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**The establishment of maternal clinic's in Norway –
infant mortality and marital fertility.**

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A reduction of infant mortality had started from the middle of the 19th century, but it was not until around 1900 that an abrupt fall occurred. In twenty years – between the turn of the century and the early 1920's infant mortality rates were almost halved. (Table 1, Dyrvik 1975) The reduction continued and in the 1950's infant mortality about one fifth of what it had been around 1900. An almost similar trend manifested itself at the same time where marital fertility was concerned. The number of children born per 1000 married women, aged 15 – 49 years fell abruptly between 1900 and 1930. Urban communities, especially Oslo, pioneered this trend, the western part of the city starting a little earlier and from a somewhat lower level than the eastern part. A parallel development may be observed in rural areas.

So, infant mortality and marital fertility fell at the same time. These themes occupied public opinion and discussions often touched on a possible connection between the two phenomena. Some found that the fall in fertility necessitated extra work to keep the fewer children born alive. Their main goal was to accelerate the reduction of infant mortality. This view was a driving force behind the earliest maternal clinics established in Norway from 1907 and forward, first by medical men, but soon also by philanthropic middle-class women. Others saw reduced fertility as a precondition for reducing infant mortality. Their argument was that fewer children would enable mothers to spend more time and efforts to keep the children already born alive and healthy. This was the policy of another kind of maternal clinics, the 'hygienic clinics' that started in Oslo in 1924. Although the pioneer behind these clinics, Katti Anker Møller, also came from a middle class family, these clinics were mainly supported by women from the Labour Party. But as we shall see, for mothers frequenting these clinics, the possibility to give better child-care was only one of many reasons forwarded by for reducing fertility.

In this paper I shall first look at the different characters of the two kinds of mothers' clinics, how they were received by the mothers they were meant to assist and the reactions they provoked in political quarters. Then, using a number of women's journals as sources I shall listen to discussions on the connection between infant mortality and reduced fertility. I shall also point to other factors than infant mortality that were seen as important for the fall in fertility. The last part of the paper also builds on a collection of more than 4000 letters to the first 'hygienic clinic' that started in Oslo in 1924. The discussions were mainly among women, but some men also let their voices be heard.

Control clinics for mothers and children.

The first maternal clinic was established in Oslo in 1907 at the local lying in hospital. It was modelled on the ideas of the French doctor Budin, who worked to establish ‘consultations des nourrissons’ – consultations for infants. The aim clearly was to reduce infant mortality. Dr. Budin strongly promoted the idea that breast-feeding was the very best way to reach this goal. But not any kind of breastfeeding. Mothers should be taught how to breastfeed according to the medical understanding of the best way of nourishing a newly born child. That meant breast-feeding regularly at three hours interval, no more, no less. He stressed that it was dangerous to let the child have too much milk, since that would lead to digestive problems. He regarded breast-feeding as a natural process that any mother could perform and did not accept mothers’ worries over problems with breastfeeding.

It comes as no surprise that a French doctor would promote this policy. The reduction of fertility in France had set in already during the 18th century, and apart from what proved to be a short pause in declining fertility, from the 1880’s France saw a new reduction of the number of babies born. To keep the fewer children born alive was an important goal.

Women who had given birth at the Oslo lying-in hospital were urged to come to the clinic once a week to have the baby weighed, measured and checked for possible health problems. All information was duly noticed in the case sheets. According to the doctors who had started this clinic, this worked excellently. But attendance was not as good as expected. In order to encourage mothers to come to the clinic, a prize was created for mothers who had the best cared- for infants. They were given a silver badge marked ‘FS’ – Fødselsstiftelsen, the lying in hospital. Despite this effort, after some years the clinic was closed because of low attendance.

A similar clinic was opened in Bergen in 1910, also following the same regime as the one in Oslo. Dr. Looft who was the driving force behind this clinic was eager to have mothers breastfeed longer. He had made a survey of 1404 Bergen mothers and found out that about half of these mothers only breastfed for less than 6 months. They had stopped because – as they said – they did not have enough milk or they had themselves fallen ill. Looft wanted to persuade mothers to continue breastfeeding at least for a full year, and follow Budin’s regime feeding the child regularly every three hours. Attendance at this clinic for the first decade was also low, but the Bergen clinic survived. At the end of the 1920’s mothers started crowding in

to consult the clinic. Surprisingly, however, statistics now revealed a decrease in the number of infants that were breastfed. This was true not only for Bergen, but for the country as such. (Rosenberg 1991). Nevertheless, infant mortality was more than halved. (Blom 1987).

This poses three interesting questions. First, why would only a minority of mothers consult the early clinics? Second, why would breastfeeding be reduced despite the efforts of the clinics? And third, why would infant mortality be reduced even as breastfeeding was also reduced?

Discussions in women's journals indicate that the low attendance might have a number of explanations. It might have been the result of a competition between physicians and midwives. Midwives considered themselves the real experts on infant care, but physicians were reluctant to give midwives a say in consultations. Consequently, midwives did not recommend mothers to contact the clinics. As for the clinic in Bergen, it was said to be too far away from where the mothers lived and therefore difficult to reach.

But low attendance may also have something to do with the second question, why breastfeeding was reduced. A reduction in breastfeeding took place all over the country, and lasted until the 1960's. Explanations may be found in the marketing of artificial milk products, especially from Nestle. This stimulated the reluctance many mothers had to breastfeeding. The growing practice of pasteurising the milk gradually furthered bottle-feeding, and so did the construction of an apparatus to sterilise milk and bottles in an easy way.

Some mothers protested the stiff-legged regime set up for them at the clinic. They maintained that a young baby would need food more often than at three hours interval. Some also insisted that breastfeeding was not like the easy and natural process described by physicians. It could be a painful and difficult business. They also complained that husbands had no understanding for the exhausting and time consuming business of caring for a toddler, but on the contrary expected wives to continue to look young and sexy. Husbands were also accused of wanting babies to sleep at least as long as the father needed a peaceful rest. (Blom 1987).

Finally, mothers reacted to the top-down advice of physicians working in the clinics. Some of the physicians' reports confirm this approach. Mothers were characterised as ignorant and

lazy, unwilling to learn better breastfeeding practices and too reliant on the dangerous advice from grandmothers and aunts. In the opinion of dr. Kjelsberg, one of the other physicians working at the Bergen clinic, mothers had to be convinced of the importance of breastfeeding. As he said: “We physicians should treat our clients from the moralistic side: let us tell them that they are weak-willed and irresponsible beings if they do not breastfeed. Then any woman will be able to live up to her maternal duties.” Ironically, Anna Lykke has recently pointed to new knowledge showing that regular breast-feeding, disregarding the infant’s wish for food ‘between meals’ will result in less milk in the mother’s breasts. At the age of 2 – 3 month a healthy child will usually suddenly want more food. If breast-feeding is then done more often, this will stimulate the mother’s capacity to produce more milk. If not, the mother will not be able to produce the amount of milk the child needs. (Lykke 1998). Consequently, during the early 20th century physicians may without knowing it have contributed to creating problems for mothers who wanted to breastfeed for more than 2 – 3 months.

Whether such approaches were widespread or an exception is hard to say until detailed studies of other clinics have been performed. But there are indications that an arrogant physician might scare mothers away from the clinic. In 1926 a female doctor succeeded dr. Looft at the Bergen clinic. Shortly afterwards, the clinic was moved nearer to the city centre and a roomy and attractive waiting room was opened. By then also midwives were attached to the clinic. All this stimulated attendance.

Gradually, more clinics were opened. By 1940 Bergen had four maternal clinics. The same happened in Oslo and in other cities. From 1915 also the Norwegian Women’s Sanitary Association, (Norske kvinners nasjonalråd), an all-female voluntary association, opened what was called ‘control clinics for mothers and infants’ all around the country. In 1946 there were around 400 mothers’ clinics, most of them run by private initiatives. (Martinsen 1986). They all stressed breastfeeding, but also gave advice on clothing, sleep and other problems pertaining to infant care. If needed, they would send mothers and infants to a physician for medical assistance.

In some of the bigger cities also other initiatives were taken to combat infant mortality. Voluntary organisations started ‘the Milk Drop’, an initiative also following a French idea, the ‘gouttes de lait’. Mothers were admonished to breastfeed for at least 8-9 months, but where this was impossible milk was distributed free to poor families with children under 3 years of

age. Infant care was controlled by visits to the homes both from the charitable women who ran the 'Milk Drop' and from health authorities. Public help was followed by public control.

Despite all these efforts to have mothers breastfeed their babies, during the 1960's only around one third of Norwegian mothers breastfed their babies for more than three months. Now social legislation was initiated to ease women's possibility to breastfeed. Working mothers were allowed 30 minutes to feed their babies twice a day without a reduction of their wages. (1956). Three months paid maternity leave from 1963 had the same effect.

From the early 1970's breast-feeding increased rapidly. No doubt, better time for child care had an effect. But the establishing of the organisation 'The breastfeeding assistance' (Ammehjelpen) in 1968 has also been honoured for this change. This institution may be characterised as a 'woman to women assistance'. Voluntary centres were established where mothers could discuss problems they might have with breastfeeding and they would be met by understanding and practical advice from other women who had themselves experienced breastfeeding. Helpful understanding of mothers' problems may have worked better than top-down admonishing from male physicians and public control of homes. Easy access – for instance over the telephone – to this assistance also counted and so did, probably, the attitude of the new women's movement where breastfeeding was seen as a positive feminine activity.

Summing up it may be said that women were unwilling to follow breast-feeding advice from physicians who did not understand the problems that confronted mothers. But when more understanding advisors were introduced and some of the practical problems were solved by allowing time for infant care, mothers took up breastfeeding to a much higher degree.

The third question - why infant mortality fell even as mothers breastfed less – has been met with a number of answers. One seems to be that bottle-feeding was not dangerous to the health of the infant if the milk and the bottles were immaculately sterilised. Routines of pasteurising milk and sterilising bottles made bottle-feeding a safe approach. But such practices presupposed better living conditions, cleaner houses, better health also for mothers and more time for infant care. Changes in society certainly had an important impact on infant mortality. Higher standards of living have been credited with the sharp reduction that took place between 1900 and 1935 of infectious diseases as a cause of infant deaths. (Table 2). Infant deaths caused by diarrhoea and intestine infection was reduced to almost one tenth

from the 1900- level, deaths from tuberculosis to one fifth. This witnessed a rising standard of living that no doubt saved many infants' lives.

Other important structural changes no doubt also had important effects. National legislation already in 1892 prohibited women from working in certain trades the first months after giving birth. But since mothers were not offered any financial compensation for loss of income it may be assumed that this was of little help. It was only in 1911 that the law on sickness insurance opened the right to economic assistance for six weeks surrounding the arrival of a baby to mothers who had been insured at least ten months before giving birth. The idea was obviously to avoid that women when they found themselves pregnant would rush to be insured. Since insurance was offered only to people with paid work, most married mothers would not have this assistance. But from 1915 wives whose husbands had sickness insurance were offered free assistance from a midwife and some economic support to cover expenses involved in the birth of a child. More rest and better assistance to women who had given birth was seen both as provisions against infant mortality and to avoid weakening the mother. After the Second World War this policy was continued when in 1963 mothers got a twelve weeks maternal leave.

Much of these changes had been introduced in order to reduce infant mortality. As the assistant secretary at the Department of Social Policies, George Wiesner, maintained in 1922: 'It is now generally accepted that one of the most important reasons for the terrible infant mortality is that the mother does not get enough rest and service during the time surrounding delivery, and that the infant is not naturally breast-fed...' Consequently, better access to medical assistance and more breast-feeding was needed. This was the main concern of the 'control clinics'.

But others were of the opinion that better service during the time of delivery and better infant care would not be obtained unless a reduction of fertility took place. In 1919 Katti Anker Møller who five years later opened the first 'hygienic mothers' clinic' said: 'We must prize motherhood higher. The lives of children must become more worth, costlier... Throughout the coming 50 years we must see to it that there will be a steady decrease in fertility; then, maybe, authorities will listen to our demands...'

A reduction in the number of children born to an average family was meant to assist in taking care of the children already born. This happened between 1900 and 1930. Taking care of two or three kids must have been a lot easier than coping with four or six.

This was one of the core arguments for those who opened the hygienic mothers' clinics.

Hygienic mothers' clinics – (Mødrehygienekontorer).

The name of the other kind of mothers' clinics was 'hygienic mothers' clinics'. The term 'hygienic' was a metaphor for contraception, a very controversial phenomenon and strongly tabooed during the first half of the twentieth century.

The first of these clinics was established in Oslo in 1924. The founder of the Oslo clinic was Katti Anker Møller. She had for decades worked to improve the situation of poor mothers. She had fought for a law that in 1919 gave illegitimate children the right to the name and inheritance of their biological father. More importantly, this law secured unmarried pregnant women a certain economic support during the weeks immediately before giving birth and for some months afterwards. Already in 1913 Katti Anker Møller criticised the draconic law that made abortion a crime. According to the penal code a woman who had provoked an abortion might be sentenced to three years imprisonment and the abortionist to six years imprisonment. This law was not changed until 1960

Katti Anker Møller had a wide international network. She corresponded with German and British emancipationists, such as Helen Stöcker and Charlotte Perkins Gilman. In 1912 she attended the First International Eugenics Congress in London. But she was repelled by the way eugenicists reasoned. She did, however, meet leaders of the Malthusian League and she was attracted to their arguments because of their interest in alleviating poverty by family planning.

Inspiration for Katti Anker Møller's clinic came from the United Kingdom. Here Mary Stope had caused a sensation with her book 'Married Love', where she recommended contraception within marriage. In 1921 Katti Anker Møller translated a brochure written by Mary Stope. The title was 'A letter to Working Mothers on how to Have Healthy Children and Avoid Weakening Pregnancies'. This brochure recommended contraception and rejected abortion. Katti Anker Møller disagreed with Stope on the question of abortion. Consequently, in the

Norwegian translation of the brochure, the part that concerned abortion was left out. In 1922 Katti Anker Møller went to London to study how the clinics opened there by Stope functioned. Two years later she opened the first 'hygienic mothers' clinic' in Oslo. In 1937, 19 'hygienic mothers' clinics' existed, spread all over the country. A national association of hygienic mothers' clinics was founded to support and inspire the work in these clinics. The intention of the hygienic mothers' clinics was to make it possible for women to decide on their own – even without consulting their husband - how many children they wanted. The hygienic mothers clinics stressed the need for worn-out mothers to avoid another pregnancy. The means was to give women information on and access to contraception. .

The clinics, especially the first one in Oslo, were strongly criticised. Conservative politicians and clerical people saw children as a gift from God and maintained that pregnancy should not be interfered with. “Those who can not or will not take the consequences of sexual gratification... must abstain from gratification. We can not compromise the Christian ideals and recognise artificial and unnatural means in this matter” said a statement from a meeting of authorities within Christian quarters in 1926. They stressed the importance of seeing sexual intercourse as something that belonged within marriage and as a means to beget children. If no children were wanted, sexual abstinence should be the solution.

A lawsuit was filed against the activities of the Oslo clinic. The clinic was attacked not only by conservative people, but also by influential women, such as the leader of the Housewives Association, Marie Michelet and the first female factory inspector, Betzy Kjelsberg. But the critics were not heard. The law court in 1927 decided that it was legal to spread information on contraception.

The Oslo clinic was supported by the Women's organisation within the Labour Party, and from 1930 received some economic support from municipal authorities. This was very welcome and seen as a means to combat the dangerous illegal abortions.

Other 'hygienic mothers clinics' were also pioneered by women within the Labour Party. Also in other cities they often had to fight strong opposition. A clinic starting in Stavanger in 1932 was met with critique from the city physician. It was demanded that a physician be attached to the clinic. This was too expensive for those who had started the clinic and they asked for municipal economic support in order to be able to meet the demand. At the meeting

of the municipal council where a decision on this support had to be made, all the representatives of the Labour Party were absent. They gave priority to a demonstration to protest unemployment. The result was that economic assistance to the clinic was denied and the clinic had to close down.

Also in other municipalities economic assistance to the hygienic mothers' clinics could depend on shifting political constellations. By and large, Liberals and Conservatives were critical and religious concerns were forwarded to hinder the use of contraception. While members of the Labour Party supported these clinics. Inspiration from Sweden where the couple Gunnar and Alma Myrdal published a book on the population crises, helped change the arguments within the Labour Party for supporting the 'hygienic mothers' clinics'. During the 1930's argumentation shifted from assisting worn-out mothers to using the fall in fertility in the fight for wider social reforms that would strengthen the health of working class families. Now also younger socialist physicians started to support contraception, among them Karl Evang, the future director of health.

But resistance to contraception continued to be wide-spread. In 1938, a Labour government decided to give economic support to control stations for mothers and children where no information on contraception was given. The following year a group of women within the Labour Party proposed state subvention also of hygienic mothers' clinics. A minority in Parliament voted against this, maintaining that the control clinics offered the best advice to mothers. But this time some economic support was accepted also for the hygienic clinics. During the war all the hygienic mothers' clinics were suspended by the German occupational forces. When the clinics reopened after the war confrontations over contraception resumed in Parliament. Attitudes changed slowly and until the 1970's financial support for information on contraception had to cope with strong opposition. Finally, open information on contraception was gradually accepted.

It should however be said that the use of the form of contraception promoted by the hygienic mothers' clinics, the cervical cap, was problematic. A certain degree of private space and cleanliness was a precondition for a successful use of this contraceptive device. The condom was much simpler to use, but this needed cooperation from husbands. It should also be considered that the use of condoms was closely related to prostitution. Introducing this means of contraception into a respectable marriage might be a difficult step to take. Since all talk of

contraceptives was highly tabooed, many researchers have concluded that the sharp fall in marital fertility between 1900 and 1930 was made possible by a combination of sexual abstinence and withdrawal, both methods depending on cooperation between spouses.

Both the control clinics and the hygienic mothers' clinics aimed at reducing infant mortality. But the means were different. While the control clinics gave priority to better infant care, the hygienic clinics saw a reduction of fertility as their main goal.

If we return to the question of the connection between reduced fertility and the fall of infant mortality, we may ask if the lively and prolonged discussions on contraception throughout the interwar period give any indications of such a connection. Did infant mortality play a role in these discussions? The answer is yes.

Discussing fertility and infant mortality.

Discussions in middle class women's journals show that the need to take better care of infants was a prominent motive for having fewer children. These journals were full of advice on better child-care and also pointed to the complicated character of modern child-care. A book on this theme was reviewed in one of these journals in 1900 with rather sarcastic comments:

“These days one probably ought to be a physician to talk about a book on child care... but I venture to do so, since I believe that the one who wears the shoe knows best how it fits...The only help a young mother and her husband has today in these questions is the physician. But under normal circumstances you cannot have a physician around the house all the time to give orders as to child-care morning and night. And the famous advice from the always helpful army of grandmothers and aunts to comfort and assist mothers, will today be avoided by modern parents as sheer quackery...”

Another contribution warned against leaving the infant with a nurse maid ‘ who mostly would not have the clue as to sensible child-care’. Mothers should rely on medical experts and should themselves take care of the child.

It was stressed that fewer children would greatly enhance the health of mothers, and healthier mothers would provide better child-care. In letters to the hygienic mothers' clinic in Oslo working class mothers showed great concern for their own health. With a great number of children and often complications when giving birth, working class mothers complained of not having enough strength to take care of the children they already had.

Some found such preoccupations much too prominent. In 1916 the conservative MP Ole Malm wrote ironically about child-care: “What hullabaloo about all that is needed... to have children: refined childcare, bathtub, thermometers, an overload of children’s clothes, suitable artificial food if you cannot breastfeed, the assistance of midwives until the age of 15, nurses, attending courses and lectures and vocational training, all that costs money, time, work and servants...” In his opinion worries over the health of children and mothers were strongly exaggerated and he saw such worries as causing a regretful reduction of fertility.

Other motives for reducing fertility

It is, however, important to stress that the wish to take better care of infants was not the only reason why fertility declined. Letters to the Mothers’ clinic in Oslo and discussions in a number of women’s magazines between 1900 and 1930 reveal a number of other reasons for the decision to have fewer children.

For women from middle class families, the family economy, the need to secure a certain acceptable standard of living for the family, was important. They discussed the problem of the rather new need to let not only boys, but also girls have an education. Also, marriage was no longer the automatic livelihood for women. Heavy emigration of young men, especially to the USA, caused an alarming growth in the rate of unmarried women from around the turn of the century. If a middle class girl did not marry, she would need education to find a decent occupation in order to survive economically. But the costs of education of children were high, and this need sometimes collided with the need for a servant girl. Sending a daughter to a good private school might be as expensive as a full years salary for a servant girl and a servant girl was seen as indispensable. It was even said that a family with two or three children would need two servants. Otherwise the mother would soon be completely worn out.

The threat of unemployment was much more important to working class mothers who wrote to the hygienic mothers’ clinic in Oslo. They did not complain of the cost of education for their children. They were used to see both boys and girls attempt to fend for themselves and assist in making the family economy viable. For working class families economic disaster, caused by unemployment or the sickness of the breadwinning husband weighed heavily.

Finally, modernity seemed to result in new approaches to motherhood. As the Norwegian author, Bjørnstjerne Bjørnson formulated it already in 1900: “Modern is only the woman who – in contrast to women of the past – realises that the fate of her children mainly depends on what happens in society, and that her efforts are aimless and may be in vain if she does not take part in forming conditions in society.” Discussions in women’s journals reveal that younger middle class women wanted more time not only for child care and cultural activities – reading and playing the piano – but also to get involved in what happened in society. Katti Anker Møller encouraged women to ask themselves whether marriage and children was the only goal for their lives, or whether they felt the need to ‘further goals, higher ideals for their lives...’. She expected that women would no longer feel content to limit their activities to ‘the simple demands of the nursery or to the second rate position of a spiritual intermediary between the world and her flock of children...’ (Blom 1980, p.121).

For women within the Labour Party, reducing the number of children could be seen as a weapon in the class struggle. This would strengthen the economy of the working class family and consequently make also working class women more efficient in the class struggle. During the 1930’s they also stressed that ‘women’s economic and political independence ... has erased the thousand year long male suppression and male guardianship. Today women reject being perceived as an object for men’s lust or to be considered a child-bearing machine.’ (Arbeiderkvinnen January 1934). The importance of ideas about women’s emancipation surface clearly in the study undertaken by Sølvi Sogner. Hege Brit Randsborg and Eli Fure. They have shown that in areas where women were eager to use their newly won right to vote at national elections, i.e. where women were interested in politics - marital fertility tended to fall earlier than where this was not the case.

Summing up -

There was a clear connection between the reduction of infant mortality and the fall in fertility. Attempts to reduce infant mortality by changing women’s breast-feeding habits, as it was done by pressure from medical men in the first clinics - did not seem too successful. Easy access to understanding and helpful advice were better means of encouraging mothers to breastfeed. The many ‘control clinics’ working to reduce infant mortality by assisting mothers with advice on infant care, no doubt had importance. Increasing awareness of measures to safeguard the health of mothers also made them better able to take care of their

infants. Structural changes in society made all these efforts easier. Higher standards of living and early welfare policies made better room for mothers to take care of their infants.

But the falling birth rate was not without importance. There were a number of reasons why women wanted fewer children. Among these reasons was the possibility of taking better care of the children they already had. By spreading knowledge of and access to contraception, the 'hygienic mothers' clinics' helped women to avoid unwanted pregnancies. It should, however, be said that there is little reason to believe that there was a strong discrepancy between women's and men's opinions on fertility. Cooperation between spouses figures as an important means to reduce marital fertility. But women's growing self-confidence and ability to make decisions strengthened their possibilities for reaching their goals.

All in all, though giving priority to different problems, both the control clinics and the hygienic mothers' clinics must have been involved in the strong reduction of infant mortality between 1900 and 1950.

Table 1.

Deaths under one year of age per 1000 live births, Norway, 1866 – 1965.					
	1866-70	1891-95	1921-25	1941-45	1956-60
Rate	113,5	97.6	51,7	37,3	19,9

Source: Dyrvik 1975, p. 18

Table 2.

Deaths from the most important causes, age 0 - 1 year. 1900 – 1935. Reduction in percentage.		
	1900	1935
Diarrhoea and intestine infections	100	13
Tuberculosis	100	22
Other infectious diseases	100	25
Pneumonia and influenza	100	46

Source: Backer 1966, table 25, p. 47.

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