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Editorial

AWAY TO OBSTRUCTED LABOUR BY 2000 A.D.

To achieve health for all by 2000 A.D. M.C.H. services has to play a very important role. Obstructed labour has remained a major factor bringing about high maternal (4 to 8/1000) and perinatal (40 to 140/1000) mortality rates. For the reasons very well known it is practically impossible to give exact figures. There is a vast difference between obstetric practice of today and that of 30 years back. The progress as in all walks of life is so slow and continues that it is imperceptible. One feels that what one sees today was forever existant. In those days drastic complications of obstructed labour like ruptured uteri, abnormal presentations with protracted labours was an every day occurrence in a medical college. Mothers were brought in such a bad condition one hardly had time to think of the baby. Emergency admission was rule and regular antenatal care was an exception. Transport was a big problem. Today in a medical college especially in better developed states one hardly sees such complications. Much of the load is taken up by district hospitals and there is definite improvement in M.C.H. care. This is not true for all the medical colleges, of the country. In some states like Asam and Bihar the situation just described does prevail; in others it would be somewhere in-between. So one obstetrician deals with dying mothers and another with foetal monitors and ultrasounds. How far our postgraduate education is able to provide efficient doctors to carry out jobs required? Here I stress the need of efficiency oriented training. Balance has to be maintained between developing science and community needs. As our postgraduate training is on-job this should automatically be achieved. The foundation should be strong, concepts clear and thinking and approach analytic. We also have to reframe our undergraduate teaching. W.H.O. has developed a special curriculum for undergraduate and interne teaching. It also has published a ready reference pocket book for MCH care.

Our next problem is utilization of MCH services by the community. Child birth is a social and personal problem. In the community traditions are deeply rooted and difficult to change. Child birth since time immemorial has taken place in woman's natural surroundings. Deliveries are conducted at home either by a senior lady in the family or by a dai trained or untrained. A.N.Ms. who are supposed to provide antenatal care are busy with family planning work. Gradually by A.N.Ms skills to carry out obstetric work is lost. Women are rushed to hospitals when they fail to deliver. At this stage a medical graduate at P.H.C. proves inefficient to manage the case. Obstetrician is needed. By the time woman

reaches an institution lot of damage is done. To achieve the goal of minimising incidence of obstructed labour I propose a step-up system.

1. Community—Education to avail MCH care.
2. TBA and Dais—Conduct normal labour, use delivery kit.
3. A.N.M.—100% A.N. care, Intranatal care.
4. Medical Graduate—Manage minor antenatal and intranatal problems. Do forceps.
5. Consultant at District level—Manage all types of obstetric emergencies.
6. Consultant at Apex Hospital—Foetal and Maternal monitoring in high risk cases.

From each lower step there should be timely identification of danger signals and reference to the higher step. Separate risk scoring should be formulated for all levels. With sincerity of purpose, devotion, hard work and co-ordination we have with us a decade to achieve health for mother and baby by 2000 A.D.

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