployed persons at February, 1935, as follows: males, 19·8 per cent.; females, 9·7 per cent.

At no period since the establishment of Unemployment Insurance has the level of women's unemployment risen to the level of men's, and it is obvious that a system of assessing separately the risks of men and women, such as exists under Health Insurance, would, if applied to Unemployment Insurance, benefit women contributors. Differentiation between men and women does exist, however, under Unemployment Insurance in regard to the conditions under which benefit is payable.

No difference is made between the conditions applicable to men and single women, but there are now embodied in the Unemployment Insurance Act stringent conditions, formerly operated as Anomalies Regulations, which apply to married women only. A woman who has less than fifteen contributions since marriage or less than eight in the preceding benefit quarter must prove (a) that she is normally insured and normally seeking insurable work and (b) that in all the circumstances she has reasonable expectation of securing work. During 1934 alone, the claims of 36,867 married women have been disallowed under these conditions.

IV—INDUSTRIAL LEGISLATION

During the past hundred years there has been a considerable volume of industrial legislation designed to protect workers in regard to such matters as safety, health, and reasonable working conditions. In most of this legislation women and girls are protected in the same way as men and boys, but there have been certain special measures for the protection of women and girls.

The main Acts laying down standards for workers generally in regard to safety, health and welfare in factories are the Factory Acts which cover a wide range of safeguards against unhealthy and dangerous conditions, and prohibit overtime in excess of 55 hours in textile factories. The last Factory Act was passed in 1901, and there is

urgent need for an up-to-date measure. There have been a number of Shops Acts to regulate conditions in shops, but there is no restriction of working hours for shop workers beyond 18 years of age. The new Act, passed last year, regulated working hours for juveniles under 18. Besides these Acts there are numerous others which contain protective measures, even though it is not apparent in the title that they deal with industrial employment.

Special Legislation for Women

Special measures for the protection of women are included in the Factory Act of 1901, which prohibits the employment of women within four weeks from childbirth, and imposes restrictions on the number of hours which women may work in factories. The Shops Acts laid it down that seats should be provided for women shop assistants, but until last year's Act there was no provision that the seats should be *used*.

The Employment of Women, Children and Young Persons Act, 1920, gave effect to an international convention agreed to in 1919 prohibiting the night work of women and making provision for two-shift orders. An amendment to that convention was adopted last year to permit night work in the case of women holding responsible positions of management who are not ordinarily engaged in manual work, but it has not been ratified in Great Britain.

The Women and Young Persons (Employment in Lead Processes) Act prohibits the employment of women in processes using lead, and a Coal Mines Act prohibits the employment of women underground.

We believe that further protective legislation is necessary for both men and women workers and that in certain directions the additional protective legislation is necessary in the interests of women workers. It is impossible to ignore the differences in physique between men and women, when we are considering certain forms of employment, or to ignore the fact that the function of child-bearing falls entirely on women. Without special protective legislation, employers would have greater freedom, especially in unorganised industries, to exploit women workers, with damaging results to health sooner or later and particularly to maternal health.

V—WOMEN IN TRADE UNIONS

In 1914 there were 437,000 women in Trade Unions, and in 1933 the numbers were 737,000. During the war period women were encouraged by their men colleagues to join Trade Unions. The women learnt to appreciate the fact that non-unionists undermined the wage standards which had been established in many trades and to understand the value of collective bargaining.

Since the industrial depression in 1920 there has been a tendency among many classes of workers to think only of their job and not to bother about its conditions, and Trade Union membership generally has decreased. But it is imperative that we should endeavour to bring all employed workers, men, women or juveniles, into the ranks of the Trade Unions.

The first function of the Trade Union to-day is, as it has always been, collective bargaining in regard to wages and working conditions. Where organisation is good a trade union is able to secure agreements on wage rates and on hours and conditions of labour in the workshop or factory.

The work of a trade union is not confined to negotiating wage agreements. Very few people realise the enormous amount of day-to-day work which trade unions, through their branch officials and full-time organisers, are performing on behalf of their members. They deal with National Health Insurance and Unemployment Insurance; they appoint delegates to various Trade Boards in which they may be interested and discuss the policy to be pursued on matters that arise there; they take action in political matters that affect their members; they secure the representation of their members on Courts of Referees, &c.

The unorganised worker is always at a disadvantage as compared with the organised worker in protecting her interests. Without the knowledge of trade conditions and legal regulations such as can be obtained only from a trade union, she is always at the mercy of her employer in any legal action that may be necessary, for example, under Workmen's Compensation law. Many women workers, because they are not trade union members, must have been deprived of their rightful compensation in cases of accident arising in the factory or workshop. Legislation for the improvement of the conditions of industrial workers has been

obtained only through the pressure of the workers themselves, and the workers who are able to exert pressure on Parliaments and Governments are the *organised* workers

VI—MARRIED WOMEN IN INDUSTRY

It is impossible to give exact figures as to the proportion of married women among the total number of insured women, but in the evidence submitted to the Royal Commission on Unemployment Insurance it was estimated that the proportion of married women was no more than 30 per cent. As this was an estimate made in a time of depressed trade and of unemployment among men, when there is always a tendency for married women to remain in or to enter into industry to a greater extent than in normal times, it may be taken that the percentage in normal times would be less than 30.

Many private firms make it a rule to dismiss women after marriage, and Municipal Authorities, with few exceptions, and the Civil Service operate this rule. In the higher paid ranks the rule is applied, but in some of the lower paid jobs a means test has been instituted; for example, a cleaner employed by an education authority, although already submitted to a means test when first employed, has, after several years, received notice of dismissal with the explanation that many are worse off than she is, who are at present on the waiting list. Yet her position has not altered since she was first employed. Another authority waives the rule when they cannot get sufficient labour from the single women and widows. Expediency rather than principle appears to dictate this policy.

When a man applies for a job under any of these authorities he is not asked "What is your income?" or "Are you married or single?" but "What are your qualifications?" This should be the employer's only concern.

It is sometimes argued that the only ambition of the average girl is to marry for a home and then leave industry. This may be true of some, but with the desire for a higher standard of living, amongst lower paid as well as skilled workers, women realise that they must take their share in the maintenance of the standard. Hence, we have what seems to be an increase of married women in employment, although the figure estimated at 30 per cent. does not, on

investigation, represent so great an increase as might at first appear. In this percentage are included the textile, laundry, hat and millinery and some other trades, in which married women have always been employed. Further, as we have already pointed out, part of the increase in women's employment is in new trades.

Married women are penalised in the Health Insurance and Unemployment Insurance Acts, and the suggestion is frequently made that the dismissal of married women from industry would relieve unemployment among men and unmarried women. It must be noted that criticism of married women's work does not as a rule extend to the large number of married women who work in their own homes, taking in boarders, making their own clothes, etc.

At a time when unemployment is severe the argument against the employment of married women may seem plausible, but if we look at the experience of Germany, where married women were first singled out for attack, we find that this was merely the prelude to an attack on the single woman, and statistics from Germany do not show either an increase in the employment of men or in their wage rates; in fact the reverse is shown.

The dismissal of the married woman would not necessarily mean the employment of a man or a single woman in her place. On the contrary, it would probably mean the employment of a machine and a child straight from school. In any case, the exclusion of married women as a class would not in the end reduce unemployment; it would merely shift its incidence. It would certainly lead to lower standards in many homes, and it would lower the industrial status of women workers generally.

Discrimination against married women or any other particular section of workers is no cure for the injustices of a profit-making economic order. We believe that the freedom to work should not be denied to a woman simply because she is married, and that fitness for the job should be the test in regard to the employment of the women, just as it is the test usually applied in the case of men.

VII—EQUAL PAY FOR EQUAL WORK

It is comparatively simple to claim equal pay for equal work where men and women are working on the same

jobs, especially in the professions, such as teaching, medicine, law, etc. In industry the suggestion is more complicated, because of the large increase in the employment of women that has taken place in the new industries, where new processes have been introduced and there are no comparative rates as between the sexes.

It is difficult to summarise the exact position, but it seems to be broadly true in industry that women working on jobs where they do not come into competition with men are paid substantially lower rates than where they do compete with men for similar jobs.

It is sometimes argued that it is not worth while training girls because they are likely to be in industry only for a short period and should, therefore, be kept to the lower-paid jobs. But with the increased mechanisation of industry this argument no longer holds good as most processes can be very quickly learned.

The main argument for different rates of pay between men and women has been that a man is regarded as having family responsibilities and a woman as having none. This of course, is not by any means true, but so long as it is normally the fact that the provision for his children falls on a man, there will be a tendency to pay what is regarded as a married man's wage to all men and a single woman's wage to all women.

Owing to modern development of industry, the problem is no longer simply a sex problem, but of how to get a fair rate fixed for the job, irrespective of who is working on it—man, woman or juvenile. In many occupations men's rates are so depressed that equal pay for equal work if applied in the old sense of the phrase would actually mean reductions for women.

VIII—WOMEN WORKERS IN OTHER COUNTRIES

The status of women workers of all grades in most industrial countries advanced during the war and in the early post-war period they showed little sign of losing their foothold. In endeavouring to make a comparison, even of the most general kind, it is necessary to remember that the Southern and Eastern European countries were less advanced in pre-war days than the Northern and Western countries.

Of the European countries the Scandinavian countries are the most advanced both in regard to the political and economic position of women, but these countries are not to any great extent industrial.

In the Fascist countries the position of women, particularly in Germany, has been put back a hundred years. In Italy, before the advent of Fascism, there had been very little movement towards the emancipation of women and the task of the Fascist Government has been to keep women down. In Germany, however, where the 1918 Constitution gave women political freedom and established the principle of equal pay for equal work, there has been a great advance in the economic position of women for fifteen years. The advent of the Nazi Government meant the complete degradation of women.

Marriage loans were promised as a means of removing women from industry, and extensive propaganda initiated with a view to confining women to child-bearing and the kitchen. Some of the most popular Nazi slogans are: "A woman's occupation is the recreation of the tired warrior"; "To every true German a job; to every loyal woman a good German husband"; "Woman's sphere should be Church, Children, Kitchen." These slogans, of course, have been accompanied by pressure on employers to dismiss women and replace them by men, but there seems to have been sufficient protest to cause the Government later to send a circular to the effect that "while men are preferable there is still a use for women in employment." Bitter suffering has been caused in homes which were dependent on the wages of women as a result of dismissals.

Prior to the advent of the Clerical-Fascist dictatorship in Austria in February, 1934, women had the right "to live and work on equality with men." Since then a decree has been issued forbidding a wife to hold an office in paid State or public service if her husband holds one. There has not been the same ruthless suppression of women's freedom that we have seen in Germany, but there is much bitterness among many women workers who have been deprived of their livelihood, and at the assumption of the present regime that woman is an inferior worker.

WOMEN MUST ORGANISE

From whatever angle we look at the position of women in industry there are two points which it is important to emphasise :—

(1) Women have established themselves in the industrial life of this country. To say that they are "competing" with men is to imply that a man is more important as a human being than a woman and has a prior right in industry.

(2) The protection of women's standards cannot be separated from the protection of wage standards generally and the only means of protection is a strong Trade Union Movement.

We, therefore, urge all sections of the Labour Movement constantly to use their influence to secure the better organisation of women workers in industry, and particularly of those young girls who are entering industry in such large numbers. We believe that many of the women represented at our Conference can give effective help in this work, not only in meetings and at the work-gate, but inside their homes, where they should try to make their daughters and other young women workers with whom they are in contact see clearly that both bread and self-respect depend on Trade Union organisation.

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