**Contrasting Municipal Responses to the Provision of Birth Control Services in Halifax and Exeter before 1948**

Pamela Dale and Kate Fisher*

**Summary.** Research exploring the development of the birth control movement in Britain continues to reveal new insights. Local case studies highlight the contentious nature of birth control debates and the significant obstacles that had to be overcome before services could be provided. Moving away from a focus on the activities of birth control campaigners and organisations, such as the Family Planning Association, this paper highlights other local actors in the statutory and voluntary sectors to map why clinics emerged when and where they did. The contrasting examples, provided by Exeter and Halifax, demonstrate the importance of multiple points of contact between local authorities and supporters and opponents of birth control. They also suggest that the attitude of local medical and political elites is not sufficient to explain the success or failure of any clinic.

**Keywords:** birth control; eugenics; health visitor; medical officer of health; Halifax; Exeter

In an expanding historiography exploring all aspects of the provision of birth control, there is increasing interest in the work of local clinics. To date, however, there has been a strong tendency to map the emergence of such clinics through the records of the Family Planning Association and other national bodies. This focus risks masking the differences between clinics and marginalising the efforts of other statutory and voluntary services. The attitudes and priorities evident in their work were vitally important, not least because they shaped the environment in which any birth control clinic would have to operate. This paper is a study of the local dynamics surrounding the establishment of two very different birth control clinics.

The Exeter and Halifax birth control clinics both developed under the umbrella of the National Birth Control Council, renamed the Family Planning Association in 1939, but they were very different in terms of what they aimed to do, how they operated and what they achieved. These differences may be explained with reference to their relationships to other statutory and voluntary services. A second factor was undoubtedly the strength of local support for birth control and/or other eugenic policies. This paper seeks to extend analysis from the people directly connected to the clinics to the wider milieu in which they worked. The intention is to link birth control provision to a range

---

* Pamela Dale and Kate Fisher, Centre for Medical History Office, Room 329 Amory Building, University of Exeter, Exeter EX4 4RJ, UK. Email: Pamela.L.Dale@exeter.ac.uk; K.Fisher@exeter.ac.uk

1 Florence 1956; Leathard 1980; Fisher 1998; Court and Walton 2001; McCormick 2008.

2 The Family Planning Association webpage http://www.fpa.org.uk/Aboutus/fphistory/Ourfirst80years (accessed 3 February 2010).
of municipal health projects and thus connect the clinic histories to a wider literature examining ideological debates in interwar public health spheres.\textsuperscript{3}

The relationship between eugenic rhetoric and the development of municipal health services has been identified as important, if somewhat ambiguous.\textsuperscript{4} This is especially true in the case of birth control.\textsuperscript{5} It has been argued that the significant controversy attaching to birth control clinics made them a vital marker in overall service-development.\textsuperscript{6} Yet some overviews of the origins of the British Welfare State make virtually no mention of them.\textsuperscript{7} This divergence of opinion about the importance of birth control clinics may be explained with reference to a gap in the literature. The traditional focus on eugenic rhetoric and policy elites generally fails to connect debates about the provision of birth control advice to the day-to-day practices of clinics that did so.\textsuperscript{8}

This paper seeks to address two major themes within a wide survey of the municipal context for the development of different birth control clinics. The first issue is concerned with staffing. The second relates to demand for clinic services. Did individual local authorities allow, or even encourage, the participation of their public health staff in such projects? What were the attitudes of such staff towards the provision of birth control and how did this impact on patient demand? These questions have generally been answered with reference to the position taken by the local Medical Officer of Health (MOH) but he was not intimately connected with the work of the clinics.\textsuperscript{9} This was left to women doctors, nurses and health visitors in the statutory and voluntary sectors. There is certainly much more to understand about the roles of female public health staff. Clinic medical officers could provide a direct link between municipal medical services and the provision of birth control advice in statutory and voluntary sector clinics.\textsuperscript{10} But in numerical terms the work of local authority health visitors was potentially more significant. The problematic involvement, and also non-involvement, of health visitors with birth control services has been a topic of debate in some feminist texts and specialist histories of birth control organisations but is only just starting to attract wider scrutiny.\textsuperscript{11}

\textsuperscript{3}Welshman 2000; Niemi 2007.
\textsuperscript{4}Welshman 2000, pp. 86–8, 96–106. Julie Grier also explores these relationships and usefully develops Soloway’s work on eugenics. Grier 1998; Soloway 1995.
\textsuperscript{5}Niemi 2007, p. 17.
\textsuperscript{6}Hoggart in Digby and Stewart (eds) 1996; For discussion of pertinent work by Clare Collins, see Marks 1996, p. 145.
\textsuperscript{7}There are no index references to birth control, contraception or family planning in Harris 2004.
\textsuperscript{8}Grier raises a number of issues relating to municipal provision, which build on Cohen’s work on the Mothers’ Clinics. Grier 1998; Cohen 1993.
\textsuperscript{9}For discussion regarding the role of the MOH, see Lewis 1986.
\textsuperscript{10}This kind of ‘dual appointment’ could, however, also be a focus of opposition and conflict. Niemi 2007, p. 93.
\textsuperscript{11}Liddington 1984, pp. 323–4; Cohen 1993, pp. 106–8; Grier 1998, p. 454. See also Smith’s work on the archives of the Health Visitors’ Association. Its records mention some of the controversy attaching to unwelcome health visitor duties in connection with birth control services but the archive for the pre-1948 period is somewhat London-focused and not a comprehensive source of information about developments elsewhere. Smith 1995, p. 362.
Given the controversies attached to birth control it seems likely that the take-up of services would be as patchy as their provision but this has not been fully explored. Instead there appears to be an assumption that services were created, by progressive individuals and organisations, in response to demand and were subsequently well used. Yet this is surely incorrect as recent research suggests clinics were few, and attendances limited. There were many obstacles to attending a pioneering birth control clinic and then carrying out all the complex procedures necessary to avoid conception, but some women were motivated to overcome them and became the core clientele of the clinics.

The historiography has been less concerned to identify why some women (often the ones targeted for birth control advice) shunned the clinics. Here a different literature, addressing the ongoing problem of teenage motherhood, which suggests ambiguous attitudes towards sexuality and maternity as much as lack of knowledge of and access to contraception, is worth considering. Some women were apparently fatalistic about successive pregnancies, but there are factors beside personal preference and carelessness that need to be taken into account. This paper suggests that the very success of the Exeter clinic, in meeting the priorities and policy-preferences of elite male and female groups in the city, went some way towards explaining its failure to capture the imagination or allegiance of its target population. In Halifax, the clinic lacked official support and in a climate of hostility the women running it arguably made a more successful attempt to meet the needs of women actively seeking their services.

**Exeter: A Model of Co-operation and Progress?**

In Exeter, discussions about birth control and the later provision of services evolved within a distinctive set of concerns. The first was a somewhat unusual relationship between the statutory and the voluntary sector that prioritised philanthropy and gave a prominent role to elite women. A second feature was strong local interest in eugenic ideas. These factors shaped the development of many Exeter services, but are perhaps especially pertinent when considering birth control.

Ministry of Health reports from the 1930s expressed frustration that the City Council offered limited municipal services, apparently choosing to rely on the resources and leadership offered by the voluntary sector. The dominant role of ladies’ committees and volunteer helpers even within the council’s own maternity and child welfare schemes concerned the Ministry, although local actors regarded lay activism as essential. It is therefore

---

12 Fisher in Gijswijt-Hofstra et al. (eds) 2002.
13 Marie Stopes’ first Mothers’ Clinic provides a useful case study. Briant 1962, pp. 132–42.
14 Fisher 2006, pp. 143–9, 164–5.
15 Florence 1956, p. 193.
16 Zabin and Hayward 1993, pp. 79–81.
17 Kathleen Dayus attributes the large families of her mother’s generation to a jealousy of larger families, and a desire to replace dead children with new babies, yet blames her own multiple pregnancies in the inter-war period on a lack of knowledge of birth control. Dayus 1988, pp. 2–3, 192. See also Fisher 2006, pp. 76–95.
18 Dale 2003, pp. 414–18.
19 National Archives (hereafter NA), MH66/608, Exeter County Borough Public Health Survey, 1930 (hereafter Exeter PHS), pp. 32–3.
not surprising that birth control provision was developed through an informal partnership which encouraged the establishment of a voluntary sector clinic in Exeter to provide services to patients referred by local authority medical staff.

The first overtures were made by the voluntary sector, with a strong input from women’s groups that tended to promote the validity of fertility choices rather than the narrower concern with preventing maternal deaths that was stressed in Halifax and elsewhere. The first recorded Exeter Maternity and Child Welfare Committee (hereafter Exeter MCWC) discussion of birth control services followed receipt of a communication from the Exeter and District Society for Equal Citizenship in February 1928.20 This invited the committee to press the government to ‘allow scientific information on birth control to be given to married women who ask for it or need it, at its maternity clinics and infant welfare centres’, but no action followed immediately. Yet, in Exeter, a variety of statutory and voluntary organisations were enthusiastic supporters of birth control and anticipated changing government guidelines. Following the February 1928 communication, the Exeter MCWC gave the matter more thought and in December of that year medical officers in charge of the infant welfare centres were instructed to ‘recommend to the dispensary for information on birth control any woman whose health, or that of her husband, makes pregnancy a danger to her and her family’.21

Following a change in Ministry of Health guidelines, in January 1930, the Council decided to pay an inclusive fee for women attending the birth control clinic.22 The clinic was referred to as the Exeter and District Women’s Welfare Association and continued into the NHS era. The council supported the voluntary sector clinic with the offer of direct financial, and implied political, support, while the quasi-independence of the clinic allowed for more ambitious and controversial activities than a purely municipal enterprise could contemplate. This was viewed as a model of progressive co-operation and the Exeter clinic later achieved national and international recognition as a centre of excellence.23

Yet the Exeter clinic was not without problems. It faced funding difficulties in the 1930s, probably linked to an initial lack of referrals.24 There is no evidence that P. H. Stirk, the Exeter MOH, was hostile to birth control, but his interest in new projects was waning at this time. After he retired in 1933, his successor, G. B. Page, proved something of an enthusiast and his interests chimed with those of his committee. The Exeter MCWC simply could not understand why relatively few women attended the

20 Devon Record Office, ECA/27/1, Exeter Maternity and Child Welfare Committee Minutes (hereafter Exeter MCWC Minutes), 29 February 1928, minute 529. The Exeter MCWC Minutes make no explicit reference to any contribution from female health practitioners or representatives of working-class women’s groups although records from the birth control clinic itself confirm their active involvement. A finding that contrasts with the overt role these groups played in the Birmingham campaign. Niemi 2007, p. 167.

21 Exeter MCWC Minutes, 5 December 1928, minute 411.

22 Exeter MCWC Minutes, 22 January 1930, minute 507.

23 Contemporary Medical Archives Centre at the Wellcome Trust for the History of Medicine (hereafter CMAC), SA/FPA/A4/B6.1, papers headed ‘Exeter Clinic’, signed by Joan Lennard, 20 December 1971. These recount the early history of the Exeter clinic, but with most examples taken from the post-1948 period, the influence of the local authority is not highlighted.

24 CMAC SA/FPA/A4/B6.1, Exeter and District Women’s Welfare Association, Third Annual Report, 1932.
Table 1. Referrals to Exeter Women’s Welfare Clinic, 1941–1946

|                    | 1941 | 1943 | 1945 | 1946 |
|--------------------|------|------|------|------|
| Total Exeter City Council referrals since 1930 | 136  | 169  | 193  | 210  |
| Failed to attend   | 10   | 9    | 12   | 11   |
| Left City          | 6    | 9    | 9    | 9    |
| Died               | 6    | 6    | 7    | 7    |
| Known to have become pregnant | 26   | 31   | 36   | 37   |
| Taken off books for non-attendance | 25   | 33   | 36   | 39   |

Source: Exeter MOH Reports, 1941, p. 34; 1943, p. 38; 1945, p. 41; 1946, p. 44.

birth control clinic, and the MOH provided fairly gloomy assessments of the work, noting ‘this statement does not include others who decline to make use of the clinic’s services’.25

Although the Exeter MCWC never undertook direct provision of birth control services, it would be misleading to present this as a particularly controversial activity in the city itself. In 1933, a critical statement on the subject by the Bishop of Exeter provoked a series of responses in local newspapers.26 These claimed the undeniable right of every married person to have access to birth control information, and suggested that people had a responsibility to use birth control where this would benefit individual families and the wider community.27 The birth control clinic was meant to be carefully co-ordinated with an array of council health and education services.28 Campaigners, however, were concerned by an apparent failure to reach their target population:

What is to be done with such people [who did not accept referral to the clinic], or with women and men like a feckless pair who recently took their discharge from a public assistance committee institution, with their six children, including an infant of three week’s old? Quite kindly they were advised that the wife should go to a birth control clinic. Whereat the woman remarked, with a toss of her head, ‘oh, us always thinks you’ve got to have the number what’s ordained for ‘ee’.29

Enthusiastic supporters of birth control in Devon almost invariably extended their analysis from the health benefits of fewer pregnancies, and the economic case for smaller

25West Country Studies Library, SB/EXE 614EXE, City and County of Exeter Annual Reports of the Medical Officer of Health (hereafter Exeter MOH Reports) 1941, p. 34; 1943, p. 38; 1945, p. 41; 1946, p. 44.
26The Ministry of Health believed the ecclesiastical influence in Exeter had a mixed impact on public health work in the city. The Bishop and his wife tended to discourage public discussion of controversial topics in public but privately did much useful work. Exeter PHS, p. 8.
27CMAC SA/FPA/A11/13, Exeter press cuttings including Express and Echo, 17 and 21 March 1933, and 24 April 1933; Western Morning News, 17 March 1933 and 19 June 1933. An earlier set of Exeter cuttings covering similar themes date from 1932. Julie Grier notes similar debates in North Wales. Grier 1998.
28In Exeter, new municipal housing estates had homes designed for families of exactly two parents and two children, and other services were planned accordingly. See Exeter MCWC Minutes, 24 May 1933, pp. 208–10.
29CMAC SA/FPA/A11/13, Exeter Press cuttings, Express and Echo, 21 March 1933.
families, to a clear preference for preventing the reproduction of the unfit.\(^{30}\) It is perhaps this emphasis on the welfare of the community, rather than the health of individual women, that explains the cautious reception potential clients made to the clinic.

**Halifax: Different Priorities and Official Disapproval**

If concern about the needs of women whose lives were imperilled by childbirth was the driving force behind the birth control debate, it might be expected that Halifax would prove to be a centre of activity. The maternal mortality rate was consistently high, and was the subject of detailed investigations by successive Medical Officers of Health.\(^{31}\) The Ministry of Health was also concerned.\(^{32}\) For many years, however, concern about maternal deaths was overshadowed by anxieties about infant mortality rates in a town with an unusually low birth rate.\(^{33}\) In the Edwardian period, the Halifax MOH highlighted a decline in population (mostly explained by outward migration) to press his case for a pioneering scheme of municipal health visiting to improve the welfare of pregnant women, new mothers and their babies. From the outset, the MOH conceived of the health visitors as his health missionaries. They were meant to take his programme for health improvement into the community, and were supported by voluntary organisations the MOH set up to further his/their work.

This left little scope for health visitors to develop their own agendas or respond to client needs outside of officially approved schemes. These did not include the provision of birth control. In part, this reflected a policy that was initially pro-natalist, and data that suggested promoting birth control would not reduce maternal mortality. There were also strong personal, professional and political objections to any provision of birth control in Halifax.\(^{34}\) Many progressive local politicians, and officials, had strong religious beliefs that complicated their response to the issue.\(^{35}\) This situation left the campaigners who favoured birth control services cut off from vital sources of information and political support. It also disrupted access to the statutory–voluntary sector partnerships, so vital to the Exeter model, and left emergent services vulnerable to hostility from religious leaders and local doctors.\(^{36}\)

\(^{30}\) Grier underlines the importance of these agendas but does not directly link them to demand for clinic services. Cohen, however, found that the Marie Stopes clinics did not let their eugenic agenda impinge upon the delivery of birth control advice and this policy made services more attractive to clients. Grier 1998; Cohen 1993.

\(^{31}\) Halifax Local Studies Centre, 614 HAL, Annual Reports of the Medical Officer of Health (hereafter Halifax MOH Reports), 1929, p. 66, for one of many local investigations.

\(^{32}\) The urban and rural parts of the County Borough of Halifax were burdened with all the problems that Janet Campbell identified as risks for excessive maternal mortality. Loudon 1992, p. 252.

\(^{33}\) For discussion regarding unusually low fertility rates in Halifax, see Szreter and Hardy in Daunton (ed.) 2000, pp. 658, 665–6.

\(^{34}\) Hargreaves 1999, p. 184.

\(^{35}\) Patricia Dawson suggests that from c. 1900, a progressive municipal agenda formed the basis of a new Lib–Lab alliance and also drew support from philanthropic families otherwise known for their Conservative politics. Dawson 1994.

\(^{36}\) The Halifax MOH’s personal opposition to birth control is more evident in G. Roe’s frostily polite correspondence with the National Birth Control Association than his own reports, which tend to avoid reference to the subject. CMAC SA/FPVA11/20, Halifax CB 1934–42, correspondence.
The Halifax MOH who introduced the first municipal health visitors was J. T. Neech. He was unashamedly pro-natalist and sought to increase the population of Halifax, which had tended to stagnate from the 1890s, after an earlier period of sustained economic and demographic expansion that had brought wealth and status to the town. Neech was determined to reduce the death-rate, and placed particular emphasis on reducing infant mortality. Efforts to save babies drew attention to the problem of maternal health. Health visitors and medical officers at the infant welfare centres (always female in Halifax, though not in Exeter) were familiar with the suffering of some of their multi-parous clients. Yet by the 1930s, it was women having their first babies (especially older primigravidae) and those having twins and triplets who seemed to be in the greatest danger of dying.37 Instrumental and caesarean births (often associated with the above) also added to the annual death-toll. The Medical Officers of Health advocated improved obstetric services rather than birth control.38 The idea that all women would ‘naturally’ want children permeates the Halifax MOH reports; ideas that found ultimate expression in the attention given to investigating infertility and childless marriage in the 1940s.39

Halifax Medical Officers of Health repeatedly warned women of the dangers of late marriage and delayed child-bearing. In 1934—the significance of this date for birth control services will be explained later—G. C. F. Roe (Halifax MOH) blamed ‘the present limitation of families’ for an excess ‘of primiparae, many of them 30 years or more’, who had again added to the maternal mortality rate.40 In 1934, twelve Halifax women died in or as a consequence of pregnancy and childbirth. Five women aged between 20 and 30 died, three of these were having their first child and one death resulted from abortion. Amongst older women aged between 30 and 40 there were seven deaths; two involving first children and one connected with abortion.

The spectre of illegally procured abortions haunts the Halifax MOH reports, in a way that tended to increase official hostility towards birth control by underlining the ‘selfishness’ and ‘immorality’ of women who might want to control their own fertility. A whole section of the 1924 report was devoted to these issues, but they were recurring concerns that had shaped municipal services from the outset.41 The earliest Edwardian debates about maternity and child welfare took place against the backdrop of a number of sensational stories in the local press. These drew attention to deaths resulting from abortions, and a series of tragedies that linked unwanted pregnancies to illicit sex and both to the highly emotive issues of infanticide and suicide.42 In one 1900 case, an unmarried servant girl was unsuccessfully prosecuted for infanticide and in 1910 an unemployed man and

37 When the infant and maternal mortality rates edged upwards in 1950 this was attributed to multiple-births, Halifax MOH Report, 1950, p. 22.
38 The Birmingham MOH expressed a similar view. Niemi 2007, p. 93.
39 Halifax MOH Report, 1949, p. 27.
40 Halifax MOH Report, 1934, p. 53.
41 The MOH theorised that babies were unwelcome in certain parts of Halifax and the low birth-rate combined with high rates of infant mortality, prematurity (resulting in live birth but subsequently dead infant), still-birth and miscarriage were the result of deliberate steps taken to prevent their safe arrival. Halifax MOH Report, 1924, pp. 8–9.
42 Evening Courier Millennium Souvenir, 1906 and 1909.
his pregnant fiancée completed a suicide pact. With concern focusing on the mental state of the women, the issue of contraception was simply not considered. A similar narrative stressing mental distress rather than the benefits of contraception was adopted in the cases of two married women, apparently deranged by grief over a dead child quickly followed by another birth, who killed themselves and their surviving children. The Halifax MOH reports do not propose birth control clinics as a way of reducing abortions as a first step to bringing down maternal mortality rates, nor do they suggest birth control as the best method of reducing the strain on poor married women.

Table 2. Maternal Mortality Data Collected by the Halifax MOH, 1921–1948

| Year | Sepsis | Other causes | Maternal Mortality Rate (MMR) | MMR—live births only |
|------|--------|--------------|-------------------------------|----------------------|
| 1921 | 3      | 9            | 6.7                           | Not recorded         |
| 1922 | 3      | 7            | 6.2                           | Not recorded         |
| 1923 | 3      | 7            | 6.5                           | Not recorded         |
| 1924 | 0      | 6            | 4.0                           | Not recorded         |
| 1925 | 1      | 7            | 5.6                           | Not recorded         |
| 1926 | 1      | 7            | 5.7                           | Not recorded         |
| 1927 | 1      | 9            | 7.4                           | Not recorded         |
| 1928 | 5      | 8            | 10.2                          | Not recorded         |
| 1929 | 3      | 6            | 6.8                           | Not recorded         |
| 1930 | 4      | 8            | 9.2                           | Not recorded         |
| 1931 | 0      | 4            | 3.2                           | Not recorded         |
| 1932 | 7      | 4            | 8.7                           | 9.2                  |
| 1933 | 5      | 6            | 9.4                           | 10.0                 |
| 1934 | 4      | 8            | 9.9                           | 10.5                 |
| 1935 | 1      | 7            | 6.4                           | 6.8                  |
| 1936 | 2      | 7            | 7.0                           | 7.5                  |
| 1937 | 0      | 3            | 2.2                           | 2.3                  |
| 1938 | 2      | 2            | 2.8                           | 3.0                  |
| 1939 | 3      | 3            | 4.4                           | 4.4                  |
| 1940 | 1      | 10           | 8.8                           | 8.8                  |
| 1941 | 1      | 1            | 1.5                           | 1.5                  |
| 1942 | 3      | 2            | Not recorded                 | 3.4                  |
| 1943 | 1      | 2            | Not recorded                 | 1.9                  |
| 1944 | 1      | 3            | Not recorded                 | 2.3                  |
| 1945 | 1      | 2            | Not recorded                 | 2.0                  |
| 1946 | Not recorded | Not recorded | Not recorded                 | 1.1                  |
| 1947 | Not recorded | Not recorded | Not recorded                 | 0.5                  |
| 1948 | Not recorded | Not recorded | Not recorded                 | 0.5                  |

Source: Halifax MOH Reports, 1925–48.

43Evening Courier Millennium Souvenir, 1900 and 1910.
44Other contemporary literature drew attention to the number of married women seeking abortions and made their poor physical/emotional condition part of the case for birth control. Fisher 2006, pp. 113–4; McIntosh 2000.
45Evening Courier Millennium Souvenir, 1903 and 1904.
women. By contrast, these issues were investigated by Ministry of Health officials surveying the surrounding administrative county of the West Riding of Yorkshire.  

J. T. Neech, Halifax MOH until 1921, had simply advocated more births; using his report to celebrate increases in the birth rate, or express concern about its decline. He viewed the marriage rate as the best predictor of births in the following year. His successor, Cyril Banks, also commented on the falling birth rates but his concerns were more obliquely expressed within discussions that linked continuing anxieties about delayed motherhood and illegal abortions to the maternal mortality rate. Banks was not in post long enough to fully develop his thinking on these points and his successor, G. C. F. Roe, adopted new areas of interest. Roe tended to argue that reducing the infant mortality rate and the overall death rate had compensated for falling birth rates, although he did not always bother to conceal his personal opposition to birth control and concern about differential fertility rates.

This was not an explicitly eugenic debate but echoed some long-standing local concerns that certainly had a eugenic dimension. Until the 1930s, Halifax Corporation had only tried to control the fertility of two groups. These were people identified as ‘active’ cases of pulmonary tuberculosis and individuals subject to the provisions of the Mental Deficiency Acts. In both cases, it was restrictions on marriage, rather than contraception within marriage, that had been advocated by the Halifax Medical Officers of Health.

Yet in 1934, a municipal birth control clinic was established in Halifax. This is the only health initiative that receives virtually no attention in the usually comprehensive Halifax MOH reports. The clinic was probably based at the Infant Welfare Centre at Northgate, although neither its location nor opening hours are listed in the annual guide to council services where all the other clinics, including those for venereal disease, are openly advertised. If the clinic was based at Northgate then the centre’s usual complement of female medical officer and team of health visitors probably staffed it. Unusually, though they received no official thanks for starting, conducting, or even winding up this service. The service ended just two years later, ostensibly on the grounds that ‘since the voluntary clinic commenced to operate in the town the municipal clinic has practically ceased to operate’, although the suspicion must be that the fragility of the service encouraged alternative voluntary sector provision.

---

46 NA, MH 66/289, West Riding of Yorkshire County Council Public Health Survey, including report by Dr Carol Sims, 29 March 1934, pp. 15, 15a, 23–4.
47 Halifax MOH Report, 1924, pp. 6–9.
48 Halifax MOH Report, 1936, p. 6.
49 Neech had been especially concerned that patients would meet and marry at the local sanatoria and then produce many offspring pre-disposed to the disease. Halifax MOH Report, 1918, appendix.
50 A key task for voluntary workers, later supervised by the health visitors, had been urging upon patients ‘the necessity of abstaining from entering into matrimony’. Halifax MOH Report, 1918, appendix. The marriage of ‘mental defectives’ was made illegal following the 1913 Mental Deficiency Act.
51 The relevant committee minutes are also remarkably uninformative about the origins and aims of the scheme. Halifax Local Studies Centre, 352, Anon., Halifax Corporation Minutes of Committees, 24 January 1934, p. 563; 21 February 1934, p. 732; 7 March 1934, p. 801.
52 Halifax MOH Reports, 1934, p. 51; 1935, p. 50; 1936, p. 56. The NBCA was not able to discern what had happened to their satisfaction. CMAC SA/FPA/A11/20, letter from Mrs Pyke to Mrs Bowman, 14 October 1937, and reply 19 October 1937.
The Halifax Women’s Welfare Club/Family Planning Clinic

The Halifax branch of the National Birth Control Association (NBCA), known as the Halifax Women’s Welfare Clinic (WWC), was also established in 1934, but received no local authority support. The archives of the Halifax Women’s Welfare Club (hereafter Halifax WWC) later Halifax Family Planning Clinic (1934–75) are held at Calderdale Records Office by the West Yorkshire Archives Service. Misc 190: 1, notebook of minutes February 1934 to March 1938 (hereafter WWC Minutes).

53 The first Halifax WWC meeting named a deputation to see Roe and the Chair of the Health Committee, but Roe was unavailable and then refused access to MCWC premises. WWC Minutes, 2, 13 and 26 February 1934. For refusal to use education committee clinics and further denial of help by Roe, see WWC Minutes, 14 March 1934.

54 Approaches to the education committee were similarly rebuffed although its chairman was a close relative of Mrs Elizabeth Whitley, the chair of the WWC committee. The clinic was therefore unable to access the resources and information networks seen as vital to the operation of the Exeter clinic, although key members of its committee were the wives of prominent citizens in the same way as in Exeter.

This tended to foster both caution and radicalism. The women’s clinic seems to have gone out of its way to meet client needs in a way never contemplated in Exeter. In addition, by being forced to act cautiously, several aspects of the work that were apparently taken for granted in Exeter were subject to extensive debate and can be reconstructed from very full records. While Exeter services always emphasised their local connections, despite national affiliation, the Halifax centre was forced to look for support from elsewhere. Strong links developed between the doctors, nurses and committee members of various NBCA centres. The Halifax clinic was closely modelled on the one in Sheffield, with regular exchange visits and updates on policy and practice, but its original organisation owed much to the personal efforts of Mrs Freeth from Rotherham. Vital support was also received from other women doctors and lay activists, as well as the NBCA.

The Exeter services developed within existing provision and there were no reported problems securing premises or staff (through voluntary efforts that echoed the pattern of other service development). Funds were made available by the City Council (though

55 A Miss S. (probably a nurse) always had to be thanked for her services prior to the AGM as her name could not appear in any published material. WWC Minutes, 11 March 1936.

56 Plans for large public meetings were constantly put on hold but word of mouth recruitment was encouraged and efforts were made to help women from distant parts of England and abroad who approached the clinic for aid. WWC Minutes, 26 February 1934.

57 There was extended discussion on the best methods and products to use with manufacturers’ samples and advice from headquarters taken very seriously. Without assistance from the council, thought also had to be given to equipping the clinic and getting its administration on sound lines.

58 The Exeter and Halifax clinics both appear on a list of 34 English voluntary sector birth control clinics issued by the NBCA in October 1934, included in the Halifax WWC minute book. WWC Minutes, 26 February 1934.

59 This had been especially important when setting up the clinic in 1934 but a lively correspondence was carried on with various supporters. Attendance at meetings in London kept the Halifax group up to date with the latest scientific studies of birth control and an invited speaker was a key part of the Halifax branch AGM.
following the model of other statutory–voluntary sector partnerships, there would have been additional revenue from subscriptions and some means-tested patient payments). In Halifax, the initial effort relied on a volunteer doctor and nurse and fundraising was a constant worry. Finding suitable premises was very difficult with no help from the town hall, but eventually the Toc H allowed trial use of their rooms. This was always controversial and the lease was quickly terminated, involving the WWC in considerable wasted expenditure as equipment and furnishings had to be moved and new advertising material prepared.

Without access to the usual source of medical information in the town—the MOH—the members of the WWC looked elsewhere for ways of improving their own knowledge of birth control and the best ways of communicating this to clients. Books and pamphlets were ordered from the NBCA, and these were regularly updated to provide the best advice using the latest methods. The committee still hoped to co-operate with municipal medical services and special efforts were made to both inform Roe of the opening of the new clinic and ask him if he wanted information about the health of clinic patients collected to further his work. In public statements about the work of the clinic, the WWC made detailed reference to concern about the local rates of maternal mortality as the justification for their existence, but, while the message of ‘saving mothers’ had some parallels in the MOH reports, there was a strong divergence of opinion over what the problems were and how to alleviate them.

While the MOH was very discreet in his references to abortion, and was determined not to support a municipal birth control clinic, the WWC reported:

> We nevertheless maintain that in order to mitigate the evils of poverty and overcrowding, and as an alternative to much self-induced or attempted abortion, such advice should be readily available through the Public Health Services to every married woman who needs it.

Roe remained non-committal, refused to refer MCWC patients to the clinic, and was understood to be hindering attempts to reach other potential clients. This limited the work of the clinic in a number of ways. Overt official disapproval undoubtedly made it more difficult for women to approach the clinic, despite its emphasis on respectability and the promise of consultations with a ‘qualified married woman doctor’. The lack of referrals became less important as the clinic built up its own patient list but the absence of local authority support undermined the finances of the clinic and skewed

---

61 Toc H was originally an organisation for ex-servicemen.
62 WWC Minutes, 7 May 1934.
63 WWC Minutes, 6 June 1934.
64 WWC Minutes, 6 November 1934, text drawn up by Halifax WWC and sent to the Minister of Health, Mr Gilbert Gledhill (Halifax MP) and the town clerk in response to NBCA request for resolution in response to Ministry of Health circular 1408.
65 WWC Minutes, 6 November 1934.
66 From correspondence, it was discovered that the Halifax MOH had given the address of the clinic to a local mother but had somehow left her with the impression it ‘was a place of doubtful character’. WWC Minutes, 11 March 1936.
67 WWC Minutes, 12 September 1934.
the type of patients who could be helped. In Exeter, poor women who were deemed to need birth control advice (on eugenic, health or other grounds) had their fees for advice, consultations and materials covered by the city council. This was not the case in Halifax where all patients had to contribute to the costs of their care, though fund-raising subsidised some of the expense and payment plans spread costs.68

This meant that unlike Exeter, where the clientele was shaped by deliberate attempts to target poor mothers, there was a significant overlap between clinic and private patients in Halifax. This could create confusion, offend local doctors and upset the work of the clinic; especially where women felt able to request services the clinic did not want to offer.69 This presented problems when unmarried women demanded access to birth control advice and equipment.70 They were initially refused any help, even a leaflet, but later policy was relaxed to allow ‘genuine brides-to-be’ to discuss ‘matters’ with the doctor and special arrangements were put in place for couples who were ‘secretly married’. These arrangements were meant to balance client needs and a responsible approach to birth control but had to be constantly defended against charges of immorality.71

These issues proved problematic, but their resolution tended to promote inclusivity. This was quite different to the situation in Exeter where birth control services provided by the elite for the poor were not taken up as enthusiastically as had been expected. In Halifax, they were more clearly a service provided by women for women (potentially of all classes) and levels of demand and compliance with treatment gratified the committee (Table 3). At least some of the Halifax volunteers and fundraisers used the clinic themselves, and special arrangements were put in place for them to purchase equipment and supplies.72

While some of the debate about scientific birth control can come across as very cerebral and technical, discussions in Halifax had a strong practical bent. Rather than make pronouncements about the future of the race and the fecklessness of the poor, the committee happily tested sheaths and other contraceptives that at least some of them intended to use themselves.73 This sense of shared concerns extended from the clinic’s staff and volunteers to the patients and a variety of women’s groups. The first WWC treasurer developed a mini-lecture circuit and Dr D. Heynemann, the clinic’s doctor, spoke to lay and medical audiences, including the Women’s Co-operative Guild and a group of Huddersfield midwives, about aspects of birth control.74

---

68 In a later survey of national provision, the Halifax committee were surprised to find out how much some local authorities paid voluntary sector clinics per case and negotiated a discount price for West Riding of Yorkshire County Council patients sent by the County MOH, Dr T. N. V. Potts. WWC Minutes, 8 March 1939.
69 For discussion regarding the attendance of private patients at the clinic, see WWC Minutes, 23 January 1939.
70 Cases of Miss K. and Miss H. WWC Minutes, 11 March 1936 and 22 April 1936.
71 For example, Mrs Bowman’s address to the Halifax Gas Development Association. Undated newspaper clipping inserted into Halifax WWC minute book.
72 WWC Minutes, 10 July 1935.
73 WWC Minutes, 6 November 1934 and 24 January 1935.
74 WWC Minutes, 24 June 1936.
number of professional women were encouraged to support the clinic, which was also used to train nurses. The birth control clinic eventually found a home in the Halifax District Nursing Association premises and drew increasing support from other voluntary organisations. Yet links with the Health Department’s medical officers and health visitors remained problematic until the NHS era. What is never officially mentioned in the records of the clinic, which emphasise Dr Heynemann’s work as a local general practitioner, or the health department, which say nothing about the staffing of the voluntary clinic, was that Dr Heynemann was employed by the Halifax Education Committee to do some school medical work.

The role of lady councillors and other elite women was also ambiguous. It seems significant that the birth control movement began in Halifax in 1934 when Miriam Lightowler was serving as the first lady mayor. The WWC, however, experienced problems when trying to interest successive lady mayoresses and lady magistrates in their work, with a pointed boycott of their AGMs. In the end, the open hostility of Roe prompted a direct appeal to two lady councillors to come along to the clinics and see for themselves. This visit must have impressed them as they quickly became a source of support and information. It was the lady councillors who notified the clinic ‘that the cause of stopping birth control information at the... clinic had been a deputation to the health committee from the Catholics’. This led to another deputation to see Roe and seek an explanation for this new policy and the lack of referrals from Dr Margaret M. McDowall (Medical Officer to the MCWC).

The clinic was never just about birth control advice, a point underlined by Dr Heynemann at the first AGM. While it might be assumed that some relationship counselling might be provided alongside contraceptive advice, Heynemann was talking about discovering unmet health needs. It was not uncommon for birth control clinics to be

| Year     | New patientsa | Second visitsb | Six monthly checks |
|----------|---------------|----------------|-------------------|
| 1 1934/35 | 75            | Not stated     | Not stated        |
| 2 1935/36 | 129           | 88             | 36                |
| 3 1936/37 | 112           | 102            | 44                |
| 4 1937/38 | 135           | 104            | 67                |

Notes: aNew patients were examined and fitted with an appliance and/or offered a sheath; bA follow-up visit was made about a fortnight later to check fit and issue supplies.

Source: Halifax WWC Minutes, 26 March 1935, 23 March 1936, 16 March 1937, 14 March 1938.

75 WWC Minutes, 13 March 1935.
76 A cordial but apparently unofficial written correspondence was maintained with Sister Oram, the superintendent health visitor. WWC Minutes, 11 March 1936.
77 NA, MH 66/1071, Halifax County Borough Public Health survey, 1932, paragraphs 52–6.
78 Hargreaves 1999, pp. 188–9.
79 WWC Minutes, 22 April 1936.
80 WWC Minutes, 27 October 1937. These visits were also reported to the NBCA. CMAC SA/FPA/A11/20, letters from Mrs Bowman, 14 November 1937 and 19 December 1937.
associated with clinics diagnosing and treating gynaecological disease.\textsuperscript{81} Symptoms of cancer provided a potential link back to municipal services and cancer as a public health priority.\textsuperscript{82} However, evidence of prior botched abortions proved more problematic.\textsuperscript{83} Heynemann stressed that birth control services could and did save lives as well as unnecessary suffering (terming the clinic ‘the health and life-saving clinic’ at the 1937 AGM), but owing to sensitivities of local doctors other medical problems were referred back to the patient’s own doctor.\textsuperscript{84} Dr Heynemann’s successor, Dr Janet Cockcroft, had a similar agenda to save women’s lives and improve their health that she developed in the women’s clinic, in her role as assistant MOH (in Halifax in the NHS era), and as a national figure in the women’s movement.\textsuperscript{85}

The Halifax clinic did not just aim to prevent future pregnancies (the mark of success of work in Exeter). It also recognised the value of delaying future births. Women in Halifax were meant to be reassured by the news that patients who had decided to stop practising birth control in order to deliberately have a baby were quickly able to become pregnant.\textsuperscript{86} Through their work with brides, mothers-to-be, new mothers and the mothers of several children, the Halifax group developed a holistic approach to family planning in stark contrast to the eugenically-minded birth control campaigners, though not necessarily the clinic, in Exeter.\textsuperscript{87} Halifax had its own problems with contraceptive failure (with occasional product recalls and individual cases passed to the medical sub-committee for investigation) but efforts to encourage people to become regular attendees, by making the clinic welcoming and sensitively framing reminder letters, produced promising results.

A key source of support was the \textit{Halifax Courier and Guardian}. The newspaper accepted notifications of clinic opening times in its classified section and also carried what the WWC acknowledged were generous reports of its AGM.\textsuperscript{88} It even offered the WWC a disused office when it appeared that the clinic would be made homeless. Media support was especially important in Halifax because of problems with publicising the clinic through the council’s well-developed health propaganda machinery (as Exeter did). Yet, without the support of members or officers of the council, the WWC was vulnerable to external criticism and spent considerable time dealing with different religious and medical groups who expressed objections to various aspects of the work. At the

\begin{footnotesize}
\begin{enumerate}
\item Florence 1956 and Court and Walton 2001 both mention municipal gynaecological and birth control clinics in Birmingham.
\item Moscucci 2005.
\item In her address to the fourth AGM, Dr Heynemann reported ‘during the year we have come across definite evidence of abortion and it is to avoid such practices and to help women with frequent pregnancies… that the clinic had been started’. WWC Minutes, 14 March 1938.
\item Despite the limited health services available to poor women, ‘deserving’ cases could use attendance at municipal and voluntary clinics to secure referrals to more specialist treatment.
\item See biographical notes composed by John Hargreaves available via website ‘From History to Herstory—Yorkshire Women’s Lives online, 1100 to the present’. The project was run by the West Yorkshire Archive Service with funding from the New Opportunities Fund. See http://www.historytoherstory.org.uk (accessed 19 November 2008).
\item WWC Minutes, 16 March 1937.
\item WWC Minutes, 8 October 1936, agreed that childless married women could be advised though they should be reminded of the advantages of having a family.
\item For text of advertisement, see WWC Minutes, 12 September 1934.
\end{enumerate}
\end{footnotesize}
outset, there was a very difficult meeting between representatives of the WWC and the Rt Revd George Horsfall Frodsham (Vicar of Halifax 1920–37).\(^89\) He said that while he could never support the work of the clinic he ‘would not give it its wholesale condemnation’ and this led the WWC to conclude that he would not ‘take an active part with the Catholics against the movement’.\(^90\) Catholic opposition remained strong in Halifax throughout this period.

By the late 1930s, there was an attempt to get health department staff to quietly refer individual patients to the clinic rather than publicly advertise the work in the council clinics. Dr McDowall explained to the committee that she would herself give birth control advice to clients ‘when it was really necessary on health grounds’, but if other mothers asked for advice she gave them the name of the voluntary clinic. However, ‘official referrals’ would be an ‘unlikely event’.\(^91\) The WWC made efforts to maintain cordial relations with the health visitors who were also in a position to unofficially refer clients, and draw Dr McDowall’s attention to cases of exceptional hardship. Miss Elsie R. Oram, the superintendent health visitor, was a key point of contact.

Yet the national agenda, especially one with an overt eugenic dimension, was never far away. Halifax relied on external support for its clinic and this was increasingly supplied and manipulated by eugenicists. Thus, pamphlets on birth control were increasingly supplemented by promotional films supplied by the Eugenics Society and speakers at the AGM fore-grounded their own concerns. In 1937, the MOH for Brighouse (a neighbouring town) feared a falling birth rate would simply depopulate the country. He drew attention to conflict between personal choices leading to individual benefits and wider national agendas. In his account it was permissible, even sensible, to use birth control to ‘space’ children to optimise maternal health and family resources.\(^92\) Problems only began when people used birth control ‘without any real reason’ leading to fears that ‘it might from the racial point of view, do quite a lot of damage’.\(^93\) A succession of lady speakers drew attention to women’s unique role in protecting the future of the nation and the race, one with a paper entitled ‘The Responsibilities of Birth Control’.\(^94\) These anxieties were given particular piquancy as committee members weighed clinic duties with likely commitments in the event of war.\(^95\) Yet meeting specific local needs in a time of national emergency became a strong theme in wartime Halifax MOH reports and, while not specifically mentioning birth control, there is a strong sense of protecting and expanding existing provision in anticipation of post-war planning for a yet more comprehensive service.

In Exeter, the situation was quite different, and more difficult. The wartime dislocation of population tended to reaffirm the worst fears of eugenicists as large numbers of evacuees and unofficial refugees brought not only visible evidence of the slum but also its

---

\(^89\)See *Who Was Who*, vol. III, 1929–1940.
\(^90\)WWC Minutes, 26 February 1934.
\(^91\)WWC Minutes, 8 December 1937.
\(^92\)WWC Minutes, unsourced newspaper cutting of the 1937 AGM filed with minute book.
\(^93\)Ibid.
\(^94\)WWC Minutes, 14 March 1938.
\(^95\)WWC Minutes, 11 October 1938.
attendant diseases to Exeter. The problem was compounded by serious disruption to the statutory–voluntary sector partnerships as key personnel were lost to the war effort and lack of petrol constrained their freedom of operation. The Exeter blitz then threatened the total collapse of local services and the recovery plan was hindered by the MOH’s obvious frustration with the series of schemes and initiatives emanating from central government.

Conclusion
This paper originated in a comparative study of health visiting in Devon and the West Riding of Yorkshire which raised questions about the acceptability of birth control. In 1922, Nurse E. M. Daniels, a local authority health visitor, was dismissed for giving birth control advice to her clients. Despite the notoriety of this case in histories of birth control and biographies of leading birth control campaigners, most studies of health visiting ignore the profession’s historical involvement with birth control altogether. Textbooks for health visitors, going back to the 1960s, strongly suggest that the health visitor was and is in an excellent position to offer birth control advice. She met pregnant women, new mothers and parents of small children in a variety of settings designed to be conducive to discussion of intimate health topics and facilitate advice giving. It should, however, be noted that the senior health visitors writing the books viewed family planning advice as less important than visiting new mothers and their babies to check on their overall well-being. In a list of priorities for busy health visitors in the 1970s, Grace Owen placed work with family planning services firmly in a non-urgent category.

Before the advent of the Pill enabled discussions of contraception that did not touch on sexual behaviour, it is clear that birth control was a difficult subject for individual health visitors, and the profession of health visiting, as well as their employers in the municipal and voluntary sectors. Concerns about meeting health needs and promoting women’s rights presented themselves differently to the various actors involved and no uniform position or response should be assumed. The key divisions in the debate are usually assumed to be class, gender, political allegiance and religious affiliation, but the ideological complexity of the debate supported unusual alliances and for many it was a matter of individual conscience. In a similarly fraught debate over mental deficiency policy, Mathew Thomson notes the importance of recognising professional interests and the culture of service-provider organisations that often operated independently of the considerations outlined above.

Health visitors were in a difficult position with regard to birth control as the profession itself was far from united on the question, at least before the NHS era. This left individual health visitors, irrespective of their own opinions, vulnerable to local campaigns for or against the greater availability of local birth control advice and clinics. Where local...
authorities employed health visitors they were the direct subordinates of the MOH. Since he was central to the propagation of any municipal health and/or welfare service, his attitude to birth control played a significant role in any development of services. Yet his position was constrained by the political composition of the local authority he worked for. Women councillors, in the tradition of Patricia Hollis’s *Ladies Elect*, were keen to speak with authority on women’s issues and often made vocal contributions to these debates but did not provide consistent support. Public interest and support could also not be relied upon.

There was no entirely safe position on birth control but health visitors were undoubtedly at their most vulnerable where they personally supported birth control in opposition to the attitude of their MOH and/or local authority and were prepared to advise individual women and even unofficially refer them to independent voluntary sector clinics. This high-risk strategy was justified, explicitly in the Nurse Daniels case, by reference to the problem of need. In the course of their professional duties, health visitors were confronted by the problem of married women who were unlikely to survive another pregnancy but had no readily available means of preventing one. Health visitors do not seem to have attempted to work with the couple in these circumstances but do on occasion appear to have favoured giving the woman guidance about managing her own fertility. This approach, perfectly understandable within the context of the woman-to-woman mission at the centre of health visiting, chimed with the interests of at least some progressive health visitors exposed to feminist ideas during their extended period of education and open to ideas about science and medicine within a hygiene discourse as a result of their training.

Health visitors, regardless of personal beliefs, contributed to the process of gathering evidence of maternal morbidity and mortality. This paper argues that this was their crucial contribution to service development. There was little sign of health visitors personally and publicly advocating birth control clinics. Later, however, when services were established, health visitors played an important role in staffing clinics and making referrals to them, although again they tended not to speak publicly about this work. Thus, this paper argues that health visiting was not central to the birth control movement, and birth control services made a limited contribution to the consolidation of the profession of health visiting in this period. One of the key issues for feminists, therefore, made an incoherent contribution to the development of the essentially female profession of health visiting before 1948, and health visitors proved unable (though this is not incompatible with them being unwilling) to make an independent impact to the development of these municipal services.

**Acknowledgements**

This article draws on research conducted as part of Wellcome Trust Grant 074999, for which Pamela Dale is very grateful. We would like to thank the many archivists who

---

102 Hollis 1987.
103 In Birmingham, a health visitor was sacked in 1931 because of involvement with the promotion of birth control in the face of opposition from the MOH and local Catholic groups. Niemi 2007, pp. 92–3.
104 Watts 2007, pp. 167–92.
identified material for this article and acknowledge the generous support offered by the editors and anonymous referees. Funding to pay the Open Access publication charges for this article was provided by the Wellcome Trust.

Bibliography

Primary sources
Devon County Records Office, Exeter, UK.
Exeter Maternity and Child Welfare Committee Records, Exeter, UK.
Halifax Corporation Records, Halifax, UK.
Halifax Local Studies Centre, Halifax Central Library, UK.
National Archives, Kew, London.
Wellcome Trust for the History of Medicine, London.
West Country Studies Library, Exeter, UK.
West Yorkshire Archives Service, Calderdale, Yorkshire, UK.
Evening Courier Millennium Souvenir, Halifax Courier.
Express and Echo.
Western Morning News.
Who Was Who, vol. III, 1929–40, London: Adam and Charles Black.

Secondary sources
Briant K. 1962, Marie Stopes: A Biography, London: Hogarth Press.
Cohen D. A. 1993, ‘Private Lives in Public Spaces: Marie Stopes, the Mothers’ Clinics and the Practice of Contraception’, History Workshop Journal, 35, 95–116.
Court A. and Walton C. 2001, 1926–1991 Birmingham Made a Difference. The Birmingham Women’s Welfare Centre. The Family Planning Association in Birmingham, Birmingham: Barn Books.
Dale P. 2003, ‘Implementing the 1913 Mental Deficiency Act: Competing Priorities and Resource Constraint Evident in the South West of England before 1948’, Social History of Medicine, 16, 403–18.
Dawson P. A. 1994, ‘Liberalism and the Challenge of Labour: The 1906 Progressive Election in Halifax’, Halifax Antiquarian Society Transactions, new series 2, 107–24.
Dayus K. 1988 [1982], Her People, London: Virago.
Fisher K. 1998, ‘“Clearing up Misconceptions”: The Campaign to Set up Birth Control Clinics in South Wales Between the Wars’, Welsh History Review, 19, 103–29.
Fisher K. 2002, ‘Contrasting Cultures of Contraception: Birth Control Clinics and the Working-Class in Britain between the Wars’, in Gijswijt-Hofstra M., Van Heteren G. M. and Tansey E. M. (ed.), Biographies of Remedies: Drugs, Medicines and Contraceptives in Dutch and Anglo-American Healing Cultures, Amsterdam: Rodopi, 141–57.
Fisher K. 2006, Birth Control, Sex, and Marriage in Britain 1918–1960, Oxford: Oxford University Press.
Florence L. S. 1956, Progress Report on Birth Control, London: Heinemann.
Grier J. 1998, ‘Eugenics and Birth Control: Contraceptive Provision in North Wales, 1918–1939’, Social History of Medicine, 11, 443–58.
Hargreaves J. A. 1999, Halifax, Edinburgh: Edinburgh University Press.
Harris B. 2004, The Origins of the British Welfare State: Social Welfare in England and Wales, 1800–1945, Basingstoke: Palgrave Macmillan.
Hoggart L. 1996, ‘The Campaign for Birth Control in the 1920s’, in Digby A. and Stewart J. (ed.), Gender, Health and Welfare, London: Routledge, 143–66.
Hollis P. 1987, Ladies Elect: Women in English Local Government, 1865–1914, Oxford: Clarendon Press.
Leathard A. 1980, *The Fight for Family Planning: The Development of Family Planning Services in Britain 1921–74*, London: Macmillan.

Lewis J. 1986, *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health since 1919*, Brighton: Wheatsheaf.

Liddington J. 1984, *The Life and Times of a Respectable Rebel: Selina Cooper (1864–1946)*, London: Virago.

Loudon I. 1992, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality 1800–1950*, Oxford: Clarendon Press.

McCormick L. 2008, ‘“The Scarlet Woman in Person”’; The Establishment of a Family Planning Service in Northern Ireland, 1950–1974, *Social History of Medicine*, 21, 345–60.

McIntosh T. 2000, ‘“An Abortionist City”’: Maternal Mortality, Abortion and Birth Control in Sheffield, 1920–1940, *Medical History*, 44, 75–96.

Marks L. 1996, *Metropolitan Maternity: Maternal and Infant Welfare Services in Early Twentieth-Century London*, Amsterdam: Rodopi.

Moscucci O. 2005, ‘Gender and Cancer in Britain, 1860–1910’, *American Journal of Public Health*, 95, 1312–21.

Niemi M. 2007, *Public Health and Municipal Policy Making: Britain and Sweden, 1900–1940*, Aldershot: Ashgate.

Owen G. 1977, ‘The Health Visitor Today’, in Owen G. (ed.), *Health Visiting*, London: Baillière Tindall, 30–47.

Smith J. 1995, ‘The Archive of the Health Visitors’ Association in the Contemporary Medical Archives Centre’, *Medical History*, 39, 358–67.

Soloway R. 1995, ‘The “Perfect Contraceptive”’: Eugenics and Birth Control Research in Britain and America in the Inter-war Years’, *Journal of Contemporary History*, 30, 637–64.

Szreter S. and Hardy A. 2000, ‘Urban Fertility and Mortality Patterns’, in Daunton M. J. (ed.), *The Cambridge Urban History of Britain. Volume III, 1840–1950*, Cambridge: Cambridge University Press.

Thomson M. 1998, *The Problem of Mental Deficiency: Eugenics, Democracy and Social Policy in Britain c. 1870–1959*, Oxford: Clarendon Press.

Watts R. 2007, *Women in Science: A Social and Cultural History*, London: Routledge.

Welshman J. 2000, *Municipal Medicine: Public Health in Twentieth-Century Britain*, Oxford: Peter Lang.

Zabin L. S. and Hayward S. C. 1993, *Adolescent Sexual Behaviour and Childbearing*, London: Sage.