Maternity And Child Welfare–Need For a Forward Policy

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IT is a good sign that problems of rural health are increasingly attracting the attention of the authorities in India. At the recent Public Health Conference held in New Delhi, both the Health Minister and the Prime Minister of India emphasised the need and importance of measures directed to improving the health of the population in any plan for the future development of the country. Good health does not merely mean the absence of sickness or disease in the community. It is a positive state of well-being in which mind and body are able to function to their best capacity. " Good health," it has been rightly said " is the pre-requisite of well-being and ability to work, the safeguard of intellectual and moral balance, and the most valuable asset of the individual, the family and the community."

Health depends on various factors. In discussing the principles of a health policy, the British Medical Association emphasised that " the health of the people depends primarily upon the social and environmental conditions under which they live and work, upon security against fear and want, upon nutritional standards, upon educational facilities, and upon the facilities for exercise and leisure." *(British Medical Journal*—7th Aug., 1943).

Plans may be made for the agricultural and industrial development of the country for raising the standard of living of the masses, but measures to improve the health of the people,—for raising the standard of personal and environmental hygiene under which they live and work at present must be given first priority in any scheme of national uplift. There can be no question that the standards of health in the different States in India are extremely low. The rates of infantile and maternal mortality compare Very unfavourably with certain other countries. The survey conducted by the Health Survey and Development Committer appointed by the Government of India in October, 1943 Invented an apalling state of things. Epidemic diseases like Malaria, Cholera, Small-pox, Dysentery and other fevers and respiratory diseases take a heavy toll: endemic diseases such as Leprosy, Filariasis, Hookworm, etc., are responsible for a considerable amount of morbidity although their contribution towards mortality is relatively small.

This is how the Committee sums up the position: " The present low state of the public health in India is reflected in the wide prevalence of disease and the consequent high rates of mortality in the community as a whole and, in particular, among such vulnerable groups as children and women in the reproductive age period. It is considered that at least 50 per cent, of the existing mortality in the country is prcventible and should therefore be prevented."

" The maintenance of the public health requires the fulfilment of certain fundamental conditions which include the provision of an environment conducive to healthful living, adequate nutrition, the availability of health protection,—preventive and curative,—to all members of the community, irrespective of their ability to pay for it, and the active co-operation of the people in the maintenance of their own health. The large amount of preventible suffering and mortality is mainly the result of an inadequacy of provision in respect of these fundamental factor?. Environmental sanitation is at a low level in most parts of the country, mal-nutrition and undernutrition reduce the vitality and power of resistance of an appreciable section of the population, and the existing health services are altogether inadequate to meet the needa of the people; while lack of general education and health education adds materially to the difficulty of overcoming the indifference with which the people tolerate the insanitary conditions around them and the large amount of sickness that prevails."

It may be noted that there has been some reduction in the mortality rates in India during the period 1938-46 as the following figures taken from the Annual Report of the Public Health Commission of the Government of India for the year 1946 will show:

	Death-rate per mile				Infantile mortality per 1000 births			
	1946	1945	Avge. for 1941-45	Avge. for 1938-41	1946	1945	Avge. for 1941-45	Avge. for 1938-41
British India	18.4*	21.5	22.5	22.0	136.4	150.9	161.7	160.1

* excluding Bengal.

Although there has been some improvement in the general death rate and an appreciable reduction in the rate of infant mortality, the figures still bear no relation to the corresponding figures of, say, Australia, U.S.A., England and Wales, Canada or Germany. A considerable leeway must still be made up.

The infant mortality rates for different states in India vary const derably; the rates for rural and urban areas also show striking differences according to the varying degrees of attention given to mothers and children in the different areas on this important subject of health protection. Table II compiled from the Statistical appendices to the Annual Report of Public Health Commissioner for India for 1946 will illustrate these remarks.

There is a general downward tendency which probably reflects the increasing care taken in certain parts of the country in maternity and child welfare, and the figures for 1946 show a further decrease in almost all the States. Except in certain States where possibly the recording is imperfect the mortality figures in urban areas are generally higher than in the rural areas. The table below shows high infant mortality figures in certain towns in 1946:

Delhi City	...	...	146.5
Hardwar	...	...	287.5
Khurja	...	...	261.5
Etawah	...	...	289.2
Cawnpore	...	...	248.5
Benares	...	...	238.9
Arrah	...	...	280.0
Puri	...	...	239.2
Howrah	...	...	264.5

TABLE I

A Comparison of Indian Mortality Ratal A Expectations of Life With Those of Certain Other Countries.

Country	Death rate 1937	Inf. mortality rate 1937	Expectations of life at births	
			Male	Female
New Zealand ...	9.1	31	65.04	67.88 (1931)
Australia	9.4	38	63.48	67..4 (1932-34)
Canada	10.2	76	59.32	61.59 (1929-31)
U.S.A.	11.2	54	59.12	62.37 (White population
U.S.A.	—	—	47.55	49.51 (Negro population
Germany	11.7	64	59.86	62.75 (1932-34)
England & Wales ...	12.4	58	58.74	62.88 (1930-32)
Italy	14.2	109	53.76	56.0 (1930-32)
France	15.0	65	54.30	59.02 (1928-33)
Japan	17.0	106	44.82	46.54 (1926-30)
Ceylon	21.7	158		
British India ...	22.4	162	26.91	26.56 (1921-30)
Egypt	27.2	165	—	—

(Source: *Report of Health Survey and Development Committee.*)

TABLE II

Infantile Mortality in India

per '000 of live births.

Provinces		1941	1944	1946
N.W.F.	Rural	172.0	132.9	...
	Urban	133.3	108.7	...
Delhi	Rural	159.8	168.0	123.2
	Urban	166.0	162.9	129.2
Bombay	Rural	149.8	157.2	155.8
	Urban	192.2	192.5	182.2
Punjab	Rural	186.1	173.4	...
	Urban	178.6	171.6	...
Central Provinces	Rural	216.2	224.0	206.6
	Urban	208.3	203.0	176.0
Assam	Rural	137.0	163.4	114.9
	Urban	99.0	116.5	65.3*
Bihar	Rural	108.9	111.2	89.4
	Urban	114.2	116.0	115.0
Bengal	Rural	155.2	201.9†	135.6††
	Urban	163.7	291.9†	191.5††
United Provinces	Rural	119.8	111.8	83.4
	Urban	199.3	192.6	169.6
Orissa	Rural	226.1	209.4	172.2
	Urban	199.7	172.6	144.9
Madras	Rural	159.7	191.8	147.5
	Urban	273.7	195.6	144.5
All-India (Provinces)	Rural	152.9	165.5	133.2
	Urban	200.2	193.6	163.0

* Obviously unreliable figures.
† Due to the Famine in 1943.
†† West Bengal.

Bhatpara	220.5
Calcutta	243.4
Nagpur	194.0
Bombay	195.2
Surat	267.3
Poona	332.1
Madras	183.0
Tuticorin	187.2
Tinnevelly	215.5

As regards maternal mortality, a special Committee appointed by the Central Advisory Board of Health reported in 1938 that the rate for the country as a whole was "probably somewhere wear 20 per 1,000 live births". We are told that in British India maternal deaths total annually about 200,000; the number of women suffering from various degrees of disablities and sickness as a result of child-bearing must be very large; a probable estimate based on the ratio of maternal morbidity to mortality accepted as reasonable elsewhere, gives the number as about four millions.

There is no question that the wastage from maternal and infantile deaths, which is largely preventible, is still very considerable. As a matter of fact, it has been estimated that nearly one-half (48.4 per cent.) of the total deaths at all ages in British India takes place among children under 10 years: and, of these, nearly a half (24.3 per cent.) is among infants under one year. Against our maternal mortality rate of about 20 per 1,000 live births other countries have brought it down to about 3 to 4. Then, again, " for every woman who dies as a result of pregnancy or child-birth, 20 suffer from impaired health and lowered efficiency ". (Report on National Maternity Service, May, 1944, issued by a Committee appointed by the Royal College of Obstetricians and Gynaccologists in England). On this basis as we have already pointed out, no less than four million of our women suffer from the ill effects of child-bearing. These figures show conclusively how important it is to pay special attention to measures for protecting the health of mothers and children in any plan for the improvement of the health of the community.

There are other considerations also which make it imperative that a country-wide attempt should be made to save the children from death and disease. The children of the country constitute a national asset, and the nation cannot allow such a huge wastage of human material at the source. Maternity and child welfare service has been appropriately described as a ladder to a healthier and happier nation. Undertaken on an adequate and comprehensive scale, it has demonstrated its value in other countries. It is only necessary to inaugurate a special health service for mothers and children on a comprehensive scale in the different States in India for which the State should take the entire financial responsibility. Some haphazard work has already been done by non-official agencies—mainly through voluntary effort,—under the direction of the Maternity and Child Welfare Bureau of the Indian Red Cross Society. But this has only touched the fringe of the problem. The Health Survey and

Development Committee, stressed the urgent need for providing adequate measures to protect the health of toothers and children and rightly included in its long and short term programmes, the development of special health services for women and children. These services include "domiciliary and institutional services and hospitalisation of cases requiring institutional treatment, supervision of the health of mothers and children, and health education for mothers and families." It is of the utmost importance that the Union Government should advise all States to implement these recommendations of the Committee in this sphere as quickly as possible. The number of trained " Dais ", Midwives, Health visitors and wemen doctors trained in maternity and child-welfare, available in the country, is far too inadequate for starting such services on a comprehensive scale. Facilities for training the required personnel must be urgently provided by the State and Union Governments so that the main difficulty in implementing the Committee's recommendations may be removed within a reasonably short period. The matter is of such importance that lack of funds should be no excuse for delay. The Union Government must find the funds for this national purpose if the States are unable to finance these schemes unaided.

The following extract from the Chapter on " Maternity and Child Welfare " in the Annual Report of the Public Health Commissioner for India for 1946 (Sec. IV) gives an idea of the difficulties and the steps proposed to overcome them.

> " The lack of trained staff without which such centres cannot function efficiently continue to hamper their progress. Efforts to remedy this shortcoming of lack of trained personnel haw been initiated both by the Centre and by the Provinces, by expanding training facilities, encouraging candidates by offering them stipends and scholarships and deputing suitable women candidates overseas for training, but the pace of progress is slow. Scales of remuneration offered are relatively poor, and need considerable improvement to attract women doctors and health workers,"

No time should be lost in making a determined effort to overcome these difficulties.

India and Ceylon stand to benefit from the forthcoming Japanese trade agreement under which Japan will import £29,617,000 *worth of textile goods from the sterling bloc nations, according to The* New York Journal of Commerce.

Under this agreement, Irdia would supply £2,600,000 *wort of. raw cotton as well as about* £142,000 *worth of carpet, wool Ceylon and India -will supply about* £42,000 *worth of coir fibre.*

The New Import Policy

THE import policy for the first half of this year announcca by the Government of India incorporates some of the more important recommendations of the Import Control Enquiry Committee, viz., continuity in policy, the continuation of Open General Licences for an indefinite period, the issue, of licenses to cover currency areas instead of specific countries and the centralisation of licensing work in one Ministry.

The need for a consistent and definite policy cannot be over-emphasised. The present policy does not aim at bringing about any changes in the pattern or structure of our trade, and is guided solely by the availability of foreign exchange resources and is aimed at establishing an equilibrium in our balance of payments. That the announcement does not. contain any major changes is perhaps just as well. Policies should not change every half year.

Open General Licenses arc to be continued indefinitely, with some more items brought under them. Capital goods essential for industrial and agricultural development and industrial raw materials continue to enjoy a high degree of priority. Essential consumer goods too are allowed to be imported. But it has been decided to ban the imports of cotton textiles for consumer use. except umbrella cloth and Italian's of satin weave, which are not produced in sufficient quantities in India.

Licences will cover currency areas, instead of specific countries. Exporting countries are broadly divided into two areas—the doila area and the soft currency area. The dollar area includes the US, Canada and most of the South American countries, and the soft currency area includes all the other countries except Japan, Pakistan and South Africa. Japan forms a separate area by itself. This innovation incorporated on the recommendation of the Import Control Enquiry Committee would make it easier for licensees to change over from one country to another without having to secure permission of the Government, which entails great delay and inconvenience.

Specific licenses, however, might be issued following a bilateral trade agreement between India and any other country for articles covered by such agreement; such licenses cannot be used for importing the same goods from other countries of the currency area in which the country in question lies.

On the recommendation of the Import Control Enquiry Committee, it has also been decided to centralise all licensing work in one ministry—-the Ministry of Commerce.