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"An Abortionist City": Maternal Mortality, Abortion, and Birth Control in Sheffield, 1920–1940

TANIA McINTOSH*

In May 1935, the National Council for Women held a conference on health in Sheffield. At the time, concern about rising rates of maternal mortality was at its height nationally. Many of the delegates to the conference commented on the particularly poor situation in Sheffield, which had one of the highest maternal mortality rates (MMR) in the country.[1] Councillor Asbury, the long-standing Labour Chair of the Council's Health Committee, rose to defend his Council against the charge that not enough was being done to tackle the problem. He agreed that "The one black spot is maternal mortality."[2] However, he turned the issue round by explaining that:

> Unless [we] can make some headway in the direction of reducing the number of sepsis deaths arising from abortion, over which the local authority [has] no control, the maternal mortality rate must inevitably remain high ... Even if it should result in Sheffield being regarded as an abortionist City, we intend to focus public attention on this grave problem and shall continue to do so until this foul thing disappears from our midst.[3]

These comments were widely reported in the local press under such banner headlines as "The Toll of Motherhood". The very secret world of abortion was achieving a high profile on the back of the apparently intractable problem of maternal mortality.[4]

This paper focuses on Sheffield, an industrial city in the north of England which was very severely affected by the economic slump of the inter-war years. Maternal mortality in Sheffield rose in the inter-war period, reaching a high of 7.27 per

* Tania McIntosh, MA, PhD, Department of History, University of Sheffield, S10 2TN.

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[1] The maternal mortality rate is deaths of mothers, from birth-related causes, per thousand births.

[2] He was speaking at the Sheffield National Council for Women's Health Conference; *Sheffield Independent*, 24/5/35, p. 7.

[3] *Sheffield Telegraph*, 24/5/35, p. 8.

[4] Fox has argued that maternal mortality never had a particularly high public profile, but in Sheffield it certainly did. The issue was canvassed in the press on a very regular basis, usually as a result of crusading statements by councillors or obstetricians. E Fox, 'Powers of life and death: aspects of maternal welfare in England and Wales between the wars', *Med. Hist.*, 1991, **35**: 328–52.

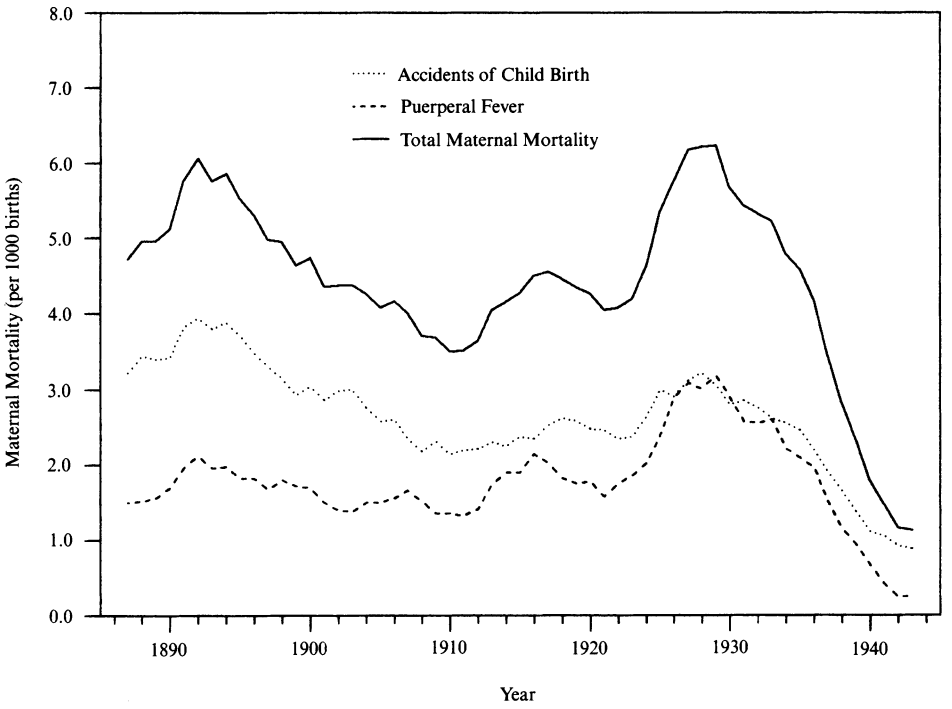

Figure 1: Maternal mortality (per 1000 births) in Sheffield, 1885–1945 (5 year rolling average).
Source: *MOH reports*, Sheffield

thousand births in 1927 and 6.11 per thousand in 1934 (Figure 1).[5] This latter figure compared with an average English rate of 4.60 per thousand for the same year, and demonstrates that Sheffield had a significant problem. In England and Wales between 1927 and 1935, abortion was estimated to account for 22.4 per cent of deaths from puerperal sepsis; in Sheffield in 1934, abortion made up 59.6 per cent of such deaths.[6] This meant that abortion deaths in Sheffield represented 39 per cent of total maternal mortality in the city. Abortion was not high in all English areas with high levels of maternal mortality; of 25 areas with maternal mortality over 5 per thousand, Bolton and Sheffield were the only places singled out as having high abortion rates.[7]

The experience of Sheffield highlights the fact that it is impossible to disentangle maternal mortality and abortion. Contemporary policy makers saw the two as linked and believed that one could not be solved without also tackling the other. It was this linkage which led to the creation of birth control clinics specifically in the areas

[5] The latter was the figure reached even after stillbirths were included in the calculations (from 1927), which had the effect of slightly reducing the total MMR by increasing the total of births into which deaths were divided.

[6] Council figures; *Sheffield Independent*, 24/5/35, p. 7.

[7] HM Govt, *Report on an investigation into maternal mortality*, London, HMSO, 1937, Cmd 5422, p. 216.

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of Sheffield where maternal mortality was highest. The factors connecting abortion and maternal mortality were probably more extreme in Sheffield than in some other areas, but they do provide an illustration of the complexities of the issues. The first part of the paper examines the links between rising rates of maternal mortality and abortion in Sheffield between 1920 and 1939. It demonstrates that the patterns of abortion-related maternal mortality found in Sheffield were peculiar to the area. The second part of the paper considers why the abortion rate, and therefore maternal mortality, was so high in Sheffield. It deals with the inter-relations between abortion, social structure, and the economic situation in Sheffield. It also considers the impact of the attitudes, and actions, of women, of men, and of policy-makers.

All of the issues considered in this paper have been examined by historians from a variety of angles. However, apart from Marks' detailed study of maternal and infant health in four London boroughs, most of the work done has been national or international in character.[8] Local case-studies are vital in refining large-scale conclusions about maternal mortality, and attitudes to fertility. Furthermore, the use of case-studies can demonstrate the impact of wider factors, such as economic pressures and social structures, on the patterns of fertility and mortality. Loudon has argued that maternal mortality was often strongly associated with poor quality care around the time of birth. Social factors such as unemployment, inadequate housing, and poor nutritional status were less important causal factors in maternal mortality.[9] However, considering the national picture of maternal mortality alone masks significant regional variations.

Maternal Mortality and Abortion

The attitude of politicians in Britain to abortion was informed by their concern about the high rate of maternal mortality. Infant mortality, which had been a very politicized subject before 1914, seemed to be falling in response to the various sanitary and personal healthcare efforts directed at it.[10] In stark contrast to this tale of success, the toll of women dying in childbirth seemed at best to be on a plateau,

[8] L V Marks, *Metropolitan maternity: maternal and infant welfare services in early twentieth century London*, Amsterdam, Rodopi, 1996. On maternal mortality, see I Loudon, *Death in childbirth: an international study of maternal care and maternal mortality, 1800–1950,* Oxford, Clarendon Press, 1992; on birth control, see A Leathard, *The fight for family planning: the development of family planning services in Britain, 1921–74*, London, Macmillan, 1980; A McLaren, *Birth control in nineteenth-century England,* London, Croom Helm, 1978; W Seccombe, 'Starting to stop: working class fertility decline in Britain', *Past and Present*, 1990, **126**: 155–88; R A Soloway, *Birth control and the population question in England*, Chapel Hill, University of North Carolina Press, 1982; on abortion, see B Brookes, *Abortion in England, 1900–1967,* London, Croom Helm, 1988; J Keown, *Abortion, doctors, and the law*, Cambridge University Press, 1988; A McLaren, 'Women's work and regulation of family size: the question of abortion in the nineteenth century', *Hist. Workshop J.*, 1977, **4**: 70–81. A useful study of the situation in USA is L J Reagan, *When abortion was a crime: women, medicine, and law in the United States, 1867–1973*, Berkeley, University of California Press, 1997.

[9] C Webster, 'Health, welfare, and unemployment during the depression', *Past and Present*, 1985, **109**: 204–30.

[10] G F McCleary, *The maternity and child welfare movement*, London, P S King, 1935; D Dwork, *War is good for babies and other young children: a history of the infant and child welfare movement in England, 1898–1918,* London, Tavistock Publications, 1987.

and in some areas to be rising. There were numerous government enquiries and committees set up in the 1920s and 1930s which considered the problem of, and possible solutions to, maternal mortality. Generally, all sides of the debate accepted the basic belief that it was only through improved ante-natal care and birth attendance that lower maternal mortality could be secured.[11] However, the 1937 *Report ... on maternal mortality* drew attention to the possible impact of deaths from abortion.[12] The Inter-departmental Committee on Abortion (known as the "Birkett Committee", after its Chairman) was set up as a direct result of this, and reported in 1939.[13] The Birkett Committee made no new ethical or policy suggestions beyond attempting to apply the law better as it stood.[14] However, its creation demonstrates not only that contemporaries viewed maternal mortality and abortion as entwined, but also that abortion itself was becoming increasing politicized.

Some middle-class women campaigned for the relaxation of the law through the Abortion Law Reform Association. Supporters of abortion reform included those, such as Stella Browne, who were not generally in the mainstream of middle-class thought. Browne supported abortion for women simply because their bodies were their own, and suggested that if reproductive control through contraception was acceptable, then abortion was simply another method.[15] Other women's groups linked the legalization of abortion specifically to the goal of reducing maternal mortality. During the annual conference of the Women's Co-operative Guild held in 1934, one delegate argued that:

> In advocating the legislation of abortion, we emphatically claim to have that operation carried out by skilled members of the surgical profession. The high maternal death rate is largely reflected in the practices of quacks and by making it legal for a woman to have an abortion, it would remove the dangers that arise through the employment of quacks.[16]

Placing abortion entirely in the hands of the medical profession was all very well but doctors had considerable difficulty in clarifying their collective position on the issue. This was because though doctors all abhorred "illegal" abortions (self-induced or procured because of the wishes of the expectant mother), they demanded the right to perform "therapeutic" abortions for mental or physical conditions which only they could determine. By the 1930s there was a feeling that doctors were themselves carrying out abortions for a far wider range of reasons than previously.[17] In 1934, a British Medical Association (BMA) committee on the medical aspects of

[11] *Report on ... maternal mortality*, op. cit., note 7 above. Sir Henry Brackenbury (Chairman of the Council of the British Medical Association) suggested that clinical issues had been over-emphasized at the expense of environmental and sociological factors; H Brackenbury, 'Maternity in its sociological aspects', *Soc. Serv. Rev.*, 1937, **18**: 37–47.

[12] *Report on ... maternal mortality*, op. cit., note 7 above.

[13] *Report of the Inter-Departmental Committee on Abortion,* London, HMSO, 1939.

[14] There was some support for a change in the law; Dorothy Thurtle, a member of the Birkett Committee, submitted a Minority Report in which she argued that: "it is unsatisfactory for the law to be flouted with impunity; but when such a situation has arisen, it is necessary to consider whether the law is in accordance with modern thought and tendencies." Ibid., p. 143.

[15] F W S Browne, A M Ludovici, H Roberts, *Abortion,* London, Allen & Unwin,1935, pp. 31, 38.

[16] J Gaffin, and D Thoms, *Caring and sharing: the centenary history of the Co-operative Women's Guild*, 2nd ed., Manchester, Holyoake Books, 1993, p. 107.

[17] *Br. med. J.,* 1932, **ii**: 255, 337–41.

abortion came down in favour of it in certain circumstances, such as after rape, incest, or when the life or even health of the woman was threatened. However, the BMA baulked at making this their official policy, although it was seen as a indication of the liberalization of the views of the profession.[18] By 1937, the basic fear of doctors about abortion had come to a head: that they would be prosecuted for performing illegal interventions, because, even though they felt themselves to be acting properly, they were still technically on the wrong side of the law.[19] In 1938 an obstetric consultant, Aleck Bourne, allowed himself to be prosecuted for performing an abortion on a 14-year-old rape victim and was acquitted. This was felt by doctors to clarify the situation and gave them greater confidence to perform such operations.[20] It did not solve the problem of whether, in general terms, abortion should be legalized. Perhaps because maternal mortality itself began to fall dramatically after 1935, abortion ceased to be seen as such a life or death issue. Furthermore, by the time the Birkett Committee actually reported, Britain was gearing up for war, and cities such as Sheffield, where abortion was a problem, were once again experiencing full-employment and high wages.

In all these debates the views of working-class women were almost totally absent; yet it was they who continued to practise abortion. Understanding their experience is a challenge given the paucity of evidence relating to the issue. However, it is vital to try and draw out the motivation of these women, as without this it is impossible to get to the root of the issues of maternal mortality and abortion.

Loudon has described in detail the difficulties in measuring maternal mortality in the early twentieth-century.[21] For the purposes of this paper, the most significant problems concern puerperal fever, which accounted for between 33 and 50 per cent of total maternal deaths, and abortion.[22] There was confusion over the terminology and definition of deaths traceable to puerperal fever, which impacts on the reliability of the figures, as it was a very vague condition, not traceable to one single organism.[23] The statistics were further confused by the lumping together of "post-abortive" and "post-partum" sepsis as "puerperal sepsis", making the separation of full-term fever deaths, and those following abortion, hard to distinguish. Abortion was generally believed to carry a higher risk of infection than full term labour. In 1925, the Sheffield branch of the BMA claimed that of 25 recent puerperal fever deaths, 11 were

[18] Brookes, op. cit., note 8 above, p. 61.

[19] 'When is abortion lawful?', *Br. med. J.*, 1937, **i**: 393–4.

[20] *Br. med. J.*, 1938, **ii**: 225–7; Keown, op. cit., note 8 above, ch. 3.

[21] Loudon, op. cit., note 8 above.

[22] Puerperal fever had been effectively described as a contagious disease in the mid-nineteenth century, spread by staff, family, or caused by auto-infection. However, deaths from puerperal fever did not begin to decline until 1935. The initial decline was due to a natural cyclical decrease in the virulence of the causative streptococci. The fall was intensified and given permanence as a result of the introduction of sulphonamides, which dramatically reduced deaths from sepsis after 1937; it was this which caused total maternal mortality to begin its steep decline. For documentary sources on the development of knowledge about puerperal fever, see I Loudon (ed.), *Childbed fever: a documentary history*, London, Garland Publishing, 1995.

[23] In an attempt to tighten up notification, the term "puerperal pyrexia" was adopted in 1926 and defined as fever of any cause within 21 days of childbirth with a temperature of 38°C which was sustained or recurred within 24 hours: I Loudon, 'Deaths in childbed', *Med. Hist.*, 1986, **30**: 1–41.

Table 1
Maternal mortality rates (maternal deaths per 1000 total births) in selected towns 1911–14 and 1923–29

	1911–14			1923–29			
	Puerperal fever	Accidents of childbirth	Total	Puerperal fever	Accidents of childbirth	Total	Difference in totals
Sheffield	1.50	2.35	3.85	2.74	3.00	5.64	1.79
Barnsley	2.04	3.77	5.81	2.18	3.87	6.05	0.24
Bradford	1.95	3.63	5.58	2.42	2.91	5.33	−0.25
Dewsbury	2.44	6.10	8.54	2.21	3.44	5.65	−2.89
Halifax	1.22	5.01	6.23	1.39	4.87	6.26	0.03
Huddersfield	1.55	4.52	6.07	1.79	3.83	5.62	−0.65
Wakefield	2.97	3.59	6.56	1.51	3.59	5.10	−1.46

Source: J M Campbell, I D Cameron, and D M Jones, *High maternal mortality in certain areas: reports*, London, HMSO, 1932.

associated with abortion: "puerperal fever is much more frequent in connection with abortion than it is with normal labour." [24]

Shorter has claimed that deaths from puerperal sepsis fell after the introduction of antiseptic and aseptic techniques in the 1880s, but that these favourable figures were obscured by high abortion rates which carried high fatality rates.[25] Loudon has argued that if childbirth mortality was improving then accidents in childbirth should show a drop commensurate with the abortion induced rise in fever cases.[26] In fact, the total share of maternal mortality accounted for by fever fell from 57 per cent in 1880–85 to 41 per cent in 1935.[27] Many areas confirmed this experience; in 1919–22, of 44 maternal deaths in Breconshire, only 9 were due to fever, and of 30 deaths in Westmoreland, none was due to fever.[28] This was made explicit in a government report of 1932 where it was confirmed that in most areas, "It is clear from the figures given in the reports that the excessive maternal death rate is attributable to complications of child-birth in a greater degree than to puerperal sepsis."[29] This situation was confirmed by figures given for most of the regions with high maternal mortality. Sheffield stands out as having a relatively low accident rate and very high rates of fever, in the inter-war period. Table 1 illustrates this by reference to a representative group of such towns.

[24] Minutes of the Sheffield branch of the British Medical Association, 22/1/26, Sheffield Archives, LD 2384 (4).

[25] E Shorter, *A history of women's bodies*, London, Allen Lane, 1983, p. 100.

[26] Loudon, op. cit., note 8 above, p. 107; see also Fox, op. cit., note 4 above, p. 329.

[27] Loudon, op. cit., note 8 above, p. 26.

[28] B V Heagerty, 'Gender and professionalisation: the struggle for British midwifery, 1900–36', PhD thesis, Michigan State University, 1990, p. 166.

[29] J M Campbell, I D Cameron, and D M Jones, *High maternal mortality in certain areas: reports*, London, HMSO, 1932, p. 3.

One of the difficulties in the debate over abortion, and its effect on maternal mortality, centred around measurement of incidence and fatality. The Birkett Committee estimated that of about 110,000 abortions per year, 66,000 were probably spontaneous, and 44,000 procured.[30] Abortion statistics can only be impressionistic; an incalculable proportion of abortions, natural, self-induced, or procured, was never reported, and never found its way into statistics.[31] The figures which are available probably over-estimated the danger from abortion because it was generally only if things went wrong and cases were seen by doctors that they came to light.[32] As the Birkett Committee accepted, however, with even apparently clear-cut cases, cause could be impossible to attribute. They tried and failed to make a distinction between natural and procured abortions.[33] The report admitted that procured abortion could be made to look natural by skilled practitioners; this was borne out by a Sheffield case in 1934. Dr John Blakely was acquitted of the abortion-related death of his lover, because, although the doctors who examined the victim obviously believed she had taken something, there was no direct evidence that it was not natural. Phyllis Staton, an unmarried, unemployed waitress, died as a result of septicaemia. Blakely was accused of injecting her with an un-named drug which was "generally used in maternity work".[34] Dr James Clark, the Medical Superintendent of the City General Hospital, admitted that it was possible for a doctor to "procure abortion without leaving evidence."[35]

One of Loudon's main arguments, supported by nineteenth- and early twentieth-century writers, has been that maternal mortality is very sensitive to factors surrounding the treatment of the birth, but is little influenced by environmental factors.[36] The 1937 government *Report* into maternal mortality supported this contention, citing figures for 1930–32 which suggested that social classes I and II were at greater risk than those in lower classes.[37]

[30] *Committee on Abortion*, op. cit., note 13 above, p. 3.

[31] The doctor attached to the Rotherham Birth Control Clinic commented in 1929 on "the number of miscarriages and abortions which no official statistics record", but which women discussed with clinic workers. 'First annual report of Rotherham Birth Control Clinic, 1929–30', p. 3, Contemporary Medical Archives Centre, Wellcome Library (hereafter CMAC), SA/FPA/A.11/36, Box 313.

[32] An article on abortion cases admitted to the Derby City Hospital between 1930 and 1937, showed the difficulties in obtaining accurate figures for procured abortions. Of the 350 cases considered, only 117 were prescribed to a definite cause; nearly 50 per cent of these (63 cases) were natural, due to maternal disease or foetal abnormality. Of the remainder, 57 were adjudged "probably natural", 91 "probably procured", and a further 80, "indefinite"; R G Cooke, 'An analysis of 350 cases of abortion', *Br. med. J.*, 1938, **i**: 1045–7; see also T N Parish, 'A thousand cases of abortion', *J. Obstet. Gynaec. Br. Empire*, 1935, **42**: 1107–21.

[33] The report specified 3 different types of abortion: spontaneous, natural abortion; therapeutic, undertaken by doctors in what they believed to be the best interests of the patient; and criminal abortions; *Committee on Abortion*, op. cit., note 13 above, p. 3, see also p. 9.

[34] This may well have been ergometrine which was used by doctors to induce labour. It was a purified version of ergot, a mould found on rye, which had been used as an abortifacient for centuries.

[35] *Sheffield Telegraph*, 21/3/34, p. 5.

[36] Loudon, op. cit., note 8 above, p. 244.

[37] *Report on . . . maternal mortality*, op. cit., note 7 above, p. 111. The evidence of Charles Cullingworth for London in 1898, and J S Fairbairn for Leeds in the 1920s that MMR was higher in well-off areas was accepted as proof of the dangers of high GP delivery rates. For, example, in Leeds between 1920 and 1921 the maternal death rate was 4.49 per thousand for

However, reverse causality did not hold true for all areas; most of those investigated for the government in 1932 because of exceptionally high maternal mortality were urban areas of high industrial unemployment and consequent poverty. The inaccuracies in the collected statistics concerning MMR mean that it is impossible to construct a water-tight statistically based argument for the pattern of MMR in any part of the country, not just Sheffield.[38] The available evidence points to the prevalence of high rates of maternal mortality in the heavily industrialized, eastern districts of Sheffield. Equally important was the contemporary perception that the problem lay in the abortion/MMR link. The working-class areas of heavy industry in east Sheffield such as Brightside, Attercliffe, Handsworth and Tinsley, which had been badly hit by unemployment and underemployment, had the highest rates of maternal mortality. Attercliffe, Brightside, and Tinsley had a combined MMR of 13.2 per thousand in 1926, compared with 6.4 per thousand for more middle-class Sharrow, Ecclesall South, and Ecclesall West Central. In 1934, the differences remained acute, with the eastern districts having an MMR of 13.3 per thousand, compared with the western districts' 4.5 per thousand.

However, there were in fact years when the western districts of Sheffield recorded the highest MMRs. One such was 1923, when Sharrow, Ecclesall South, and Ecclesall West Central had an MMR of 4.0 per thousand, compared with 2.5 per thousand for Attercliffe, Brightside, and Tinsley. Such fluctuations are partly a result of the small total numbers of deaths involved each time. More importantly, deaths in Sharrow and Ecclesall were not seen by doctors, women's groups, and politicians as part of a significant problem. They were never mentioned in debates on maternal mortality in Sheffield. This seems to have been because the connection between maternal mortality and abortion was always seen as the prime issue, and as an exclusively working-class problem.

At a Labour Women's Conference held in Sheffield, local Labour Councillor, Mrs Cumming, repeated the contention that the majority of deaths were caused by illegal abortions, about which the Council could do nothing.[39] It might be suspected that this was comfortable rhetoric for the Council which absolved it from the need to seek other solutions such as the provision of birth control clinics or measures to tackle poverty. However, none of the local campaigning groups challenged the Council's reading of the situation. Indeed the Sheffield Women's Welfare Committee (SWWC) gave the link between maternal mortality and abortion as the explicit reason for starting its birth control clinic in an area where "the figures for maternal mortality and septic abortion are abnormally high".[40] This was a view supported by

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the city, but up to 5.93 per thousand in middle-class areas, and only 3.01 per thousand in working-class areas. However, in 1929, the MOH for Leeds commented that although two residential wards had the highest MMR between 1921 and 1925, the next four highest were working-class wards. Loudon, op. cit., note 8 above, pp. 244–6. Cullingworth's map of London was reproduced in J M Munro Kerr, *Maternal mortality and morbidity: a study of their problems*, Edinburgh, E and S Livingstone, 1933, pp. 14–15; see also J S Fairbairn, 'The medical and psychological aspects of gynaecology', *Lancet*, 1931, **ii**: 999–1004, p. 1003; Discussion, 'Puerperal fever and puerperal pyrexia', *Public Health*, 1927, **40**: 205–18, p. 210; Marks, op. cit., note 8 above.

[38] Loudon, op. cit., note 8 above, ch. 2.

[39] *Sheffield Telegraph*, 17/5/35, p. 4.

[40] SWWC, *Annual report, 1933–34*, p. 3, Sheffield City Library.

local commentators such as the local branch of the National Council for Women. Elinor Pike, wife of the Conservative National Party MP for Attercliffe, castigated the Labour Council for its failure to deal with the situation, and repeated the call for more welfare centres, particularly in east Sheffield where the greatest rates were found.[41] In autumn 1935, a meeting of the newly formed "Maternal Mortality Save the Mothers Action Committee" was held in the City Hall, although nothing appears to have come out of it. The following year, a Conservative Councillor, Mrs Longden, called for the establishment and funding of four branch ante-natal clinics, principally in the eastern districts where one-third of all births occurred.[42]

The medical profession in Sheffield supported the view of politicians and women's groups that abortion was the significant factor in producing high MMR. At a national level, civil servants such as Dr Janet Campbell, Medical Officer for Maternal and Child Welfare at the Ministry of Health, agreed with Dr John Rennie, the Medical Officer of Health (MOH), who commented that "So long as the rate of infected abortions continues at this high level, the maternal mortality rate for the City must be abnormally high".[43] He reported that 13 of the 15 abortion deaths recorded by the city that year were due to sepsis.[44] Dr Clark, the Medical Superintendent of the City General Hospital, suggested in a survey of the situation in Sheffield between 1930 and 1937 that "not an inconsiderable proportion of the [maternal] death rate of Sheffield is due to abortion".[45] He also stated that: "We have one of the highest mortality rates from abortion, if not the highest of any town in the country", and that the City General Hospital had more cases of abortion than any other hospital in the country, with the Jessop Hospital for Women second (Table 2).[46] In fact, 1934 proved to be a watershed, and the following year the numbers of septic deaths dropped dramatically. The MOH made no mention of a possible reduction in the virulence of the streptococcus, or of the later use of sulphonamides in combating infection. However, as Table 2 shows, numbers of women with abortions who presented at hospital continued to rise after 1934, but the death rate was dramatically reduced. As this began to happen before the introduction of sulphonamides, it suggests that the natural virulence of the bacteria may have been in cyclical decline.[47]

[41] *Sheffield Telegraph,* 21/5/35, p. 6; *Sheffield Telegraph,* 23/5/35, p. 6.

[42] *Sheffield Telegraph*, 6/2/36, p. 5.

[43] *MOH report*, Sheffield, 1934, p. 96.

[44] Spontaneous abortion ending in sepsis was very rare, so in practice, septic abortions were taken to equal illegal abortions.

[45] *Sheffield Independent*, 18/2/37.

[46] *Sheffield Independent*, 18/2/38.

[47] L Colebrook, 'The story of puerperal fever—1800 to 1950', *Br. med. J.,* 1956, **i**: 247–52; J Webb and P Weston-Edwards, 'Recent trends in maternal mortality', *The Medical Officer*, 1951, **86**: 201–4. L Colebrook and M Kenny, 'Treatment with prontosil of puerperal infections due to haemolytic streptococci', *Lancet,* 1936, **ii**: 1319–22, p. 1322; the example of the Jessop is mentioned in this paper, but I have not come across any direct evidence relating to the issue. However deaths from abortion seen at the City General Hospital in Sheffield dropped dramatically between 1934 and 1935, despite the numbers of abortion related cases rising; this might suggest a possible cyclical decline in streptococcal virulence. The sulphonamide drug prontosil was discovered in Germany in 1935, and taken up enthusiastically in Britain in the following year. This was mentioned in the *Sheffield Telegraph* as early as 8/6/36, p. 5, when the trial was still in progress, and illustrates the interest surrounding any possible "cures" for problems in maternity. I Loudon, 'Puerperal fever, the streptococcus, and the sulphonamides, 1911–1945', *Br. med. J.,* 1987, **ii**: 485–90.

Table 2
Abortion cases treated in the gynaecology department of the City General Hospital, 1930–40

	Abortion Total	Deaths	Abortions ending in death (%)
1930	318	8	2.5
1931	309	7	2.3
1932	327	4	1.2
1933	280	5	1.8
1934	337	15	4.5
1935	385	3	0.8
1936	461[1]	7	1.5
1937	403	10	2.5
1938	412	7	1.7
1939	440	7	1.6
1940	379	0	0

Source: *MOH reports*, Sheffield.

[1] A record abortion rate for any hospital in the country; Dr Clark thought that 400 of these were procured; *Sheffield Independent*, 24/3/37, p. 5.

Fertility and Unemployment

The economic situation in Sheffield had a significant impact on fertility control. The town experienced a period of major industrial expansion in the 1860s and 1870s, when huge steel works were built on the flat land to the east of the town centre. Districts such as Tinsley and Attercliffe saw large-scale immigration from rural areas as workers were attracted into Sheffield by good wages and apparently steady employment. Sheffield's population rose by 100,000 between 1851 and 1871 (from 135,310 to 239,946), partly as a result of in-migration, but also due to escalating birth rates.[48] It was believed that trade and the birth-rate were closely linked in Sheffield. In 1913, the MOH compiled a graph in which he compared dividends paid by several leading Sheffield steel firms with the marriage rate. Both peaked in 1873, and dropped away at the same pace.[49]

From the 1880s onwards, and particularly after 1900, Sheffield experienced trade slumps, and consequent unemployment, of increasing severity. There was an employment boom in the city, sustained by the demands of the First World War. It broke dramatically in 1921. In mid-1920 the total unemployment in Sheffield was about 5,000. It climbed throughout the next twelve months, rising from 25,500 in March 1921 to 59,100 in April. A coal strike that summer saw the numbers of

[48] Attercliffe had a birth-rate of 39.7 per thousand population in 1900, compared to the middle-class district of Ecclesall which had a birth-rate of 28.6 per thousand population in the same year.

[49] E M Elderton, *Report on the English birth-rate; part 1 England North of the Humber*, London, Dulau and Co., 1914, p. 12.

registered unemployed reach their high point at 69,400. Between then and 1939, unemployment never dropped below 25,000. From 1930 to 1939 it remained steady at between 50,000 and 65,000.[50] A D K Owen studied the problem in 1930 for the local Social Survey Committee. He found that the unemployed had 49,330 dependants in all, including 29,370 children, and suggested that "we reach the huge total of about 100,000 persons directly affected by the unemployment problem at the time when this investigation was made".[51] Owen also commented on the unique character of unemployment in Sheffield:

> Although there are several areas in the country to-day where unemployment is more widespread than it is in Sheffield, there is no other large town, with the possible exception of Glasgow, which has suffered so chronically since the War from this scourge of social life. There have never been less than 20,000 people out of work in Sheffield at any time since 1921, and for a long period now there have been over 40,000 persons unemployed.[52]

The recent "healthy/hungry" debate has offered two quite polarized views on the impact of economic dislocation on health. Winter has made the case for an optimistic view of health, despite high unemployment and poverty. His conclusion is that:

> Because of public provision, medical intervention, and long-term improvements in working-class nutrition, the 1930s must be seen, therefore, despite the stubborn survival of pockets of terrible deprivation, as a period of major improvement of the health of mothers and infants in Britain.[53]

This view has been challenged by Webster and by Mitchell, who have both argued that the health of mothers and children was adversely affected by poor standards of living and nutrition in the 1930s. Webster has suggested that, in most areas, welfare measures would have had only a modest impact on health, as they were not implemented until the late 1930s when unemployment was falling.[54] Mitchell has further commented that it is misleading to sideline those in the worst affected areas as not representative of the whole; women and children in deprived areas were experiencing real deprivation, and in some cases, malnutrition.[55] The example of Sheffield demonstrates that economic depression had an impact also on women's lives and health through their attempts to regulate fertility in the face of poverty.

Even in the bad times, the economic profile of Sheffield was a highly patriarchal one with very few employment opportunities for married women.[56] In 1911, the

[50] T McIntosh, '"A price must be paid for motherhood": the experience of maternity in Sheffield, 1879–1939', unpublished PhD thesis, University of Sheffield, 1997, ch. 3.

[51] A D K Owen, 'A report on unemployment in Sheffield', *Sheffield Social Survey Committee*, Sheffield, 1932.

[52] A D K Owen, 'The unemployment problem in Sheffield', manuscript, 1931, Sheffield Archives, MD 1228 (A).

[53] J M Winter, 'Infant mortality, maternal mortality, and public health in Britain in the 1930s', *J. Eur. econ. Hist.*, 1979, **8**: 439–62, p. 462.

[54] Webster, op. cit., note 9 above, p. 213.

[55] M Mitchell, 'The effects of unemployment on the social condition of women and children in the 1930s', *Hist. Workshop J.*, 1985, **19**: 105–27, p. 119.

[56] Even midwives were widowed rather than married; T McIntosh, 'Profession, skill, or domestic duty? Midwifery in Sheffield, 1881–1936', *Soc. Hist. Med.*, 1998, **11**: 402–20.

proportion of married women working was 7 per cent, and that of widows 29 per cent; paid employment was not part of the culture of women's lives in Sheffield.[57] This compared with textile towns, in particular, where the employment of married women was more common. The 1911 Census gave figures of 31 per cent of married women in employment for Bury, 40 per cent for Burnley, and 43 per cent for Blackburn.[58] Women with children in Sheffield were even less likely to work than those who had none. A survey carried out in 1908 demonstrated that of those mothers who worked in factories before their first confinement over 70 per cent were still at home one year after the birth.[59] During the War this pattern changed, with married women, especially, moving into employment. This shift was a temporary one, however, and, as Owen noted, firms quickly shed wartime employees after 1918, "this number included a great many women, who were gradually re-absorbed into domestic life now that the wartime demand for their services no longer existed."[60]

This, then, was the landscape of women's lives in inter-war Sheffield; high male unemployment grafted onto a patriarchal culture, which made joint decisions about fertility control difficult to achieve, and impacted on levels of abortion and maternal mortality.

Women and Abortion

The nature of abortion in inter-war Sheffield is illustrated by information collected by Sheffield City Council's Health Department and the SWWC Clinic in the mid- to late-1930s.[61] Both groups were co-operating with a questionnaire-based enquiry being conducted by the Joint Council for Midwifery (JCM) into the prevalence of abortion.[62] Susan Williams has discussed the survey in detail, including its many methodological flaws.[63] In fact both Dr Rennie, the MOH for Sheffield, and Mrs Hilda Cunnington, the Secretary of the SWWC, commented to Lady Williams, the organizer of the enquiry, on its inherent difficulties.[64] Mrs Cunnington explained to Lady Williams that:

Here is the only other form for the Joint Council of Midwifery that we have been able to complete. Often, however, we find that our patients at the Clinic have procured an abortion by overdoses of purgative medicines, gin, raspberry leaves, etc, etc. But so often the information is too casual to warrant the full enquiry that this form entails. Women are so resigned to

[57] *Census 1911*, table 13.

[58] HM Govt, 'Maternal mortality in connection with childbearing and its relation to infant mortality', *LGB 44th annual report, 1914–15, Supplement*, Cd 8055, p. 122.

[59] *MOH report*, Sheffield, 1909.

[60] Owen, op. cit., note 52 above, p. 25.

[61] The SWWC ran a voluntary birth control clinic in Attercliffe from 1932; see next section of this paper.

[62] A S Williams, *Women and childbirth in the twentieth century: a history of the National Birthday Trust Fund 1928–93*, Stroud, Sutton Publishing, 1997. Lara Marks has also used the survey in her work on maternity in London; Marks, op. cit., note 8 above.

[63] Williams, op. cit., note 62 above.

[64] The City Health Department eventually returned 363 completed questionnaires (completed at the City General hospital), the SWWC, 6 completed questionnaires.

physical pain and anxiety that the additional discomfort following an abortion is taken as for granted as part and parcel of married life.[65]

Dr Rennie phrased his comments rather less sympathetically:

Dr Clark, the Medical Superintendent of the City General Hospital, informs me that he is satisfied that many of the replies which are given to enquiries are not truthful but I assume that the information given in Sheffield will just be as reliable as from any other source.[66]

Despite the difficulties in obtaining and presenting accurate information about issues such as the motivation behind attempted abortions, the survey questionnaires nevertheless provide a rich source of qualitative material, including evidence of the quite different agendas of the women and the doctors treating them. One patient seen at the City General Hospital was a married woman of 37 who had lost five pregnancies at between two and five months after having produced three live children. She apparently claimed that the miscarriages were all spontaneous, but the doctor who filled in the questionnaire commented, "It is my opinion the course of abortion is known and patient is not telling the truth. It seems useless taking a history from most of these patients, the majority of whom are far from truthful."[67]

The questionnaires were filed according to the perceived category of abortion. For the purposes of this paper, only those filed under "illegally induced abortion" have been considered. There were a wide variety of supposed abortifacient substances mentioned, including pennyroyal, quinine powder, steel pills, bile beans, Dr Hooper's Pills, and Beecham's Powders.[68] They were probably mentioned by women in order to draw attention away from the real cause of the abortion. Women would not have wanted to implicate abortionists in the deed, as to do so would have risked prosecution for both mother and abortionist. Despite this, instrumental methods such as slippery elm were the abortion triggers mentioned most commonly in the survey. In 1932, Dr Rennie told Margaret Pyke, the founder of the National Birth Control Council, that the most popular method of abortion in Sheffield was the Higginson's Syringe.[69] Both syringes and slippery elm were most likely to have been used on a pregnant woman by a third party, that is to say, an abortionist. One woman in the JCM survey was found to have a "stick of bark" in her vagina on examination, after she had been admitted to hospital following haemorrhage.[70] In two further cases, women claimed that a

[65] Letter from Hilda Cunnington to Lady Williams, 29/3/38; CMAC SA/NBT/S.6/3.

[66] Letter from Dr Rennie to Lady Williams, 1/6/37; CMAC SA/NBT/S.6/3.

[67] CMAC SA/NBT/S.9/6/2. Questionnaire number 1939.

[68] This is not to suggest that any of these substances were necessarily efficacious, although some, including lead and quinine, would probably have had an effect if taken in sufficient quantity. Given the estimate that 20 per cent of all pregnancies abort spontaneously, and that these women were not nutritionally optimal some abortions may have been coincidental to the taking of drugs. The intention to abort was nevertheless real. See also P S Brown, 'Female pills and the reputation of iron as an abortifacient', *Med. Hist.*, 1977, **21**: 291–304.

[69] Notes made by Pyke on her visit to Sheffield, 19/10/32, CMAC SA/FPA/A.11/38 Box 313.

[70] CMAC SA/NBT/S.9/6/2. Questionnaire number 1892. Slippery elm acted by expanding when wet and thereby dilating the cervix which resulted in miscarriage.

fall had resulted in miscarriage, but as each led to puerperal sepsis, most commonly seen in instrumental abortions, the form filler commented that one was "a very suspicious case to say the least", and of the other that her story was "probably untrue".[71] It is not surprising that these types of abortion were so prevalent in the survey as they were most likely to result in complications such as sepsis, and therefore to present in hospital. As Table 2 demonstrates, numbers of hospital admissions after abortion were increasing. This shows that instrumental abortions were either taking a larger share of a static total of attempted abortions, or that total abortions, however procured, were rising. The available evidence is not sufficiently detailed to confirm which of these cases was the more probable.

Despite the fact that the forms were filled out by doctors with a certain bias, and indeed created by the JCM, which was explicitly anti-abortion, the different attitudes of women and doctors to abortion can be discerned. Women did not talk about "foetuses" or "abortions", both of which were medical terms. One patient was admitted to the City General Hospital in Sheffield in August 1937 with a threatened abortion for which she apparently admitted taking "pills and herbs". She was re-admitted on 2 September with a complete abortion, but refused to admit that she had "passed a foetus".[72] The doctor who completed the form was annoyed that the woman did not see the situation in his terms. Before about eighteen weeks of gestation, when movement can first be distinguished, "putting yourself right" was acceptable. After this point, with the presence of a baby confirmed, attempted removal was perceived to be wrong. Due to the lack of tests for pregnancy, quickening was the first unambiguous evidence, given that a missed period for ill-nourished and harassed women was probably not necessarily a foolproof indicator. One woman who was treated at the City General Hospital had perforated her uterus and developed peritonitis as a result of the use of slippery elm.[73] She was not in fact pregnant at all; a demonstration of the difficulties of confirming conception, and the desperation to be rid of a suspected pregnancy as quickly as possible.

The majority of those aborting in the inter-war years were married with children. In a study of the 1802 total cases of abortion seen at the Jessop Hospital for Women in Sheffield, between 1923 and 1936, researcher Dr Pindar found that 1715 were to married women.[74] Of the 45 cases from Sheffield in the illegal-abortion category of the JCM survey, only 7 were single women. All but five of the married, widowed or separated women had at least one child.

Only six of those in the JCM survey used contraception, two of whom stated that their method was withdrawal, one that it was "being careful". Abortion was

[71] CMAC SA/NBT/S.9/6/2. Questionnaire numbers 2026 and 2033.

[72] CMAC SA/NBT/S.9/6/2. Questionnaire number 1891.

[73] CMAC SA/NBT/S.9/6/2. Questionnaire number 2290.

[74] D Pindar, *Investigation into abortions; their incidence, causative factors and sequelae*, Public Record Office, MH/71/28, p. 4. In Camberwell, London, it was found that the average patient age was 28.4 years. 397 of the cases had 3 or more children, 193 had 2, and 207 had 1; Parish, op. cit., note 32 above, p. 1108.

considered by these women to be a risk worth taking; and a previously successful attempt would have confirmed this view. One woman took Skelton's Silver Pills followed by a trip to an abortionist which cost her two guineas. She aborted successfully with no ill-effects, which encouraged her to try again, although this time unsuccessfully.[75] Nearly half of the women surveyed admitted to having had previous abortions.[76] Several women had attempted the procedure on many occasions, including a mother of seven who took castor oil and magnesium sulphate after deciding that she had "sufficient children".[77] The SWWC claimed to have come across 13 cases of self-induced abortion in 1935–6. A 42-year-old with eight children, and an unemployed husband "stated that she had procured on herself anything up to 20 abortions, nearly losing her life over the last one".[78]

Abortion was always a risky strategy, because, apart from the physical dangers to health and life, there was a good chance that the attempt would not succeed. A 36-year-old woman, seen at the SWWC, had had 11 pregnancies, resulting in 9 living children; she had attempted abortion "several times" but had succeeded only twice. The Rotherham Birth Control Clinic, just a couple of miles from Attercliffe, saw "One wife of an unemployed steel worker who had had eight pregnancies and one miscarriage. To procure the latter she spent £5 on abortifacients, and was pregnant again in two months."[79] Such cases give a graphic picture of the wearying, ceaseless, and expensive battle against pregnancy in the face of economic stress and uncooperative spouses.

Information Networks among Women

Recent debate has centred around the relationship of abortion to the social power structure of an area, and to that within the family.[80] Several writers have stressed that abortion might have been a positive choice for many because action need be taken only in the actual event of a pregnancy, which was cheaper than continual use of contraceptive aids.[81] It also allowed decisions about the economic or practical implications of another child to be postponed almost until the last minute. McLaren has argued that "in contrast to the male middle class contraceptive approach to fertility control there was also a working-class female model of control through abortion."[82] Gittins and McLaren have both linked the use of birth control, including abortion, to areas of high female employment. McLaren has suggested that these

[75] CMAC SA/NBT/S.9/6/2. Questionnaire number 1975.

[76] Sixteen out of the 38 non-single women.

[77] CMAC SA/NBT/S.9/6/2. Questionnaire number 1980.

[78] SWWC, *Annual report, 1935-36*, p. 6, Sheffield City Library.

[79] The Rotherham Clinic ran only from 1929 to 1931 when local apathy, and Council hostility combined to close it down. CMAC SA/FPA/A.11/38 Box 313.

[80] S Szreter, *Fertility, class and gender in Britain, 1860–1940*, Cambridge University Press, 1996; D Gittins, *Fair sex: family size and structure, 1900–1939*, London, Hutchinson, 1982; Seccombe, op. cit., note 8 above; McLaren, 'Women's work', op. cit., note 8 above.

[81] McLaren, *Birth control*, op. cit., note 8 above; P Knight, 'Women and abortion in Victorian and Edwardian England', *Hist. Workshop J.*, 1977, **4**: 57–68.

[82] McLaren, 'Women's work', op. cit., note 8 above, p. 78.

areas provided the reason for fertility limitation, in that women's work was essential to the household.[83] Women also had access to the workplace networks and the domestic power necessary to acquire and to use information about limitation.

In opposition to this, Szreter has argued that abortion was in fact most prevalent in patriarchal communities, such as mining areas, where women had least access to domestic power, and workplace information networks.[84] He claims that abortion was an expression of female isolation and weakness rather than strength and community. The experience of Sheffield generally supports Szreter's view, as it was a very patriarchal city based on male employment in the heavy industries of steel and mining with very few employment opportunities for married women. The highest rates of abortion and maternal mortality were found in the eastern districts where most heavy industry was based. However, women in these communities were not totally without control over their fertility. The evidence suggests that there existed female networks based on the neighbourhood which allowed dissemination of information about, for example, abortifacients.

Evidence of how such a network operated is very difficult to tease out given its ephemeral nature. That channels of communication operated between women is suggested by abortion surveys and through the work of the SWWC. The women questioned for the JCM survey were inevitably representative of only a particular group: those willing to seek abortions. The numbers presenting suggest, however, that theirs were not unusual experiences, and other evidence bears this out. One woman was advised to take pennyroyal and Beecham's Pills by her neighbours.[85] Mrs Cunnington, writing on behalf of the SWWC, told Lady Williams, the organizer of the JCM survey, that:

> An old woman who frequently brings patients to the Clinic told me that she used to keep a jar of slippery elm and pennyroyal in the oven for the benefit of harassed younger neighbours ... though they could hardly crawl across the street afterwards (to quote her) she felt that she was doing them a kindness when they could not afford to feed the children they already had.[86]

In the *Annual report* of the SWWC, it was commented that:

> Most abortions were carried out by women on themselves or by neighbours or relatives. There were women who also performed back-street abortions for money. Most women had tried to abort themselves at least once. Women talked freely about abortion to some of the clinic members.[87]

This demonstrates that abortion was both an acceptable and fairly frequent remedy. The MOH of the area around Thurnscoe, a mining village near Sheffield, stated in 1935 "we are almost completely at the mercy of the abortionist."[88]

[83] Gittins, op. cit., note 80 above, p. 16; McLaren, 'Women's work', op. cit., note 8 above.

[84] Szreter, op. cit., note 80 above, pp. 426–8.

[85] CMAC SA/NBT/S.9/6/2. Questionnaire number 1965.

[86] The old woman apparently did not charge for her services. Cunnington to Williams, 29/3/38. CMAC SA/NBT/S6/3.

[87] P Dennell, 'Attercliffe Clinic: a study of a local initiative in the history of birth control, 1933–43', BA Hons Dissertation, Sheffield Polytechnic, 1989, p. 44.

[88] *Sheffield Independent,* 8/8/35, p. 7.

There is very little evidence as to who these "abortionists" were. The involvement of midwives in the dissemination of abortion information is hinted at in some material. In 1935 a midwife, Florence Ellen Deakin, was sentenced to ten months in prison for conspiracy with intent to procure an illegal operation. At Deakin's trial, Detective-Inspector Allen explained that:

> Deakin first came to the notice of the police as an abortionist in 1929 and she has undoubtedly performed a large number of operations, both at her own home and at the homes of women who have visited her. She can properly be described as a clever professional abortionist and a woman who takes every precaution against possible complications. She has received large sums of money, and this has been used largely to support her family—she had eleven children.[89]

The case highlights how far apart women and the hospital, police, and political authorities were in their attitudes towards abortion. Deakin appears to have regarded her work as a neighbourhood service; treating women in their own homes must have been risky for her. The money she made was spent on keeping her own large family. She was a 58-year-old widow and therefore dependent on her own income. The authorities branded her a "professional" with the implication that she came from outside the community and was preying on women. However, her social position tallied with that of the other untrained midwives that the Council was seeking to remove from employment at that time. Like Deakin, midwives were older women, often widows, who had to support themselves in the difficult economic and social climate of Sheffield. The majority of midwives lived and practised in the east of the city, where most of the abortions occurred. The suspicion must have been that midwives always knew more about abortion than they let on. Midwives remained subject to careful supervision by the Council in the 1930s, suggesting that they were still considered to be at least potentially subversive in their activities.

The Development of Contraceptive Clinics

By the inter-war period abortion and contraception were accepted by policy makers as two unrelated issues. Although anti-abortion, not least because of its impact on maternal mortality, the Labour Council in Sheffield took a very progressive view of birth control. Their attitude may have been partly influenced by the views of their energetic and opinionated MOH, Dr Fred Wynne (1921–1930), and his successor, Dr John Rennie. As early as 1923 Wynne was addressing the Sheffield Federated Health Association on the benefits of contraception, particularly in so far as its use reduced the numbers of "undesirables" in the population.[90] Six years later he was explaining to the National Society for the Prevention of Cruelty to Children that it was cruel to bring children into the world in a "haphazard way", and that he saw it as his "duty to advocate a proper and reasonable restraint."[91] His Council leaders took a more pragmatic line, emphasizing

[89] Ibid.

[90] *Sheffield Telegraph*, 12/10/23, p. 10.

[91] *Sheffield Telegraph*, 16/10/29, p. 2.

the personal issues of poverty and ill-health. The Council was debating the possible supply of contraceptive services from the period of the first Labour administration in 1926. In March 1930 it supported a resolution put to the Ministry of Health by Shoreditch Borough Council asking that public services be enabled to provide "working class married women with reliable and private information as to methods of family limitation", and that such women should not be deterred by lack of means.[92] The need for this service was linked explicitly to the problem of abortion by Councillor Asbury who remarked that "He had heard no evidence that women died as a consequence of the use of contraceptives, but he did know that the numbers who died from abortions were going up year by year."[93]

As a result of unremitting pressure for the provision of birth control advice, primarily from the urban, Labour-led councils, the Labour government finally gave way. In 1931 Memo MCW/153 was issued, which agreed to the creation of birth control clinics within the wider health clinics run by local councils. However, women could be treated on very limited health grounds only; the conditions were so stringent as to exclude most applicants. It was probably because of this that Sheffield did not in the end get its municipal clinic underway until two years after the circulation of the Memo. Even then, its presence was negligible in a city of half a million people. Up to 1939, the municipal clinic was seeing, on average, only 10 new patients per year, with total yearly attendance of about 30.

The Council's birth control clinic was restricted in its reach by the rules laid down by the Ministry of Health.[94] However, the Council circumvented this by supporting a voluntary clinic initiative, run by the Sheffield Women's Welfare Committee, which faced no such restrictions. The Council leased the Attercliffe Vestry Hall to the SWWC free of charge, and also provided free heat, light and care-taking.[95] In addition the Council voted an annual grant of £50 to the Clinic; the first authority in the country to do so.[96] The support the Attercliffe Clinic was given demonstrates that Councillors encouraged family limitation on grounds of economic or personal choice as well as maternal health.[97] However, the women of Sheffield did not endorse this position.

[92] *Sheffield City Council Minutes* 5/3/30. See also Soloway, op. cit., note 8 above, p. 309.

[93] *Birth Control News*, April 1930, p. 183.

[94] Asbury explained to Margaret Pyke that the Council was afraid to challenge the Ministry of Health because "the Exchequer Grant, which amounted to £7,037 last year, would be in jeopardy." Asbury to Pyke 29/9/30. CMAC SA/FPA/A.11/38 Box 313.

[95] The SWWC had originally wanted to use the premises of the Maternal and Child Welfare Clinic, but this had been refused; *Sheffield Branch of NBCA, minutes,* Sheffield Archives, LD 2374. The SWWC was an affiliate of the National Birth Control Association (Family Planning Association after 1939), which had been formed in 1930, and founded a local branch in May 1933. By 1938 the NBCA had set up 66 clinics across the country as a reaction to what its members felt was a failure by the state, at national and local level, to address effectively the issue of contraceptive supply.

[96] Later raised to £75; SWWC, *Annual report, 1937–38*, Sheffield City Library.

[97] This was opposed by the Conservative group on the Council, although Asbury explicitly stated that the Clinic deserved support because of the high rate of abortion in the city: *Sheffield Independent,* 3/1/35, p. 7.

Table 3
Attendance figures for Sheffield Women's Welfare Clinic, 1933–40

	1933–4	1934–5	1935–6	1936–7	1937–8	1938–9	1939–40
New patients	177	219	300	358	396	440	292
Repeat patients	—	152	n/k	480	626	747	508
Total	177	371	n/k	838	1022	1187	800
Total attendance as a % of women aged 15–44 in Sheffield	0.14	0.30	n/k	0.68	0.83	0.97	0.65

Source: SWWC, *Annual reports*.

The Lack of Demand for Contraception

The SWWC claimed considerable success for their endeavours in propagating "scientific" contraception among working-class women in Sheffield, but the Clinic did not strike a popular chord. As late as 1932 Dr Janet Campbell suggested of Sheffield that: "There is said to be little knowledge of effective contraceptive methods and there has been no demand for the setting up of a birth control clinic."[98] Attendance figures give no idea of the numbers attending only once, or how many women failed to get along with the prescribed methods and gave up (see Table 3). Given the total eligible female population of Sheffield, the numbers attending were very slight.

The fact that the subject of contraception was still a delicate one, together with the practical difficulties associated with attending a clinic and carrying out the instructions, probably also played a part in the low take-up of clinic services. The majority of British birth control clinics prescribed the cap, although it had considerable drawbacks as an effective device for use in working-class households. For real efficacy, it required a professional fitting, and six-monthly or annual check-ups. This was promoted by clinics as a bonus because it allowed women to have access to a gynaecological examination. Women were occasionally referred to hospital with problems such as fistulas and prolapses. However, for most women the image of clinics as pseudo-medical arenas would have been a reason for them to stay away; doctors were not part of their daily lives. Furthermore, the cap was relatively expensive to buy and needed additional spermicide for effective protection. Finally it required cleaning after use and storing where it would not be punctured or damaged. As workers at birth control clinics everywhere

[98] Campbell, *et al.*, op. cit., note 29 above, p. 42.

found, problems of use and reliability predisposed to failure in many cases. Nationally, Lewis-Faning found that even in 1924, only 31 per cent of women practising contraception used barrier methods, this rose to 47 per cent by 1934.[99] Since these methods included condoms, it is clear that acceptance of the cap was slow. Mrs Cunnington, one of the SWWC's most committed members, commented that generally women did not have much knowledge of their own anatomy, and found the cap difficult to use "with work hardened fingers".[100] They were also afraid of losing it in their bodies.

Important though these issues were, none of them was unique to Sheffield, and they do not fully explain why women continued to reject contraception in favour of abortion. Probably one of the most important reasons for the failure to take up birth control in Sheffield was the attitude of men. Dr Rennie told Margaret Pyke in 1932 that there were no "rubber shops" in Sheffield. These were places where men, in particular, could purchase contraceptives such as condoms. The lack of such shops highlights the failure of Sheffield men to play a part in decisions about fertility control. On a wider level, the absence of instinctive male working-class support is demonstrated in the failure of the SWWC Clinic to attract Trade Union subscriptions.[101] In 1937, when the SWWC asked for annual contributions of 1*d* from each Trade Unionist in Sheffield, only £4 5*s* was actually raised, despite the fact that the Sheffield Trades and Labour Council, which represented over 35,000 workers in the city, pledged their "official support" for the Clinic. This failure on the part of the Trade Unions is significant, as workmen had always provided generously for charitable ventures, not least for the Jessop Hospital for Women.

In many cases it seems there was little communication between husband and wife. The SWWC felt that its mission encompassed more than just the provision of birth control, "Ignorance, superstition and wrong knowledge are so prevalent that the Clinic has often to act as a sex education centre and a marriage advisory bureau before it can fulfil its aim."[102] The Clinic provided "sound" books on marriage for loan or sale, and sex education literature also became available in city libraries for the first time.[103] Mrs Cunnington suggested that women tried to keep their use of birth control secret from their husbands. It was admitted by the SWWC that "Whatever method of Birth Control is taught to these patients they find it difficult to apply for lack of privacy."[104] Contraception in Sheffield was held back by the nature of the society where women remained economically dependent on men, and lacked the power to insist on its use. Female networks existed to provide knowledge about abortion, but the networks between

[99] E Lewis-Faning, *Report on an enquiry into family limitation and its influence on human fertility during the past fifty years,* Papers of the Royal Commission on Population, vol. 1, London, HMSO, 1949, pp. 7–8.

[100] J McCrindle and R Betterton, 'Interview with Mrs Cunnington on the Sheffield Women's Welfare Clinic', 1st November 1981, at Sheffield City Library.

[101] *Sheffield Independent*, 6/7/37; SWWC, *Annual report, 1937–38*, Sheffield City Library. A clinic was set up in nearby Rotherham in April 1928, but closed in November 1930 due to a lack of funds. CMAC SA/FPA/ A.11/36. Box 313.

[102] SWWC, *Annual report 1937–38*, Sheffield City Library.

[103] *Sheffield Independent*, 22/4/37.

[104] SWWC, *Annual report, 1935–36*, p. 6.

husbands and wives were not adequate to cope with the demands of the use of contraception.

Revealingly, there was a surge of interest in the SWWC Clinic in January 1949, when one of its doctors began to prescribe Dienoestrol-Organon tablets. As Mrs Cunnington explained to the Family Planning Association headquarters in London "patients are getting the idea that, in cases like this, 'you can get something at the Clinic.' In short, are these tablets abortifacients?"[105] The FPA replied in reassuring tones, but the fact remains that as late as 1949 women appear still to have been seeking abortion, rather than contraception.

Conclusion

This article has necessarily been somewhat speculative, as knowledge of attitudes and behaviour surrounding abortion and contraception is so limited and incomplete. However, the evidence for Sheffield suggests certain features. The centrality of abortion as a method of birth control, and its link with maternal mortality is significant. The two cannot be understood adequately in isolation from each other. Abortion-related deaths were very high in Sheffield compared to most of the rest of the country, and it was these which gave the city such a high total maternal mortality. This situation indicates that Loudon's theory of reversed social class mortality is perhaps not universally applicable, and that studies of specific areas are necessary in order to refine the concept.

Reasons for the observably high rates of abortion in Sheffield compared to other areas are impossible to draw out with any certainty. It seems that the vast majority of those aborting were working-class women, and, given the employment and social structure of Sheffield, perhaps abortion was the only practical option for them, as they did not have the independence within the family to demand other forms of control. Szreter has argued that abortion was not generally a feature of textile towns with high female employment because women had the power within the domestic sphere to secure the use of contraception. Abortion was, therefore, an expression of female weakness in a patriarchal society.[106] There was little male support for birth control. The Labour Council pursued a deliberate policy of trying to encourage women in the high abortion areas of the city to take up birth control. They were largely unsuccessful. The services contraceptive clinics offered did not prove to be satisfying a pent-up demand, and had only a marginal impact on fertility control up to 1939. However, women in Sheffield were not totally powerless as regards their fertility, and were able to rely on a

[105] The doctor in question was prescribing the tablets "to bring on delayed menses", a description which sounds very similar to the claims made for patent medicines back in the nineteenth century. A very large dose of oestrogen would have had an abortive effect, so the women who came to the Clinic were not wrong in their understanding of what was being offered; although why such a drug was being prescribed is unknown. CMAC SA/FPA/A.4/A.14/1-5. Box 43.

[106] Szreter, op. cit., note 80 above, p. 426; see also C Chinn, *They worked all their lives: women of the urban poor in England, 1880–1939*, Manchester University Press, 1988, p. 148.

neighbourhood-based network of support in attempts to control fertility through abortion. Nevertheless, they paid a heavy price in terms of maternal mortality. The study of a city such as Sheffield provides a useful counterpoint to research on working-class areas of low fertility. However, it also demonstrates that the picture is very complex.

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