

Obstetrics in the Transkei*

DAVID SIMMONS, M.B., CH.B. (CAPE TOWN)

SUMMARY

A survey of 1 286 deliveries was conducted at Sir Henry Elliot Hospital, Umtata, over a period of 6 months, from July to December 1970. All the patients were Bantu, mostly from primitive social backgrounds. Incidence of illegitimacy was remarkably high because of the custom of proving fertility before marriage.

Complications during pregnancy and labour such as eclampsia, postpartum haemorrhage, ruptured uteri, vesicovaginal fistulae and high perinatal mortality, were often a result of poor antenatal care and deficient family planning. Antenatal attendance has to be encouraged if obstetric care is to improve. There is obviously an urgent need for medical services in the Transkei to provide maternity clinics in the outlying districts. There is also the problem of teaching the primitive Bantu modern family care.

S. Afr. Med. J., 45, 1081 (1971).

The most important duty of woman in the Xhosa tribal life is to bear children. This custom has led to busy obstetric units in Transkei hospitals, though there is currently a tendency for this custom to be replaced by the more civilized idea of family planning. Similarly, more modern methods of childbirth are now being adopted. The traditional method involved the woman giving birth in a squatting position in a special hut. The umbilical cord was cut with a reed, and a mixture of ash and sugar was smeared on it. This lack of adequate supervision and antenatal care has resulted in a fair amount of mortality and morbidity due to ruptured uteri, vesicovaginal fistulae, eclampsia and postpartum haemorrhage, etc.

CLINICAL MATERIAL

This survey was conducted at Sir Henry Elliot Hospital, Umtata, Transkei, from July to December 1970. A total of 1 286 deliveries were conducted at the Obstetric Unit of the hospital, approximately 200 deliveries per month. The Bantu were mostly Xhosa from all their social strata. There were a small percentage of Coloured deliveries and no White deliveries in this series. Patients came from areas surrounding Umtata, as well as from distant areas after being referred to this hospital from mission hospitals in the Transkei.

Illegitimacy

The Xhosa woman is often traditionally required to prove her fertility before she marries because the husband

TABLE I. GENERAL INCIDENCE OF OBSTETRIC FEATURES IN A SURVEY OF 1 286 PATIENTS

	No.	%
Illegitimacy	483	40
Pre-eclamptic toxæmia	39	3.0
Antepartum haemorrhage	22	1.9
Twin pregnancy	44	3.6
Vacuum extraction	40	3.3
Caesarean section	78	6.3
Ruptured uterus	12	1.0
Postpartum haemorrhage	18	1.5
Sterilization	15	1.3

has to pay her father 'lobola' of a number of cattle. He wants to make sure that she will bear him children before he enters into the deal. We find that there is consequently a high incidence of illegitimacy. Many of these unmarried mothers were subsequently married but many were not for various reasons, so that some unmarried women had up to 9 children. There were 483 unmarried women who had their deliveries in hospital, making a total of 40% of all the deliveries in this series. This percentage is much higher than any in a Western community.

Age

The patients' ages varied from 16 years and more, perhaps because they realized that they had to state that they were older than 16 years. Often they progressed at a rate of one baby a year, which resulted in the previous baby being removed from the breast at a tender age and being fed with 'Ngnoosh' water from a bottle instead. This is the liquid obtained from boiled mealies—a favourite food of the Xhosa. Consequently some children are malnourished while others are very well nourished as a result of continued breast feeding.

Antenatal Attendance

Antenatal clinics are very poorly attended by the vast majority of women because of their ignorance and also because of their distance from the clinics. Those attending are mainly the more affluent Xhosa and the Coloureds.

COMPLICATIONS DURING PREGNANCY

Pre-eclamptic Toxaemia¹

This occurred in the usual way in young primigravidae and in elderly hypertensive women. Pre-eclamptic toxæmia

*Date received: 15 March 1971.

was diagnosed by the presence of two or more of the following signs: blood pressure of 140/90 mmHg or more, albuminuria and oedema. One maternal mortality occurred in an unmarried girl of 18 years who had fits after the delivery of a stillbirth. However, another young girl who had eclampsia and was unconscious for 3 days made a remarkable recovery. The incidence of pre-eclamptic toxæmia was 3.0% (39 cases).

Antepartum Haemorrhage²

Antepartum haemorrhages occurred in 1.9% (22 cases) over the 6-month period. They can be divided into all aetiological types: accidental haemorrhages, placenta praevia and antepartum haemorrhages of unknown cause. There was one maternal death and numerous foetal mortalities. The maternal mortality was due to a massive postpartum haemorrhage after caesarean section in which a grade 4 placenta praevia was diagnosed. Unfortunately the woman had bled severely in the ward. She died under anaesthetic while a caesarean section was being attempted.

Twins

The incidence of twins was 3.6%—a total of 44 cases of all the deliveries. The twins delivered were often premature. Two cases had had previous caesarean sections which had to be repeated due to cephalopelvic disproportion. Two second twins had to be breech extracted. There was 1 maternal mortality and 5 cases of foetal mortality. The maternal mortality occurred in a young unmarried woman of 19 years old who had an excessive postpartum haemorrhage after delivery during the night. When she presented at hospital she was immediately resuscitated, but she went into irreversible acute renal failure from which she never recovered.

COMPLICATIONS DURING LABOUR

Prolonged Labour

The Bantu are known to have a high incidence of android-shaped pelvis and this often causes delay in labour due to cephalopelvic disproportion. On pelvic examination the foetal head is seldom found to be engaged before the onset of labour. If the second stage is not completed within 60 minutes the delivery is assisted, provided there is no maternal or foetal complication before then. The efficiency of uterine action in the Bantu woman can be judged by the number of times the baby is delivered spontaneously despite minor cephalopelvic disproportion.

Because of the android shape of the Bantu pelvis, there is simply no place for forceps, so that vacuum extraction was used to assist delivery in 40 cases, which constituted 3.3% of all deliveries. This mode of assisted delivery was successful in overcoming minor degrees of cephalopelvic disproportion but in major degrees caesarean section had to be resorted to.

There was 1 case of vesicovaginal fistula. This occurred in a primigravida who had a severe tuberculous kyphosis, which caused the maximum pressure to be on the vaginal wall separating it from the bladder. She had been in labour for some time before she came to the hospital, where she had a caesarean section.

Soft-tissue disproportion is known to be common in the Bantu, as they have better-developed perineal musculature than Whites.

Caesarean Section

Cephalopelvic disproportion was the most common indication for caesarean section. Other indications were, in order of incidence: placenta praevia, prolapsed cord and tuberculous spine. The total number of patients who had caesarean sections was 78, which constituted 6.3% of all cases. Foetal distress as manifested by meconium-stained liquor was often secondary to a major degree of cephalopelvic disproportion causing prolonged labour. The babies delivered under these conditions were often found to have very low Apgar ratings, and needed vigorous resuscitative measures, such as suction of thick meconium and intubation to supply oxygen. In the case of a prolapsed cord, with the cervix only 1-2 fingers dilated, the woman is rushed to the theatre if the cord is still pulsating, and caesarean section is commenced within quarter of an hour after the patient leaves the ward. This is made possible by the availability of an anaesthetist and theatre staff who are on constant standby for any emergency throughout the year.

Ruptured Uterus

This surgical emergency was unfortunately common, namely 12 cases, constituting an incidence of 1.0%. The reason for this is that the rural Bantu women are uneducated and not aware of the advantages of antenatal supervision. All 12 cases were sent in from outlying areas after being in labour for 2-4 days. They were usually suffering from shock, with the foetus easily palpable through the thin abdominal wall which was stretched from numerous previous deliveries. These patients were immediately taken to the theatre, where they were resuscitated and operated on simultaneously. A subtotal hysterectomy or suturing of the tear was usually done. Two patients in whom the tear was in the lower uterine segment scar had had previous caesarean sections. Two cases were primigravidae who had been in labour for a long time. One ruptured as the abdomen was being opened, and the tear was simply extended so that the baby could be delivered. The other primigravida had a large tear almost completely around the lower uterine segment, so that it was virtually only held by the uterine arteries. A sub-total hysterectomy had to be performed. Forceps are virtually never used so that there were no cases of instrumental rupture of the uterus.

The results of immediate operation in the case of a ruptured uterus were excellent even when the patient was severely shocked. All patients operated upon recovered and

after 7-10 days were discharged from hospital. Thus immediate diagnosis and surgical treatment of these cases are mandatory.

DISCUSSION

This survey illustrates the problems encountered in a primitive society where there is a gross lack of antenatal instruction and supervision. The correction of this state of affairs should be one of the main objectives of medical services in the Transkei. Some mission hospitals have large antenatal attendance figures and give instruction while the mother is in the ward during the delivery. Another suggestion is that there should be clinics run by qualified midwives in the outlying districts.

The management of complications during pregnancy are well illustrated in this study: pre-eclamptic toxæmia should be controlled and early admission to hospital is desirable in order to prevent eclampsia. Early resort to caesarean section should be considered in order to save the foetus. Antepartum haemorrhage is always to be regarded in a serious light as there is the constant threat of a fatal haemorrhage. These cases should always be admitted to hospital for investigation and management. Cases of multiple pregnancy are known to be more prone to all the complications of pregnancy than single pregnancies. The most important of these complications is probably postpartum haemorrhage, which, if anticipated,

can be managed in all cases by commencing intravenous fluid therapy during the first stage of labour. If there is any suggestion of postpartum bleeding, oxytocics may be added to the intravenous fluid.

In the management of complications during labour the following was thought to be most acceptable in the case of prolonged labour: A trial of labour was conducted in cases of minor cephalopelvic disproportion. If at the end of 60 minutes in the second stage the woman had not delivered, vacuum extraction was attempted, and if this failed, vaginal bypass was resorted to for delivery.

Caesarean section was considered mandatory if there had been 2 previous caesarean sections, but if there had been only one previous section, a trial of labour was allowed, provided the pelvis was adequate. Sterilization was advised after the fourth caesarean section. This was usually readily agreed to as this method of contraception is the most acceptable to the Bantu.

The incidence of ruptured uteri presented a grave problem, but the prompt diagnosis and management of this condition yielded gratifying results. Immediate resuscitation and surgical intervention were found to be life-saving in every case.

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