MIDWIFERY IN MANY LANDS

BY

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An attempt is made below to draw a brief comparison between the practice of midwifery in nine different countries of which the author has, during the past thirty odd years, had personal experience. The problem is approached more from the sociological than from any other aspect.

South Africa

Thirty years ago the maternal mortality rate among Europeans in South Africa was very high—7 per 1,000—but the significance of this fact was not realized by the majority, and was entirely ignored by those—unluckily a large number—who considered death in childbirth an act of God. At this time one heard extraordinary tales of midwives and their doings. In the Eastern Transvaal for several years the common hangman varied his death-dealing duties with an extensive midwifery practice, while a certain mentally deficient midwife was also much in vogue. "How else could the poor woman earn her living?" was the argument advanced by her supporters. In South Africa the long distances between farms and towns necessitate the arrival of the midwife before the onset of labour, and some of the methods of hastening the baby's arrival are extraordinary. In one instance a primipara was made to squat down and then leap about like a frog. As this did not produce the desired result the midwife put the woman on the floor with her legs at right angles against the wall. She then seized the ankles and worked the legs alternately backwards and forwards till labour started. This patient died two days later. Another midwife decided on Caesarean section: the family carving knife was too blunt, so she smashed the neck off a bottle and used that. Mother and child died of haemorrhage.

Puerperal sepsis accounts for more than half the maternal deaths. Possibly the custom in many rural districts of having the labour on a mat—for preference an old goatskin—may have something to do with it. It is also considered dangerous to wash the patient at all, or to comb her hair for ten days, and the umbilical cord is not cut lest it should be drawn back into the uterus. The remedies for puerperal septicaemia are primitive in the extreme. For example, a hot drink is made from an extract of goat's dung and given to the patient, while to alleviate the pain a plaster is made from the fat of a sheep's kidney with grease and pepper, or from an egg mixed with fat and paraffin.

Most of the big South African towns have large well-equipped maternity hospitals as training centres, and Die Moeder's Bond at Pretoria gives free training to country girls on condition that they work for two years in their own districts. For twenty-five years various women's societies had been making representations to the Government without marked success until the advent of Lady Clarendon, wife of the Governor-General, who, with her wonderful energy and ability, took the matter up, and was instrumental in the formation, in 1933, of a section in the Union Health Department for maternal and infant welfare. There are no actual statistics of births and deaths among the natives, though there appear to be a large number of stillbirths among the primiparae. When labour is prolonged, strips of reimpje (raw ox-hide) are bound round the mother from the ribs downwards, and drawn as tightly as possible, or a plank is put across the abdomen and pressed down hard. One interesting custom is that at the age of puberty girls go into retirement for ten days to be instructed on maternal duties by an older woman.

Among the coloured (half-caste) the only records—those for the Capetown area—show a mortality about four times as great as that of Europeans; tuberculosis and overcrowding in slum areas probably contribute largely to this.

Australia

The Bush nurses of Victoria (seventy branches) and New South Wales are doing a great deal towards lessening maternal mortality in the back-blocks of this continent. In far-away places tiny hospitals of two or more beds are established with a three-room cottage for the nurse-midwife. A subscription of £1 10s. a year gives the right to free attendance for minor ailments, and half fees are charged for operations or confinements. Aeroplanes transport doctors and nurses in cases of emergency; 3,000 cases have been attended with only two deaths. The absence of domestic help is considered responsible for a large number of deaths, especially after the fourth child. In Sydney 37 per cent. of the deaths from septicaemia are said to be the result of illegal abortion.

Canada and the U.S.A.

A few years ago a questionnaire was sent to every Canadian doctor to obtain information on maternal mortality from the social as well as from the medical aspect. The conclusion drawn from the detailed replies was that absence of medical or skilled help at labour, want of means and proper food, and absence of domestic help, were the determining factors, especially in multiparae.

The death rate in the U.S.A.—6.4 per 1,000—includes negroes and coloured people as well as whites. Strenuous efforts are being made to lessen it. In Tioga County, New York State, a committee was formed, every house was visited, and inquiries made as to whether there was a prospective mother. If there was, leaflets were left, an invitation was given to attend a clinic, and home helps were offered so that the mother could stay in bed at home or in the hospital as long as requisite.

Other Countries

In Japan the death rate is 3 per 1,000. Midwifery is on a par with medicine and surgery, and no one is allowed to practise midwifery with less than three years' training and a certificate of competence.

In Norway the rate is 2 per 1,000. The midwifery training period is a minimum of two years. The country is divided up into squares, with an adequate provision of doctors, midwives, and nurses for the population. Attendance is given free to necessitous cases.

In Holland the figure is 2.29 per 1,000. Three years' training is required. The midwife attends at labour, but the subsequent nursing is done by an assistant. There is at least one midwife to each commune. In Denmark the mortality rate is 2.74 per 1,000. The midwife must have had two years' training.

In Germany, with a death rate of 3.48 per 1,000, two years' training is required; the first month the midwifery student only sees the actual birth—usually about a hundred cases. No practising midwife is allowed to dig her own garden for fear of germs from the earth.

Conclusion

From many years of observation in different parts of the world, one conclusion seems definite, that the largest factor in maternal mortality is ignorance—ignorance on the part of the mother and her relations, who do not realize the significance of symptoms and the necessity of skilled advice all through pregnancy. In South Africa the doctors are trying to obviate this by charging one fee from the time of first seeing the patient as early as possible in pregnancy till complete recovery after confinement. There is also ignorance due to want of adequate training on the part of the midwife. There seems to be a definite correlation between a longer training and a lower death rate, and there is a great deal to be said for the insistence on training in medical and surgical nursing as well as in midwifery. Too frequent and too many pregnancies play a large part, most especially in countries where homes are so isolated that the woman can get no help in her daily work. Want of proper food—and in this I include "slimming"—allows no reserve of strength to draw upon. Finally, in dealing with maternal mortality as in many other things, "Knowledge is Power."