

## MCH Indicators in South Asia

The recent publication on this topic was informative (1). It was rightly stated that "This indicates the need to focus attention on causes of U5MR (under five mortality rate), other than the vaccine preventable diseases, such as neonatal mortality, if there has to be a significant dent in U5MR in the coming years." However, the observations and comments regarding Maternal Mortality Rate (MMR) need some clarifications. It was stated "It can be seen that MMR is inversely related to contraception prevalence rates, presence of trained attendants during delivery and adult female literacy rates. Countries with high MMR need to focus their attention on improving female literacy, bridging the unmet contraception needs and promoting the health seeking behavior, of pregnant women."

In the two neighboring countries, Bhutan and Nepal, MMRs are similar, i.e., 1600 and 1500, respectively; though adult literacy rates are very different (28% in Bhutan and 14% in Nepal). The percentage of births attended by trained attendants is 15% in Bhutan and 7% in Nepal. According to these parameters, pregnant women in Bhutan are placed in much better position but their MMR is slightly higher than that for their counterpart in Nepal.

The total fertility rate (TFR) for Pakistan (5.9) and Bhutan (5.7) are similar, percent-

ages of births attended by trained attendants (19% and 15%), contraception prevalence rates (12% and 19%) and adult literacy rates (24% and 28%) are not very different, but MMR in Pakistan is 340 while it is 1600 in Bhutan.

When we compare these vital statistics for India and Pakistan, we find that women in India have a definite advantage over women in Pakistan regarding these parameters. The TFR is 3.6, birth attendance by trained attendants is 34% contraception prevalence rate is 41% and adult female literacy rates is 38% for India while the corresponding figures for Pakistan are 5.9, 19%, 12% and 24%, respectively. However, MMR is 570 in India and 340 in Pakistan.

The author has stated that "female literacy and care of adolescent girls are important strategies that are likely to pay long term dividends for improving MCH indices." As he has stated that there is need to focus attention on causes of U5MR, other than the vaccine preventable diseases; perhaps we should look for causes of high MMR, other than these parameters.

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### REFERENCE

1. Ramji S. MCH indicators in South Asia, *India Pediatr* 1997; 34: 420-423.

## Reply

The point made by Dr. Yash Paul that countries with similar MMR could have, dissimilar proportion in contributing factors is well accepted and the article(1) does not disagree with these observations. How-

ever, I wish to reiterate two important facts that the article attempts to highlight:

1. In spite of intercountry differentials in prevalence of variables such as contraception and female literacy, the general trend for the South Asia region depicts an inverse relation-

ship between MMR and these variables (refer to *Table III* and *Fig. 2* of the article).

2. Secondly, compared to industrialized nations, the countries of South Asia region have a lower prevalence of contraception and female literacy and several fold higher MMR (*Table II* of the article). This clearly supports the argument as to

why the countries of the South Asia region need to focus attention on contraception and female literacy as - strategies ^for reduction in MMR besides the ongoing health inputs.

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## **Consumer Protection Act and Medical Profession**

Collusion, says the much venerated Oxford English Dictionary, is a Fraudulent secret understanding, especially between ostensible opponents. Why Bal(l) uses this word to describe the holding of a medical conference by a medical association is beyond comprehension. The pharmaceutical industry does offer financial support to such academic activities, but there is nothing secret about this. Associations hold conferences and continuing Medical Education programs to update the knowledge and enhance the skills of their members, which ultimately benefits the consumers; surely there is nothing ill-intentioned about such activity?

The article (l) on Consumer Protection Act (COPRA) is full of such unwarrantedly strong language towards the medical profession. There is no argument, of course, about the content of the article. Much of what is written is unfortunately true, and the deterioration in standards of medical care and ethics is cause for grave concern.

A vocal section of the medical profession has opposed the COPRA, but they are

by no means representative of the profession as a whole. There are many who feel that some form of regulation was overdue, to prevent this once-noble profession from sinking further into the murky depths of crass commercialisation. If this act can reduce medical malpractice, incompetence, and carelessness, it is something to be welcomed wholeheartedly.

Even today, there are many honorable men and women in medical practice, who approach their vocation with honesty, skill, ethics and compassion. To denounce the entire body of medical persons as "ill-equipped, uncontrolled, and mercenary" is not fair. I share the author's obvious anguish at the state of medical practice today, but abusing the entire profession in print does not seem to be a viable remedy for the ills plaguing us.

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## **REFERENCE**

1. Bal A. Consumer Protection act and medical profession. *Indian Pediatr* 1997; 34: 319-327.