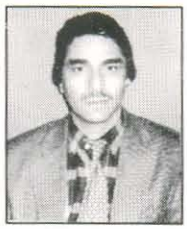
EDITORIAL



Reproductive Health in the Developing Countries

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We all face poignant moments sometimes or the other in our clinical practice, after all we are all human beings in the first instance. I encountered one of these poignant moments last month when a young lady living 70 miles from Srinagar came to my Gynaecological out-patients' clinic. Holding her frail father's hand, she entered the consultation room stinking of urine and tears in her eyes. She indeed had a urinary fistula following delivery of her fifth child at home, six months ago. I had no problem establishing the cause of her fistula which of course was the rupture of her previous caesarean section scar, involving the bladder as well. She had been lucky to have escaped death from post - partum haemorrhage, but had been living with a socially unacceptable condition ever since. This resulted in ostrisisation and separation from her husband. The account of this unfortunate young lady is enough to make us understand the gravity of maternal morbidity in places where maternal care can almost be nonexistant at times.

The appalling global problem of maternal mortality received belated recognition and in view of this the first international conference on Safe Motherhood was held in Nairobi in the year 1987. Ever since the majority of developing countries have made efforts to reduce the estimated 5,00,000 deaths occurring mostly in the developing world. There were expectations and everyone hoped that the various programmes that were being developed locally in individual countries, would substantially reduce maternal deaths. Despite increase in coverage of prenatal care in many countries, it seems very little has been achieved in respect of reducing maternal mortality (1). On the other hand countries like Chile, China, Cuba, Iran, and Sri Lanka have all developed a long term plan, supported by a strong political will to reduce maternal mortality. They were able to achieve this through successful development of systems of care to harness scarce resources including human, educational, and financial to maximise reproductive health (2). The countries who were unable to meet the goals, could learn from their (Cuba, Iran etc) policies and help prevent maternal mortality and morbidity. Policies for example would include setting national standards, using evidence based protocols, improving staff strength and attitudes and most importantly having a long term national plan for the development of maternal health care. We should try to stand shoulder to shoulder with everyone and anyone involved in the world wide Safe Motherhood Initiative.

There remains the less clearly highlighted problems of the reproductive morbidity affecting millions of women in the developing world including sexually transmitted disorders especially HIV, pelvic

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inflammatory diseases, infective sequeale of unsafe abortions and obstetric fistulae. There is little information about morbidity, "the hidden part of the ice berg" but for every maternal death, it is supposed that another 16 women suffer serious health consequences from either pregnancy or childbirth (3).

Both maternal mortality and morbidity can be avoided if some basic principles are observed for example preventing unwanted pregnancies by providing good family planning services thus reducing deaths and morbidity from septic abortions, preventing complications during pregnancy through provision of effective antenatal care and delivery services or by making sure that the complications that do arise are taken care of effectively through proper referral and tertiary care services.

At the same time Obstetricians and Gynecologists in the developing world must go beyond the provision of immediate care and in addition involve themselves in developing effective system of care together with midwives, nurses, traditional birth attendants, teachers and anybody who can influence the society including local leaders and politicians, they need to be armed with the skills to assess local priorities to deliver effective local solutions and monitor the effectiveness of planned changes. They must place themselves in positions where they can influence and then implement policies which will deliver and then improve reproductive health.

The image of the young woman I saw and treated (the patient is continent after a successful fistula repair) is a powerful symbol of current needs.

References

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2. WHO (1991) Essential Elements of Obstetric Care at First Referral Level. World Health Organisation. Geneva, Switzerland.
3. Liskin LS. Maternal morbidity in developing countries. *Int J Gynaecol Obstet* 1992 ; 37 : 77-87.

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