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## XX ALL INDIA CONGRESS OF OBSTETRIC AND GYNAECOLOGY

### PRESIDENTIAL ADDRESS

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I am deeply grateful to all members of our Federation for electing me President for 1976-77 and thank you for the great honour you have conferred on me. I am particularly overwhelmed when I look back on the illustrious list of Past Presidents—all doyens in our speciality, and many of them my teachers. I refer in particular to two of them, the late Dr. V. N. Shirodkar, who was Professor of Gynaecology at the Grant Medical College, Bombay, where I was a student, and Dr. J. Jhirad, under whose inspiring guidance and supervision I had the privilege of working for a period of 3½ years at the Cama and Albless Hospitals, Bombay, after completing House surgeonship and House-physicianship at the J.J. Group of Hospitals. To these two, and particularly to Dr. Jhirad, I owe a debt of gratitude that can never be repaid, but I would be failing in my duty as President, if I did not acknowledge the debt. Indian Obstetrics and Gynaecology owes to personalities like the late Sir Laxmanaswami Mudalier, Sir Kedarnath Das, Dr. N. A. Purandare, Dr. Dossibai Dadabhoy, Dr. Ida Scudder, Dr. Subodh Mitra, Dr. Tampan and Dr. Chunilal Mukherji, who are no more with us, but have left an indelible mark on the practice of our speciality, and have lit the torch that has so successfully been carried by succeeding office bearers of our Federation, who by their untiring efforts have made it the powerful organisation that it is to-day.

Before I proceed any further I would like to say something about the activities of our Federation which has now completed 26 years of its existence. From a mere amalgam of 5 Obstetric and Gynaecological Societies which took place in 1950 under the able stewardship of Dr. Jhirad, it to-day comprises of 52 societies and has a membership of approximately 2,400. With the careful nurturing it has received since its inception, its growth is hardly to be wondered at, but taking into account the size of our country, we will be happy to include more new societies in our fold. The Federation, therefore, is one family that does not have to practice Family Planning, even though carrying this message to all corners of our vast country constitutes one of its most important function at the present time.

The vital need for providing effective family planning methods for our masses to enable us to reach the goal of economic prosperity and improvement in maternal and child health, is too well known to require reiteration. Effective family planning methods, to-day, mean either hormonal contraceptives or IUDs for spacing, and sterilisation procedures for those who have completed their families, but all

these require the services of trained gynaecologists and this is true of the MTP services also. The involvement of all of us practicing this speciality is therefore a *must* for the success of this national programme which is of such crucial importance to our well-being.

One of the greatest benefits which the Federation has provided is the sense of solidarity which it has engendered. As an organised body we have an official platform from which we can voice our opinions and seek the solution of common problems. In the field of scientific endeavour, the sharing of ideas with people engaged in the same sphere of activity is a very stimulating exercise, and we all look forward to our annual get-togethers, which not only enable us to get to know each other better, but to learn of work that is being done at Centres other than our own. Two junior members of the Federation, were this year able to visit Centres of their choice and work there for a period of 6 weeks, on the Ethicon Travel Fellowships which became available this year, and I hope that the number of such Fellowships can be increased in the near future.

Another achievement has been the endowment of the Rallies Oration in 1975, and we are now in a position to invite scientists of International repute to address our members every year. This year's oration is the second in the series, and will be delivered by Prof. Berislav Beric shortly after the conclusion of this inaugural function.

A very important activity of the Federation, since its inception, is the publication of our Journal, which we take as a matter of course without realising the great debt we owe to those responsible for its existence—to Dr. Jhirad, the Founder Editor, Dr. K. M. Masani, the present Chief Editor, and Dr. Gool Vazifdar, our Journal Secretary. With the enormous increase in the amount of material now received for publication it has become necessary to supplement the Journal Staff by the appointment of two Associate Editors (Drs. V. N. Purandare and R. D. Pandit), one Assistant Editor, Dr. M. N. Parikh, and Dr. Shirin Mehtaji as Assistant Secretary and to all of them our grateful thanks are due.

In the International sphere our Federation to-day enjoys a position of prestige which is not by virtue of its size, but by the outstanding contributions of several of our members. In the realm of Obstetrics, the name of the late Sir Laxmanaswami Mudalier is almost legendary. An eminent educationist and an outstanding clinician, the number of national and International Organisations and Conferences he presided over, are too numerous to mention. Another internationally known figure is that of the late Sir Kedarnath Das, whose monumental work on the evolution of the Obstetric Forceps is widely acclaimed, and whose Forceps is part and parcel of the standard equipment of all practicing Obstetricians in this country. The credit for placing Indian Gynaecology on the world map is largely due to two illustrious Past Presidents of our Federation the late Drs. V. N. Shirodkar and Subod Mitra, the former by the operation for cervical incompetence which bears his name, along with his outstanding work on the recanalisation of blocked Fallopian Tubes, and the latter for the Mitra operation for carcinoma of the cervix. Dr. Shirodkar was honoured by the Asian Federation by being elected its Second President, and two other Past Presidents

of our Federation, Drs. Krishna Menon and B. N. Purandare have served as its Vice Presidents, but the most signal honour has been the election of Dr. B. N. Purandare as President of the International Federation in 1973, and we are very proud of the recognition which he has received.

In addition to these "star" personalities, many other Federation members have done valuable work on Advisory Committees on Maternal Health, Family Planning and Medical Education at both Central and State levels and at the I.C.M.R., but this has been mostly in their individual capacities and not as official representatives of the Federation. Recently however, official agencies such as the W.H.O. have started inviting a representative of the Federation when matters pertaining to Obstetric practice are subjects of discussion. This is a step in the right direction, and I feel the Federation should also be represented on the Medical Council of India for matters pertaining to our discipline at both graduate and postgraduate levels. The important role played by representatives of our Federation in the final shaping of the MTP Act of 1971 is well known to you all, and I earnestly hope that Government will in future, make greater use of the expertise which the Federation can provide in the formulation of any scheme for improving the maternity services of our country.

A good example of this was the launching of the Post Partum Programme by the Ministry of Health in 1969 at about 30 selected Centres, for it had become apparent by then that the Family Planning Programme of the country would never succeed if run in isolation, but had to be offered as an integral part of national welfare planning for better maternal and child health by involving the obstetricians and gynaecologists of the country. This programme has now been extended to 324 Hospitals including 108 Teaching Centres, and as you know this has provided very welcome additional inputs for the Department of Obstetrics & Gynaecology at these Centres, and has made it possible to integrate M.C.H. and Family Planning services with routine postpartum care.

All that I have said so far must be known to the majority of you, but stock-taking is always a useful exercise, and it is only by assessing what we have already achieved that we can best decide how best to proceed further. As custodians of the health and welfare of the mothers and newborn babies of this country, who will be its future citizens, we have a heavy burden to shoulder. How creditably have we performed this task, as measured by the maternal and perinatal mortality and morbidity rates of our country, and have we at all succeeded in the early diagnosis of genital cancer, which alone can improve the cure rate of this dread disease?

Not very well, I am afraid, for both our maternal and perinatal mortality figures are still about the highest in the world, and all of us gathered here can bear tragic testimony to the large number of cases of genital cancer, particularly that of the cervix, that come to us too late for any effective therapy. Since the yardstick for measuring the standard of health care available for the women of a country is its maternal mortality rate, let us give the matter some consideration. Fifty years ago, the mortality associated with child birth in our country was as high as 20-25 per thousand live births, the major killers being sepsis, anaemia, haemorrhage and accidents of labour.

With the advent of the sulphonamides and antibiotics, and facilities for the transfusion of blood, this figure declined to about 11/thousand in 1955, but even to-day the figure is not below 5/thousand, i.e. we have now reached the stage at which Great Britain was at the turn of the century (the recent figure for the U.K. is only 0.1/thousand births). When these figures are separately analysed for urban and rural communities, it is seen that the lowering in mortality has occurred chiefly in urban areas where the maternity services are better organised, but when we recall that 80% of our population is rural, and against a figure of 600,000 villages in our country we have less than 3,000 towns, the magnitude of the problem becomes evident. In rural communities, even to-day, many births take place without any supervision, or are conducted by untrained "Dais" with disastrous consequences. Much of the gynaecological work we are called upon to do is the result of faulty obstetrics. The "patch-work" operations, repairs of genital fistulae and complete perineal tears which we perform in such large numbers are examples of this. Most of us have become very proficient in these repairs, but this is a skill of which I atleast am not proud of, and would be far happier if the need for performing such operations could be entirely eliminated.

What then can we do to improve this state of affairs? The size of our country and the paucity of our resources neither permit the planning of a full scale Health Service nor does this come under our purview, but a great deal can be achieved by establishing priorities and concentrating on the two most vulnerable groups in our population, the mothers and their children, and this is where we can play an important role. But this, you will say is easier said than done. The country is vast and the hurdles so many, and only education, economic prosperity and improvement in the standard of living and sanitation can produce tangible results. But this will take years to achieve, and we cannot, in the meantime, just sit back and do nothing. Better organisation of the maternal and child health services in the rural areas is therefore urgently necessary and emerges as one of the foremost duties of our Federation.

Every State in the country now has a branch of our Federation, and every State has one, or more than one, Medical College. It is for the teachers in our Medical Colleges to come forward and evolve a concrete plan for maternal and child care in the area around the parent Institution. Reorganisation of undergraduate and postgraduate teaching in Obstetrics & Gynaecology is urgently necessary, and that is why I said earlier that the Federation should have representation on the Medical Council of India. We have so far been giving both undergraduates and postgraduates only institutional training, and the products we turn out have been totally institution oriented. Further, it is common knowledge, that even students from semi-rural communities, once they have qualified as Doctors, after having spent over five years in an urban setting, are unwilling to go back to their original environment. We therefore must come to terms with conditions as they exist, and for the next decade or so devise means to utilise the services of persons who are already part and parcel of the rural scene, and have the confidence of the local people. Even the services of the traditional "Dias" can be turned to advantage by just teaching them simple rules of cleanliness in the conduct of delivery and the tying and cutting of

the cord, thereby eliminating the scourge of dread diseases like neonatal tetanus, which to-day take such a heavy toll.

A dynamic change is therefore necessary in our teaching methods, for unless we take students out into the community and make them realise the impact of environmental and social factors in the genesis and progression of disease, we will not be turning out the right type of Doctors. This has been debated at length at several Conferences on Medical Education, and many Past Presidents have laboured this point, but once our Conferences are over, we go home and forget all about the matter. The Heads of Departments of Obstetrics and Gynaecology in our 108 Medical Colleges should give the matter thought and take the lead in organising maternal and child health schemes in the area covered by the Primary Health Centre attached to each College, so as to provide atleast the minimum supervision of all pregnant women in the area throughout pregnancy, labour and postpartum period, along with a package deal of family planning and infant welfare. Medical students need to be actively involved in this community approach, but this can only be fostered if the Staff set an example and evince interest in the matter. Such a programme, to be effective, requires active collaboration between the Departments of Paediatrics Social and Preventive Medicine, and Obstetrics and Gynaecology, for there are many areas where the care of mother and child overlap, and which provide opportunities for instituting family planning and other preventive measures for maternal and child welfare which are not appreciated by students when these subjects are taught in separate water-tight compartments as we do at present. A new dimension, that of comprehensive M.C.H., has therefore to be incorporated in the teaching of Obstetrics & Gynaecology to give the correct perspective to our young doctors so that they go out into the community equipped to give this type of basic health care. Mere theoretical training is not enough, and the manual skills necessary can be taught to all our young graduates during the period of compulsory Internship. Training in family planning methodology should be an integral part of the training programme in Obstetrics, and all interns should know how to insert an IUD or select a case for hormonal contraception and should also be made to assist at vasectomy and peurperal sterilisation operations. They should be able to give proper ante-natal care and taught how to identify "high risk" cases for referral to specialists. They should be made to perform simple obstetric operations such as the application of low forceps, know how to conduct a breech delivery, and be able to deal with sudden emergencies in domiciliary midwifery such as the occurrence of postpartum haemorrhage. They should be able to evacuate an inevitable or incomplete abortion and to carry out emergency resuscitative measures on the newborn, and be able to diagnose and treat the common ailments of infancy and childhood, and see that the children in the community are given the standard immunisation inoculations by the paramedical staff posted at the Primary Health Centre. The W.H.O. has held two very interesting seminars on this most challenging problem, both of which it has been my privilege to attend. Pilot projects have since been started at three Medical Colleges, and the results when available will provide useful guide lines for initiating such training programmes in Medical Colleges all over the country, and we will be hearing more about this in the panel discus-

sion on Medical Education on the last day of this Conference.

*Postgraduate Training*: It is important to realise that the quality of our postgraduates is largely determined by the teaching and training they have received as undergraduates and interns. We constantly bemoan the fact that standards have gone down but have we taken the trouble to find out to what extent we ourselves are to blame? One of the reasons for this is the large number of students that are being admitted to all our medical colleges without a corresponding increase in the number of teachers. In a subject as vital as medical education there is no room for compromise and it is never right to sacrifice quality for quantity. I would at this juncture make an earnest plea for the retention of English as the medium of medical education, as it is a link language which is spoken and understood practically all over the world. If any other language, Russian or German for example were as widely known as English is today, I would say we should learn that language in order to keep abreast with the fast changing frontiers of scientific thought. Another point to bear in mind is that technical competence in the manual skills of our speciality is acquired much earlier than the sound judgement which is the hallmark of the true specialist. A minimum of two, and preferably three resident training is necessary before we can produce a consultant worthy of the name. The hallmark of specialisation, up to now, was either an M.D. or an M.S. Degree from one of our Universities, and up to quite recently the acquisition of foreign Diplomas was very popular, but now with the derecognition of our M.B.B.S. Degree by the U.K. where the maximum numbers used to go for postgraduation, this is no longer possible. In order to set up uniformity of standards in postgraduate training, Government have now set up a National Board of Examinations which holds examinations on an All-India basis, and admits successful candidates to the Membership of the Indian Academy of Medical Sciences (M.A.M.S.). The examination is in two parts, a Primary one on the basic sciences, followed by a final examination after a minimum period of training of three years. This training is not restricted to the teaching hospitals alone, as is the case for our M.D. and M.S. Degrees, but may be at suitable Army, Railway or District Hospitals, where adequate training facilities are available, under Specialists recognised by the National Board. This is a step in the right direction, as the teaching hospitals alone cannot provide enough resident posts for all who seek postgraduation, and without edequate resident posts, worthwhile postgraduate training is possible. Adequate library facilities should be available at all such training Centres to permit of wide reading, and the training programme should aim at cultivating sound clinical judgement in addition to the acquisition of technical competence in carrying out standard operative and therapeutic measures. Obstetric practice has undergone a radical change in the last thirty years from the policy of "masterly inactivity" to "timely help" in all the stages of labour, and with the phenomenal advances in scientific technology we have reaped a rich harvest in the form of new equipment and new techniques for ante-natal diagnosis and for monitoring the well-being and maturity of the foetus in "high risk" pregnancies. But, it is well to remember that no sophisticated gadgetry can replace sound clinical judgement, and the operative zeal of our

younger colleagues often leads to the performance of unnecessary operations, particularly Caesarean Section, which even to-day is not as safe as many would like to believe. In the Confidential Enquiry on Maternal Deaths in England and Wales for 1966-69, the mortality rate for Caesarean Section was 1.2 per thousand, which is about 10 times the overall maternal mortality rate for that period, and it is well to bear this in mind before resorting to the operation on flimsy grounds. What I am decrying is not Caesarean Section, but its unnecessary performance, mainly on hypothetical grounds of foetal distress, or merely as a "labour saving" device. There is no doubt that the introduction of the Lower Segment operation in place of the old Classical one into Obstetric practice approximately 45 years ago, has been one of the most significant advances that have occurred in the practice of our speciality, for it has virtually made obsolete all the difficult and hazardous vaginal procedures which were part of obstetric practice in the past, and in conjunction with the advent of antibiotics has been responsible for the spectacular fall in maternal mortality and morbidity rates all over the world in recent years. Useful though the operation is, it should only be performed on proper indications. The practice of performing the operation as a time saving measure merely because the woman also wants to be sterilised is a reprehensible one, for the morbidity of a puerperal sterilisation following a normal delivery is always much less than when the procedure is combined with a Caesarean Section, and there is no justification for subjecting any woman to this added risk.

In the field of Gynaecology, improved methods of hormone assay, and the isolation and synthesis of gonadotrophin releasing hormone from the hypothalamus have given us a better insight into endocrine problems and the management of infertility due to anovulation. Newer instruments such as the laparoscope and hysteroscope have proved valuable diagnostic adjuncts, but in spite of these advances many unnecessary gynaecological operations, D & Cs, ventrisuspensions and sometimes even hysterectomies, continue to be performed. The abuse of antibiotics is widespread and ovulation inducing drugs are very often given to normally ovulating women. Laparoscopic sterilisations are being done at many Centres in large numbers, and though the method is quick and appears easy, it is not without its pitfalls, for though it involves the making of very small incisions in the abdominal wall, it is as much an intraperitoneal procedure as a laparotomy, and the same aseptic precautions need to be observed. For mass use therefore it seems better to continue with methods currently in use, such as mini-laparotomy or colpotomy-tubectomy and every young gynaecologist should be adequately trained in both these procedures. It is however well to bear in mind that though tubectomy is an extremely simple operation, it is not an entirely inocuous procedure, and may be followed by serious complications if sound surgical principles are not adhered to or if cases are selected in a haphazard manner. The desire to perform the operation in larger and larger numbers is understandable, but it should be borne in mind that it is never safe to sacrifice quality for quantity. Recently some deaths due to peritonitis following tubectomy operations in camps in rural areas have come to light, and following on this the Central Government have issued instructions that these operations should only be performed at Hospitals or Primary Health

Centres where all facilities for their performance exist. The camp approach does not lend itself favourably for the performance of this operation unless autoclaved sets of instruments and dressings are available for every case operated upon and far better results will be obtained by ensuring a sustained rise in the number of such operations performed daily, all the year round, in properly equipped hospitals and Health Centres all over the country, than by resorting to a "crash" camp approach with all its attendant dangers.

At a time when tubectomies are being performed by different methods all over the country in such large numbers, and as this number is likely to increase in the near future, it is essential to institute a proper follow-up of these cases to be able to assess the merits and demerits of the methods currently in vogue. The I.C.M.R. has recently started such an enquiry on a nationwide scale, and the results when available will throw much needed light on this operation and the best technique for its performance. It should also be remembered that when the operation is performed in young women with less than three living children, if something untoward should happen to the existing children, the couple may request re-anastomosis. The chances of successful re-anastomosis are much better if the original operation has been done by a method such as Madlener's or Purandare's where no segment of the tube has been excised, than when a method such as the Pomeroy or a fimbriectomy has been carried out. In spite of the slightly higher failure rate reported for the Madlener operation (1.4% as against 0.@% for the Pomeroy), it is better to do this type of operation when the tubectomy is being done on a young woman of low parity, so that the chances of successful recanalisation, should that become necessary later, are not jeopardised. The chances of recanalisation after electrocoagulation are practically non-existent because of the extensive scarring produced, and hence this procedure is again not suitable when the operation is performed on women with less than three living children.

Many of us of the older school feel today that there was a lacuna in our training, particularly regarding the methodology and tools of fundamental research. On the other hand, we were fortunate in being trained under outstanding clinicians who laid great store by careful history taking and physical examination, and this training has stood us in good stead during our professional lives. Modern research requires the co-operative efforts of scientists from many different disciplines and familiarity with modern techniques and instrumentation in microanatomy, neurophysiology, genetics, endocrinology, biochemistry and biophysics, and cannot consequently be undertaken by clinicians in isolation. How fortunate are the young scietists of to-day, who have unlimited opportunities for such collaborative work at the numerous Research Centres and Postgraduate Institutes that have been established since the attainment of Independence. With all these facilities and the wealth of clinical material in our country there is no reason why many problems apparently insoluble at the present time, should not be successfully solved in the near future. One such priority area is in the field of Contraceptive methodology. We have been doing sterilisation operations for over 20 years now, and the figures published by the Ministry of Health since 1956 show that upto date over 23 million such operations have been performed, but we are still nowhere near the solution of our popula-

tion problem. In the current financial year there has been an enormous spurt in the number of these operations all over the country, and the annual target, which was fixed at 4.3 million, was exceeded by the middle of October 1976. But, laudable though this achievement is, we should remember that sterilisation operations alone cannot solve the population problem, for as fast as older couples are sterilised, younger ones will enter the arena, and unless simple and effective spacing methods are used on a mass scale, the problem will remain unsolved. You might well ask "what is wrong with the two spacing methods, pills and IUDs, which we can currently offer?" Oral pills, as we all know are very effective contraceptives if regularly taken, but the sustained motivation for their regular and sustained use is difficult to inculcate by and large all over the country, and though alternate methods of delivering the contraceptive steroids in the form of long acting pills or injections, or subdermal implants, have all been and still are, the subject of study, the dosage required for maximum contraceptive effectiveness with minimal alteration of menstrual function still eludes us. The IUDs in this respect have an edge over the pill for sustained motivation is not required for their use, but they are not free of side effects, and large numbers of suitably trained medical personnel are required for their insertion and for the subsequent follow-up of those opting for this method.

All of us know the set-back suffered by the Loop programme after its initial popularity, owing to the development of complications such as bleeding and pain, about which we had not warned the women in our anxiety to get the maximum number of loops inserted in the minimum period of time to fulfil the "targets" laid down by the authorities, and an excellent method of spacing fell into disrepute. With the introduction of the newer Copper coated devices, the method is again gaining in popularity, but we have so far given contraceptive coverage to only about 22% of the total eligible couples in the country. The need for a simple but effective methods of contraception, which would require the minimum medical supervision, is therefore the need of the hour. Several interesting leads have become available in the last couple of years, one of the most promising being the immunological approach advocated by Talwar and his co-workers at the All India Institute of Medical Sciences, at Delhi, which when perfected will prove a major breakthrough, and anti-pregnancy vaccine injections could be given on a mass scale just as smallpox inoculations are being done at present. Even this would not be necessary if we could discover a simple prospective test for ovulation, which the woman could carry out on herself, the problem would be solved for most couples, as it would involve a minimal period of abstinence or if a Prostaglandin analogue free of side effects could be found, which the woman could use herself as a vaginal suppository or inhale as "snuff" the large number of MRs and MTPs we are called upon to perform would become unnecessary. Perhaps such a breakthrough is just round the corner, but till it occurs we have to shoulder the burden and do our best with the methods available.

Let us play a meaningful role in the spectrum of human existence and enrich it with our endeavours—help the sterile woman to conceive, and for those who come to us already pregnant, strive to reduce the hazards of pregnancy and

labour to the irreducible minimum for both mother and child. Let us not forget the other side of the coin, the problem of preventing unwanted pregnancies by popularising effective family planning methods, or terminating pregnancy safely where these methods have failed. No case where M.T.P. has been necessary should be allowed to leave without an effective method of contraception or a concurrent sterilisation operation if the family is complete in order to minimise requests for repetition of the procedure. Repeated abortions, no matter where, or how, or by whom they are performed, lead to considerable morbidity and chronic ill-health, the very things that the M.T.P. Act was introduced to do away with. Another point that needs to be borne in mind is that there are reports from Hungary and Czechoslovakia of a correlation between induced abortion and subsequent premature births. One of the reasons for the high perinatal mortality rate in our country is the high incidence of prematurity and low birth weight, and we should be wary of introducing iatrogenic factors with would further increase their incidence. The fact that a procedure is legal does not make it ethical and though I do not deny that there are many instances where M.T.P. is genuinely indicated, we would do well to remember that quite a number of these terminations could be avoided by regular contraceptive use. The old adage, "prevention is better than cure" could be appropriately altered to "prevention is better than termination" and we should all help our patients to achieve this understanding, by introducing them to effective methods of contraception. The gynaecological examination which is obligatory when this is done, provides an excellent opportunity for screening cases of early carcinoma of the cervix and permits the taking of PAP smears or biopsies in all suspicious cases.

Eradication of poverty, ignorance and superstition, as envisaged in the Twenty Point Programme of our dynamic Prime Minister, will go a long way in making our task easier, but none of this can be achieved unless we can check the growth of our population, and it is for all of us to work together and see that this is done as speedily as possible. Man has reached the moon, and is now on his way to other planets, but has left many problems on Mother Earth still unsolved. Let us do our best to improve the lot of the mothers of our country and of the babies who are its future citizens, and by doing this add to the welfare of all the families that collectively constitute our nation, and in this crusade every member of our Federation can play a most meaningful role.

I have gone on much longer than I had intended, but I crave your indulgence and thank you all for your patient hearing.

Before I conclude, I take this opportunity to thank the Hon'ble Chief Minister of Assam and the Health Minister for being with us this morning. I also thank Professor Gogoi and his devoted band of workers for all the pains they have taken and the warm welcome they have accorded us. A most interesting programme has been arranged for us by the Organising Committee, and I am sure we will all go back from this beautiful part of the country enriched with new ideas, and wiser than when we came.

May our Federation grow from strength to strength and play a meaningful role in improving the health and well-being of the women and children of our country, and by so doing add to the glory and prosperity of our beloved Motherland.

JAI HIND