Obstructed labour is one of the most common preventable causes of maternal and perinatal morbidity and mortality in developing countries. The incidence varies from 0-6%. It is more common in humans than in primates because the birth canal of a woman is not as straight or as wide as in primates. It is prevalent in communities in which under-nutrition in childhood is common, resulting in abnormally small pelvises in adulthood. Unfortunately, areas in which nutrition is a problem, are also those in which there is no easy access to functional health facilities with the capacity to perform operative deliveries.

The most frequent causes of obstructed labour are cephalo-pelvic disproportion, malpresentation (brow or shoulder) and malposition of the fetus (persistent occipito-posterior positions). Less commonly, locked twins or pelvic tumour. The management of any obstruction is by careful management of labour to initially diagnose the problem and then to manage maternal exhaustion, dehydration, ketosis as well as any infection before delivery which may be vaginal or Caesarean Section.

Complications of prolonged obstructed labour for both mother and baby are many and include intrauterine infections, trauma to maternal structures including uterine rupture with long term sequelae such as fistulae formation, postpartum haemorrhage, infection, stillbirth, nerve palsy and cerebral damage.

Risk factors for prolonged obstructed labour include short stature, lack of obstetric care, poor nutrition, diabetes and fetal macrosomia,

Prolonged obstructed labour remains a major reproductive health concern in many developing countries where there is urgent need for improved nutrition, education, health systems and the establishment of well resourced obstetric care.