Review of Perinatal Mortality in Kashmir
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Perinatal death rate reflects the amount of pregnancy wastage due to the fetal losses in the last trimester of pregnancy and the neonatal deaths during the first week of life. It is a sensitive indicator of reproductive medical care.

In the UK the stillbirth rate is around 5/1000 births and the neonatal death rate is around 3.3 per 1000 live births. The perinatal mortality rate (PNMR) is manifold higher in the developing countries due to nonavailability and/or suboptimal obstetric and neonatal care.

Fetal and neonatal death rates continue to be high in Kashmir. A study was undertaken by Javeid and Mir in a tertiary care hospital setting in Srinagar (1987-88), to identify the preventable factors operative in fetal and neonatal losses (1). Over a period of one year, out of a total of 1,600 consecutive deliveries, 1,107 obstetric deliveries were considered to be at-risk; there were 33 fetal and 31 early neonatal deaths with an overall perinatal mortality rate of 40/1000 births.

Perinatal mortality was higher in mothers who had received inadequate antenatal care and/or those with a bad obstetric history. Major maternal and obstetric factors associated with high PNMR were: advancing maternal age and parity, antepartum hemorrhage, diabetes mellitus, anemia, instrument and vaginal breech delivery. Overall the cesarean section rate was 16.9%. Infants with a gestational age of <37 weeks and/or of birth weight of <2,500 gm contributed for 56.2% and 68.7% of the total perinatal losses respectively. PMR was three fold higher among twins compared with singleton births. Identifiable causes of perinatal deaths observed were: asphyxia (31%), congenital anomalies (18.7%), sepsis (18.7%) and low birth weight (25%).

It was clear from this study that preventable factors were operative in over two third of the cases of perinatal loss and better maternal health and an improved obstetric and neonatal care would favor a better outcome in the majority of cases.

A further study by Fazili and Mattoo in a hospital setting in Srinagar (1994-5) showed PNMR to be still over 43/1000 births; the still birth rate (SBR) and early neonatal death rate (ENDR) were 27.5/1000 and 16.0/1000 births, respectively (2).

A high proportion of babies die from asphyxia due to lack of adequate resuscitation facilities at birth (3).

What is the plight of babies born in the villages, at home or in the district hospitals in Kashmir? How can the family planning measures be effective if the healthcare system is unable to offer a safe delivery and appropriate medical care to the newborn infant?

It is high time the state government adopts a structured and effective healthcare system for the expectant mother, the fetus and the newborn infant (4).
References:


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