

SOCIAL OBSTETRICS—REDEFINED

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It is nearly two decades since the term "Social Obstetrics" found an important niche in obstetrics. But for some strange reason scant attention had been paid to it in India—may be we were all practising and teaching social obstetrics all the time without giving it a dog-tag—until the World Health Organization came into the picture for the first time in 1966 and offered assistance to medical colleges in India to include social obstetrics in the training of medical students. Many attempts have been made to define the term precisely. So far it has eluded precise definition. At the 1968 meeting on social obstetrics held in Delhi under the auspices of the World Health Organization wherein many teachers from India participated it was observed that the term social obstetrics covers a wide area of responsibility.

The central act of birth is regarded as a culmination of a sequence of events and interacting factors during the whole period of pregnancy and going back to the preconceptional and even premarital periods. The delivery of the child similarly initiates a sequence of events embracing the puerperal and neo-natal periods harmonizing with the paediatric care of the infant and the pre-school age child. The cycle is symbolically completed and the concept of comprehensive family care introduced when the mother returns with her child to an antenatal clinic with a subsequent pregnancy.

There is yet another dimension to this concept of extended obstetric and paediatric care, namely the environment.

Also influencing the reproductive process are other factors—marriage, pregnancy and child bearing are equally conditioned by social, economic, religious and kinship experience. The forms of marriage, expectations from marriage, age at marriage and child bearing, child spacing, etc., bear the distinctive marks of the society in which they occur. Levels of education, degree of literacy and the role of women in society influence the reproductive process.

Social values change slowly and the effective use of a new service must often wait upon a slow re-orientation of customs and beliefs. The merits of obstetrics or gynaecological intervention must frequently be weighed against the patient's fears and beliefs and its repercussions on her status as a woman, wife and mother or wage earner. It then becomes obvious that the obstetrician's freedom of manoeuvre is limited. Thus the obstetrician, particularly in developing countries, is beset with many problems beyond his control.

In a subject as practical as obstetrics, there is a tendency to believe that steady improvement of clinical care will, in time, ensure that childbirth is equally safe for all mothers and babies. The success or failure of childbirth depends as much upon a wide variety of social influences as upon the skills and knowledge of doctors and nurses. With the rise in hospital confinement rates and increasing availability of sophisticated methods of investigation and treatment, it is more than ever important to remember the patient

herself; for the hospital doctor may know nothing of her social and psychological background and is apt to think of her simply as a case for investigation and treatment. Social obstetrics demands that the patient be treated as a human being, a member of a family and community whose various environmental and other factors influence her and her illness and therefore necessitate the consideration and understanding of these factors in planning her treatment by the doctor. She is not just a case.

In so far as social obstetrics is defined as the study of the interaction between the environment and human reproduction, it follows that its problems will necessarily differ from one environment to another. Some of the important differing factors are striking—the large population in the country, estimated to be about 574 million, its distribution (80% rural and the rest urban), and the annual rate of increase of about 2.3%. Forty per cent of the population are under 15 years of age and about 22% are potential mothers within 15-44 age group. It is estimated that 82% of the potential mothers live in over 55 million villages mostly of fewer than 500 inhabitants widely scattered with poor communications. Only a small number live in the towns where they are within reach of maternity services.

Malnutrition of the large majority of the mothers, its influence on their height and weight and the birth weight of infants, associated diseases complicating pregnancy—infectious diseases (smallpox, cholera), gastro-intestinal disorders, infective hepatitis, anaemia and tuberculosis, to mention a few—are other factors influencing the reproductive process and differing from those in the well developed regions. Neglected labour, a high incidence of grand multiparity with its at-

tendant high risks, the attitude of patients to existing obstetric services which often leads to under utilization, are other features peculiar to developing countries.

A high birth rate is characteristic of developing countries, thus again differing from the well developed regions. The risks of high parity births for mother and child are well known and documented. The higher incidence of both spontaneous and induced abortions, of antepartum haemorrhage, severe anaemia, maternal diseases such as diabetes and hypertension, obstructed labour and rupture of the uterus are some of the serious complications observed in women who have had more than four pregnancies. So also is the maternal and perinatal mortality, which shows a sharp rise after the fourth pregnancy. The adverse influence of maternal ill-health on the babies is also demonstrable, particularly in the low socio-economic group. Malnutrition of surviving infants and high perinatal mortality are often associated with a large family resulting from repeated pregnancies at frequent intervals. Hence any scheme of social obstetrics cannot but take into consideration the problem of fertility control as an important factor in its programme.

High infant mortality is one reason for consecutive pregnancies that debilitate the mother and result in maternal morbidity. Family planning will not be individually accepted until optimal outcome of pregnancy is ensured by a reduction in foetal, infant and childhood mortality. In developed countries the reduction in mortality rates caused by improved public health and medical services has already been accompanied by a gradual decrease in family size. Reduced family size in fact is one of the factors contributing to decreased infant mortality. Apart from mortality rates the hope of positive health

for mother and child and an acceptable standard of nutrition in reasonable living conditions is endangered by excessive family size. Family planning should be advocated as a means of improving family nutrition by limiting the number of children so that all can be cared for adequately.

If, therefore, there is a dire need for controlling reproduction from the point of view of maternal and child health, there is greater need to ensure the survival of the babies born by reducing perinatal and infant deaths. Only then will family planning be acceptable to the parents. Parents who are satisfied that their children are likely to remain alive appear to show a greater tendency to practice family planning, but reproduction remains largely unregulated in countries where infant and child mortality are still high. To bring about further reduction of infant and child mortality a sustained effort must be made to strengthen the health infrastructure and to provide at least essential curative and preventive services including family planning.

Many potential advantages result from providing family planning through the system of health care. The management of problems of reproduction associated with pregnancy, lactation, sterility, family planning, abortion, sex education and many other problems require skills and techniques that are available in the general health services, particularly maternal and child health services. Family planning services that are integrated with such services can deal with all these related problems. It now behoves us to seek ways and means of integrating family planning services with general health care and more particularly maternal and child health care. Herein is a vital role for social obstetrics.

Another striking feature is the distribution of available physicians. It is stated that in India the ratio of physicians to population is about 1:5000. But their distribution is very unbalanced. More than 80% of the physicians are working in urban areas while 80% of the population is rural. This obvious maldistribution of doctors demonstrates clearly their unwillingness to settle down in rural areas, whatever their reasons may be. Running parallel is the great dearth of trained nurses, auxiliaries and midwives. Such a dearth of trained personnel poses very difficult problems in offering obstetric service to the community in villages.

Thus in India not only do we see the unchecked uninhibited play of environmental factors to an extent unknown in the developed countries but we can expect the nature of our social obstetric problems to differ from those documented in those countries. It also becomes obvious then that the concept of social obstetrics in the well developed regions of the world cannot be transplanted in its entirety to the less developed regions. Because of various differing social, economic, cultural and other factors a different interpretation of this concept has become necessary. While accepting the influence of environmental factors on human reproduction which have been so well documented, in developing countries social obstetrics has yet another dimension and that is the influence of these factors on the organization, delivery and utilization of obstetric services by the community.

The influence of environment can be removed by taking away the pregnant mothers from their homes to hospitals or by providing good medical care at home as is happening in the developed regions of the world where almost all are delivered in hospitals or under good medical

supervision. In India, perhaps less than 20% have any form of skilled attention at delivery and for years to come it may not be possible to offer institutional delivery or medical care to all pregnant women. This important aspect of social obstetrics while having little relevance to the situation in the developed regions of the world has greatest relevance to the developing regions of South East Asia. Further the teaching of "social" aspects of obstetrics has become a routine in obstetric teaching in all medical colleges and is now considered as part of good obstetrics. Nevertheless, if it is to be relevant to the context in South East Asian countries, social obstetrics should include the mode of delivery of comprehensive maternal and child health care service including family planning so that they can be brought within reach of the total community. The term 'social obstetrics' should now be redefined and replaced by maternal and child health including family planning (MCH/FP).

Objectives in training students

Social obstetrics having been redefined to include delivery of comprehensive maternal and child health and family planning services, it is necessary to have a clear idea of the objectives of training students. Whatever the content and type of training, the aim is to enable him to play a decisive role in the national health programme which is based on the primary health centre as its unit. About 60% of a physician's work at a primary health centre comprises of maternal and child care—not only preventive but also curative. The first objective of training students should be to instill into them the concept of comprehensive maternal and child care and remove from their minds the age old concept that obstetrics is

only antenatal, intranatal and postnatal care and is thus concerned mainly with technical skills. More than 80% of India's population live in villages. The problem of obstetrics in India thus being a rural one, an equally important objective of training students should be to teach them how to deliver an integrated MCH/FP service in the rural area.

With the upgrading of a large number of primary health centres envisaged in the next Five Year Plan there will be a great need for physicians trained in the delivery of comprehensive integrated MCH/FP service. This raises the question what is MCH?

Maternal and Child Health (MCH)

It is difficult to define precisely this term at present but in actual practice it would mean comprehensive maternal and child care (preventive and curative). Such care necessarily includes family planning advice and service, for the evil effects of unchecked multiparity on both mother and child are well known. Family planning thus forms a part of family health, more particularly maternal and child health services.

MCH has many components. Its important components are (a) obstetrics, (b) paediatrics, (c) family planning, (d) knowledge of health administration, (e) the role of various health personnel in a primary health centre and (f) the health team concept. All these components require to be taught in theory and practice with different degrees of emphasis. At present there is no curriculum which implements this teaching. There is an urgent need for one.

MCH is a comprehensive term more comprehensive than obstetrics or paediatrics in certain aspects. It is an integrated service and not a fragmented one.

Amongst others it emphasizes the fact that mother and child together form a single unit and not two—a tendency that has crept into the students' minds in teaching institutions as a result of the two disciplines—obstetrics and paediatrics—working in water tight compartments and not in an integrated manner. Integrated teaching between the two departments is perhaps the only way to impress on the students' minds the basic fact of the mother and child being one unit.

Pre-requisites for training

There are two dimensions for MCH/FP training. They are: (a) training in the field, (b) institutional training. Of these, training in the field requires a greater emphasis than that given to it at present since the aim is to prepare the student to deliver MCH/FP service to a rural community within the environment. This does not mean institutional training is to be ignored or neglected. The academic and scientific aspects of obstetrics now being taught are very necessary as they are the basis on which the technical skills necessary to deliver the service are built. So are the technical skills themselves which can be taught only in institutions.

Institutional Training

Co-operation between the obstetric, paediatric and preventive and social medicine departments in planning the theoretical and practical curriculum, so as to avoid overlapping and duplication of effort, is essential. Such integrated teaching is now well understood and can be done in many different ways. The clinical and practical integration in MCH/FP could best be done by introducing the subject early in the para-

clinical years through the family care of a mother under proper supervision and periodic monitoring. Continuous reinforcement of this concept is necessary while teaching the three disciplines (obstetrics, paediatrics and preventive and social medicine).

Training in Urban and Rural Health Centres

During his undergraduate training, particularly at the rural health centre and in the field practice area, the student is beset with many problems of which one is the heavily loaded curriculum. Even so it should be possible to give him some idea of MCH/FP care in the community. A family attachment in the second clinical year, if not earlier, would be of help. But unless such an attachment is properly supervised and monitored it loses much of its educational value. Residence at the rural health centre, for a short period at least, at any time during the clinical years, would be of value if there are teachers from the three disciplines in the centre to teach him. Alternatively, periodic visits to the rural health centre with a member of the staff to guide him could be arranged, and that is what is happening now in some institutions. If these periodic visits are to be productive it is essential that there be integrated teaching at the centre by the three departments of obstetrics and gynaecology, paediatrics and preventive and social medicine. The aim should be to demonstrate to the student the interplay of various environmental, social and cultural factors in health and disease and the delivery of MCH care under those conditions. Training at the urban health centres is much less difficult as it involves no residence. Periodic visits to these centres to demonstrate the

integrated MCH/FP service should be organized by the three departments as often as possible.

Internship training

Throughout the whole period of medical training, a three months' rural internship in preventive and social medicine is the only experience the internee has of offering medical care through a team based in the community as opposed to in the hospital. This short, three-month encounter is the only training he gets to equip him for dealing with problems at the primary health centre when he is posted there. It is during the rural internship therefore that he must be familiarized with the techniques required for providing a comprehensive MCH/FP service through the health centre team.

An internee, before he is posted to the rural health centre, should be taught the technical skills necessary for providing MCH/FP services to the community. This means that he should have adequate training in the obstetrics, paediatric and family planning components of MCH/FP. The details of these components need to be worked out and a curriculum prepared. The emphasis during the internship should be on the practical acquisition of technical skills in the different departments. During his three-month internship in obstetrics the internee should participate in the provision of MCH/FP care at the urban centre for a period of two weeks.

Internship in the rural health centre

The most important part of his training is in the rural health centre and field practice area when he is posted to the preventive and social medicine department for a period of three months. It is essential that the staff from the three

departments of obstetrics and gynaecology, paediatrics and preventive and social medicine work jointly at the centre to train him in the provision of an integrated MCH/FP service. In addition to technical skills he should also be taught the limitations of the rural MCH/FP service and learn how to select referral to the parent hospitals. He should learn health administration and come to understand the concepts of the health team. The role of the physician in teaching and managing a team of health workers should be demonstrated. On visits to sub-centres the limited amount of MCH care that sub-centres can provide should be clearly explained. There is a great need for a definite curriculum, otherwise the training may be vague and prove ineffective. None of these programmes can be effective unless both interneers and the teaching staff are resident at the rural health centre for which adequate facilities must be provided.

Administration

The curriculum and pattern of training has to be carefully worked out. It should be the joint responsibility of the departments of obstetrics, paediatrics and social and preventive medicine. A curriculum committee with the Dean/Principal as the chairman and the Professors of the three disciplines concerned should be responsible for chalking out a curriculum both for institutional training and training in the field. It should spell out the specific training programmes both in the pre-internship and internship period. To be borne in mind is the fact that internship is the period when there will be more time for training in the field and this training should be practical and effective. This is the most crucial period when the student can be taught to provide ma-

ternal and child health and family planning care to the community as an integrated service. The programme should be so arranged as to meet this objective.

A working committee (implementation committee) consisting of members from the three disciplines who are actively concerned in the field training should review the programme and progress of training every month and report to the curriculum committee. This committee should be responsible for the implementation of the curriculum particularly in the field. There could be various other mechanisms of administration of the programme. They should, however, be simple and workable if adopted.

The Integrated physician MCH/FP

The primary health centre physician of the future should be one who combines in himself both curative and preventive aspects of MCH. The MCH training programmes and services at present are heavily oriented towards administrative

and the preventive aspects. Preventive methods will be more acceptable to the rural community if at the same time curative services are also offered along with it. There is need for a clinically oriented MCH course which would help to develop an integrated physician.

Lastly, if MCH/FP is to have the status in the medical colleges which it certainly deserves, the senior teachers themselves must actively participate in the training of the students in the rural field practice area.

The problem is vast and difficult. It is challenging and urgent. But the challenge has to be met. It can be met if, at least as a first step, all teachers in the faculty are re-oriented with, a bias to community approach and facilities are made available for such re-orientation and training of staff, students and health personnel.

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