mortality in developed countries in the past decades. In developing countries the operative background for cesarean section is not widely available. In these countries the attending personel need to be trained to perform breech deliveries to safely deliver these fetuses.

L123

POSTPARTUM HEMORRHAGE

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Postpartum hemorrhage is defined as excessive blood loss following delivery of the fetus. Bleeding might occur before, during or after the delivery of the placenta. As the consequence of increased blood volume in pregnancy and that of the hemodynamic changes occurring postpartum most patients can tolerate blood losses up to 1500 ml., provided that they are in good health and were not anemic before pregnancy. The diagnosis of postpartum hemorrhage is usually imprecise because for the wide range of blood loss following delivery encountered normally and the inaccuracy of the estimation of the amount of lost blood. The incidence of postpartum hemorrhage is approximately 5-10 % after vaginal delivery.
Postpartum hemorrhage is one of the leading causes of maternal mortality worldwide. Major causes of early postpartum hemorrhage are uterine atony, obstetric trauma, retained placental tissue, uterine inversion and coagulation defects. Causes of delayed postpartum bleeding include: uterine subinvolution, retained placental tissue, endometritis or placental polyp. As caesarean section rate increases in the well-developed areas of the world, dehiscence of the previous uterine scar may be an increasing cause of postpartum bleeding.
When the risk factors of postpartum hemorrhage are suspected or present, preventive measures should be instituted. Correction of anemia before delivery is a basic preventive measure to be instituted. Blood should be readily available in risk patients, like those with known placenta previa. Predelivery replacement of coagulation factors in patients with bleeding disorders should be managed. Prophylactic and proper use of oxytocic agents during and especially after delivery might decrease the risk of atony in the postpartum period.
Two basic principles govern the treatment of postpartum hemorrhage: the bleeding must be arrested and the blood volume must be restored as soon as possible. Successful management with a favorable outcome can be achieved only by correct identification of the cause of the bleeding and a very rapid decision-making at the same time. Wasting time might result in maternal death. Decrease in mortality rates can only be achieved in places where all the vital criteria of controlling serious postpartum hemorrhage met, and a real teamwork is established.

L124

PERINATAL SCENARIO IN INDIA

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New born constetali the foundation of life. Healthy and sturdy baby are likely to evolve as physically and mentally strong adults. Healthy mother produce healthy baby. Female child must be accorded special status and attention. Current population of India is one billion plus.
National Literacy rate is 52% of Female literacy rate is 37.7%. Current perinatal scene in India are indeed dismal. Some Antenatal care of poor quality is received by 60 % of pregnant women. Only 24.5% of deliveries occur at health post and Hospitals. Among domicillary births, only 24.5% of deliveries are attended by trained traditional birth attendants. The current Neonatal and Perinatal mortality rate is 47 and 44 per thousand like births.
There is an excellent pyramid of MCH Services through the network of Sub Centers, Primary Health Centers District and States Hospitals for providing Health care services in rural area. 75% Population still leave in villages.

The provision of health is in domain of individual states but Federal/Central Govt. provide the policy of guidelines and resources for any national programmes. As opposed to recommended allocation of 5 % and 15 % of Gross National Product for health and education respectively by W.H.O., India spares only 2.1 % of GNP for health and education. Only 15 % of health budget is spent on MCH.
Due to integrated child survival services scheme the infant mortality rate has come down to 74/ 1000.
All India Post Partum programme was introduced three decade ago for providing population control services and immunization. But no inputs have been provided to create level II new born care facility.
Govt. of India launch the Child Survival and Safe Motherhood Programme with the help of World Bank and UNICEF in 1992. child survival component comprises of universal immunization, VitaminA PROPHYLAXIS, and rational case management if acute Diarrohea and acute respiratory infection and essential new born care, Neonatal resuscitation and care of sick and low birth weight babies in community.
In 1997 the CSSM PROGRAMME has been replaced by the integrated RCH PROGRAMME. The concept of neonatology first started in early sixties and since then there ahs been a gradual increase in the number of such units in the country.
Ina survey in 1987 only four hospitals was equipped wit level II neonatal untis.
At present 30 Neonatal nurseries fulfill the requirement of level II units. Intensive care services and Ventillation are provided by fifteen of them. Most of them are located at Teaching hospitals in metropolitan cities. National Neonatal Forum was formed in 1980.
Neonatal Resuscitation Programme was launched in 1985 and around 200 paediatrician have been trained. National Neonatal Perinatal Data Network is located at All India Institute Of Medical Sciences, New Delhi.
Neonatal forum has conducted regular annual meetings with Indain Society of Perinatology and Reproductive Biology to enhance collaboration with obstetrician for improving New born survival.
Innovative strategies further care of newborn has been introduced by introduced by introduction of spoon and cup feeding, expressed breast feeding to very small babies in NICU.Most of NICU are focusing efforts on babies 1000 gms. Only a very few tertiary care centers are focusing the care of babies upto 750 gms.
Unlike developed countries where cross training nurses has revolutionized the new born care,in India resident doctors have been trained for this. Due to unsatisfactory referral systems efforts are being made to develop module for identificationa dn management of sick new born babies in community
The future prespective are to improve maternal health,to raise female literacy, to launch healt education programme.
Furthur expansion and strengthening the facilities at First Referral units and District Hospitals and better utilization of MCH Services. Basic Antenatal care to all the preganat mothers delivers to be conducted by trained birth attendants in community. High risk pregnant women to be referred to hospitals for delivery.
Level II perinatal services to all the medical colleges,political commitments, community involvement and multisectoral approach to health is key to health for all
It is hoped due to economic liberalization the MCH care in private sector women expand rapidly and there will be a significant improvement in the status of Neonatal services..

L125

CAN WE GET MORE INFORMATIONS FROM PERINATAL AUTOPSY?

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Most of neonatal deaths occur in perinatal period in developing countries and there are some differancies of mortality rates in one country to another.
Recently; non-invasive techniques for fetal analyses and studies for diagnosis in malformations and hereditary diseases get more people to make detailed pathological analysis of death fetuses and stillbirths. Informations obtained by perinatal autopsies are useful in clinical applications and different scientific areas.
There are important benefits of autopsy like understanding death reason abnormalities in growth of fetus, control of the healt core units, correlation of clinical findings, suplement of cumulative national and