A PLEA FOR MATERNAL SERVICES IN SOUTH AFRICA WITH PARTICULAR REFERENCE TO THE RURAL AREAS*

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This subject is of great importance to us as doctors, but it is of greater importance to the women of our country. The care of women during childbirth is a measure of the degree of civilization of a community. A baby saved at birth has a chance of living 60 years but, with its loss, that is the time society is denied a potential citizen.

Maternal and infant mortality is the index of a nation's status in the modern world. The first demand is to bring the mother safely through pregnancy labour and puerperium. The second is to secure the birth of a healthy infant with the best possible endowment of its tissues. The third is to leave the mother at the end of her lying-in period as well as she was when she became pregnant. The key or solution to these demands is a good maternity and infant health service.

THE PROBLEM

In South Africa with its progressive industrialization there has been an ever-increasing urbanization of the country population, particularly the Bantu population. Agriculture still remains a major industry. There will always be a large rural population in this country. In Europe 18-22% of the population need to be employed in agriculture in order to provide for its countries' requirements. In USA it is considered that 8½% is sufficient. In South Africa 47% of the population still live on farms.

Social welfare, housing, health and education, town planning, road services, and the building of new roads are our main problems. Health however, is our biggest problem. The social and health problem which history and geography have imposed on South Africa is the organization of a country where 2,907,000 Whites must live and work with 1,281,000 Coloured people and 9½ million Natives in a continent of 150 million Blacks.

We are particularly concerned tonight with the welfare of mother and child in the southern portion of this vast continent. Although there has been a steady fall in maternal and infantile mortality in the enlightened areas, the wastage of maternal and infant life is still far too high. The stillbirth and neonatal deaths remain almost stationary. Delee's famous quotation still holds today, that there is no form of preventative medicine that gives such glittering returns (in the saving of mother's and infants' lives, as an efficient maternal and infant service.

If the stillbirth rate of Great Britian could be reduced to that of Denmark there would be an annual saving of 6,000 lives. It would be of interest to know what the comparative and relative figures for South Africa would be. The saving of infant lives has a far greater economic and social influence than the reduction of deaths from, for instance, heart disease.

One of the major aims of State policy in South Africa should be to make it possible for every mother, irrespective of her social position, to have the best possible maternal service. There has been an increasing demand on the part of women to have their confinements in institutions. With economic insecurity go bad housing, overcrowding, squalor and ignorance. If *these* exist the technical side of maternal health services function with great difficulty, and with much less effect. One of the conclusions of the Royal College report on National maternal services is that good results depend primarily on the technical side. The rise of institutional midwifery has helped to raise general standards throughout the UK.

The integration of institutional, domiciliary, antenatal and consultant services has had a notable effect on maternal mortality in England. This was my personal experience during the time I was acting for Mr. Rufus Thomas as consultant to the county borough of Croydon. The low maternal infant death rates in countries like New Zealand and Sweden are not accidental gifts from heaven. They are acquired by the efforts of their own people.

UNITED STATES AND CANADA

In the USA all the states make special provisions for the health and related welfare of mothers and children. Many general health facilities and services vitally affect their well-being and actually furnish a framework for programmes organized specifically for these selected population-groups. Improved sanitation—particularly supervision of water and milk supplies—has done much to reduce infant mortality. Certain other services designed especially for mothers, mothers to be, infants and pre-school and school-age children have been initiated to supplement the more general health services. An outstanding function of State health programmes is the promotion of maternity and child health. However, special mention should be made of the fact that State efforts have been enlarged appreciably as a result of Federal financial aid. Health services for mothers, infants and pre-school children are provided in the main by the State government. State university hospitals, 24 of which are listed, afford primary health centres for both out-patient and in-patient maternity and pediatric care. Special provisions are made for women with complications developing during pregnancy, or for whom delivery problems are anticipated.

The important features include training of nurses and physicians in premature services; research into causes of pre-maturity and methods of improving care; establishment of strategically located premature centres equipped to give specialized care. Continued supervision of midwives, by State health-department personnel. takes the form of training and review through classes, and institutional and individual instruction. For the USA as a whole the maternal mortality in 1950 was 0·83 per 1,000. In the state of Minnesota the figures were 0·3 (1951). In Minnesota a vigorous approach has been made to the problem of antenatal care and the handling of complications and anticipated complications in pregnant women.

In *Canada* there is a Department of National Health Welfare. The Indian and Eskimo population also fall under the scheme. The field unit in the Indian health service is under the charge of graduate nurses who conduct prenatal and health-educational clinics. Some of the health centres have beds and sufficient auxil-

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liary staff to take care of maternity cases. The birth rates are high—between 25 and 50 per 1,000. The death rates are high, too, but the nett gain is a normal population-increase of about 1½% per year. In Canada, like any other country, the infant and maternity mortality rates are valuable indications of the status of maternal and child health. The maternal mortality figures for 1951 remain at the low level of 1·1 per 1,000 births.

SWEDEN

As regards northern Europe, special mention should be made of the 5 countries of Denmark, Finland, Iceland, Norway and Sweden. They form no political or economic union of any sort, but they are often looked upon as a collective entity. They are related to each other by firm bonds of geographical proximity and cultural ties. Out of these countries I particularly want to select and speak of Sweden. One of the most impressive aspects of its public-health service is its maternity service and its child welfare clinics. If South Africa should ever embark on a State maternity service the health service of Sweden should be seriously studied. It is surprising how much of their methods could be adopted with advantage to South Africa. I made a special study of the maternity services in Sweden, and I got some very valuable information from the book *Freedom and Welfare—Social Patterns in the Northern Countries of Europe*, edited by George Nelson, of Denmark.

Sweden is a large country by European standards. It is nearly twice the size of Great Britain. Five of its towns would be considered large by South African standards. More than half the population live in rural areas, including small towns and villages. It is a long narrow country measuring nearly 1,000 miles from north to south and transport problems are difficult. The winter climate is bitterly cold. There is much agricultural development, and timber is used extensively for building. The general standards of living are good, if not exceptionally high. There is apparently not much wealth, but there is little if any real poverty. Sweden has only become industrialized during the last half century, and as a result Sweden has benefited by the experience of all the countries. The government has for many years interested itself in the housing problem of the new townships.

For administrative purposes Sweden is divided into 24 provinces each with its own Provincial Council. The Royal Medical Board is responsible for the health services. There are about 600 Provincial doctors who deal with all matters of medical care outside the institutions, including maternal and child welfare and preventive health services. These doctors do their work outside the large towns. The administrative medical officers in the employ of the Swedish Government are allowed to carry on private work. In the remote and sparsely populated districts a system or network of cottage hospitals has been established. The system of district nursing is an essential and very valuable feature of the Medical Service. The nurses organize and attend maternal and child welfare clinics. Formerly a large number of district midwives were employed but, with the modern tendency for practically all deliveries to take place in hospitals, the numbers have been reduced. Sweden is noted for its hospitals. Professor J. T. Louw and I took the opportunity of seeing the two famous hospitals in Stockholm. The very fine Karolinska and the even better and more modern Southern Hospital erected during and since the last war. One of the most impressive aspects of public-health services in Sweden is their child welfare work. The public-health work is educational in character. Sweden has had a system of state-aided care through so-called Provincial doctors since 1688 (over 200 years). The Provincial doctor deals with matters of preventive medicine and maternity services.

A SCHEME FOR SOUTH AFRICA

The expectant-mother population of the larger towns and cities of South Africa have been taught to become hospital minded. The demand by the mothers themselves for institutional confinement is increasing for a variety of reasons. This demand should be encouraged. Delivery in a hospital unit, or in a maternity home, staffed by general practitioners in the country and outlying districts, offers greater safety to mother and child than delivery in a patient's home. Modern institutional midwifery can be made remarkably safe. General practitioners will take advantage of hospital facilities more than before, and will attend more maternity cases.

I feel that my talk this evening would not be complete without a brief outline of maternity services in South Africa. Primarily the facts to be considered in such a scheme are the geography of the country, the large sparsely populated areas, the density of the population in the city and in the industrial areas, the size of the towns and, of course, transport.

The country should be divided into large health regions, each based on a maternity centre, and there should be 3 grades of maternity centres—the key or *Primary* centre, the *Divisional* centre and the *Peripheral* centre.

The *Primary centre* would be the chief consultative centre in the region. Such a centre would consist of a maternity unit, and there would be an associated gynaecological unit. The centre should, wherever possible, be associated with a university and attached to a medical school. The maternity unit would consist of lying-in beds and an appropriate number of antenatal beds with a department for infants, an ambulance and emergency service complete with flying squads and antenatal and postnatal clinics.

The *Divisional centres* would be in the larger towns. These centres should be just as well equipped as the Primary centres. Specialist staff should be provided, both obstetric and paediatric. The beds in the hospital would provide accommodation for their own booked cases as well as emergency cases sent from outside.

Peripheral centres would be small units in the smaller platteland towns and villages, in charge of selected general practitioners. These centres should also be provided with antenatal and postnatal clinics. Beds should be available for local women who wish to have institutional confinement, and also for emergency cases. These centres should be in touch with the nearest Divisional centre, from which the specialist staff could come for consultations or operations.

General practitioners should take an important share in maternity services—primarily those with special experience. There are those who for years have been specially interested in obstetrics in their practices and have become skilful and experienced in that way. There are those who after qualification have held resident obstetric appointments in approved hospitals, and those who have fitted themselves by a course of postgraduate study and have obtained special qualifications to become general practitioner-obstetricians in a sense originally intended by the National Health Service Act of England. General practitioner-obstetricians should be given every facility to see in the clinics and wards those patients whom they have referred for special treatment. The smooth working of maternity services in the best interest of expectant mothers depends on cooperation and goodwill between all those who are working in the field. I am convinced that the College of Physicians and Surgeons of South Africa will soon after inauguration willingly provide for a diploma in obstetrics to general practitioners.

The aim should be to restrict domiciliary midwifery to those practitioners who have themselves become general practitioner-obstetricians. The training of midwives has been progressively improved in South Africa. They aim at natural labour and their results are excellent. Midwives should not be regarded as competent to undertake unaided the antenatal care of the expectant mother, but should always work in collaboration with a general practitioner or the obstetrician of the clinic.

In summing up I wish to state that those of us who have devoted our lives to obstetrics, and have known the conditions of practice in South Africa, realize that good results are dependent on the following essentials:

1. Efficacious antenatal and intranatal care for every pregnant mother.

2. Adequate accommodation in well-organized institutions for all patients requiring institutional treatment.

3. A body of midwives well trained to do their routine domiciliary obstetric practice.

4. A body of doctors with adequate experience and interest in obstetrics, who appreciate the limitations of operative obstetrics performed at home.

5. A body of specialists who have received a very complete and thorough training as assistants, and have not simply picked up experience by their own mistakes.

In conclusion I want to express my gratitude to Dr. B. Maule Clark, Deputy Chief Health Officer of the Union, who, through the Government Medical Library, sent me some very valuable

literature on health services in many countries of the world. I want to thank him specially for including in this collection a copy of his own work *Impressions of some Health Services in Europe and America*.

The briefly outlined proposed maternity services are largely based on the 1944 and 1955 reports drawn up by the Council of the Royal College of Obstetricians and Gynaecologists by request of the National Health Services in Britain.