

Maternal Morbidity

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THE subject of ill-health among mothers, arising from child-bearing, is, I think, one about which we do not concern ourselves enough. For too long we have been complacent and satisfied if, at the end of our ministrations, the mother and her baby are alive. It is high time we raised our standards much higher than this.

After all, we have so many things nowadays to help us in our care of mothers and babies, that it ought not to be difficult to keep them alive. In the first place, we have all had highly specialized training to enable us to understand the process of parturition and the anatomy and physiology involved, as well as the mechanics of the job. Secondly, almost all of us practise our profession within reach of medical aid. Thirdly, we have a knowledge of the causes of infection and how to prevent it, and at the same time we have the life saving antibiotics behind us if the need arises. Again, we have a wide range of oxytocic drugs to help us to prevent post-partum hæmorrhage, the means to administer them quickly and efficiently, and blood transfusions to save those in whom bleeding occurs.

Yes, certainly, mothers today should not lose their lives in child-birth, but what about their health? We have only to look around us to see that there are all too many mothers who have not died as a result of their child-bearing, but who are certainly not healthy in any sense of the word. Are we responsible in any way? I think we are, and I propose to discuss some of the ways in which the health of mothers can be impaired by childbearing and the responsibility of all those who attend mothers before, during and after delivery.

But first let us think for a minute what it must be like to be the mother of a family and not

feel fit and well. There is no more important, more exacting, more relentless job in the world than that of being a mother. There are no "off-duty" periods for the average mother, no days off, no annual holidays. The job goes on day and night without a break, and the utmost time, energy, patience and love are demanded of a mother all the time.

The responsibility of bringing up her family to be good, happy, useful citizens is chiefly the mother's. Yet how can she do this important job properly unless she is fit and well mentally and physically?

So it behoves us to think seriously about the ways in which a mother's mental and physical well-being may be impaired, and about our own responsibility in this matter.

Anaemia

Here in India anaemia is probably the greatest cause of ill health among mothers. It is true, of course, that many of the more severe types of anaemia are coupled with malnutrition, and are present long before the girl enters motherhood. It is equally true that no matter how carefully and efficiently we do our job, many of the more common causes of anaemia such as malnutrition and hookworm infestation cannot be immediately eradicated because of the social and economic conditions associated with them. These things are well recognised now, and measures are taken to treat such cases as effectively as possible during the antenatal period.

It is not of this kind of anaemia I am thinking just now. Rather I remember the numerous times I have seen mothers lying on labour room beds after delivery, and have found the uterus soft and flabby and full of blood clot, because the bladder has not been kept empty by the nurse in attendance. Or,

again, I have seen a loss of six or eight ounces dismissed as "normal" in a woman with a Hb. already as low as 55 or 60%, and no steps taken to ensure that further loss is prevented. Of course, we know the textbook says eight ounces is to be regarded as a normal loss after delivery, but if we read the textbook carefully we shall find that it assumes the Hb to have been almost 100% before the loss occurred—then only can an eight ounce loss be dismissed as entirely normal. Most Indian mothers do not have a Hb even approaching 100%, and it is my belief that every possible effort must be made, to reduce blood loss, at the time of delivery, to an absolute minimum and if several ounces are lost, to see that the matter is reported honestly and the proper treatment instituted at once. The tiredness and lowered resistance which result from anaemia due to blood loss, is certainly a potential cause of maternal morbidity.

Injury to the Genital Tract

(a) Prolapse: A visit to any

Here we have an article that we commend to every Midwife (and Obstetrician) in India.

We are indebted to Miss Barker for her stimulating article which focuses attention on some of the important aspects of maternal care. Many of us, who are proud of being midwives, have for a long time felt a deep concern for the midwifery taught and practised in India.

For all the talk about Maternal and Child care, midwifery is quite obviously the cinderella of the Health Services. Until nursing leaders recognise the need to raise the standard of basic education for applicants for the midwifery course and the need to revise the old fashioned teaching and practice, we can expect little progress.

Let us emphasise, that if the Mother and her Infant is to have expert care, Midwifery must be recognised as the Major Health Service.

Editor.

gynæcological ward in the country and a few heart-to-heart talks with some of the wrecks one finds there ought to have a salutary effect on any nurse in midwifery practice. For all too many women, some of them very young women, are suffering as a result of prolapse which may have started with nothing more than a mildly torn or badly healed perineum, or even with an over-stretched perineum. Many of these women were delivered by trained nurses or midwives who were unaware of the possible results of injury to the pelvic musculature. It is fatally easy to ignore a slight perineal tear, or to let a perineum stretch just a bit too much, rather than go to the trouble of getting medical aid.

It is just as easy to forget that in this country most women are discharged from hospital in the first few days after delivery, and that, this being so, it is waste of time to perform good perineal care for those few days in hospital. If we failed to teach the mother the importance of boiling the water she washes herself with on her return home, and the necessity of using clean diapers an infected perineum cannot be expected to heal properly, and the result will be a weakening of the pelvic floor.

What about the other supporting structures of the uterus? Do we always recognise the damage done to the cervical ligaments by the practice of encouraging or allowing the mother to "bear down" on an incompletely dilated cervix, or the damage done to the cervix itself by the same practice? Do we always try hard enough to prevent premature "bearing down" efforts?

The discomforts associated with prolapse are legion, and I would go so far as to say that the effects of these discomforts on the mother can materially contribute to the tensions and unhappiness which can break up a home.

(b) *Fistulae*. Here in India it is still all too common a sight to see a young—often very young, woman brought into the gynæcological clinic in a state of abject misery, her clothing saturated and offensive from the continual dribb-

ling of urine due to vesico-vaginal fistula. It is equally common to admit to the labour room, a young primigravida who has already endured days of torturing labour. The macerated foetal head will be jammed in the excoriated vagina, and the bladder will be grossly distended. A day or two after the birth of her stillborn baby, the mother will develop a fistula. The plight of these girls with fistulae is pathetic in the extreme. Only seldom is a plastic repair entirely successful; the majority of the sufferers are doomed for the rest of the lives to a state of virtual widowhood, childless and unwanted in their husband's home.

"It doesn't happen to my patients", you say? Well, perhaps not, but it **does** happen, and every trained nurse and midwife must take it upon herself to preach to others the necessity for a continually empty bladder in labour and the importance of recognising delay in the second stage. This is particularly the duty of those who work in the domiciliary field, and have contact with untrained women practising midwifery.

Recto-vaginal fistulae are, mercifully, rather less common, but they too, occur, and are always the result of failure to recognise delay in the second stage of labour.

We, as trained nurses, cannot be entirely blamed for disasters which occur as a result of failure on the part of the patient to seek proper care from qualified people, but it is salutary to ask ourselves "Why do so many women still call the untrained *Dai* when their labour starts, although they know where trained attention is to be had?" The answer to this question is very important. We know, of course, that tradition dies hard, and traditional practices account for some of the mistakes, but is it not also true that one very important reason why women call the untrained *Dai* is because they know with certainty, that they can rely on her for sympathy and understanding and **constant attendance** during this time, and they are not at all sure they can

rely on us for the same things? Too often in hospital they are left alone on the labour room bed with no one to offer an understanding word or touch, and too often the relatives are treated with a total lack of sympathy in their natural anxiety. Too many domiciliary midwives tend to adopt a "superior" and officious attitude when they visit the home. These things weigh against us when a mother is deciding who she wants to deliver her baby, and she chooses to risk her life in the hands of the untrained *Dai*.

We **must** look to these things if we honestly wish to see better care for all the mothers of India.

Infection

Sepsis used to be first on the list of causes of maternal death. Since the advent of antibiotics, deaths from this cause have been greatly reduced, though not eliminated altogether, and most certainly the incidence of morbidity from this cause must still be very high. I am not referring so much to those women who run a high temperature in the puerperium, and have obvious signs of sepsis; such patients will almost certainly receive the treatment needed to put them right. Rather, I am thinking of the patient who has a persistent mild pyrexia, insufficient to excite attention, but which will inevitably become chronic and a danger to health. Mild infection of the pelvic veins is a common cause, may lead on to infection of the femoral veins and even to infection of the kidney, and will undoubtedly produce that tired "under the weather" feeling so disastrous to the well-being of the newly delivered mother. I think it is true that many of such patients infect themselves, but isn't the fault partly ours if we fail to teach the importance of hygienic practices, such as washing the vulva with boiled water, use of clean boiled strips of cloth for diapers, and general cleanliness of the skin and clothing? I think this failure occurs more often in the practice of hospital nurses than it does in that of domiciliary nurses, but such

teaching on health matters must be regarded as an important part of the duties of all of us, if we wish to see our patients healthy when they have left our care.

There are other potential sources of morbidity about which authorities often fail to agree, among them, retroversion of the uterus and cervical erosion; neither of these can be positively stated to cause trouble in all patients, but in many women symptoms do arise which could be cured if the condition was recognised and treated. Indeed, so far as retroversion of the uterus is concerned—it appears to be a frequent cause of trouble in a future pregnancy and many women suffer from acute retention of urine in early pregnancy from this cause. This being so, it is up to us to see that all our patients understand the importance of a post-natal examination, whether they have symptoms or not, for only routine examination at the end of the post-natal period will eliminate these possible causes of future ill-health.

Mental Ill-Health

I have left this point until the last, not because it is the least important, but because it is the most difficult to assess.

Let us remind ourselves of the international definition of health, which, after all, includes mental health. It is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." It is evident, therefore, that there are all too many

women who are not really mentally healthy, and much of this ill-health can be attributed to their experiences of childbearing.

Have we, I wonder, understood and accepted our responsibility for the harm done to the mind of a woman who is frightened in labour, or who suffers excruciating pain either as a result of tension due to fear, or from actual mechanical difficulty? Do we regard it as our responsibility to try to alleviate this mental agony, or do we simply dismiss the matter as something due merely to the temperament of the woman concerned and therefore not of particular importance? Do we ever ask ourselves what it is that makes some women appear to suffer agony in what could otherwise be regarded as normal labour, while other women appear fairly calm and comfortable? Do we try those of us who work in hospital—to put ourselves in the place of the young primigravida, leaving her village home and coming to hospital for the first time when she is in labour? Do we try to imagine how it feels to be whisked away from our relatives by masked strangers, into a white-walled, curtained room often with cupboards displaying fearsome-looking instruments? Can we imagine how it feels to be subjected to examinations we don't understand, made by people who don't tell us what they are doing, or why they are doing it?

Of course, we know labour room nurses are very busy, but I truly believe that to pay attention to matters like these is even more important than the mere act of

catching the baby. I do not think we can possibly estimate the far-reaching effects in a woman's life, of the memory of terrifying labour. It is true that a certain degree of amnesia seems to be associated with labour; it is also true that the problems are perhaps greater for educated mothers, conditioned as they are by the harrowing things they read about childbirth and the harmful propaganda that is sometimes published, than they are for the unsophisticated woman who accepts childbearing as a natural biological function, but the fear is there for both types of women.

If we could only understand that the basic problem is loneliness, physical and mental, we could, without much added effort, do a great deal to alleviate this distress of mind and bring comfort to the mothers in labour under our care. By our sympathy and understanding, by our efforts to dispel the ignorance which breeds fear, and by judicious use of the pain-relieving drugs at our disposal, we could do much for the mental well-being of our patients at this time. I feel sure our reward would be in happier mothers, who make happier homes.

Those of us who have elected to practise midwifery as our profession, have taken upon ourselves a tremendous responsibility, but we have a tremendous privilege also, for in our hands lie the health and happiness of so many women, and through them, the happiness of so many homes. It is up to us to see that our job is carried out to the very best of our knowledge and ability.

World Health Day - April 7
