OBSTETRIC PROBLEMS IN RURAL AREA

by

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Introduction

About 80 per cent of population of India is rural. Expectant mothers do not have sufficient or any antenatal supervision. Deliveries are conducted by traditional midwives who are untrained. Though this service is domicillary, it is not only unsatisfactory but also dangerous.

Primary Health Centres do offer obstetric care satisfactorily in the uncomplicated cases but these services do not appear to be fully utilised by the rural population for many reasons. Under the Primary Health Centres, a large section of the pregnant population is not covered by an adequate care perhaps because of lack of health education, prevailing traditions and taboos. Unless the health care is so programmed as to cover every pregnant woman the high-risk group mothers are likely to go unnoticed till serious and major complications appear. It is only when life-threatening complications are established, the medical advice is sought for.

In the present study, an attempt is made to study the mothers admitted from rural area for the accidents of pregnancy, childbirth and peurperium over a period of one year.

Material and Methods

Obstetric cases coming from rural area were studied over a period of one year from June 1979 to June 1980 at Medical College Hospital, Aurangabad. There were 540 such women admitted during the period. Total number of deliveries during this period were 6,645 and there were 715 abortions either spentaneous or induced (MTP). Only 50 women were referred by the medical officers at various Primary Health Centres and private medical practitioners. Rest of the women came directly to this hospital without seeking any medical advice. Four hundred and seventy-two women were undelivered, 15 were delivered and 53 were admitted with abortions.

Majority of the women 92% were young. Minimum age was 15 years, a case of eclampsia and maximum age was 50 years, a case of septic abortion.

About half of the women were primiparas (44.07%), 41% were multiparas and 15% were grandmultiparas. Maximum parity was thirteenth.

The special symptoms for which admission was sought by undelivered women is shown in Table I.

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TABLE I
Special Symptoms at the Time of Admission

Symptoms	No. of cases
Premature rupture of membrane	33
Antepartum haemorrhage	78
Eclampsia	18
Retained placenta	9
Arrest of after coming head	5

Cephalic presentation was present in majority of the women (86.9%) out of which only two cases had face presentation. Rest of the women had either breech presentation (5.2%), transverse lie (3.3%), multiple pregnancies (3.1%) or compound presentation (1.5%).

Delivered mothers came with either pyrexia, haemorrhage, convulsions or abnormal behaviour (Table II .

TABLE II
Admission of Delivered Women

Diagnosis	No. of cases
Puerperal Sepsis	11
Puerperal psychosis	07
Puerperal thrombophlebitis	02
Traumatic postpartum haemorrhage	01
Postpartum eclampsia	03

Active line of treatment required is discribed in Table III. Majority of the undelivered mothers ended in vaginal delivery which required either episiotomy, forceps, intrauterine manipulation or destructive surgery. Caesarean section was performed in 55 cases (11.6%) Manual removal of placenta was done in 3 cases. Evacuation was required in majority of the 38 women who came with incomplete abortion out of 53.

During the study period the total maternal admissions were 7360 and the total number of maternal deaths were 26. Out of these 26 cases, 20 maternal deaths were from the rural areas. The computed maternal mortality for rural cases comes to 2.71 per 1000. The causes of maternal mortality were sepsis, haemorrhage and eclampsia as shown in Table IV.

TABLE III
Active Treatment Given

Treatment	No. of Cases
Caesarean Section	55
Caesarean hysterectomy	01
Pitocin enhanced labour	30
Artificial rupture of membranes	16
Low forceps	50
Low midforceps under G.A.	04
Internal podalic version	04
Assisted breech	25
Craniotomy	02
Manual removal of placenta	03
Evacuation	38
Episiotomy	120

TABLE IV
Causes of Maternal Mortality

Cause of Death	No. of cases
Puerperal sepsis	07
Rupture of uterus (Undelivered)	02
Eclampsia	05
Septic abortion	03
Acute pyelonephritis	01
Placenta previa	02

The computed perinatal mortality was 125 per 1000 livebirths.

Discussion

There are 19 Primary Health Centres at the periphery attached to Medical College Hospital, Aurangabad, each having 3 medical officers, with 2 staff nurses. 6 auxillary nurses alongwith 250 multipurpose workers, working at different cen-

tres. Apart from the doctors, various other factors that are required for successful programme according to Bhatnagar *et al* (1971 are:

1. Intense education and community participation
2. Training of 'dais'
3. Injudicious working of family planning
4. Improved means of communication
5. Proper supervision and administration
6. Training of paramedical staff

In the present series, 58.34 per cent cases were upto the age of 25 years.

Eighty per cent cases were not attending any antenatal clinics in rural area. Age at first childbirth was very low (Upadhyay, 1975). In the present series, minimum age of patient was 15 years who came as an antepartum eclampsia and maximum age was 50 years with septic abortion.

Cases of malpresentation and disproportion if referred in early labour, timely interference will give better foetal salvage and reduce maternal complications. Cases of premature rupture of membranes with infection were 33. Out of them, 4 cases had rupture of membrane for more than 48 hours and wtre handled by 'dais'. Nine cases were of retained placenta, out of these, 8 deliveries were conducted by ANMs.

Out of 2 cases of obstructed labour, 1 case was threatened rupture and one rupture uterus. Both received pitocin drip for prolonged labour.

Out of 21 cases of eclampsia, 10 were attending at P.H.C. either regular checkup or were getting treatment for toxaemia of pregnancy irregularly. Among 53 cases of abortion. 14 had septic abortion, out of which 2 died of septic chock.

From the study it is obvious that the cases are not referred at a proper time whether they seek any advic or not. The outcome is that:

(1) Reluctance or ignorance on the part of patients to avail the obstetric care.

(2) Inability of the staff of the P.H.C. to provide proper antenatal clinics, is also a contributory factor.

(3) Cases of obstructed labour, retained placenta, transverse lie, eclampsia are referred from the periphery in late stage.

(4) ANM and trained dais should cover the obstetric cases properly.

(5) The medical officer should be obstetric oriented.

(6) There should be proper facilities for transport to the hospital, because that also played a factor in present series.

Conclusion

As the bulk of deliveries in rural areas are still conducted by 'dais', there is a need for training to dais, proper antenatal and natal care, detection of high risk pregnancy and referral of such cases to the hospital in time.

Acknowledgement

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References

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