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Between Home and Hospital: Midwives and Their Maternity Wards in Postwar Poland (1945–1970)

Abstract: *The article's aim is to describe the history of maternity wards, institutions that were unknown in prewar Poland. By presenting the midwives narratives in interviews this article focuses on the unique form of obstetric care on local community level, organized and managed by midwives. The article will not be a chronological description of the creation and development of maternities, but more a coverage of events that influenced their creation and activities.*

Key words: *Maternity ward – Midwife in Poland – Midwifery in postwar Poland – childbirth in postwar Poland*

> *"You know, when a woman gives birth, she needs the support of a wise woman. Woman suffers during delivery, and midwife can help a great deal. And they are also independent, not reliant on anyone, and can work at any moment."*[1]

This is how the mother of midwife Karolina described the nature of a midwife's profession, giving her advice and helping her to choose a profession in the early 1950s. However one-sided this statement may be, it illustrates how the role of the midwife and the profession of midwifery were perceived and serves as a testimony of sorts to the contemporary image of midwives.

The article's aim is to describe the history of maternity wards, institutions that were unknown in prewar Poland. By presenting the midwives narratives in interviews this article focuses on the unique form of obstetric care on the local community level, organized and managed by midwives. The article will not be a chronological description of the creation and development of maternities, but more a coverage of events that influenced their creation and activities.

1 Interview fragments used in the article are from my master's thesis written under the direction of Prof. Dr. Barbara Duden at the Universität Hannover in 2005: "Between House and Hospital: The History of the Midwives and the Maternity Wards in Poland 1945–1970, unpublished. Here p. 63.

The maternity wards were opened starting in the second half of the 1940s and for almost three decades became a part of rural areas, exercising a major influence on the future shape of perinatal care in Poland. The history of the establishment and development of maternities is, however, inextricably linked to the history of the professional work of the midwives employed there, who ran these facilities independently. The selection of the source database used for the article is therefore of major importance. In addition to professional journals, legal ordinances, and official documents, I use fragments of interviews that I conducted with midwives, who studied at a midwives' school and started their professional activity in the 1950s and 1960s. The dominant theme of the interviews was the life and work of the midwives in maternity wards. Such sources enriched with the personal experience of the midwives make it possible to paint a full picture of maternity. The interviews are a unique source, as access to these midwives is particularly difficult due to their progressively older age. I give equal treatment to the sources; which complement each other throughout the article.

As Marion Schumann demonstrates for the Federal Republic of Germany, the way pregnant women were treated and the practical activities associated with childbirth are influenced by culturally and socially influenced norms, which are reflected in the profession of midwifery and determine obstetric practice. At the same time, pregnancy, childbirth, and motherhood are important biographical examples of the changes occurring in the lives of women and men.[2]

In the years immediately after the war, the events of World War II and the reconstruction of the country within the new geopolitical boundaries absorbed a major share of Poland's national energy.[3] The wartime destruction and the twofold occupation by Germany and Russia were followed by the expansion of Soviet domination.[4] The Polish population found itself in a "new reality."

In January 1947, the Office of War Compensation published a report on war losses in Poland and estimated the number of people murdered to be six million, as the result of

2 Marion SCHUMANN, *Vom Dienst an Mutter und Kind zum Dienst nach Plan. Hebammen in der Bundesrepublik 1950–1975*, Osnabrück 2009.

3 The country's territory was about 20 percent smaller in relation to the area of the Second Polish Republic, with more than half of prewar Poland incorporated into the USSR. Poland was given land to the west and north (East Prussia), which belonged to the Third Reich before the war. The end of the war did not spell the end of migration. For example, processes related to forced migration occurring in the Upper Odra region between 1945 and 1948 were discussed extensively by Beata HALICKA, *Polski Dziki Zachód. Przymusowe migracje i kulturowe oswajanie Nadodrza 1945–1948*, Kraków 2015. See also Norman DAVIES, *God´s Playground: a History of Poland*, Oxford 1989.

4 See Katherine R. JOLLUCK, *Life and Face: Race, Nationality, Class and Gender in Wartime Poland*, in: Catherine BAKER (ed.), Gender in 20th Century Eastern Europe and the USSR, London 2017, pp. 96–112.

German terror.[5] The deteriorated health of the population left much to be desired. Hunger, the spread of disease, disabilities, epidemics, the mental effects of the war, as well as the consequences of losing relatives were rife in a society already exhausted by warfare. The consequences of the war were severe for the survivors: an increase in general mortality from 13 to 18 percent; raging tuberculosis, which affected 80 percent of school-age children; a decrease in the weight of schoolchildren by 30 percent compared with the prewar average, a considerable increase in the incidence of trachoma; the spread of venereal disease, psychoneurosis, and alcoholism; an increase in the crime rate. A particular problem for reconstructing the nation was an increase in infant mortality from 10.9 to 26.5 percent, the frequency of unlawful abortions, and the increase in the number of miscarriages, premature births, and stillbirths.[6]

The emerging state was confronted with the need to rein in lifestyle diseases and restore the nation's health. Due to the "disproportions between the slim budgetary framework and the vastness of the issues," overcoming them required a "strong and coordinated collective effort."[7] At its first general meeting, the Commission to Fight the Effects of Biological Attrition of the Nation, established under the Minister of Health, determined that the most urgent issue was that of mother-child-care, and the fight against tuberculosis. The first three points of the thirteen-point action plan concerned: care for newborns, children, and youths; care for orphans, half-orphans, and illegitimate children; care for pregnant women and mothers.[8]

In the late 1940s the Polish government set out to organize health care and remodel the health care system, which was to operate in accordance with the principles of the country's established political system. The objective was to create a socialist health care system modeled after the Soviet one.[9] "Its basic tenets were that every citizen should have

5 Soviet actions were not considered into account. BIURO ODSZKODOWAŃ WOJENNYCH PRZY PREZYDIUM RADY MINISTRÓW, *Sprawozdanie w przedmiocie strat i szkód wojennych Polski w latach 1939–1945*, Warszawa 1947; [Polish War Reparations Bureau, Report on the losses and damages of war in Poland in 1939–1945], Warszawa 1947.

6 Zdzisław ASKANAZ, *Zadania komisji do walki ze skutkami biologicznego wyniszczenia narodu*, Opiekun Społeczny: miesięcznik poświęcony zagadnieniom opieki społecznej, 1947, no. 1, pp. 9–13.

7 Z. ASKANAZ, *Zadania komisji*, p. 11.

8 The Commission included representatives of the Ministry of Health, the Ministry of Labor and Social Welfare, the Ministry of Education and the Central Planning Office, which initiated the Commission's establishment. See Z. ASKANAZ, *Zadania komisji*, p. 11.

9 The adapted socialist healthcare model was developed in the 1920s in Soviet Union by Nikolaj Aleksandrowicz Siemiaszko. In this so-called "Semashko model", the state was primarily responsible for the organisation, financing and delivery of health service and medical care. See more Urszula DROZDOWSKA, *System organizacji służby zdrowia w Polskie Rzeczpospolitej Ludowej jako przykład modelu obowiązującego w krajach tzw. Obozu socjalistycznego*, in: Teresa Mróz (ed.), Uwarunkowanie systemu opieki zdrowotnej w Polsce, Białystok 2012, pp. 54–59, here p. 54.

access to free "medical care and the so-called medicalization of the health."[10] In accordance with the Act of 1948 on social health care institutions and a planned health care economy, health care facilities were unified and nationalized, and their reconstruction linked to that of the state and economic plans.[11]

In postwar Poland, a high birth rate and a natural increase were observed. In 1946, the number of births was 622,500, by 1950 it had reached 763,100 and in 1955 793,800 births were recorded. In 1946 there were 26.2 newborns per 1,000 inhabitants, and by 1951 it reached its peak with 31 newborns per 1,000. At the same time, the infant mortality rate was appallingly high, and was a matter of concern for authorities and the medical community. In 1950, infant mortality was at a level of about 111 per 1,000 live births, and about 6 out of 1,000 children died before the age of 5.[12] The mortality rate of perinatal mothers was 11.7 deaths per 10, 000 births.[13] Accordingly, the national population policy was aligned in favor of childbirth. These undertakings were strictly related to assuring every woman had proper perinatal care under the supervision of professionals, as well as providing appropriate premises for organizing medical facilities.

For obstetrics, this meant a centrally controlled relocation of the birth site from the domestic environment of the delivering women to the public spaces of the health care services, as well as the establishment of a fine-meshed network of counseling centers for pregnant women, mothers, infants, and small children. Even though the relocation of the birth site from the delivering women's homes to the clinic was a political aim, the expansion of obstetric wards in hospitals proceeded only slowly. Medical facilities were in a catastrophic state. Most medical, preventive, and sanitary facilities were bereft of equipment, laboratories, apparatus or medical instruments. There were no buildings for collective health purposes. Material losses incurred by health care facilities, destroyed buildings, and the damaged or, often, stolen inventory of the facilities were estimated to be around 55 percent.[14]

10 The Semashko model was adopted by all satellite countries of the Soviet bloc after WWII. See Witold A. ZATOŃSKI - Mateusz ZATOŃSKI, *Health in the Polish People s Republic*, J Health Inequal, 2016, 2 (1), pp. 7–16, here p. 2.

11 *Ustawa z dnia 28 października 1948 roku o zakładach społecznych służby zdrowia i planowej gospodarce w służbie zdrowia* (Dz. U. 1948, nr 55, poz. 434) [Act of 28 October 1948 on social health care institutions and planned health care economy. (OJ 1948, No. 55, item 434)]. With the Act's introduction, the term social health care institutions became applicable, which defined them as institutions maintained by the state, state institutions, local self-government associations and social insurance institutions. See Urszula KOZŁOWSKA - Marek BULSA, *Polish health care transformation between 1950–1960. Issue of maternal and child health care (major problems)*, in: Hygeia Public Health 2015, 50(1): pp. 244–246, here p. 244.

12 Eugenia POMERSKA, *Ochrona zdrowia matki i dziecka w XX-leciu PRL, Zdrowie publiczne*, 1964, Nr 7, pp. 279–286, here p. 282.

13 E. POMERSKA, *Ochrona zdrowia*, p. 280.

14 See Jan RUTKIEWICZ, *Odbudowa szpitalnictwa warszawskiego*, Opiekun społeczny: miesięcznik poświęcony zagadnieniom opieki społecznej, 1948, No. 7–8, pp. 258–273.

Staff shortages also hit hard at the time. The losses among medical personnel were proportionately higher than in the overall population. Nearly half of the medical personnel were lacking compared with the prewar years.[15] The number of physicians decreased by 39 percent from 12,917 in 1938 to 7,732 in 1946. The number of midwives fell accordingly, from 9,356 in 1938 to 6,311 in 1946.[16]

The year 1949 saw the introduction of the registration of health care professionals, which allowed the number of employees and their place of residence to be ascertained, including areas that lacked a sufficient number of employees as well as areas without health care facilities.[17] The aim was to ensure the even distribution of medical personnel throughout the country and organize appropriate obstetric care in the rural areas.[18] That same year, the regulation on midwives' obligation to work in social health care facilities required midwives to work solely in state-owned institutions: in maternity wards, as a local midwife or in treatment facilities operated by national insurance institutions.[19]

In order to quickly and economically make up for the lack of doctors in obstetrics, the government assigned nearly all of the responsibilities related to childbirth to midwives, which included care and advice during the pregnancy, normal delivery, and the post-natal period, as well as infant care and maternal counseling.

Educating an appropriate number of highly qualified midwives became a decisive issue. The high requirements for the candidates were meant to allow the comprehensive implementation of broad curricula, "therefore, giving society well-prepared, mature and responsible midwives."[20] The curriculum also included subjects related to national population policy and this was reflected in the textbook for middle-level medical staff

15 As a result of the actions of both of the occupying forces directed against the Polish intelligentsia, such as the arrests of Polish professors, sending them to concentration camps, a significant part of medical professionals was murdered. The German occupiers successively replaced Polish with German midwives, and Polish women—like Jewish women—were excluded from training to become midwives, see more Wiebke LISNER, *Geburtshilfe im Kontext von Gemeinschafts- und Rassenpolitik. Hebammen als weibliche Expertinnen im 'Reichsgau Wartheland' 1939–1945*, in: Matthias Barelkowski et al. (eds), Zwischen Geschlecht und Nation. Interdependenzen und Interaktionen in der multiethnischen Gesellschaft Polens im 19. Und 20. Jahrhundert, Osnabrück 2016, pp. 238–263.

16 GŁÓWNY URZĄD STATYSTYCZNY (ed.), *Rocznik statystyczny 1949*, Warszawa 1950, p. 233.

17 *Rozporządzenie Ministra Zdrowia z dnia 29 października 1949 r. w sprawie rejestracji fachowych pracowników służby zdrowia oraz zezwoleń na przekroczenie normy ilościowej* (Dz. U. Nr 58 Poz. 454).

18 In 1946, over 68 percent of the population lived in rural areas. In 1947, out of a total of 7,869 physicians, only 631 physicians took up employment in rural areas. Maria LIPIŃSKA, *Lekarze w zwierciadle „Służby Zdrowia" w latach 1949–1956*, in: Bożena Urbanek (ed.), Zawód lekarza na ziemiach polskich w XIX i XX wieku, Warszawa 2009, pp. 399–420, here p. 401.

19 *Rozporządzenie Ministra Zdrowia z dnia 29 listopada 1949 r. w sprawie obowiązku pracy położnych w zakładach społecznych służby zdrowia* (Dz. U. R. P. Nr 61, poz. 483).

20 PREZYDIUM SEKCJI GŁÓWNEJ POŁOŻNYCH, *Wielki sukces zawodu położnych*, Pielęgniarka i Położna, 1960, Nr. 11, p. 19.

Obstetrics and Women's Diseases, in which the role of midwives was defined as follows: "Population growth increases a society's strength, its importance, and its prosperity. The Polish state aims to increase our population with each passing year in our nation's interest. A Polish midwife who wishes to fulfill her duties properly, must be aware of these goals and, if possible, help implement them."[21]

The state was banking on the active participation of midwives, in a campaign to lower the mortality of women and of children in the first year of life, in promoting motherhood, combating infertility, and in preventing miscarriages, as a result of which the state suffered the greatest losses in terms of population growth.[22]

The health department took steps to combat domestic childbirth assistance by unqualified obstetricians, so-called *babkas*, who were seen as the main cause of high perinatal mortality, and whose help was mainly sought out by residents of villages. Babkas were folk women who acquired their knowledge about childbirth through experience. In the spirit of neighborly help, they cared for peasant women during childbirth and performed the housework during the lying-in period. They usually received money or natural produce as remuneration for their work, which was less expensive for the farmers, who did not have health insurance, than having to pay for the services of a qualified midwife. Babkas were accused of having carried out large number of illegal abortions.[23]

In order to make up for the lack of hospital beds, obstetric care—especially in rural areas—was supplemented on an interim basis by a new type of institution: **the maternity ward**. It was intended to bring the "childbirth bed" to peasant women and thus improve the care of mothers and children. With the establishment of the maternity ward, peasant women could give birth to the child under better hygienic conditions than in their own homes, which often did not have running water or were only poorly heated, receive the necessary care and time to recuperate after childbirth, and have a break from performing strenuous physical farm labor. It was often the case that the women arrived at one of the maternities directly from working in the fields and were already in an advanced phase of childbirth. As soon as they arrived, delivering women were prepared for the birth depended on the phase of childbirth they were in. They were generally washed, their genital area

21 Henryk BRĘBOROWICZ, *Opieka nad matką i dzieckiem*, in: Tadeusz Zwoloński (ed), Położnictwo i choroby kobiece,Warszawa 1950, pp. 424–437, here p. 424.

22 The argument was that it was good for children, whose proper development in childhood requires the company of a larger number of siblings, who in later life can support themselves. The ideal was a marriage with 3 or 4 children, due to about 10–15 percent of couples being infertile. The midwife's help was to be limited to instructing and referring the patient to a specialist after just 1 year of marriage. Also, each woman suffering a miscarriage should be sent to a hospital or a doctor.

23 See more Sylwia KUŹMA-MARKOWSKA, *Walka z „babkami" o zdrowie kobiet: medykalizacja przerywania ciąży w Polsce*, Polska 1944–45/ 1989, Studia i Materiały, 2017, vol. 15, pp. 189–215, accessed, 14th April 2019, http://dx.doi.org/10.12775/Polska.2017.1.

shaven, and were given an enema, since, as midwife Karolina attested, not many houses had a bathroom: "Then people really didn't wash, there was no hygiene, no bathrooms."[24] Midwife Janina: "We gave them a sponge bath, with the kind of soap that did not cause pimples or eczema. They started to deliver, their feet so muddy, and the baby's head was already showing; then you didn't look at their dirty feet but quickly washed their genital area and delivered the child."[25]

The new institution run by midwives quickly established itself and became a permanent part of communities. The first maternity ward, with five beds, was initiated in 1945 by midwife Hoffmann in Laski near Warsaw shortly after the end of the war. She managed it independently, without a budget and without auxiliary personnel.[26] By 1949, there were already 85 maternity wards, and a year later 250. Thus, in the early 1950s, a high point was reported in the expansion of maternity wards. In 1956, 140,000 births took place in a maternity ward run by a midwife, the equivalent of 16 percent of all births. Of the total of 8,055 midwives, 1,081 worked in 788 maternity wards. These houses enabled securing the institutionalization of childbirth under the conditions of a short supply of personnel resources in areas in which there was no clinic infrastructure.

In 1950 the Ministry of Health published the *Instruction on the Organization and Operation of the Maternity Wards* according to which the maternities constituted part of the health care center and had, depending on local requirements, three to ten beds. [27] The maternity's tasks included: "providing obstetric aid during normal births, caring for lying-in women and newborns, directing a woman for delivery to a hospital in the event of a pathological birth, puerperal fever (over 38 C), or complications occurring both for the woman and for the newborn." Women under the jurisdiction of the health care center were admitted to a maternity ward. However, depending on the occupancy level, women from other local communities could be admitted. The staff of a five-bed maternity ward included a doctor, a midwife, an aide, and cleaning personnel. The doctor bore the official responsibility for the maternity wards. Besides supervising the birth, he was obligated to comply with each of the midwife's requests to examine and treat women giving birth.

The instruction describes the responsibilities of the midwife in the maternity ward in detail, as follows:

> *"1) Admitting women giving birth to the maternity,*
> *2) delivering normal births,*

24 E. KASSNER, *Between House and Hospital*, p.86.

25 E. KASSNER, *Between House and Hospital*, p.86.

26 Firstname unknown. Leokadia GRABOWIECKA, *Rozwój i działalność izb porodowych*, Położna, 1958, vol. 3, pp. 6–8, here p. 6.

27 *Instrukcja o organizacji i prowadzeniu izby porodowej*, stanowiąca załącznik Nr 8 do okólnika Nr 57/50 z dnia 6 lipca 1950 r (Dz. U. Min. Zdr. Nr 14, poz.122).

3) caring for women giving birth and newborns,
4) calling the doctor in cases of pathological births,
5) referring complicated, abnormal and febrile cases to a hospital,
6) issuing birth certificates,
7) reporting the birth of a child to a registrar, if the father is unknown or absent,
8) referring mothers to a pediatric clinic,
9) notifying the pediatric clinic of every birth of a live child and of the death of a newborn in the postpartum period,
10) notifying the women's clinic in the case of a death during birth, stillbirth and fever in the postpartum period,
11) performing activities and procedures ordered by the maternity ward doctor,
12) propagating knowledge of hygiene through the practical instruction of mothers on feeding and care of babies,
13) monitoring hygiene and sanitary conditions at the maternity,
14) assuring proper heating, ventilation and lighting of the maternity and sustenance nourishment for patients,
15) monitoring the condition and the completeness of the ward, tools, medicines, materials and linen,
16) supervising and managing the work of the orderly and other manual workers,
17) preparing applications related to the budget, supply of medicines, medical equipment, etc.,
18) bookkeeping and accounting,
19) preparing periodic reports,
20) wearing correct clothing (white coat and cap) at the maternity ward."

The instruction also defined how the maternity ward was to be equipped. The following rooms were to be available: waiting room, admission room, office, delivery room, maternity and newborn room, isolation room for patients with fever, bathroom, kitchen, laundry room, utility room, toilet, basement, attic, apartment for the midwife. If possible, every house was to have a telephone connection, electricity, central heating, and running water. In a maternity ward with ten beds there was to be an additional room for newborns. Moreover, the building was to have a room for laying out deceased mothers and infants, and there was to be a pit in the basement for burying the placenta.

Yet such spatial conditions were rare in postwar Poland. There were critical voices on the part of the county's doctors, who warned of excessive building requirements, which could impede the establishment of the maternity ward. A county doctor from the community of Olkusz, for example, held the opinion that even a maternity ward that did not completely correspond with the requirements offered better delivery conditions compared with confined, overcrowded working-class apartments or farmhouses, where women often give birth in the presence of other family members and ignored the lying-in period.[28]

However, how did it come about that a maternity ward was established in a village, in a local community? In Olkusz county, a decision was made to establish maternity wards in

28 M. KICIARSKI et al., *Izby porodowe w powiecie olkuskim*, Zdrowie Publiczne, 1951, no. 4, pp.103–115.

three-, two- and even one--roomed premises. Before the war, Olkusz county was among the poorest in Poland. The situation remained unchanged after the war. Despite significant difficulties in locating appropriate premises, about 20 maternity wards were established in there: a few in health care facilities, nine in rural buildings and even in ordinary straw huts. In Olkusz, the maternity wards were set up a few months before the instruction referred to above was issued. The local midwives themselves sought the locations with the assistance of the local administration. However, local citizens also frequently initiated the establishment of a maternity ward. The community, and sometimes even the midwives, donated the furnishings, such as tables, beds, and chairs. The midwives initially worked with their own medical instruments. It was easier to supplement the lack of equipment or to move to better locations if the house already existed. Furnishing the kitchens caused difficulties. In the beginning, the families of the women who had given birth brought the meals; the midwife often cooked at home. It was not until the maternity ward kitchens were equipped accordingly that the aides or the cleaning lady prepared the meals. In many communes the maternities were opened immediately if there was a midwife and premises suitable for temporary use. As Dr Kiciarski stressed, this was tactically necessary, as it forced local authorities to find appropriate rooms and organize the necessary equipment faster.

Almost all midwives I interviewed began their professional life in maternities as a young woman. They came to an unknown community. The midwives were issued work orders, generally introduced to health service beginning in the early 1950s, prompting the midwives to leave their current place of residence and to go to the specified area with a personnel shortage.[29] The action of directing midwives to rural areas was carried out in a systematic manner. Within a few years, the "first health care avant-garde" was created in rural areas.[30]

For the young midwives, these were completely new conditions, both in terms of private and professional life. The maternity ward was an attractive workplace. In the postwar years, the prospect of an apartment provided by an employer was an inviting one. Midwife Irena describes her maternity ward as follows: "It was a birthing house with 12 beds. There was a treatment room with files and a telephone, a delivery room with access to the newborn room, a kitchen with a utility room, and a laundry room with a rotary iron. The birthing house's spaces were on the ground floor, and there were two apartments on the upper floor for the midwives employed there. The living conditions for raising a child were good

29 This principle included nurses, midwives, and physicians. *Ustawa z dnia 7 marca 1950 r. o planowanym zatrudnianiu absolwentów średnich szkół zawodowych oraz szkół wyższych* (Dz. U. Nr 10, Poz. 106). [Act of 7 March 1950 on the planned employment of secondary vocational school and university graduates (Dz. U. Nr 10, Poz. 106)].

30 Leokadia GRABOWIECKA, *Opieka położniczo-ginekologiczna nad kobietą i noworodkiem*, in: Jerzy Krupiński (ed.), Zarys organizacji ochrony zdrowia matki i dziecka, Warszawa 1961, pp. 24–95, here p. 84.

there. I could put my son in the baby carriage on the wonderful terrace. We had a large room with a big kitchen. The house was made of larch wood. One could only dream of living in such a place."[31]

Running a maternity ward meant professional advancement. This was in part due to the fact that the head midwife had to assume responsibilities such as, for example, preparing work schedules and supervising the personnel, ensuring there were enough provisions, preparing the meals, preparing daily reports on food consumption, arranging for the supply of heating material, linens, and the cleaning of the facility. Midwife Janina reported that she had to travel to the town several kilometers away to order medication and bandaging material. There was a lack of professional staff in the area of purchasing or bookkeeping as well as auxiliary personnel for the delivery of medication and food. The tasks they had to cope with were diverse and often overstepped their professional skills, as they went far beyond obstetrics. The midwives organized and administered the day-to-day activities in the maternities. Midwife Janina recalls working in a 10-bed maternity, where she had to perform all these tasks herself: "It was good, you know, except someone for making purchased or doing the accounting was missing, because you did everything yourself, in a ten-bed house, all alone. The supplies needed, the menu, daily tasks, going to the city, ordering things in a pharmacy, yes, it was the midwife who had to take care of things."[32]

The difficult economic situation in the postwar years meant that the state could not afford administrative officers for maternities. Repeated appeals were therefore made to county instructors to put every possible effort into convincing midwives of the need and importance of assuring administrative activities: "In reality, most maternity managers have no knowledge of administrative work and, what is worse, are reluctant to do it, citing a lack of time or simply disregarding its importance. This is a significant impediment for county instructors to overcome. After all, there can be no exemplary maternity ward, even run by the most professional midwife without accurate and solid reporting."[33]

In the 1960s, the head of the midwives' association Adela Giergielewiczowa, repeatedly wrote about midwives working in maternities in the *Pielęgniarka i położna* (Nurse and Midwife) journal, whom she described as: "of these extraordinary, sacrificial, obliging beings, who by serving society will develop respect and professional confidence in midwives."[34] In retrospect Giergielewiczowa describes this development of the maternity wards as a professional success: "The surrender of the autonomous management of the

31 E. KASSNER, *Between House and Hospital*, pp. 74–75.
32 E. KASSNER, *Between House and Hospital*, p. 79.
33 J. WOJCIECHOWSKA, *Rola i zadania położnej powiatowej*, Pielęgniarka i położna, 1958, vol. 2, p. 19–20, here p. 20.
34 Adela GIERGIELEWICZOWA, *W cztery oczy*, Pielęgniarka i Położna, 1960, 6, pp. 27–28, here p. 27.

maternity wards by the Ministry of Health amounts to a major professional success. To do so not only requires a good command of one's profession, a high degree of responsibility, as well as unconditional diligence and devotion. For the management of a health care services agency, however small, every head midwife must also possess numerous additional good qualities and capabilities. These are indispensable for the performance of the duties she has undertaken."[35]

The midwives Janina and Karolina recalled that they could often rely on help from residents of the local community. Midwife Karolina recalls: "We had very good relations in the commune. Our maternity ward was right opposite to the parish house, we even borrowed an axe from the priest."[36] In most cases, it were family members who contributed their commitment in return for the care of the women. The fact that family members were involved in the events surrounding the birth certainly benefited the image of the small maternities: "Every woman brought something for the meals. One of them brought along a young chicken, and on that day, broth was made; the next day, another one brought something else, and a midwife also occasionally got a piece of meat. This had become a custom, nobody required them to do it, but they usually brought something. It happened that going into labor she'd bring milk and cake, and everything. On Sunday they might even bring a turkey, you didn't ask for anything. Hence it was an enclave of village life."[37] Midwife Janina describes the relationship between the local residents and herself: „If you got on well with people, you would always find suppliers willing to bring high-quality products. It was good at every maternity. Except there was a lot of work, of course."[38]

Unlike hospitals, the maternities quickly became an intimate space. Pregnant women liked to seek them out for the delivery of their babies. Midwife Janina remembers that they were often supported by their husbands, who even registered their wives for the planned delivery date in the maternity wards: "Fathers liked to come register their wives. They didn't want to go to a clinic."[39] With their decision to give birth in a small maternity, many women deliberately tried to avoid delivering their babies in a hospital. Midwife Irena recalls: "Some of them wanted to have their babies in the maternity because there was individual care there. There weren't as many births compared with the 'assembly line' in the hospital. Maybe the women felt the need for individual care, that it was less mechanical than in the hospital, that it was perhaps not so crowded."[40]

35 Adela GIERGIELEWICZOWA, *W cztery oczy*, here p. 27.
36 E. KASSNER, *Between House and Hospital*, here p. 79.
37 E. KASSNER, *Between House and Hospital*, here p. 80.
38 E. KASSNER, *Between House and Hospital*, here p. 79.
39 E. KASSNER, *Between House and Hospital*, here p. 77.
40 E. KASSNER, *Between House and Hospital*, here p. 77.

The instruction on organization and operation of the maternity mentioned above determined the number of auxiliary staff members there. The set standard was that a five-bed maternity should employ one orderly and two female manual workers. Larger maternities had full-time posts for cooks and laundresses. By the end of 1959, there were 814 maternities in Poland, with the number of supporting staff members employed there exceeding 4,000. In 1960 Adela Giergielewiczowa described them as follows: "a whole army of silent employees in the background, without whom even the most talented midwife could not do much. ... Their role is particularly important and requires far more responsibility than their colleagues employed in hospitals."[41] In addition to cooking, washing, cleaning, providing services for midwives, their tasks included helping the midwife in the delivery room, in the neonatal room, changing newborns, bringing them for feeding, and ensuring, alongside the midwife, the safety of newborns and women staying in the maternity. The midwife was in charge of how auxiliary staff members were prepared for tasks and work.[42] Acting on their own responsibility and bound by instructions, the midwives cared for their clients. Physicians were only consulted in unusual situations; the supervision of home births was only permitted in emergencies. The facilities were normally staffed by two midwives who took turns working a 24-hour shift. However, at the beginning of her professional life midwife Janina supervised a maternity on her own: "I was completely alone and had the aides, a cook, and a cleaning woman."[43] For emergency situations, midwife Janina trained the aides to administer first aid. She explained the course of childbirth to them and instructed them in how to perform it: "Listen, should anything happen, since I might get sick, call the doctor and check up on the woman, what she looks like, what the baby looks like, what her blood pressure is, and don't be afraid. She should shout, press; if she shouts, then she'll be having bearing down pains, won't she? You can do it."[44]

With the ministerial instruction of 1953, the midwives employed in the maternities were fundamentally not permitted to supervise home births.[45] One exception was precipitate labor, which occasioned the midwives to perform the delivery in the home of the women giving childbirth.

Midwife Janina recalled many home births that she accompanied during her activity as an employee in the maternity: "I always called the doctor; I also had a very nice one.

41 Adela GIERGIELEWICZOWA, *O nich trzeba mówić*, Pielęgniarka i Położna, 1960, 9, pp. 28–29, here p. 28.

42 A. GIERGIELEWICZOWA, *O nich trzeba mówić*, p. 29.

43 E. KASSNER, *Between House and Hospital*, p. 86.

44 E. KASSNER, *Between House and Hospital*, p. 87.

45 Instrukcja Nr 20/53 Ministra Zdrowia z dnia 8 kwietnia 1953 r. (Nr. M. Dz. 3–4116/53) w sprawie obowiązków położnych w izbach porodowych (Dz. Urz. Min. Zdr. Nr 8, poz. 62).

I remember that at the time, there were still telephones with a crank. 'Doctor, precipitate labor, the women is already giving birth.' 'But how are you going to get there? Should I drive you there?' 'No, I have a vehicle. It's only three kilometers.' In between I always called the emergency service and told them where I was going. 'Don't bring me any more new patients. I'll let you know when I'm back in the maternity.'"[46] Midwife Janina had a positive relationship with the responsible doctor. He supported her in her work, and in her absence he took over the supervision of the patients in the maternity. "He said, 'Go and don't worry; I'll go to the maternity.' He knew that I would be back in two hours. Perhaps two and a half, because I had to be present."[47] When midwife Janina arrived at the home of the woman giving birth, she had to decide if there was anything that spoke against a home birth. She examined the woman for the purpose of ascertaining the position of the child and the progress of the birth. If there were no irregularities, the woman could deliver her child at home. "When I arrived and examined her, you could feel the position on the vertex; if it was excellent, then we could deliver at home. But I prepared the diapers and the blanks beforehand. The family wanted an eiderdown, and so I said, 'You can have one if I don't see it.' With time I knew that it is better to first let the placenta come and then bathe the infant, which meant that it was sometimes smeared with blood. I only wiped the 'beak,' so that their little faces saw nicer, and then I swaddled the child."[48]

Despite the amount of work, all the midwives have very fond memories of their professional life. They have an apparent desire to maintain a positive image of the small maternities. According to midwife Irena: "It was a good time, during which I could convince myself of my independence."[49] The conviction that they can take responsibility for everything they did runs like a golden thread through the interviews. All the midwives who were interviewed describe the closure of the small maternities as a painful experience. Midwife Mirosława's maternity was closed because the authorities considered it uneconomical. Six hundred children were born there every year in the early 1970s. Midwife Mirosława explains: "Believe me, when the birthing house was closed, something was torn out of me. It was truly something wonderful to serve a patient and her child, as well as to inform the father of the joyful occasion. Just when the maternity was flourishing, it turned out that it was in the red. I couldn't find my place as a community midwife."[50]

The reason given for the closure of midwife Irena's maternity was also inefficiency: "It was technical reasons; the boiler exploded, there were such economic difficulties. A complete renovation of the maternity was necessary."[51]

46 E. KASSNER, *Between House and Hospital*, p .92.
47 E. KASSNER, *Between House and Hospital*, pp. 91–92.
48 E. KASSNER, *Between House and Hospital*, pp. 92–93.
49 E. KASSNER, *Between House and Hospital*, p. 70.
50 E. KASSNER, *Between House and Hospital*, p. 97.
51 E. KASSNER, *Between House and Hospital*, p. 97.

Small hospitals with less than two hundred beds found themselves in a similar situation. The difference in maintenance costs per bed-day was often twice as high for small facilities. The establishment and existence of small facilities was justified by the specific conditions of their founding. However, a budget analysis did not encourage them to be further organized. Small facilities were more expensive for every line item of per diem hospital expenditure – administration, nutrition, medication.[52]

The year 1959 marks a high point in the development of the maternity wards. There were 813 facilities.[53] The following year was a turning point for the development of the maternity wards. From then on, the number of facilities decreased significantly until delivery in a clinic became standard practice in the 1970s. 1970 there were only 561. In the period of 12 years, 252 maternities were closed. Another 200 were closed in the following five years.[54]

The closure of the small maternities forced the employed midwives to change their workplace. Some of them accepted positions in hospitals, while others worked in counseling centers, where they were only in charge of the preliminary care and aftercare of pregnant women. Midwife Karolina perceives the closure of the small maternities not only as a personal loss, but as a loss for the whole professional group. She equates the closure with the loss of her autonomy: "It's a pity, but the moment the maternities were closed, our independence came to an end. Yes, I regret that and think it's like in the Parable of the 'Talents,' where the master gave each of them two talents. Well, that's how I felt in health care system and after the independence of midwives was taken away, as if they had buried these talents, as if they had buried them and didn't want to do anything else."[55]

Conclusion

In this paper I have focused on the maternity wards as not only as a special place but constituting a specific type of midwifery. Characteristic of the work performed by the maternity wards midwives was the autonomous and trusting care of pregnant women, women giving birth, and after delivery of their babies. The midwife only consulted a doctor if irregularities occurred during birth. With the closure of the maternity wards, the midwives practicing in Poland at the time were deprived of their scope for acting on their own responsibility and lost their independence and their close relationships to delivering women, as they were more closely integrated into the national health care system.

52 Jan RUTKIEWICZ, *Odbudowa szpitalnictwa warszawskiego*, in: Opiekun społeczny: miesięcznik poświęcony zagadnieniom opieki społecznej. 1948, vol. 7–8, 272–273.
53 GŁÓWNY URZĄD STATYSTYCZNY (ed.), Rocznik statystyczny 1965, Warszawa 1966, p. 448.
54 GŁÓWNY URZĄD STATYSTYCZNY (ed.), Rocznik statystyczny 1976, Warszawa 1977, p. 475.
55 E. KASSNER, *Between House and Hospital*, p. 98.

Hardly had the maternities been established than they were gradually closed. They were allegedly no longer economical. For the midwives, the closure of the maternity ward also meant the restriction of their once diverse area of activity. As hospital midwives, they were always supervised by the doctors. Within the framework of clinical obstetrics, they unavoidably became doctors' helpers. All the values that were important to them—the closeness to and holistic care of the delivering women and their own independence—were taken from their hands.

The maternity wards are a kind of *intermediate space*—a birthing space between home and hospital. The birth site was shifted from the domestic environment to the spaces of the maternity wards, and finally to the hospital. Attending childbirth in the maternity wards displays features of home and hospital deliveries. They were located in larger communities and thus near the residences of the pregnant women. Unlike the hospital, the atmosphere in the maternities was a familiar one. As local residents, the pregnant women and their families knew the midwives. They were invited to family celebrations, such as, for example, baptisms.

The maternity wards offered midwives the opportunity to work on their own authority within the framework of an institution, thus upgrading the profession of midwife. The midwives repeatedly emphasized that during their training they were prepared to work autonomously and on their own responsibility. However, with the closure of the maternity wards they were deprived of all of their authority to act on their own. They lost the last space that would have them enabled them to work independently.

Foto 1. Maternity ward in Mikołajki. In: Dziesięciolecie medycyny w Polsce Ludowej. Warszawa, 1956

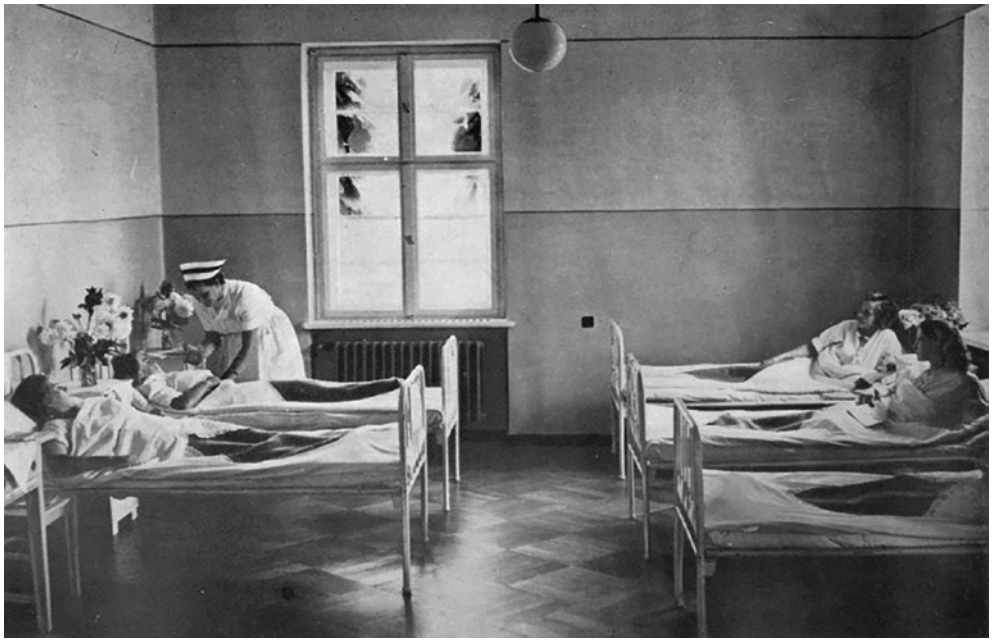


Foto 2. Maternity ward in Mikołajki. In: Dziesięciolecie medycyny w Polsce Ludowej. Warszawa, 1956

Budynek dawnej Izby Porodowej w Komorowie, pow. Tomaszów (woj. lubelskie), gdzie odbyło się 85 porodów od 1.I.51 r. do chwili uruchomienia nowej Izby Porodowej w dniu 19.X.51 r.

Foto 3. Maternity ward in Komorów. In: Położna 1952 2(2)

Rzecz jasna, że tzw. praktyka prywatna, uprawiana jeszcze przez część położnych, jest przeżytkiem, nie pasującym do nowych form lecznictwa społecznego. Rzecz jasna, że społeczeństwo będzie się broniło przed taką handlową formą „współpracy" położnej ze społeczeństwem i że praktyka prywatna będzie wypierana i będzie wyparta przez rozwój lecznictwa społecznego.

Trzeba wysuwać, pokazywać całemu społeczeństwu i nagradzać najbardziej wyróżniające się położne w pracy zawodowej i społecznej.

Położne polskie powinny brać przykład ze swych sióstr — położnych Związku Radzieckiego, które umieją doskonale łączyć pracę zawodową prowadzoną na wysokim poziomie z szeroką działalnością społeczną, które są aktywnymi bojowniczkami za sprawę swego wielkiego, socjalistycznego kraju i za sprawę pokoju.

W całym kraju odbywa się wielka praca nad likwidacją naszego zacofania, o osiągnięcie wysokiego poziomu rozwoju gospodarki, kultury, siły obronnej naszego kraju i zamożności najszerszych mas. Wszyscy pracownicy służby zdrowia, a wśród nich położne — powinny mieć ambicję wniesienia jak największego wkładu do tej pracy i wzięcia bezpośredniego udziału w kształtowaniu przyszłości naszej ludowej ojczyzny, w budowie socjalizmu i utrwaleniu pokoju.

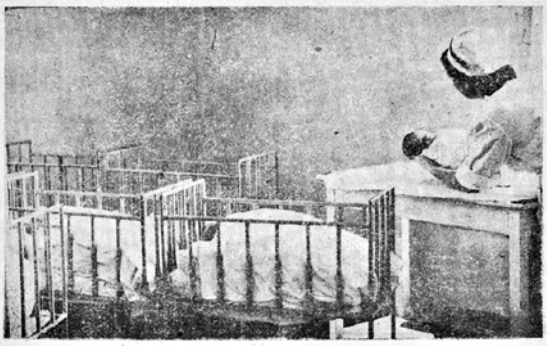
ADELA GIERGIELEWICZOWA

Podsumowanie osiągnięć

SKOŃCZYŁ się i przeszedł do historii drugi rok Planu 6-letniego. Setki tysięcy załóg z różnych zakładów pracy meldowało o przedterminowym wykonaniu zadań, warunkujących szybszy rozwój postępu i uprzemysłowienie kraju, wzrost dobrobytu mas pracujących i marsz do socjalizmu.

W końcu ubiegłego roku, na pierwszym wielkim zjeździe aktywu służby zdrowia w Ministerstwie Zdrowia ob. Minister Jerzy Sztachelski w swoim programowym referacie, w rozdziale i), „przekroczyć plan" — powiedział: „plan stawia przed nami zadania — wyznacza je w cyfrach, terminach. Naszym obowiązkiem jest nie tylko wykonać, ale i przekroczyć plan 6-letni. Hasło przekroczenia planu jest aktualne nie tylko w produkcji, ale również w każdej innej dziedzinie, a więc i w służbie zdrowia.

Przekroczyć plan w naszej dziedzinie, to znaczy drogą inicjatywy społecznej i ze środków społecznych, lub drogą wykorzystania rezerw materialnych, względnie wykonania dodatkowej pracy, zwiększyć świadczenia służby zdrowia na danym terenie, lub poszczególnych jej instytucji".



Sala noworodków w Izbie Porodowej w Wolbórzu (woj. łódzkie).

Dalej ob. Minister powiedział: „powinniśmy również zwiększyć ilość izb porodowych, wykorzystując miejscowe możliwości".

Słowa ob. Ministra Sztachelskiego stały się podstawą działania dla wielu województw na odcinku organizacji izb porodowych, stały się hasłem do współzawodnictwa między poszczególnymi Centralnymi Wojewódzkimi Poradniami Ochrony Macierzyństwa i Zdrowia Dziecka; nawet często ambitnie z sobą współzawodniczyły Wydziały Zdrowia Prezydiów Powiatowych Rad Narodowych i Prezydia Gminnych Rad Narodowych.

Biorąc pod uwagę fakt, że izby porodowe nie zawsze otrzymują nowe budynki, że lokale dla nich zdobywa teren drogą adaptacji starych budynków, wyszukiwanych przez Prezydia Gminnych Rad Narodowych — plan zwiększenia izb porodowych w roku 1951 z liczby 250 do 475 był śmiały.

Meldunki z terenu mówią, iż plan ten, mimo dużych trudności, został liczbowo całkowicie zrealizowany, w tym w kilku województwach z dużą nadwyżką.

Województwa szczecińskie i koszalińskie mają swój plan 6-letni wykonany, posiadają one po 54 izby porodowe.

3

Foto 4. Maternity ward in Wolbórz. In Położna 1952 2(1)

Summary

Between Home and Hospital:
Midwives and Their Maternity Wards in Postwar Poland (1945–1970)

The maternity wards were opened starting in the second half of the 1940s and for almost three decades became a part of rural areas, exercising a major influence on the future shape of perinatal care in Poland. The history of the establishment and development of maternities is, however, inextricably linked to the history of the professional work of the midwives employed there, who ran these facilities independently.

The maternity wards are a kind of *intermediate space*—a birthing space between home and hospital. The birth site was shifted from the domestic environment to the spaces of the maternity wards, and finally to the hospital. Attending childbirth in the maternity wards displays features of home and hospital deliveries. They were located in larger communities and thus near the residences of the pregnant women. Unlike the hospital, the atmosphere in the maternities was a familiar one. As local residents, the pregnant women and their families knew the midwives. They were invited to family celebrations, such as, for example, baptisms.

The maternity wards offered midwives the opportunity to work on their own authority within the framework of an institution, thus upgrading the profession of midwife. The midwives repeatedly emphasized that during their training they were prepared to work autonomously and on their own responsibility. However, with the closure of the maternity wards they were deprived of all of their authority to act on their own. They lost the last space that would have them enabled them to work independently.