

OBSERVATIONS ON MATERNITY CARE OVERSEAS

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IN THE SUMMER of 1956 I had the privilege of visiting Britain and the Scandinavian countries to learn something of maternal and child health services in England, Scotland, Denmark, Norway, Sweden, Finland and the Netherlands. The principal focus was on the observation of public health or preventive services. These countries were selected because their favourable maternal and infant mortality rates indicated that they enjoyed a high level of maternal and child care. The trip was very interesting because of the contrasts in point of view and in the provision of care, and reassuring because of the similarities.

In general there were more striking differences in the provision of maternity care than in child care. There were at least two obvious reasons for this. The first major difference was the presence of trained midwives or nurse-midwives in the field of maternity care. The second contrast was the wide acceptance of prenatal health supervision as a responsibility of public health services. This was manifested by the fact that in most countries prenatal care was readily available in every community, often in clinics organized by the local health department.

It would be difficult to indicate in a few words the key role which the trained midwife played in all phases of maternity care. With her excellent training in all phases of the normal maternity cycle and her responsibility to observe and refer to the physician all deviations from the normal, she was in a position to make a unique contribution to the health supervision, health education, support, and encouragement which are the main health needs of the majority of expectant mothers. One had the feeling that the very presence of the trained midwife in the community helped to remove maternity care somewhat from the field of therapeutic medicine, though never so far that all the resources of therapeutic medicine were not available for the management of complications. There seemed to be more emphasis on the normality of pregnancy which, though it is a period of physiological stress, should not be considered one of abnormality.

The duration of midwifery training varies from country to country, from 18 to 36 months. There seemed to be a tendency to co-ordinate the training of nurses and midwives to produce nurse-midwives. I was reminded more than once

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that midwifery training antedated nursing training by many years and that the midwife was sometimes understood and accepted in the community more readily than her more recent colleague, the public health nurse.

The pattern of the provision of prenatal care was in contrast to the pattern on this continent. In a number of countries visited a high proportion of women received prenatal health supervision at maternal and child health centres which were a part of the local public health service. The proportion of women receiving prenatal supervision under these auspices ranged from 50% to 70%. Prenatal clinics would be attended by physicians, midwives and sometimes public health nurses. In addition prenatal care could be obtained in prenatal clinics in hospitals with large obstetric services and from private physicians. Arrangements varied for the provision of specialist consultation at prenatal clinics. In Britain obstetrical consultants from local hospitals were made available to local public health clinics. In Norway it was emphasized that community clinics were for normal expectant mothers. Those with complications were referred to specialists or to hospital clinics. As in Canada, the availability of obstetrical specialists for consultation was limited in rural areas.

In Britain it was stated that since the inauguration of the national health service there had been some decline in attendance at public health prenatal clinics and more use of the family physician to provide maternity care. In one city visited close working relationships had been worked out between the local health department and the general practitioner obstetricians to enable the mothers to continue to receive the additional supervision of midwives and benefits of group education. One-third of these practitioners saw their own prenatal patients in local authority clinics with midwives and other staff in attendance. In another city an arrangement had been made with a group of five practitioners whereby they would see their prenatal patients on a particular afternoon, with the local health department midwife in attendance. Such programs seemed to hold real promise for the improvement of the total care of mothers and the furthering of the mutual understanding of health workers and private physicians regarding their complementary roles in this field of health care. In Denmark the program for health care of pregnant women differed. By the Pregnancy Act of 1945 mothers were entitled to three visits to a physician and seven to a midwife, the cost of which was borne by the state. About 75% of women availed themselves of these services. The Netherlands had fewer organized services for prenatal care. The usual pattern was for mothers to obtain their care directly from midwives and private physicians.

These prenatal services were extended into the home, through the home visiting program of the midwives. Home visits might be made if the mother failed to keep her appointment, to follow up a minor abnormality which had been noted at the clinic, or for health supervision and instruction.

In most countries there was considerable interest in prenatal education and preparation for labour, though the programs were of fairly recent development. This teaching was done in maternal and child health centres or prenatal clinics of hospitals by midwives, physiotherapists, and sometimes public health nurses. In Britain the exercise and relaxation phases of the program were often taught by physiotherapists and it was considered important that midwives receive their instruction in exercises and relaxation from physiotherapists. It seemed somewhat of a contradiction to encounter as much enthusiasm and interest in preparation for labour in countries where labour had always been reputed to be much more natural, less "interfered with", than on this continent.

Care at confinement was also shared by midwives and physicians, whether confinement took place at home or in hospital. The proportion of home confinements varied but, except in Sweden, where 97% of women were confined in hospital, the proportion of women confined at home was higher than in Canada. Our rate of 14% home confinements is influenced mainly by home deliveries in three provinces, Quebec, New Brunswick and Newfoundland. Only in the Netherlands, where 78% of confinements occurred at home, was the ratio reversed. In most other countries the trend towards hospital confinement seemed to have the support of obstetrical authorities though it was influenced by other factors, such as the availability of maternity beds and a long tradition of home confinement. In areas of bed shortage, primiparæ, women with previous difficulties and grand multiparæ were given priority. There always appeared to be beds for the admission of complications and I was impressed in Britain particularly with the high proportion of maternity beds set aside for the admission of prenatal complications, notably toxæmia.

The traditional role of the midwife has been the provision of intrapartum and postpartum care at normal home confinements and she still fulfilled this important function in a high proportion of home confinements. It was emphasized repeatedly that the midwife always worked under the supervision of a physician and was obliged to call him if any abnormality was noted. Also, if the physician had indicated his wish to attend the confinement himself, the midwife notified him and remained to assist. Even in hospital maternity services midwives attended normal confinements, though in that setting under more direct supervision of physicians. Nowhere did I encounter any serious dissatis-

faction on the part of physicians with this shared responsibility for maternity care. The view was expressed in Britain that the trend towards hospital confinement, in narrowing the midwife's traditional field of home confinement, would probably result in a somewhat different working relationship between the two professions.

The physical facilities of maternity hospitals were not unlike our own. One difference was that the labour and delivery room were often one and the same, the place where the spontaneous delivery took place. Special operating-delivery rooms were set up but used only for unusual complications, such as forceps application, episiotomies or Cæsarean sections.

What little I had heard of newborn hospital care overseas had led me to expect rooming-in or the care of mother and baby together to be the usual pattern. This did not prove to be so in the large maternity hospitals visited. However, in England several hospitals visited used this method and there was considerable interest in it. A memorandum from the Ministry of Health, December 1955, to all hospital authorities had drawn attention to the advantages of this method of care, and recommended its adoption in all maternity services. In Denmark babies were said to be kept with their mothers frequently and I was told that a study was being made in one hospital to enable the mothers to participate more in the babies' care. In Finland a new maternity hospital to be built for the national school of midwifery was expected to provide some rooming-in facilities. One physician on the Continent with whom this matter was discussed expressed the view that the universal acceptance and success of breast feeding went a long way towards developing and strengthening the mother-child relationship which rooming-in is designed to foster.

The incidence and success of breast feeding was a subject frequently discussed. In almost all countries visited there was some anxiety expressed regarding its decline. It was apparently a much more acute problem in Britain than in Scandinavian countries. In the latter, mothers apparently accept their responsibility to nurse their babies as a matter of course, and the establishment of breast feeding seemed to present no great problem. Difficulties arose most frequently when mothers returned to work outside the home. This was also a major factor in Britain but there also seemed to be a problem of maternal attitude there, such as is encountered here.

Postnatal medical care was available under much the same auspices as prenatal care. The impression was gained that overseas mothers, like our own, did not always appreciate the importance of postpartum examination and seek it.

In some countries family planning advice was available at postnatal clinics or through special

clinics of the local health authority. In the Scandinavian countries legislation existed to provide for the termination of pregnancy in the presence of certain precisely defined medical or sociological conditions.

It was interesting to find considerable direct assistance provided for expectant mothers in addition to medical care. This consisted of financial grants in Sweden and the Netherlands, nutrition supplements in Britain and Denmark, and a gift of clothing or equivalent funds in Finland. These were in addition to grants or insurance payments to working mothers. The tangible benefits of these subsidies were not easy to assess. However, such forms of assistance like the provision of medical care all served to draw attention to the needs of expectant mothers and helped to maintain the status of maternity in the community—a status that is perhaps higher than it is here.

CONCLUSIONS

Regardless of one's attitude towards the provision of prenatal medical care by public health authorities there seemed little doubt that in the countries visited this participation had resulted in a better distribution of maternity care outside of cities and made it more accessible by removing the financial barriers.

There are indications in some parts of our country, in terms of excessive maternal, neonatal and stillbirth rates, that all women are not receiving adequate care. An objective study of maternity care in some of these areas would be very interesting in evaluating the relative importance of economic factors, the availability of services and the mother's own attitude towards her need for medical and nursing care during pregnancy.

Though it is difficult to present tangible evidence to support the idea, a comparison of maternity services overseas with our own suggests that there may be room for some re-orientation of the attitude of everyone in contact with the expectant mother towards the normality of the event in most instances. Along with this there should perhaps be a wider appreciation of the mother's need for information about herself and the care of her baby so that she can better understand the reasons for some modifications to her routine of living and be prepared for the responsibilities of parenthood. Delivery in hospital, an institution geared to do something quickly and efficiently for the sick person, has probably contributed to an attitude of wanting to do something quickly and efficiently for this other member of the community who is not sick, but in normal labour. She has usually not come to the hospital to be treated, but because it is the safest environment for her to carry out her task of delivery with the encouragement and careful supervision of nurses and doctors.

It seems that the total health care of expectant mothers could be strengthened by better understanding and fuller co-operation between physicians and public health workers of both official and voluntary agencies. This could begin with stronger physician's support for the organized programs of prenatal teaching which have developed in many parts of Canada in recent years. The kind of support most readily understood and appreciated is, of course, referral of patients. These prenatal classes have been received with enthusiasm by parents and physicians in many communities. All the evidence indicates that they make a real contribution to the establishment of this concept of normality and alleviate many fears and anxieties of both mothers and fathers regarding pregnancy and the care of babies.

In many instances there is need for individual nursing supervision and teaching which can be carried into the home. A home visit by a public health nurse to a poor attender, or a mother too anxious at her first office visit to really listen to the doctor's advice, has been shown to be a very useful means of introducing sound advice into the home. Too, a visit to a toxic mother between office visits can give the doctor valuable information about her home problems and her understanding of his instruction to rest, restrict her diet, and so forth.

To remove any suggestion that lack of understanding is all on the part of physicians, it should be added that public health agencies have not always been as aware of the total health needs of expectant mothers, or visualized their educational and supportive role in the provision of maternity care.

Regardless of the past, there is much evidence of the growing interest of all health agencies in prenatal teaching and nursing supervision. There are, no doubt, a number of factors contributing to this change in attitude. One is the fact that a real effort is being made to prepare both public health and hospital nurses for this developing field of health education through special courses and institutes. The enthusiasm with which this preparation is being received suggests that nursing training for maternity care may not be adequate to prepare nurses for the broader supportive and educational role which they are being called upon to play in this field. And finally, I feel it would be unfair not to suggest as well that the thinking of practising physicians and the obstetric teaching of physicians at various stages of their development might be further orientated towards the normality of pregnancy and the needs of the mother for information and support, in addition to expert medical supervision and management of complications.

SUMMARY

Observations of maternity care overseas have been recorded and similarities and contrasts be-

tween their services and our own have been described. Two essential differences were noted. One difference was the participation of public health authorities in the provision of prenatal and postnatal care, thereby emphasizing the normality of pregnancy and its preventive medical aspects. The second difference was the prominent role played in prenatal, intranatal and postnatal care by the trained midwife, and her particular contribution in fulfilling the supportive, health supervisory and educational needs of expectant mothers. Similarities in the provision of care at confinement were noted, particularly the trend in most countries towards hospital delivery. The provision of assistance to mothers other than medical care such as grants, nutrition supplements or employment leave has been described. The implications of these differences and similarities for maternity care in Canada have been suggested.

SHORT COMMUNICATIONS

AN OUTBREAK OF ASIAN INFLUENZA IN A GIRLS' CAMP*

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THE CENTENARY WORLD GUIDE CAMP was held from August 8 to 19, 1957, at Doe Lake, 20 miles northwest of Huntsville, Ontario. Forty-six countries had sent their representatives, bringing 1496 guides and guiders to Ontario. A group of 30 rover scouts was stationed in a camp close by to help with the heavy work, and a group of about 70 people consisting of telephone operators, press and movie people, bankers and policemen brought the total camp population up to 1600. For administrative purposes the camp was divided into four subcamps—Mic-Mac, Iroquois, Cree and Bella Coola. The headquarters building and the infirmary were in the centre, and west of these was a log cabin, called Sunset, housing all the people responsible for the waterfront. The rover scout camp was approximately a mile west of Sunset. The youngest guide was 15, the oldest guider 71. Only about 8% of the camp population slept in houses, the rest being in tents. During the daytime the weather was fine but at night it was cold, the temperature often falling to freezing point; on many mornings fog was very heavy.

In this very isolated community an illness broke out; it was called at the time "the flu" and necessitated hospitalization of 11.5% of the camp population in a few days. Only 15 of these patients had a nasopharyngeal irrigation done,

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