

UTILISATION OF REFERRAL SERVICES BY A HIGH RISK PREGNANT POPULATION

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SUMMARY

Referral services for identification and referral of high risk pregnancy are an integral part of MCH services. A study was conducted to audit the reasons for referral, the causes of delayed referral and the status of antenatal care at the Primary and Secondary Health Care Delivery Centres.

755 subjects i.e. 58.5% had received no antenatal care. The incidence of referred cases to our institution has shown a slow rise from 9.4% in 1988 to 12.30% in 1991. The major causes of delayed referral was nonavailability of transport and inadequate intervention facilities. 14.4% patients had to travel more than 100 Kms. before definitive management was available. The highest number of referred cases were from community health centres constituting 39.10% of the total. The major obstetric and associated conditions requiring referral were severe anaemia, eclampsia, APH and obstructed labor.

Out of the stillbirths majority 60-70% were due to intrapartum and therefore avoidable factors.

An intensive empowerment of the 3 tier health care delivery system is required if the goals under the safe motherhood initiative are to be realized.

INTRODUCTION

Referral services for high risk cases are an integral part of MCH services.

The "Risk Approach" is a managerial tool for improved maternal and child health. It's purpose is to provide better services for all but with special attention to those who need them most.

The three tier health care delivery

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system was conceived in such a manner that a patient in need of a higher level of expertise and care could be referred accordingly from the primary to the secondary to tertiary and if necessary, from primary directly to the tertiary level of care.

The purpose of antenatal care is to identify those "High Risk" cases as early as possible from a large group of antenatal mothers and arrange for them skilled care. In the safe motherhood initiative, the National Health Policy has set certain normative goals to be reached by 1995 A.D. and by 2000 A.D. For antenatal care, it demands a coverage of 75% by 1995 A.D. and 100% by 2000 A.D.

There has hardly been any study to audit as to how the referral system works within this three tier health care delivery system.

With this background this study was undertaken with the following objectives.

- (1) To know the incidence of referral of high risk cases.
- (2) To know how often these cases are detected by primary health care workers.
- (3) Whether or not the cases are referred in time for tertiary level intervention to prove beneficial.
- (4) The morbidity and mortality profile in this group of subjects.

SUBJECTS AND METHODS

This is a retrospective audit of a 4 year study from 1988 to 1991 conducted at the Dept. of Obst. & Gynec., SSG Hospital and Medical College, Baroda, which is essentially a teaching hospital

and a major referral centre.

Referral cases are those which have been referred from a primary or secondary level health care centre after being identified by the health worker or doctor as the case may be. A separate register is maintained of these patients with a view to documenting the sociodemographic profile, the degree of antenatal care received at the periphery, causes of referral, distance travelled to reach our hospital, reasons for delay in referral, transport problems etc. The results are analysed within the context of the goals set under the safe motherhood and child survival initiative and are presented below.

ANALYSIS

Table I shows that the incidence of referred cases has gone up from 9.44% (287) in 1988 to 12.30% (369) in 1991. Whether the reason for this is greater awareness in the detection of high risk cases at the peripheral level or a lack of intervention facilities at these levels is not clear.

Table II elucidates the reasons for delayed referral. It might be noted here that self negligence by the patient herself forms a small group of 2.59% to 4.8% whereas, the major causes are lack of equipment, anaesthetic and blood banking facility at the primary or secondary health care centre. Transport problems constitute 14.63% in 1988 and 32.79% in 1991. The failure to diagnose patients needing referral has dropped from 26.48% in 1988 to 8.40% in 1991.

Table III analyses the distance travelled by the patient before definitive man-

agement is available to her. 46.23% i.e. 596 subjects had to travel upto 50 Kms. whereas 14.60% i.e. 190 subjects had to travel more than 100 Kms. to receive aid.

Table IV shows the distribution of referred cases by the indication for referral and the level of health care centre of referred. The largest group of 506 patients i.e. 39.1% was referred from community health care level. District hospitals and private nursing homes referred 24.25% cases. The obstetric con-

dition and associated factors, requiring referral show that anaemia, toxemia, haemorrhage and obstructed labors constituted the bulk of referral.

Table V shows the fetal outcome. It is to be noted here that in the stillbirth category, the percentage of fresh stillbirths varied from 74.28% in 1988 to 65.88 in 1991; implying that a large number of these deaths are intrapartum and therefore avoidable by timely diagnosis and speedy referral.

Table I
Incidence of Referred cases

Year	Total No. of confinements	Total No. of Referred cases	
		Number	Percentage
1988	3040	287	9.44
1989	2753	270	9.80
1990	2872	363	12.64
1991	2999	369	12.30

Table II
Reasons for Delayed Referral

Reason for Delay	1988		1989		1990		1991	
	No.	%	No.	%	No.	%	No.	%
1. Self negligence	14	4.87	07	2.59	31	8.53	18	4.87
2. Remained undiagnosed	76	26.48	60	22.22	29	7.98	31	8.40
3. Refusal to come at larger hospital	41	14.28	46	17.03	39	10.74	37	10.02
3. Transport problems	42	14.63	68	23.23	112	30.85	121	32.79
4. Intervention not available	114	39.72	89	32.96	152	41.87	162	43.90
Total	287	100.0	270	100.0	363	100.0	359	100.0

The maternal deaths amongst referred cases constituted 47.46% of the overall

maternal mortality in our institution, with eclampsia, severe anaemia and falciparum malaria as leading causes of death - a very alarming figure indeed.

Table III

Distance Travelled in Kms.

Distance in Kms.	No. of cases	% of cases
Upto 25	320	24.86
26 - 50	596	46.23
51 - 100	183	14.21
> 100	190	14.60
Total	1289	100.0

DISCUSSION

Poor utilisation of maternal and child health care is considered to be an important cause of an unacceptably high perinatal and maternal mortality. Out of the total 1289 subjects analysed 755 i.e. 58.57% had received no antenatal care. The major reasons for delayed referral were lack of intervention facility at primary and or secondary health care

Table IV

Distribution of Referral Place from Centre Referred

Cause of Referral	P. H. C.	C. H. C.	Private Hospital	Dist. Hospital	Other	Total
1. Anaemia	37	39	07	14	20	117
%	31.62	33.33	5.98	11.96	17.09	100.0
2. Toxaemia	26	79	35	21	24	185
%	14.05	42.70	18.91	11.35	12.93	100.0
3. A. P. H. & P. P. H.	37	82	29	19	29	196
%	18.87	41.83	14.79	9.69	14.79	100.0
4. Prolonged labor	51	54	13	07	21	146
%	34.93	36.98	8.90	4.79	14.38	100.0
5. Obstructed labor	33	53	10	06	07	109
%	30.27	48.62	9.17	5.50	6.42	100.0
6. C. P. D.	09	34	19	13	11	86
%	10.46	39.53	22.09	15.11	12.79	100.0
7. Rupture Ut.	09	18	02	01	00	30
%	30.00	60.00	6.66	3.33		100.0
8. Malpresentation	44	64	23	14	22	167
%	26.34	38.32	13.77	8.38	13.17	100.0
9. Misc.	60	83	47	34	34	258
%	23.25	32.17	18.21	13.17	13.17	100.0
Total	306	506	185	129	168	1294
%	23.64	39.10	14.29	9.96	12.98	100.0

Table V
Fetal Outcome in Referred Cases

Fetal outcome	1988		1989		1990		1991	
	No.	%	No.	%	No.	%	No.	%
Live births	213	85.88	187	78.57	283	77.96	284	90.73
Still births	35	14.11	51	21.42	80	22.03	85	27.15
(A) Fresh	26	74.28	33	64.70	49	61.25	56	65.88
(B) Macerated	09	25.71	18	35.29	32	38.75	29	34.11
Total LB + SB	248		238		363		313	

level and lack of availability of transport.

Mere detection of high risk cases is not an end in itself unless it is backed up by higher levels of health care delivery system. The failure to diagnose a pregnancy complication requiring referral is not so much a major factor as a failure of operationalization of the referral link system so far as M.C.H. care is concerned. Thus lack of effective functioning of national linkage between primary, secondary and tertiary levels is one of the major weaknesses of our health care system.

The primary health care system set up in 1946 following the Bhole Committee recommendations have been used mainly to render Family Planning services and public health interventions for control of communicable diseases. The primary health care infrastructure in the Model Plan adopted in the Sixth Plan period sought to set up a net work of subsidiary health centres, and primary and commu-

nity health centres. The under-utilization of health services at these centres is due to lack of adequate supplies, drugs, equipment, vaccines etc. In this context it is essential to define the minimum levels of service facilities required which will form the technical framework for action at state and district levels.

If the goals set by the National Health Policy under the Safe motherhood Initiative are to be realized, an intensive empowerment of these primary and secondary levels health centres would be urgently required - or else we have to be content with putting down policies only on paper.

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