

EDITORIAL

Obstetric Practice in a Rural Setting; The Challenges and Impacts on Maternal Mortality: An Editorial

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ABSTRACT

The quality of care available to pregnant women who live in the rural and underserved areas of the developing countries has always left a lot to be desired. The consequence of such uneven distribution of amenities, infrastructure and health professionals have affected the maternal and child health of such rural dwellers and its impact on maternal mortality has remained very high. Efforts at curbing these problems may go a long way to improving the health indices of these important proportions of our population.

KEYWORDS

Obstetric Practice; Maternal Mortality; Rural Setting

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A rural area is a region that lies outside the towns and major cities of a country. It is characterized by low population density and most of the population is made of peasant farmers, artisans and petty traders. These areas are usually associated with poor health facilities, absent amenities and other basic infrastructures especially good road networks for easy and fast transport to existing health facilities. Under these circumstances, there is always a shortage of medical personnel to cater for the health needs of the population in such areas as younger health professionals all struggle to go abroad for greener pastures.

As we all know, the desire to procreate is innate and not affected by the local realities on ground in such rural areas. The women in such areas still get pregnant, deliver their babies and are prone to more complications and increased risks of neonatal and maternal morbidity and mortality.

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Maternal health is grossly influenced by availability, accessibility and quality of obstetric care in a defined region. Lack of adequate obstetric care in the rural areas is a major contributor to maternal mortality. The United Nations through SDG (target 3.1) program projected that maternal mortality ratio should be less than 70 per 100,000 live births by 2030 with no individual country yet exceeding 140 [1]. The rural areas account for over 60% of the maternal deaths globally. Worldwide, it is estimated that maternal mortality ratio in the rural areas is about 292 deaths per 100,000 live births compared to 100 for urban areas [2]. The reality as at today is that most countries in the sub-Saharan Africa are still majorly rural in nature; and the prospects for good and adequate maternity care for the pregnant woman are still bleak.

The consequences of these realities are enormous, ranging from paucity of supporting infrastructure to lack of skilled and specialized manpower to attend to these women, resulting in preventable deaths on many occasions. The challenges faced by practitioners who dare to remain and practice in these areas are enormous and often daunting. Obstetric emergencies are usually life threatening and give little or no room for delays. Usually, immediate surgical interventions are necessary to save the mother and the child. However, the paucity of trained anesthetists poses a big problem. In situations like this the obstetrician is left to make do with local analgesia, sedation or general anesthesia, using ketamine with their attendant complications. This experience is not palatable to say the least. It may also be highlighted that most of the young doctors are not conversant with such outdated modalities of treatment which makes it impossible for them to practice under such conditions. Obstetrics practice is closely related to hematological and blood transfusion services as hemorrhage is one of the leading causes of maternal death (27%; 80% uncertainty interval 22-32) [3].

The prevalence of religious and cultural myths around blood transfusion makes these essential services not readily available [4,5]. Secondly, the unavailability of blood banks and other supporting infrastructure further worsen the already precarious situation in the rural areas; where even access is already a problem [6].

Having practiced in one of these rural areas for over 30 years has made me an unsolicited inventor just to save a life. A typical example is the use of the Doyen's retractor in dis-impacting the presenting part in cases of obstructed labor where the fetus presents cephalic. This is achieved by placing the Doyen's retractor at ANGLE 90 degrees (perpendicular to the presenting part) in the maternal pelvis with its distal end resting on the urinary bladder below that presenting part. This is done after an assistant, different from the assistant surgeon, under aseptic conditions, has gently pushed the presenting part cephalad through the vagina. The lead surgeon puts the retractor below the presenting part in such a way that the retractor's grooved part faces the presenting head of the fetus. After this, the assistant surgeon firmly holds the retractor in that position, while the lead surgeon now makes a lower segment incision at the next phase of uterine contraction which naturally and usually slides the presenting fetal head along the groove of the retractor at which point, the lead surgeon easily and readily delivers the remaining parts of the fetus. This has saved many precarious situations as prolonged, obstructed labour is a common presentation in rural areas due to lack of good health facilities and personnel to care for them. This way, the often-feared caudad extension of the lower segment uterine incision as well as injuries to the uterine vessels are avoided.

The unavailability of emergency and life-saving drugs such as oxytocin which ordinarily should be cold-chained from production to the end users and stored at between 2 and 8 degrees centigrade can become another issue when dealing with obstetric problems that demand its immediate and urgent use like PPH in severe preeclampsia during vaginal or abdominal deliveries. This also contributes to the increased rate of maternal mortality in the rural areas.

Just like the doctors, the pharmacists are not readily available to work in these areas due to the lack of basic amenities such as school, roads, electricity and potable water. The obstetrician who decides to venture into such areas is left to the good use of whatever his/her hands can find to save the situation.

To make an already bad situation worse, the rising rates of medical litigations against obstetricians even when he is sacrificing his own health further discourages the rural practitioners and almost tilts the practice to a defensive one which indirectly impacts negatively on pregnancy outcomes. In this regard, government could do well to establish legal protection and institutional support to such physicians to prevent undue legal vulnerability and professional burnout. A patient who could not afford a basic care will suddenly have a retinue of relatives and lawyers who are out to sue the doctor once the outcome is bad without considering the limitations in basic government facilities like electricity and good road networks as well as the sacrifices of the doctor in delivering services under such limitations. This situation creates a dilemma for the doctor. This does not mean that genuine cases of malpractice do not arise and in such situations, malpractice claims and patients' protection should not be suppressed as this would make the rural practitioner to try as much as possible to adhere to standard and international best practices.

It is also a known fact that most rural dwellers are poor and this predisposes them to patronizing inadequately trained birth attendants, the reason why, majority of them are managed by traditional birth attendants with little or no skill. Little wonder then why cases of uterine rupture, hemorrhage and Intrapartum maternal and fetal deaths are common. From my experience, hardly will a week pass without a case of uterine rupture resulting from injudicious use of oxytocic with resultant maternal and neonatal/fetal deaths presenting to an already busy and short-staffed clinic. The outcome is usually predictable.

These experiences call for urgent and methodical approach to arrest this ugly trend by governments and civil societies. What do we do? If the lives of these rural dwellers matter, all hands must be on deck to salvage the ugly situation.

First and foremost, the rural populace should be properly educated and empowered economically and this starts by incorporating sexual and reproductive health into the nursery, primary and secondary school curricula. The need for building basic infrastructures such as roads, schools, electricity and potable water in rural areas to encourage health workers to reside in such locations cannot be over emphasized. New health facilities should be established where none is available and existing ones upgraded to offer essential maternal care. A case in question is the establishment of secondary health facility in every electoral ward in Enugu state of Nigeria by the Enugu State government. As commendable as this may sound, adequate funding and proper staffing of these facilities are the only steps to make them bear the desired fruits.

Obstetricians and other health workers should be encouraged to take up appointments in these rural areas with good motivation. Enhanced remuneration should be considered for practitioners who accept to work in rural areas in the form of Rural Practitioners' Allowance (RPA). They should also be retrained regularly to improve their skills for optimal output.

Doctors who undertake to practice in these settings irrespective of the deficiencies and shortfalls should be protected from unnecessary litigation and harassment. Government must make laws to protect such doctors when they are harassed as well as put in place, a robust insurance framework that protects such rural doctors where valid claims of malfeasance are made during litigation as no human is perfect. Having practiced this long and almost

having seen it all, I wish to bring these sad realities to the bare so that policy makers should intervene to save the lives of these rural dwellers.

A stitch in time saves nine!!!

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