PRIMARY OBSTETRIC CARE

by

Dilip Kumar Chakrabortti

SUMMARY

Primary Obstetric Care as a part of Integrated Maternal and Child health care has been emphasised for the effective Obstetric service for the majority of the people in the Developing countries. In terms of Maternal and Perinatal mortality Primary Obstetric Care is expected to give promising results in future. This would ultimately bring greater success to population control and a greater security to this part of the Globe.

The author discusses the various aspects of the programme both for teaching undergraduates and postgraduates in Medical Colleges and Field services for application. The Author has mentioned his experiences while attending such programme as a W.H.O. Fellow and on return while implementing this in teaching centres.

The existing system of hospital oriented obstetric care has failed to serve the majority of the people in the developing countries. In India, about 80 percent of the population reside in the rural areas where hospital facilities are not available. Thus obstetric care to the people should be started from the village and provided by the primary Health care team (W.H.O., 1978). Barns (1980) mentioned that Auxiliary Nurse Midwife (A.N.M.) is the chief acknowledged intermediary and the Sub Centre is the pivot through which obstetric care should reach the Community. So the key element in this care is the small Medical Unit (Sub Centre) run by the Community it serves and is accessible enough even from remote corners of the village. Doctors, Female Nursing and Auxiliary Supervisors should mainly be engaged in supportive assistance to the A.N.M. Moreover, such obstetric care should be integrated with Paediatric and Social Medical care. It has been realised that a very high perinatal and infant mortality rate stand a real threat to the implementation of Family Welfare Programme in the developing world. It has been emphasised recently that a concept of integrated Maternal and Child Health Care (M.C.H.) will overcome such threat and an effective implementation of the Family Welfare Programme is possible. This would bring a greater success to population control and finally a greater security to this part of the Globe.

This fundamental concept of M.C.H. Care embodies that the health problems in the mother and child are interdependent and not independent. Obstetric care

From: Reader, Dept. of Obstetrics N *Gynaecology, Eden Hospital, Medical College, Calcutta, West Bengal, WHO Fellow (South East Asia).*

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is thus recognised as a part of combined service to both mother and children. So Antenatal care should be integrated with infant care. The assessment and care of other children of the mother should be undertaken. Moreover, the postnatal care should be integrated with neonatal care i.e. lactational and puerperal care should be integrated with routine infant weighing, family welfare advices and immunisations. Thus a continuous interdependance should be built between the two inseparable systems which ideally need to be presented to the budding doctor as a combined package comprising Maternal, Child health and Family welfare advices and not in piece meal as at present through separate disciplines of Obstetric, Paediatrics and Preventive and Social Medicine.

In view of this ideology of a changing treand in the obstetric care the present study is undertaken to discuss the different aspects of the programme and its implementation under the present set up.

Material and Methods

This is a preliminary report based on the experience gained, after attending WHO Fellowship programme for Integrated MCH-FP in the State of Gujarat and on return while attempting to implement the same in certain parts of West Bengal.

By teaching of the students at the Medical College and subsequently through the Field training of the Internees and Residents Primary Obstetric Care reaches the Community.

Thus the programme has two basic components :

(A) *Teaching of M.B.B.S. Students at the Medical Colleges* :

The purpose is to orient the undergraduate students about the 'Integrated Maternal and Child health care'. The whole curriculum is divided into several sessions which are limited to commoner problems during antenatal period, normal delivery procedures and first month of neonatal life. Each Session ($1\frac{1}{2}$ hours) is attended and conducted by one teacher each from three departments — Obstetrics and Gynaecology, Preventive and Social Medicine and Paediatrics in coordination so that the students may get an integrated approach to a given problem in the Community.

As it is not possible to take the students to the Community at this stage the points are illustrated from the actual case histories of the patients in the ward (social history, environment etc.) and thereby some idea about the prevailing health situation in the community can be given to the students. Selected students are given the cases beforehand to prepare and present during the sessions. The subject is then discussed from the practical point of view by the teachers of the three disciplines in succession. The students are included to take part in the discussion. Audio-visual aids are used while conducting the sessions. Final year students (7th Semester) during their clinical term in Obstetric posting should be taken for attendence. At Gujarat (Ahmedabad) 4th year students were selected for attendence to this course.

Areas where teaching is conducted under 'Integrated approach' are as follows: —

(a) Introductory class about the importance of the 'integrated MCH care'. Sensitive indices of Maternal and child Health care and health functionaries in the Community.

(b) Antenatal care and its importance.

(c) Normal labour, preparations required for normal labour at home and hospital. Principle of resuscitations of New born, cord care, role of Traditional birth attendants (TBA) and Auxiliary Nurse Midwife (ANM).

(d) Normal Puerperium — to impress the importance of postnatal care, care of the New born in the 1st week of life. Recognition of the warning signals in the New born.

(e) Concept of 'High-risk pregnancy'.

(f) Pregnancy complications. How the baby may be affected while treating the mother by drugs, blood transfusion and operations during Antenatal period.

(g) Recognition of the common gynaecological problems specially in the neonatal age group-ambiguous genitalia, vaginal bleeding and preliminary knowledge of common gynaecological conditions in all age groups.

(h) Family planning and Medical Termination of pregnancy — Various Methods for Family welfare programme and Medical Termination of Pregnancy (M.T.P.), M.T.P. legalisation.

(i) Concluding session and summary.

(B) *Field Services*

With a view of training medical graduates and paramedical persons in the Community health care a training centre should be made as working base. While at Gujarat I attended such a training centre situated about 40 km. from Ahmedabad city. There are 15 Sub Centres under this training centre for field training and for delivering Primary Obstetric care to the Community.

The Field services are divided into two groups :—

(a) *Interns' posting*:

Total duration 3 months. Of this one month is allotted in the main training centre specially for attending lectures on MCH care and for obtaining practical clinical experience including home visits. Rest of the two months they are posted in the Sub Centre. Two Interns at a time are posted in a particular Sub Centre. These Interns move from house to house with Social Worker and Auxillary Nurse Midwife and give them guidance and solve their medical problems. This continuing contact and wide coverage give Interns along with these paramedical persons a personal entry into every house and discuss regarding Family spacing on appropriate occasions along with other preventive services. The Interns also run the small Medical unit as outpatients' service including Antenatal clinic.

(b) *Training of the Postgraduates*:

Training of the Postgraduates in Obstetrics & Gynaecology and Paediatrics : total duration 3 months. During this period they are to perform the following schedule :

(i) Accompany the teachers of respective departments for visit to main training centre and sub centre for Integrated MCH teaching to Interns.

(ii) To run antenatal clinic with senior teacher at the main training centre once in a week. They pick up 'high-risk cases' and take advice of the senior teacher and refer to appropriate centres for proper management.

(iii) To visit the schedule Sub Centre with the teacher on the same day. This is for participation in rendering MCH services and Interns' teaching and guidance.

Meetings with antenatal patients are also arranged for advice regarding diet, importance of Antenatal care and other guidance. For reference and transport services and other problems the village leaders (Panchayats) are consulted. This Community participation by cultivating close relations with the Chief Panchayats for provision of building for clinics and residence of the trainee Interns is unique.

The 'Health for All by the year 2000' was the slogan of the World Health Day,

1983. How to achieve this goal in terms of Obstetric services is to be assessed. Barns (1979) mentiones that the magnitude of the cost of providing total Obstetric coverage to the population is beyond the means of most Governments. Only improvements of the existing condition can be undertaken by utilising the resources available and by Community participation in the Primary health care system.

Mejia and Varju (1983) mention that 'Health for All-2000' depends mainly on Primary Health care which in turn depends primarily on services to women population. Maternal and child health care (MCH) in the Community represents a major service to achieve this goal. Dhillon *et al* (1982) enumerated the basic activities of M.C.H. care as follows :—

(i) Surveillance of health of women from 14 years to menopause, and of children during the first six years of life.

(ii) Antenatal care of first and subsequent pregnancies, including medical termination of pregnancy where appropriate. Also Family planning advices.

(iii) Intranatal and postnatal care in home or in primary health centre.

(iv) Interconceptional care of women and their children by regular visiting to homes and villages.

(v) Education of men and women regarding family size and structure, nutrition, cooking, hygience and child care.

(vi) Supplementary food rehabilitation of malnourished children.

(vii) Referal of women or children to district or other hospitals.

The teaching and the service programme as mentioned cover most of the items of M.C.H. care activities. For better results and followup each senior teacher may be given one particular Sub Centre. The programme is arranged with a view so that each woman at Sub Centre is examined by the consultant once in each trimester. On the education side at the Medical College level the importance of 'Integrated MCH care' should be stressed to the extent of essential practical training to be introduced in the undergraduate curriculum so that all the students may participate. Instead of 9 sessions as discussed few more subjects can be brought and may be integrated.

Obstetric care in the developing countries demand a successful implementation of the 'Integrated MCH care'. Proper stress should be given on teaching of 'MCH care' at the Medical College level, Field service for Interns and post Graduates and community participation of the programme. Delivery of maternity care under this scheme have resulted in responsibilities of the auxiliaries in many centres.

WHO (1983) while evaluating the success of the Primary Obstetric care in the Developing Nations mentioned that Traditional Birth Attendants (TBA) under supervisions deliver about 60 to 80% of the infants born in 70 countries reviewed. Shah (1980) mentioned of improved Midwifery services in tribal area of Maharashtra by this scheme. In terms of reduction of Maternal and Perinatal mortalities implementation of Primary Obstetric care is expected to show promising results during the years to come.

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