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## Evaluation of the referred cases from rural areas for a period of 5 years to the obstetric department of a teaching hospital

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### ABSTRACT

*This study was undertaken at Kamala Raja Hospital Gwalior, MadhyaPradesh, India. The study included 1750 cases referred from surrounding rural areas over a period of five years. These cases were admitted and their Socio-Demographic Profile was studied. The cause for referral was noted, appropriate management was done. Maternal morbidity, Mortality and Perinatal mortality & morbidity was studied. Thus the present study was undertaken to evaluate the referred cases from rural area to analyse them and to provide a proper feed back for strengthening of Maternal & Child Health services.*

**Keywords:** Referred cases, Maternal mortality, Caesarean section, Rupture Uterus, Perinatal mortality

### INTRODUCTION

It is seen that women who live within reach of the technical educational & social development have been liberated from many risks surrounding pregnancy and childbirth. While this still remains beyond the reach of rural masses due to ignorance, carelessness, illiteracy social and religious taboos.

According to multicentric study of FOGSI by Prof. K.Bhaskar Rao (1982) MMR is 54.82 to 3254.3/100,000 live births in India i.e 5-3000 times higher than MMR of developed western countries[1]. Perinatal mortality is also very high in our country ranging from 60-109/1000 total births whereas it is only 10-22 in western countries (Dawn 1992) i.e 6-10 times higher than western & mainly higher in rural area, causes being non-availability of skilled personnel & equipment, lack of communication combined with poverty, ignorance, poor nutrition & deep rooted customs as well as beliefs[1].

### MATERIALS AND METHODS

The present study is a retrospective analysis of referred cases over a period of 5 years in Kamala Raja Hospital Gwalior a teaching hospital. Total of 1750 cases referred from rural areas were thoroughly analysed with a view of documenting the socio-demographic profile i.e. age, parity, socio-economic status, literacy, causes for referral, reason for delayed referral distance travelled to reach hospital. Degree of antenatal care received at the peripheral centre and the maternal and foetal outcome under a preset proforma.

## RESULTS

A study of 1750 referred cases from rural areas was done during a period of 5 years and maternal and foetal outcome were studied. A total of 1750 cases referred from rural areas were admitted & their socio-Demographic profile were studied.

a) Age: Out of these 87.6% of cases ( 1533 cases) were in the age group of 15-30 years & 12.40% (217 cases) were in the age group of above 31 years of age [2,3,4].

Age	Number of cases	Percentage
15-30yrs	1533	87.6%
>31 Yrs	217	12.4%

b) Parity: Out of 1750 cases 33.53% were primiparas, 49.79% (i.e 775 cases) were multiparous , While grand multipara formin high risk group were 16.68% (i.e 292 cases) in the referred cases.

Parity	Number of cases	Percentage
Primipara	583	33.53
Multipara	775	49.79
Grand multipara	292	16.68

c) Socio Economic Status :- Majority of cases 96.68% belonged to low socioeconomic status while 3.32% (i.e 58 cases) belong to middle group.

d) Literacy:- Majority of cases 80.4% (i.e 1407) were illiterate with 16.51% educated and 3.08% graduate.

e) Causes for referral: Most common causes were followed by abortions, medical & other miscellaneous causes

Causes	Number of cases	Percentage
Obstetric	1283	73.31%
Abortion & related causes	183	10.46%
Medical & related causes	284	16.22%

f) Out of 1750 majority 97.3% were unbooked

g) Type of Interference required

Below table shows the type of interference required at the hospital.

Number	TYPE OF INTERFERENCE	NUMBER OF CASES	PERCENTAGE
1.	Vaginal delivery	629	35.94%
2.	Forceps	30	1.71%
3.	Internal Podalic Version with Breech Extraction	16	0.91%
4.	Lower Segment Caesarean Section	616	35.2%
5.	Caesarean Hysterectomy	30	1.71%
6.	Repair of rent in Lowe Uterine Segment	16	0.91%
7.	Manual Removal of Placenta	26	1.41%
8.	Suction & Evacuation	177	10.11%
9.	Laparotomy	36	2.05%
10.	Miscellaneous	174	9.22%

LSCS rates are higher in referred cases[5].

Maternal morbidity is higher among the referred cases [6].

Maternal mortality rate is 5.37% i.e there were 94 deaths out of 1750 cases and maximum mortality were due to toxemia followed by postpartum haemorrhage and sepsis & most of deaths occurs with in 24 hours of admission[7].

In Nigeria the maternal deaths 59,000 annually rank second to Indians 17,000 & out of this figure it is estimated that maternal deaths due to PPH is 20% with 1000 maternal deaths for 100,000 live births [8].

Perinatal mortality rate of 50.78% ( i.e, 682 perinatal deaths were those indicating a much higher perinatal mortality rate among referred cases) .

### DISCUSSION

The present study is undertaken to evaluate the referred cases from rural areas and to analyse the maternal and foetal outcome which is poor in these cases. This study includes 1750 cases referred from rural areas.

There were 1533 cases i.e 87.6% of the cases between the age group 15-30 years and 402 cases i.e 22.9% below 20 years & 76 cases (4.36%) above 35 years of age.

In her study Ghadiali (1978) reported that 14.6% cases received treatment at PHC. Pitocin drip in 3% cases, resuscitation in 2.4% and other treatment in 9.2% cases. While 86.4% did not receive any treatment[9]. The cause for this could be either non-availability of medication at the centres or lack of clinical assessment on the part of medical and paramedical personnel. Out of 1750, majority of cases 97.3% were unbooked. The number of visits to a hospital will improve the quality of care and decrease peripartum complications. The result can be confirmed in a study in Pakistan[10].

In developing Countries only about 57% of women give birth with a skilled attendant (midwife) present.

In Nigeria, with a population of 140 million people with women of child bearing age constituting about 31 million, only about 40% of the deliveries are attended to by trained midwives[11]

### CONCLUSION

From this study we conclude that female literacy rate and the awareness for maternal health in rural population should be increased. Community health workers and media can play vital role.

Better communication and transportation facilities for the rural population should be provided. The first referral unit should be within the reach of villages with all facilities for essential Obstetric care and with flying squads equipped with all facilities to tackle the Obstetrics emergencies[12].The other important task in the country is to strengthen and reorganize primary maternity care in the remote rural areas. Maternity care centres should be well equipped and should have trained staff at Primary Health Centre.

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