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SOCIAL CARE OF MOTHERHOOD

C.P.
1951

1936

Foreword by

Dame Louise McIlroy, D.Sc., M.D., F.C.O.G.

Prepared by: The Committee Against Malnutrition.

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SOCIAL CARE OF MOTHERHOOD

With a foreword by
Dame Louise McIlroy, D.Sc., M.D., F.C.O.G.

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NOTE

This pamphlet has been prepared by the medical and scientific workers associated with the Committee Against Malnutrition, 19c, Eagle Street, Holborn, London, W.C.1. While this Committee concerns itself mainly with the influence of adequate and proper nutrition upon health, it naturally includes within its surveys all the factors that may promote the well-being of the people, physically and spiritually. The Committee believes that the present pamphlet is a useful brief summary of the whole problem of Motherhood and Maternal Welfare, as it now confronts the public. Every effort has been made so to explain the facts, that they will be readily comprehended by the working-class woman.

F. Le Gros Clark.
Hon. Sec. Committee against Malnutrition.

August, 1936.

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C.P.
1951

FOREWORD

by

Dame Louise McIlroy, D.Sc., M.D., F.C.O.G.
Late Professor Obstetric and Gynæocological Unit, London School of Medicine for Women.

The authors of this pamphlet have concerned themselves with a very important factor in maternal welfare, namely the nutrition of the expectant mother and all that it involves. The subject has been treated in a most practical manner; the language is simple, and the opinions expressed bear the stamp of a thorough scientific knowledge of the most recent research upon nutrition and dietetics.

The results of Infant Welfare Clinics have shown us how success can be obtained by work on parallel lines with regard to antenatal clinics. It is not only the question of maternal mortality which is of such importance, but that of prevention of the ill-health and disablement which result from the ravages of pregnancy and childbirth. If this prevention can be achieved, as it undoubtedly can be, it would have far-reaching effects upon maternal and infant mortality.

Owing to the difficulty of estimating the amount of maternal disablement as compared with maternal mortality little attention was given to the question, and it is only of late years that the nutrition of the expectant mother has become a matter of serious consideration by Public Health Authorities. It is by our efforts to prevent complications such as toxæmia (which is mainly due to diet deficiencies or to faulty assimilation by the digestive organs) that the incidence and dangers of ante-partum hæmorrhage and eclampsia as well as many accidents of childbirth such as shock and post-partum hæmorrhage will be reduced.

The growth and nutrition of the unborn child depend upon the nutriment supplied by the mother. If this is deficient there is a consequent drain upon the maternal tissue reserves, a condition which leads to the onset of deficiency diseases. The solution of the problem of nutrition involves not only the provision of suitable food-stuffs, such as fresh dairy produce, but the transport, storage and methods of cooking of these. The questions of employment and financial means have also to be considered.

The nutrition of the expectant mother is of paramount importance and should be the concern of all who are interested in maternal welfare. No better presentation of the subject could be found than that given in this pamphlet.

A simple guide to the problems of maternal care, maternal mortality and ill-health, and the power possessed by the local authorities to improve the welfare of the Nation's mothers.

THE SOCIAL CARE OF MOTHERHOOD

In 1918 the Government passed an important Act, in order to promote the health of mothers and young children; it is called the Maternity and Child Welfare Act. Eighteen years have elapsed; but as yet we do not associate the term "welfare" with our efforts to safeguard the health of mothers, as we associate it with schemes to improve the health of young children. We often speak of "child welfare"; and it is a sad reflection on us that we are still concerned less with the health and happiness of mothers than with the numbers who die in childbirth. We have not approached the two problems in the same spirit.

We know, of course, that serious illnesses occur among young children; but we have confidently left the treatment of such cases to our doctors and hospitals and so far the results have been fairly encouraging. Beyond this, we have, by means of welfare clinics and the education of women in mothercraft, attempted to ensure that babies will, as far as possible, reach a normal development. There is still much to be done; but the national effort has not been without its reward.

With the problem of *maternal welfare*, however, we have been very far from successful. Until recently, few people have recognized how important is the influence of good feeding and good conditions of life upon the health of the mothers. On the other hand, much publicity has been given to all the

investigations into the deaths of women in childbirth. People have discussed who was to blame for these tragedies; was it the doctor or the midwife or the woman herself? Some doctors even regret this publicity, because they say that it tends to disquiet their patients, just when they require a calm and confident outlook in face of their coming ordeal. But we do not believe that it is either possible or wise to close public discussion on the problem. It is not possible, because the nation's conscience has been thoroughly aroused, especially when we are told that many of the deaths and much of the ill-health are avoidable. It is not wise, since an enlightened public is now interested in the maternity services and should be informed about the powers of the local authorities.

We will, however, agree that it would be better to speak less about maternal mortality and more about the care of motherhood. Certain problems, such as the training of doctors and midwives and the treatment of complications, we may with advantage leave to our medical and nursing authorities. Few of us are competent to discuss these technical subjects; and ill-informed criticism often does more harm than good. Our task is rather to decide what conditions make for normal and safe childbearing and what conditions are positively harmful—and to decide further what maternity services are likely to give women the greatest help. When that task has been performed, we shall be in a position to co-operate quietly and persistently in the effort to ensure that every woman who requires assistance is granted it by the community. For, if we can accomplish this, we shall have gone far on the way towards the prevention of ill-health and death among mothers.

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THE HEALTH OF THE MOTHER

Childbearing is a natural function. As with other functions of our bodies, however, this is strictly true only when our organs are normally developed and healthy. For example, digestion is a natural function; but it becomes very unnatural when there is an ulcer in the stomach. Now we know that a great deal can be done to help anyone who has an ulcer. We know, too, that in some circumstances the life of the patient depends on the skill of the surgeon, and the promptness with which the patient can be taken to hospital. But we also realize it would be much better if we understood enough about the conditions necessary for normal digestion to be able to prevent the ulcer developing. It is the same with childbearing. It is necessary to study the illnesses and complications which influence pregnancy and labour. It is necessary to organize the best possible maternity services, in order to make childbearing safe, even when it is not normal. But while doing this we must never forget that the *first essential for maternal safety is a well developed healthy woman to whom childbearing will be a natural normal process.*

Food. We need food to supply us with warmth and energy, and for the growth and repair of our bodies. All kinds of food provide warmth and energy to some extent, but only certain foods contain the substances necessary for growth and repair.

In pregnancy the mother has to provide for the growth of her baby over and above her own needs; so it is very important that she should have enough of the body-building foods. If she does not, then she or her baby, or both, will suffer in some degree. In early childhood also, there is a great demand for these foods, because growth is then taking place very quickly. We have still a great deal to find out about nutrition, but during the last few years scientific research has shown very

clearly some of the results of a diet which does not contain enough of the body-building foodstuffs. Let us here consider the building of bones, teeth and blood.

Bones and Teeth. Substances in the food called calcium and phosphates are necessary to build bones and teeth. We get them mainly from milk, cheese and green vegetables. Before they can be used properly by the body, however, a sufficient amount of one of the vitamins or protective food substances, called vitamin D, must be present also. Vitamin D is found in small quantities in eggs, milk, butter, and in fish oils such as cod liver oil. It is also made in our skins by the action of direct sunlight. The smoky air of towns reduces this latter supply very considerably. What happens if the supply of these foodstuffs is not sufficient?

(1) *In pregnancy* the baby's need may be met by taking calcium required for the repair of the mother's own bones and teeth. This explains why it is common for women to find their teeth beginning to decay in pregnancy. It is also probable that some of the cramps and nervous irritability of pregnancy are due to the same cause. Again, if the mother's milk has not enough calcium and vitamin D in it, the baby may develop rickets whilst being breast fed.

(2) *In a young child* shortage of these foodstuffs causes rickets. The teeth are late in appearing, badly formed and decay early. The child is weakly, and has less resistance to measles, whooping-cough, diarrhœa, bronchitis and other illnesses. The bones of the lower trunk are often affected and the child grows up with a condition (contracted pelvis), which is still the commonest cause of difficult labour in the women of this country.

Labour in a woman with a contracted pelvis is longer and more painful than usual, and calls for more strength and endurance from the mother. Even in slight cases the doctor needs great skill and judgment to decide what is the safest

treatment. Very often instruments have to be used, with the risk of infection and tearing of the parts, and sometimes the fatigue leads to serious bleeding. There is also a risk of injury to the child.

Blood. Anæmia follows serious bleeding from any cause, but anæmia can also occur if we do not eat enough of the foods containing iron and other blood-building materials—meat, eggs, fruit and vegetables. Milk, which is the baby's only food during the first few months, contains very little iron; but, if the mother has been properly fed, the baby lays up a store of iron in its liver before birth, sufficient to last it until it is able to have other foods. If the mother is herself anæmic, the baby cannot do this and becomes anæmic also.

Anæmic women have less resistance to septic infection than healthy women. They are more easily tired, and recover more slowly from the strain of childbirth. If rickets and anæmia are present together the harmful effect of each is increased; for an anæmic woman is less able than a healthy woman to stand the strain of a long and painful labour, and to escape the dangers arising when complicated treatment has to be undertaken.

These examples are enough to show the far-reaching influence of diet on maternal welfare. This influence was fully acknowledged by Sir George Newman, late Chief Medical Officer to the Ministry of Health. In his annual report, " The State of the Public Health" (1933), he wrote: "After all, sound nutrition in a pregnant woman is obviously the only way of sustaining her own health and strength, and that of her forthcoming child. She should become accustomed to a diet which includes ample milk (two pints a day), cheese, butter, eggs, fish, liver, fruit and fresh vegetables."

Home Conditions. Home conditions have an important influence on the health of all members of a family both directly, and also indirectly, through their effect on the health and

efficiency of the mother. It is wonderful how many women manage to create good homes under very difficult circumstances; but even the cleverest housewife cannot altogether overcome the handicaps of bad housing conditions and poverty.

Most authorities agree that a woman is well advised to have her baby at home, if her health is normal and if her home conditions are suitable, but that it is much safer for her to go into hospital, if she has any complication, or if her home conditions are unsatisfactory. We must realize, however, that maternity hospitals cannot completely overcome the harm caused by bad home conditions. It is not often possible for a mother to go into hospital during pregnancy, and after the confinement she is only kept there for twelve to fourteen days. Bad home conditions affect her well-being in many ways. For example, crowded and insufficiently aired rooms make sleep less refreshing. The absence of labour-saving devices means that household tasks have all to be performed in the most difficult and time-consuming manner. The lack of laid-on water involves much weary carrying of heavy pails, which is definitely harmful in pregnancy and after labour. Nor can we leave out of account the depression caused by the hopelessness of keeping an overcrowded and ill-repaired house clean and decent, however hard the housewife may work.

Then there is the question of domestic help. In the later months of even normal pregnancy it is difficult for a woman to do her ordinary household work. When certain complications are present, rest is essential if she is to come safely through her confinement. The working-class mother seldom has any domestic help before the birth of her child, even if she is ill. If she has to go into hospital, it is difficult for her to arrange for her house and family to be looked after while she is away. When she has her baby at home, it is rare to find that she has any domestic help for more than the first fortnight

afterwards. Thereafter, she has to manage her housework and attend to the new baby and any other children as best she can. This makes it impossible for her to follow the advice of doctor or midwife, that she should rest and take things easy until she is quite fit again.

Employment that entails heavy lifting is harmful in pregnancy; but, as Dame Janet Campbell has pointed out, most modern factory work is less likely to be harmful than domestic work such as washing, mangling, or the carrying of heavy pails; and a woman may actually be well advised to continue her employment, if this will enable her to pay for assistance with her heavier domestic duties. Unfortunately, the need for money tempts many women to try to carry on their own housework in addition to their outside employment; and this is obviously undesirable.

It is sometimes argued against this view of the importance of good nutrition and good living conditions on maternal welfare, that some hospitals and nursing associations, whose work lies mainly among women living in the poorest parts of our great towns, have shown maternal death rates which are much below the average for the Country. It is pointed out also, that maternal deaths occur among comfortably off women. We do not think these two facts disprove the truth of what we have written. There are many causes of maternal mortality. It seems likely that some causes operate more frequently among the poor, others among the well-to-do, and that these to some extent cancel each other out, and prevent the full effect of poor nutrition and unsatisfactory living conditions from being clearly seen. For example, trouble due to the unwise use of instruments, in order to shorten the time of labour, probably happens more frequently among women who are comfortably off; on the other hand, disaster, due to the lack of equipment for emergency treatment, occasionally occurs among the poor. There are, of course, social customs

and food habits among the rich as well as among the poor, which have a harmful influence on a woman's capacity for motherhood; but they are not the same in the two classes. When the cause of such habits is the lack of means to live differently, the responsibility lies with the community.

Then, again, several harmful factors may be present together in one case. For example, a woman who had rickets in early childhood may fail to go to an ante-natal clinic, and may be attended in her confinement by a midwife who waits too long before sending for medical help. If the results are calamitous, the blame may be laid on the midwife, or on the woman herself for not going to the ante-natal clinic, where she would have been examined by a doctor, and probably sent to hospital. But the *first cause* of the disaster in this case was rickets, which led to a difficult and abnormal confinement. Rickets, as we have seen, is due to a lack of certain foodstuffs in early childhood.

Further, it is not enough to consider whether nutrition and home conditions influence the *death-rate* among mothers. We must also take account of their effect on *maternal health.* Science has shown us how in the later months of pregnancy, certain changes take place in a woman's body, to prepare her for the strain of childbirth. Poorly nourished and overtired women are ill prepared for this strain. It is one of the pleasantest things in a doctor's experience, to see how happy and well a normal healthy woman may be, shortly after her baby is born. Even when labour has been difficult, it is astonishing how quickly the mother recovers, if she is well nourished and healthy. An anæmic and debilitated woman has not this power of recuperation. She must have prolonged post-natal care, if she is to regain complete health and strength. She needs generous nourishment, rest and freedom from anxiety, and, possibly, a change of air.

Women, who are comfortably off, get these things as a

matter of course. Most working-class mothers, however, must try to get about their home duties directly the midwife has ceased attendance (generally ten days after the birth of the child). The less fit a woman feels, the less fit is she to look after herself and her family. Too often she has neither time nor energy to seek advice about what she regards as unimportant complaints; and the chance to treat them, while they are still curable, is lost. Many women take it for granted that they will never feel quite so well again after they have borne children. It must be insisted that much of this ill-health would never develop, if all women were ensured the conditions necessary for full recovery after childbirth.

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MATERNITY SERVICES

By maternity services we mean all the ways of helping a woman through pregnancy, labour and the period afterwards, until she has fully recovered her health and strength. A high level of skill in our doctors, and midwives, and well-organized maternity hospitals are, of course, of prime importance. But we have tried to show in the first part of this pamphlet why we must also provide such services as home-helps and extra nourishment for all women who need them.

Every woman should come under the care of a doctor and midwife as soon as she knows she is going to have a child. Many of the complications of childbirth can be prevented by supervision during pregnancy; and others, which cannot be prevented, are rendered much less dangerous if their presence is recognized early, and appropriate treatment arranged. Ante-natal care should therefore afford women encouragement and confidence that they will come safely through labour. It is important that the doctor and midwife should take pains to help the patient to look at it in this light, and to dispel any fears she may have.

The midwife should examine the patient at intervals during pregnancy, and should report any sign that all is not well to the doctor. She should know the home circumstances of the patient, give general advice and encouragement about preparation for the confinement, and be able to help the doctor to decide if there is need for the provision of extra food, domestic help, etc. She should see that the instructions of hospital, clinic or private doctor are carried out before, during, and after the birth of the child. She should deliver the normal case, and give all necessary nursing attention to both mother and child for at least a fortnight afterwards.

The doctor, whether in private practice, or attached to a hospital or clinic, should work in close association with the

midwife. He also should examine the patient during pregnancy, and treat, or be able to arrange treatment for any condition affecting her general health—anæmia, decayed teeth, underfeeding, etc.—as well as for any complication of pregnancy. He should advise her whether in her case it is wise to have her baby at home, or whether it would be better for her to arrange to have it in hospital. He should attend when required during the confinement (if there is any complication, or to relieve pain). He should examine mother and baby afterwards, and treat, or arrange treatment for any condition that requires it, and should keep the mother under his care until she has returned to normal health and strength again.

He should be able to call in *consultant and specialist doctors* if they are needed at any time during pregnancy, labour, or after the birth of the child.

He should not undertake any complicated treatment in an unsuitable home if it can possibly be avoided, but should send or take the patient to a properly equipped hospital, where she can come under the direct care of a senior doctor with special experience.

Domestic help should be available during the last weeks before the birth of the child when required (for example, if the patient is ill, or has several young children), during the confinement, and for as long afterwards as may be necessary, according to the circumstances of each case.

Maternity hospitals and homes. There should be sufficient beds in these for all complicated cases, whether the complication occurs during pregnancy, labour, or after the birth of the child, and for any woman whose home is unsuitable for confinement. Patients with septic infection, who cannot safely be admitted to an ordinary maternity hospital, should be under the care of doctors experienced in the treatment of this kind of case, in a special or isolation hospital. Ambulances to take patients to hospital should be provided.

These services, and necessary equipment such as dressings and towels, baby clothes, etc., should be obtainable for every case of childbirth. They should be provided by the community through the local authority, for all women who cannot afford to pay for them.

All these services should be linked up to prevent gaps on the one hand, and overlapping on the other.

Let us now consider the provision of these services more fully.

The Midwife. All authorities agree that a trained midwife should be present at every confinement, and nursing by untrained "handy-women" stopped. The new Midwives Act recently passed brought about this important reform. This Bill obliges local authorities* to provide a sufficient number of whole-time salaried midwives, either by direct employment, or by an arrangement with a local nursing association, to attend all women in the area who have their babies at home. It also proposes to compensate midwives at present practising, who for various reasons will not be accepted under the new scheme; and it makes it illegal for untrained "handy-women" to take employment as maternity nurses. Under the Act a local authority must arrange for all midwives practising in its area to attend refresher courses from time to time.

Once this Act became law the way was opened for a great improvement in midwifery practice. In the past midwives have been very inadequately paid, and have had to do their arduous and responsible work under very difficult conditions. If care is taken by the public to ensure that local authorities

* The Midwives Acts are administered by local supervising authorities, i.e. county councils, county borough councils and some councils of county districts which comply with certain conditions, whereas the Maternity and Child Welfare Act (1918) is administered by many more county districts. For the sake of simplicity we shall not indicate which council is responsible for each maternity service discussed, but merely use the term "local authority".

organize their new midwifery services well, the lot of the midwife will be greatly improved, and we may expect that this improvement will be reflected in her work. The team-work made possible by a salaried service will result in midwives being able to relieve each other during a rush of work. This will greatly lessen the strain of their duties, and should enable them to give longer time to nursing each patient than can be spared at present. It may be possible for midwives to undertake some of the work now done by health visitors, and so reduce the number of people from whom the mother receives advice. Salary and provision for old age will be secure, and holidays and off-duty times more easily arranged. The improved status and conditions of work should attract good recruits to the service, and will justify the demand for a longer training. Compulsory attendance at refresher courses will ensure that the midwife keeps up with new methods.

The Doctor. Some people think it would be better if whole-time specialist doctors undertook all maternity work. Others believe that attendance by the family doctor has some real advantages. We cannot discuss this difficult matter here, but some of the drawbacks of present practice may be pointed out.

Many women engage a midwife alone to attend them during childbirth, and, if everything goes well, they receive no medical care. During recent years, however, there has been a growing appreciation of the value of ante-natal and post-natal care, and most authorities agree that it is wiser for a doctor to take responsibility for these services, even if he (or she) is not needed during the actual confinement. In some districts the local authority has arranged for general practitioners to undertake the ante-natal and post-natal care of their own patients, but in others, women attend a clinic. A midwife is bound by her rules to call a doctor if any complication develops in a woman under her care. Owing to a clause in the Maternity

and Child Welfare Act (1918), the doctor whom the patient has seen at an ante-natal clinic cannot attend her at home. The patient's family doctor must be sent for, and it may be a serious disadvantage that he had no previous knowledge of her condition.

The ideal thing would seem to be for the same doctor to have charge of the patient throughout pregnancy, labour, and the period afterwards until she is restored to health and strength again. When this is not possible different doctors attending the same patient should obviously be in close touch with one another. At present there is often no co-operation between the doctor in private practice, the doctor in charge of an ante-natal clinic and the hospital doctor, though the same woman may need attention from all three. The experience of some districts shows that with good will this co-operation can be brought about, with great advantage to all concerned.

All local authorities have power to make arrangements for doctors of special skill and experience to be called in by general practitioners in serious and difficult cases. This is a most valuable service, but, unfortunately, a good many authorities have not yet made use of their power to provide it.

Maternity Hospitals and Homes. At the present time there is not enough hospital accommodation for all the mothers who need it. Some districts have no maternity beds at all. Many maternity hospitals have too few beds for cases of ante-natal illness. Women are often sent home from hospital ten to twelve days after childbirth, and there are seldom any arrangements made for their further care at home.

We need more hospital beds for maternity cases; but, because the septic infection, that sometimes occurs after confinement, spreads more easily when many child-birth cases are together, and because complicated cases need more nursing care than normal cases, it is very important that all maternity hospitals and homes should be of the highest

possible standard. Doctors with special experience should be in charge, and the nurses should not be overworked. There should be many single wards, and much space and fresh air. Ambulances should be provided to take the patients to and from hospital. This is especially necessary in country districts.

Home Helps. We cannot here discuss the provision of better accommodation for all who live in overcrowded and badly repaired houses. Public opinion is already alive to this problem, and is pressing forward slum clearance schemes and the erection of working-class flats and houses. We believe, however, that too little attention has been given in the past to the need of the working-class mother for domestic help, and we think it important in the interests of maternal welfare, that an effort should now be made to organize this service in all parts of the country.

The Maternity and Child Welfare Act (1918) gave local authorities power to provide home helps, but so far very few have organized such schemes. Even when this has been done assistance has only been available during the confinement and for the first fortnight afterwards. We have already suggested that this is not enough. Domestic help should be available during pregnancy when necessary, and for as long after the birth of the child as the health and circumstances of each patient demand.

An acceptable home help service is not altogether easy to organize. The households where help is most needed are often those with the poorest equipment, and no woman likes to display her poverty to a stranger. Moreover, as the mother is confined to her bed for ten days after her baby is born, the home help must be entirely trustworthy. On the other hand, the reasonable working hours and adequate pay which the local authority has power to assure, should attract capable and reliable women. The appointment by each local authority

of an experienced and tactful woman to supervise the service, would do much to make it run smoothly and successfully.

Provision of Food. We have already made clear the importance to the mother of a full and varied diet, well adapted to her needs. The local authorities have power to supplement the diet of pregnant and nursing mothers and to bear the whole or part of the cost in necessitous cases. Such provision of milk or food is usually made through the ante-natal clinics and the recommendation of the doctor is required. The local authorities draw up an income scale and decide according to that scale whether or no they will supply the nourishment free to those who are recommended for it.

In earlier years it was laid down that women might receive the extra nourishment only during the last three months of pregnancy or while nursing their children, except in abnormal cases. Now, however, a local authority has power to provide the nourishment during the whole period of pregnancy if it so desires. Not all the local authorities have as yet arranged for this service; and few of those that employ their powers supply more than milk. But where the authorities have arranged to supply nutritious meals at the clinics, often with consideration for the needs of the toddlers who accompany their mothers, the benefit to the health and well-being of the women has been marked.

The Local Authority. In this country it has for many years been accepted as a duty of the community to provide all necessary maternity services for women who cannot afford to make their own arrangements. It may be useful to summarize briefly the chief powers given to local authorities under various Acts of Parliament to provide and to aid maternity services :

Local authorities can pay the fees of specialists called in by doctors, and are responsible for the fees of doctors called in by midwives;*

They can build maternity hospitals and pay for the treatment of mothers and babies in other hospitals, and can provide ambulances to take patients to and from hospitals;

They can provide ante-natal and post-natal services either in clinics or through general practitioners, and gynæcological clinics where birth control advice may be given to women when desirable on medical grounds;

They must appoint health visitors to visit women in their own homes, both before and after childbirth, to give advice and see that any treatment advised is being carried out;*

They can provide home helps and free milk and food for pregnant and nursing mothers, and equipment such as dressings, baby clothes, etc.

They can pay for dental or convalescent treatment when it is needed;

They can arrange lectures and demonstrations and distribute leaflets, etc., to teach the people about maternal welfare, and tell them where and how to get help.

Under the new Midwives Bill they will be responsible for the provision of sufficient midwives to attend all women who have their babies at home.*

Unfortunately, the provision of all these services except those we have marked with an asterisk (payment of the fees of doctors called in by midwives, health visitors, and, under the new Bill, a salaried service of midwives), is *permissive* not *compulsory*, and local authorities vary very much in the use they have made of their powers. For some of the services no charge is made, the most important being ante-natal and post-natal clinics and health visitors. For the other services patients are generally expected to pay according to their means. Income scales are drawn up by the local authorities, and vary considerably from district to district.

There is another very important task which can best be

performed by the local authority, through the Medical Officer of Health, and that is, the task of co-ordinating the different maternity services in the district into a complete maternity scheme. One of the gravest faults of our present maternity services is the lack of co-operation between the different parts. Too often doctors, midwives, clinics and hospitals seem to be competing against, instead of combining to help one another. This makes it much more difficult to teach mothers the value of new methods, and to get them to come for examination and follow the advice given. It also leads to overlapping in some directions, and to disastrous gaps in others. We occasionally hear of a small maternity hospital being built when there is already a half-filled hospital near by, while in some parts of the country there are no maternity hospitals for great distances. Health visitors visit every baby, but have no dealings with the private doctor or midwife who may be in attendance. If a woman is too ill to attend a clinic the clinic doctor cannot visit her at home, and is rarely in touch with the family doctor who is called in. Of course there are difficulties in the way of co-operation, but they have been overcome in some districts, and could, given good will, be overcome in all.

Payments under the National Health Insurance Acts. Many employers dismiss a pregnant woman when her condition becomes obvious. She cannot easily get other work, and, though ordinary sickness benefit is payable to insured women who are ill during pregnancy, it cannot be claimed on a plea of pregnancy alone. In practice it is often very difficult to decide when a woman may claim under this clause, and there is a tendency for insurance societies to refer a pregnant woman to the Regional Medical Officer very soon after she has been certified unfit for work by her own doctor. Some societies, however, recognize that the discomforts of even normal pregnancy make it very difficult for a woman to go out to

work during the last six weeks, and they pay sickness benefit during this period if a claim is made.

After the confinement a sum of £2 is paid to the wife of an insured man, if he is "in benefit." If she is insured, and "in benefit," she gets a further £2. No other sickness claim can be made on her behalf during the four weeks following confinement. After that period she may claim sickness benefit as in pregnancy, if she is ill, but not because of her confinement alone. There is the same difficulty of interpretation here as in pregnancy.

In this country the large majority of women do not go out to work after marriage. Hence it is unusual for more than £2 maternity benefit to be payable at the birth of any child after the first, and rare for sickness benefit to be payable except during the first pregnancy. A considerable number of working-class mothers whose husbands are not in insurable occupations, get no maternity benefit at all. There is no doubt that the payment of maternity benefit has been a great boon to many women, and it would seem to be advisable that a way should be found of extending this service to those who do not at present receive it. The question of the payment of sickness benefit to insured women before and after childbirth needs revision. The present position is felt to be unsatisfactory by patients, doctors and the insurance societies alike.

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CONCLUSIONS

We have tried to explain simply and precisely what conditions are necessary to afford every mother a chance of happy, healthy and normal experiences during the whole period surrounding her confinement. A high standard of maternal welfare and hygiene will also result in bringing healthier babies into the world, with happy consequences for the families into which they are born and for the Nation at large.

We have laid special emphasis upon three points.

(1) The need for better physical health among the women—and among the girls who will later become mothers; this greatly depends on the provision of suitable food and of good living conditions.

(2) The need for our Country to improve steadily its standards of medical and nursing skill.

(3) The need for each local authority to expand the services it has powers to render—and for each authority to link up its maternity services into a comprehensive and co-ordinated scheme.

Everyone who reads this pamphlet can play a part in helping to establish these conditions of maternal care. It is probable that you are in touch, directly or indirectly, with some organization or other, e.g. the Women's Institutes, Women's Co-operative Guilds, Town Guilds, Women's Own Meetings, Mothers' Meetings, Trade Unions, Friendly Societies, Social Clubs and so forth. Within such organizations you can work to get the whole question discussed and recommendations forwarded to the right quarter. You can approach Councillors and candidates at local elections and can persuade them that the problem is one of vital importance. You can talk over the subject with your friends and neighbours and strive to interest them. You can lend this pamphlet to those you hope to influence.

As we have already pointed out, most of the legislation

which enables local authorities to provide for the care of motherhood, is permissive only. The provision made varies to a surprising degree from district to district. It is therefore wise for you to begin by finding out precisely what your own local authority has done in the matter. You will then be in a position to judge more clearly what new services are required in your district, and how the existing services might be improved. Your local authority is, of course, more likely to be influenced by proposals that are put forward from a number of different organizations; and you can work to bring about this agreement among the various organisations in your neighbourhood.

We should need a fresh Act of Parliament, if the local authorities are to be *compelled* to use all the powers they at present possess in providing for the care of motherhood. It may be that later on the public will insist that such an Act is passed. In that case we may well hope that the State will also apportion extra grants to the local authorities, particularly in the depressed areas. It would further be very beneficial if every mother, whose income falls within the limits of the National Health Insurance Act, were to be paid a cash maternity benefit.

In the meantime, let us each determine not to leave the task to others, but to do all within our power to create and to express the public demand for a steady improvement in our maternity services. Especially is it *our* concern that the social (as opposed to the medical) aspects of maternal care should be steadily improved; and by this we mean the provision of proper nourishment, the provision where necessary of help in the home, the provision of dressings, baby clothes, etc.—in short, all that the mother needs to ensure her health and comfort on the domestic side. It is in these matters that the general public can most usefully co-operate with doctors and midwives. It is here that our own personal experience can be so important. Let us endeavour, through our local authorities,

to surround every mother with an atmosphere of peace, comfort and well-being; let us make her feel that the Nation values both her own life and the life she is to bring into the world; let us release her from the haunting burdens of anxiety, strain and undernourishment.

To the extent to which we achieve these objects, we shall have the satisfaction of knowing that our efforts have contributed towards the well-being of mothers, and have raised the whole standard of our National health. No task, that confronts our generation, is of more profound significance or offers a higher reward.