

## Some Aspects of Obstetrical Practice in Malawi\*

BY

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We are told there are two sides to every question, and with regard to midwifery in Malawi they are, on the one hand, completely spontaneous delivery on the roadside, pick up the baby and walk home; and on the other hand, days of suffering followed by ruptured uterus or post-partum haemorrhage and death. This gloomy side is all too common, and will continue to be so while there are too few trained midwives, and therefore too many women dependent on granny's so-called "help."

Customs differ a little in different parts of the country about delivery; some allow it in the house, some build a grass shelter nearby (the *chikhuta*), and others—for example, the Alomwe—go out into the bush with no shelter at all. The conduct of labour in villages has to our

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\* Paper read at conference of Medical Association of Malawi.

minds three main drawbacks: the women are encouraged to push from the first contraction, they are given no encouragement to pass urine, and they are usually given little food or drink. These customs, along with a minor disproportion or a malpresentation, and with the added hazard of large doses of an oxytocic (constituents unknown) native medicine, cause much suffering which could have been avoided with ordinary care. Once things start going wrong, they obviously quickly become worse under this kind of treatment. Women here expect to have about a 12-hour labour; once delay is obvious, the cause is thought to be that the patient has committed adultery, and she is pressed to give the name of her partner in crime—pressure which can continue for some hours, thereby increasing the delay in seeking help. Further delay is caused in many areas by the need to collect enough money round the village to pay for a car or lorry or ambulance to get the patient to hospital, for not all are near a Government health unit or hospital.

The placenta is expected to be expelled by the mother's own efforts; no interference is made to help it out, which is probably lucky on the whole, but does mean some unnecessary retained placentae. We had one last month which had been in the uterus for seven days. It was caught up at one corner, but should have been expressed easily enough early in the third stage. The smell was rather overpowering, but the patient did very well. Lack of interference also means that if a patient has a postpartum haemorrhage nothing is done to stop it; and although postpartum haemorrhage is remarkably rare, we do hear of women dying at home from one.

If the baby is born alive the cord is tied with dirty string or cloth, and cut with equally dirty knife or grass. It is dried by being smeared with ashes and, inevitably, soil, hence the neonatal tetanus. In Mlanje, if grandmother sees that there has been a lot of moulding of the foetal skull, she tries to correct this by squashing the head back into shape—which I would think would not do the tentorium much good.

A few points about abnormalities. During pregnancy I would say there is less bother than with Europeans in village women—I do not refer to the urban Africans who adopt European habits. For example, hyperemesis gravidarum in uneducated women is practically unknown in my experience, and toxæmia of pregnancy is rare. Though fits are occasionally seen in labour, these are usually caused by epilepsy or native medicine. I read that in the United Kingdom the associa-

tion between toxæmia and accidental antepartum haemorrhage, which we were taught existed, is now not thought to be, yet we notice here that accidental haemorrhage as well as toxæmia are rare, which would suggest an association. A few grand multiparæ have varicose veins of legs or vulva, but this seems less common than in Europeans, perhaps because of the more active life of the African women.

We have noticed several times the extreme enlargement of breasts in very young primigravidae, pregnant immediately or within months of the menarché. This is not just disproportion of size, but really enormous enlargement, presumably because hormonal balance is upset—but why?

During labour, apart from the mismanagement mentioned earlier, there is the phenomenon of the high head in both primigravidae and multiparæ. It is the exception for the head to fit into the pelvis before labour begins. Pelvic measurements are about one inch smaller all round than in Europeans, but babies are also one pound smaller—average 6 lb. 7 oz. The non-descent is thought to be due to the tilt of the pelvic brim with exaggerated lumbar curve, probably a racial characteristic. The high head can cause a lot of alarm during labour, and it still causes me a lot of astonishment when a floating head suddenly shoots through the pelvis. But sometimes a brow presentation deceives one, and it normally does not shoot through the pelvis. We try to teach our pupil midwives about the dangers of brow presentation, and the need to recognise it promptly and to send the patient to hospital, where she may need operative delivery. Three years ago we were rather disconcerted when we had three brow presentations in one month and all delivered spontaneously—another proof that babies never read the textbooks.

During labour we now have an added help in Malmström's vacuum extractor. We use it more and more and find it a great help in very varying circumstances and degrees of parity. In our first 200 cases of vacuum extractor deliveries, 110 were for primigravidae, 48 in para 1-3, 28 in para 4-6 and 14 in para 7 and over. We find the main indication to be delay in the second stage, but have had successes using it in the first stage lately.

The main indications can be divided as follows:

1. *Delay on the Perineum on Otherwise Normal Confinements*

Delay at the end of the second stage is very dangerous to the infant, more so relatively than at any other time during labour. Here the

extractor is a great help in primigravidae who just cannot manage that last extra push; the child would be delivered probably after half an hour's more work and an episiotomy, but that half hour can be fatal to the child. Put on the extractor and the head is easily lifted over the perineum in a few minutes, with no need for an episiotomy. This makes the puerperium more comfortable for the mother and even put at its lowest value, when hospital beds are scarce, it is good to be able to prevent the need for extra days in hospital. The vacuum extractor is also the quickest means of delivering a foetal distress at this stage. No anaesthesia is necessary, and we find in these cases it is not necessary to pump slowly for ten minutes to make the vacuum; one can just pump up quickly and deliver. We do not use the lithotomy position.

## 2. *Occipito-Transverse or Occipito-Posterior Positions*

A non-rotated or partly rotated occipito-posterior is one of the main indications for the extractor; how very much easier it is than a manual rotation and forceps, especially if the head has been stuck for some time in a patient coming in from the village, with a hard dry vagina and a small primigravida in whose pelvis there is barely room for the head, let alone a hand and forceps. The extractor is applied on the presenting part, whatever it is, and traction made. The head rotates at the perineum before one's eyes. We have had complete occipito-posteriors suddenly swing round to an occipito-anterior on the perineum, and immediately the head is delivered swing right back again. Here, too, delay on the perineum in a persistent occipito-posterior kills babies, and patients even in properly conducted confinements do find it hard to deliver because of the lack of the flexion-extension mechanism. The extractor may rotate the head as mentioned or may bring it out still in the posterior position. This use alone of the extractor would be enough to warrant every maternity hospital having one. Of our 200 cases, 45 were in the transverse and 23 the posterior positions.

## 3. *Poor Co-operation in the Second Stage*

Perhaps because of being tired after pushing in the first stage, or sometimes just a difficult patient. The pull of the extractor in the latter gives more incentive to push and therefore better co-operation, and for the former provides just the help that is needed to deliver the head.

## 4. *Completely Exhausted Patient in Inertia*

Here we sometimes fail with the extractor, but if the patient can push even a little we can save a

lot of damage to vagina and perineum—damage practically unavoidable when a head has been stuck for days in the hot dry vagina. In these cases every minute's delay means greater danger of developing a fistula. If there is complete inertia we find that by applying the extractor, giving a long steady pull and asking the patient to push at regular intervals, making then a stronger pull, even in the absence of contractions, we can often succeed in delivering the head. We sometimes make a small episiotomy, although we try to avoid one, as the tissues are so damaged the wound will not heal well.

If the head is above or just in to midcavity in a similar case after days of labour, and one knows it is going to be difficult to deliver the woman either by the vaginal or abdominal route, we try the extractor for 15 to 30 minutes and, if no obvious advance is made, do a section; but sometimes the head is brought low enough to enable an easy forceps delivery. I think caesarean section in inevitable sepsis should be avoided if possible, but it is difficult to decide which route will do least damage after a three to five-day labour. We delivered one woman after a six-day labour, though the baby was naturally stillborn.

## 5. *Delay at the End of the First Stage*

With an irregular cervix, or where dilatation has ceased to progress, and where putting on forceps would damage the cervix, and section the only alternative means of delivery, we find that by applying the extractor, pulling steadily without the patient's pushes, the cervix dilates and we can then get the patient to push with contractions and deliver. We have used this mostly in multipara, but I think should use it more often in such cases of delay.

## 6. *Rarer Indications*

**Cord Presentation.**—After replacing the cord prolapsed at a few fingers' dilatation, the smallest cup can be applied to the head instead of using Willett's forceps to hold the head against the cervix. Also, if the cord prolapses with the head at almost full or full dilatation, application of the larger cup expedites delivery and saves the baby and is quicker than doing a section.

**Breech.**—We have tried the extractor twice in a breech presentation, and although it brought the breech lower into the pelvis, I still had to do a breech extraction. One baby was dead on arrival in hospital; the other was a slow descent with an 8 lb. 6 oz. baby and probably should have been delivered by caesarean section.

Compound Presentation.—The extractor can be used after replacing the arm in the uterus.

Brow.—I have not yet tried the extractor in a brow presentation, but I understand it can be used by varying the positions of the cup to convert it to a vertex presentation.

#### FAILURES

In the first 100 cases we had 17 failures, but in the second 100 only nine. Of the 17, 11 had pushed for long periods in the villages before admission, one was epileptic and unconscious and the others gave no co-operation. Sixteen of these were delivered by forceps, one by caesarean section. There were only five live babies. Of the nine failures in the second 100, six had pushed for long periods in the village, two were tentative applications of the extractor followed by section, and the ninth was an 8 lb. 6 oz. baby delivered by section. These three babies were alive, but the six delivered by forceps were lost.

The vacuum extractor works at a pressure of c. 22 lb. per square inch, and if force greater than that is needed the cup comes off; it cannot therefore be used to force a disproportionately large head through the pelvis, and it is usually insufficiently strong if the mother does not push at all. We usually apply the medium-sized cup first, and if this is not sufficient the larger one can be used when the head is nearer the outlet, and usually succeeds.

The vacuum extractor can be used with greater safety than forceps for a trial of vaginal delivery, as the cup is applied to the presenting part; there are no blades to go deeply into the pelvis round the baby's head. If it is obvious that no progress is being made, caesarean section can be done with little more danger of sepsis than that which follows a vaginal examination.

Altogether the vacuum extractor is a most useful addition to obstetric manoeuvres; we would not be without it. It has, too, the advantage of being easily taught to, and used by, midwifery sisters; this is very useful in a "one-doctor hospital."

Obstetrics can be a most happy occupation. It can also be a most worrying and unhappy one when lives of child and mother are lost or made miserable by vesico-vaginal fistulae—tragedies which could so easily have been averted by trained care. We look forward to the day when every woman in labour in Malawi will be attended by a trained midwife. May it come soon.