AN APPROACH TO RURAL OBSTETRIC PROBLEMS

by

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We have about 600,000 villages and 5,000 community development blocks in India. Most of the people in our country reside in rural area. The obstetric care of these rural mothers is quite deplorable. It is true that there has been some improvement in obstetric services over the last few decades, but it is far from the crying demand. The improvement, again is limited to the sub-divisional and district towns and there has been very little or no improvement at all in the villages. It is indeed a challenge to the nation to deal with maternal and child health care effectively.

Magnitude of the Problem

Eclampsia is still the sweeping cause of maternal mortality in subdivisional and district hospitals of West Bengal (Dutta, 1971). This singularly points out the dangerously inadequate antenatal care offered to the rural mothers. Most of these unfortunate mothers could have been saved by proper antenatal screening for which we do not require the help of specialists. Medical officers of the P.H.C. are competent enough to diagnose and treat majority of pre-eclamptic toxaemia cases. Why then there be so many maternal deaths from eclampsia? This brings out the fact that most of the rural mothers are not having antenatal check up. This is due either to reluctance of the medical officers to run regular antenatal clinics or the unwillingness of the rural mothers to undergo antenatal check up.

It is also a common observation that the number and type of patients referred to a sub-divisional or district hospital have remained almost same over a period of years (Banerjee, 1975). Even to-day a large number of eclampsia, obstructed labour and retained placenta cases are referred from different P.H.Cs. These referred cases usually reach the district and sub-divisional hospitals in a critical condition. So, to reduce maternal mortality one has to see that standard of obstetric service is improved at P.H.C. level. If this can be achieved maternal mortality of our country can certainly be reduced to a reasonably lower level. Attention to the state hospitals and district hospitals alone will not solve this national problem. There must be some amount of screening at P.H.C. level.

The author had the opportunity to work in a Primary Health Centre (P.H.C.) of West Bengal in the recent past for about 3 years. Without going into details of the figures, the loopholes of obstetric service at P.H.C. and what author practised there to obviate those are discussed below:

Staff Pattern at P.H.C. (Ten Bedded)

The obstetric services in a health centre consist of the Medical Officers, Indoor Nurses, public health nurse (P.H.N.)/ lady health visitor (L.H.V.) and trained

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'dais' (T.D.). There are two medical officers, 4 indoor nurses and 1 P.H.N. or L.H.V. and 1 T.D. All of them are resident and provided with quarters. The medical officer-in-charge should particularly see that there is a good relationship amongst his working hands. The working pattern of each staff at appropriate levels are discussed below:

(A) Indoor Nurses and Confinements at P.H.C.

The indoor nurses are the backbone of rural obstetric services as most of the deliveries at P.H.C. are conducted by them. They also have the opportunity to build up a good relation with local community particularly the womenfolk. If they are reasonably sympathetic and careful to the poor illiterate, rural expectant mothers, more and more of them will come forward for check up and confinement at P.H.C.

Some of the indoor nurses are 'Sevika' and they have very little or no sense of aseptic techniques. They had no training prior to appointment. Majority of them are not familiar with the instruments and naturally can not supply the proper ones when asked for. Here comes the scope of medical officers to guide and help them rightly. Now-a-days, however, junior trained nurses (Auxillary Nurses-cum-Midwife—A.N.M.) are being posted at health centres.

(B) Trained Dai and Domiciliary Confinements

Trained Dai is primarily entrusted with the responsibility of domiciliary confinements. She also attends the postnatal cases and the newborn babies whenever a birth is intimated to P.H.C. by 'Chowkidars' through 'Hat-Chita'.

Most of the mothers, particularly who reside at distant villages, are reluctant to come to P.H.C. for confinement. On an analysis of births at West Bengal during the period 1969-70, it was observed that only 12.25% women had institutional delivery. Relatives attended the confinement in 30.94% and 53.50% cases were delivered by untrained Dais. It is really a matter of regret that only 3.31% deliveries were looked after by trained Dais (Second West Bengal Project—Vol. I-B): So most of the deliveries took place under the inauspicious guidance of untrained and illiterate Dais or were left to the care of the old ladies of the villages. They took the full credit in the uneventful confinements, but what was horrible was their bulldog tenacity even with the very complicated cases that were absolutely beyond their ability and experience.

Though the provision of hospital beds for maternity cases is far short of requirements at sub-divisional and district hospitals, this is not a problem at health centres. But even if the number of beds is increased this does not assure an increase in number of patients attending the P.H.C. for confinement. The reason is women do not find it very convenient to leave their home and children unattended during their confinement. Domiciliary confinement will continue and hence a well-organised domiciliary service is essential for many more years to come (Das, 1972). Menon, (1972) also admitted the importance of domiciliary confinement and recommended that this must be a part of the student's training. He also insisted that during internship a doctor must spend 3 months in a P.H.C. and watch the details of domiciliary confinements.

In view of the importance of domiciliary confinement particularly at distant villages, the author feels that the posts

of trained Dai should be increased. This will vary with the geographical distribution of the villages and transport facilities existing in a given block. This should be left to the jurisdiction of the Chief Medical Officer of the District (Civil Surgeon) or Sub-divisional Health Officer (S.D.H.O.). Some of the T.D. should reside at sub-centres so that they can attend the distant villages in less time. They should be instructed to refer the labour cases to P.H.C. as soon as any abnormality is detected. They should have in-service refreshers training at district hospitals. Bhatnagar (1971) reviewed the pilot project at Ballabhagarh, Haryana, and suggested that local untrained Dai should be trained at P.H.C. and be given permission to conduct deliveries, in case T.D. was not available. He also claimed that these local Dais will be very helpful as informants, not only for the registration of an event but also in picking the high-risk mothers. The author agrees with his views.

(C) *Public Health Nurse and Antenatal Clinics (at P.H.C. and at Villages)*

It is the P.H.N. or L.H.V. on whom lies primarily the responsibility of maternal and child health care. She can train up the T.D. and A.N.M. in routine ward management with particular attention to the confinements and care of the new born babies. She can also stretch a helping hand to the medical officers in antenatal check up both at P.H.C. as well as at villages. Maintenance of antenatal register preferably Anchal-wise, and carrying it to 'Village-Clinics' held at Sub-Centres also come within the preview of her job. And last but not the least to mention—surprisingly often, she has to do herself the antenatal check up of many expectant mothers, where they flatly refuse to be examined by the opposite sex. Most of the women in India still object to the presence of and conduction of delivery by male doctors.

Antenatal Clinic at P.H.C.

The author used to hold antenatal clinic along with general O.P.D. everyday. P.H.N. and indoor nurses helped to pick up the expectant mothers. He found one unique advantage of his system, which would have been missed in separately timed antenatal clinics. This was—he could catch those would be mothers not caring for antenatal screening, who simply came with their ailing children or relatives just as an escort.

Antenatal Clinic at Villages

From his humble experience the author realised that whatever be the standard of competency and cordiality of the working staff at P.H.C., the pregnant mother will seldom come for antenatal screening from a distant village unless she is in real trouble. This is more so with the multigravid patients. Hence to help these women who live far away from P.H.C. the author decided to hold antenatal clinics at each Anchal. One or two sites in each Anchal were fixed up for such clinics and date of next visit of medical officer was announced at the end of each session. These were like 'Extension Health Centres' (E.H.C.) as described by Bhatnagar, 1971. These clinics were held at the local clubs or at the 'Baithak-Khana' (drawing room) of a village-leader (e.g. Adhyakhaya, Anchal Prodhan, School Teacher) in the afternoon. An on-the-spot examination of blood for haemoglobin and urine for albumin were done where indicated. Folifer (Iron) tablets distributed and Injection Tetanus Toxoid administered. G.D.A.s carried weight machine, B.P. Instrument,

Foetoscope, medicines, spirit lamp, registers and other equipments for examination of blood and urine.

Along with the antenatal clinics the author used to run 'four point programme' and vaccination against small-pox. It was also his practice to examine the accompanying children. In short, his was an integrated antenatal, postnatal, family Planning and well-baby clinic. Medical officer was accompanied by paramedical staff like P.H.N./L.H.V., S.W.O., H.I. (F.P.), F.P.F.W., T.D. and voluntary Field Attendants (F.P.). But the shocking truth came out as, even if the facilities were extended to their door-steps, many of them did not just care or venture to avail them. At the outset the attendance in such 'Village-Clinic' was sadly poor. This was also the experience of Purandare (1969) who opined that under the present conditions in the rural areas of India, a lot of hardship and inconvenience is involved in contacting the pregnant mother and in getting her interested in securing medical aid. However, in course of time, the attendance turned out to be encouraging as these clinics earned the confidence of the womenfolk which taxed not only tenacity but also a good amount of tact on our part. Help of voluntary female attendant of the Anchal concerned and of the influencial ladies of the locality proved to be of immense value. In addition, the old patients were excellent media for publicity of these clinics.

(D) *Obstetric-Oriented Medical Officer*

It is true that the medical Officers of the P.H.C. are stuffed upto their throat with responsibilities of Indoor, Outdoor, School-Health, Public Healh and Family Planning Works. But even then the author does not consider this substantial enough reason to allow the matter of all important antenatal clinics to be neglected. Antenatal screening is one of the sheet-anchor in preventive medicine and thus has to be well supervised.

The obstetric services in a block are bound to improve qualitatively as well as quantitatively if at least one of the medical officer is trained in obstetrics and gynaecology. During the 'Rotatory Internship' the fresh medical graduates undergo 3 months training in obstetrics & gynaecology, but it is safe to confess that such training is far from adequate. Hence the author strongly advocates a minimum 1 year resident house surgeonship training in gynaecology and obstetrics before they are posted at P.H.C. This will enable them to diagnose abnormal or difficult obstetric cases at the earliest opportunity and to send them to subdivisional or district hospital before they become too critical. It is desirable that Chief Medical Officer of the District (Civil Surgeon) should be empowered so as to post the doctors in such a way that each P.H.C. is furnished with at least one doctor trained in Obstetrics. It is a common observation that a medical graduate who has had housemanship in surgery or medicine only is posted in a health centre. By virtue of his post, he has to tackle large number of obstetric cases. If it is not possible to have all such obstetric-trained medical officers, it is suggested that the officers in service of more than 3 years may be deputed for refreshers course in any teaching institution for 3 months or they can be specially deputed for D.G.O. course. The Obstetric and Gynaecological Society of the respectiv states may take up this matter with the Governments, so that officers at health centres get proper obstetric training. Most of the Obstetricians working at district or sub-divisional hospitals have the experi-

ence that they get fewer number of referred cases from P.H.C. which are manned by a person trained in obstetrics (Dawn, 1975). Besides referring the cases early, minor obstetric emergencies can be better tackled at P.H.C. and the load on the district and subdivisional hospitals can be substantially minimised.

The doctor at P.H.C. who is trained in obstetrics would attend subsidiary health centres for examining antenatal cases fortnightly. Specialists from subdivisions or nearby district would visit P.H.C.s fortnightly or monthly and encourage and guide the young medical graduates working at P.H.Cs. This was also the recommendation of Bhatnagar (1971). They can jointly decide the high-risk cases requiring delivery at district or sub-divisional hospitals and thus such patients get all their necessary medical advice right at P.H.C. instead of attending the district and sub-divisional hospitals.

It requires great tenacity and dedication on the part of medical officers to organise the domiciliary confinements and to hold Anchal-wise antenatal clinics as stated above. Unless the medical officer is obstetric-minded he cannot take interest in building up this preventive obstetrics at his block. The author had to walk several miles to hold such clinics as there was no suitable conveyance. Unfortunately there are P.H.C.s where medical officers though trained in obstetrics are reluctant to exert their skill beyond that of midwife and serve as 'despatching officer' of the cases coming from far off rural areas. Many a times transfers of patients to subdivisions have been proved not only unnecessary but at times risky. This type of inertia and negative approach on the part of trained medical officers have to be condemned, as people will lose confidence on the P.H.C. The medical officers should exert their ability and gain confidence amongst public. If most of the cases are being referred to sub-divisions, the M.C.H. programme launched by the state will prove to be a failure in the days to come.

(E) *Public Relation*

Mass acceptance and co-operation is the keystone of success in conducting domiciliary confinement under care of Trained Dai and in running the village-clinic. Essentially all the staff of the P.H.C. should make a sincere endeavour to build up a good relationship with the local inhabitants. The medical officer of P.H.C. should be in touch with the local private practitioners so that their service can be profitably utilised in antenatal screening. A sound community contact is essential. Masses should be motivated through all possible media. They should be informed and constantly reminded that domiciliary service of T.D. is rendered free of cost and they should not hesitate to avail of it.

Obstetric Services in Districts and Sub-Divisions

Specialists' services are being offered in the district and sub-divisional hospitals. But these services are handicapped by not having anaesthetists and proper blood transfusion arrangements. The supply of medicines is far from being satisfactory in most of the peripheral hospitals. Sub-divisions are usually manned by one Gynaecologist who has to look after gynaecological, antenatal, postnatal and labour cases. He also has to attend tubectomy camps and to perform general emergency duties like other medical officers. This proves how overburdened he is and how little attention he can pay to his patients. It is better to have two Gynaecologists in densely populated sub-divi-

sions. Residential quarter within the hospital premises should be provided to at least one of them so that emergency cases can be promptly dealt with. To assess the performance and alertness in individual health centres, a register should be maintained at sub-divisional and district level of the referred cases from the different P.H.C.s. Specialists should maintain a periodic contact with the medical officers of the P.H.C.s and discuss their future strategy in the light of past failures.

Concluding Remarks

1. The obstetric problems of rural mothers are deep-rooted and multicentered and it would be just impossible to rectify it overnight.

2. Ideally there should be 2 Gynaecologists in sub-divisional hospitals.

3. Of the 4 doctors posted in health centres of a block (Primary and Subsidiary Health Centres) 1 must have had at least 1 year of Resident Housemanship training in Obstetrics & Gynaecology. Much of the obstetric services of the block will depend on the enthusiasm and dedication of this doctor.

4. Medical Officer with the help of P.H.N. should hold antenatal clinics both at P.H.C. as well as in each Anchal. This policy of Village-Clinic will help to reach the courtyard of most of the pregnant mothers.

5. Improvement of domiciliary service is a must and one had to see that the Trained Dai and not superstitious, wrinkle-faced, experienced (!) untrained Dais with their tremulous hands conduct the deliveries.

6. Obstetric services are a symphony played by the Medical Officers, Nurses, P.H.N., and Trained Dai and a perfect harmony among them is a must for smooth running of the same.

7. Hospital staff will ensure that there is a good public relation particularly with the village-leaders, so that people have confidence in health centres. The village-leaders will in turn encourage the women to attend antenatal clinics.

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