"ROLE OF FEDERATION OF OBSTETRIC AND GYNAECOLOGICAL SOCIETIES OF INDIA IN THE PRACTICAL ORGANIZATION OF MATERNITY AND CHILD HEALTH SERVICES IN URBAN AND RURAL AREAS"

by

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Introduction

India is the first country to launch a nationwide Family Planning Programme in 1953 after considering the uncontrolled population growth. Later, it was realised that the programme will not be geared up unless due consideration is given to maternal and child health. MCH was, therefore, incorporated with Family Planning Programme in 1968. However, the Programme has not yet succeeded in bringing down the birth rate as expected. Even today the MCH programme has a wide gap between the population to be covered and the actual achievement. It is surprising therefore, that the Federation has been apathetic towards it so far and has not demanded its rightful place in the implementation of the programme.

(A) Maternal and Child Health Programme MCH—Its Objectives & Scope

Mothers and children together form about 40% of the whole population. They are vulnerable groups because of increased biological demands of reproduction by the mother and growth and development by the child. A comprehensive health care is hence being given to these special groups which is included in maternal and child health services. MCH covers a wide spectrum of conditions. The contents of MCH care are premarital and genetic councelling, prenatal care, safe confinement, monitoring of growth and development of children and their immunization, nutrition guidance, day care of children, care of preschool child, school health, care of adolescents and special care for handicapped children.

In a developing country like India, the problems yet to be solved are higher maternal and child mortality and morbidity, which can be mainly attributed to the poor nutrition, widespread infection and unchecked reproduction. The developed world after successfully tackling these problems is now concerned more about genetic conditions, prevention of congenital malformations, Rh incompatibility, etc.

Present State of MCH Services and Need for Involvement of Federation

At present MCH care is being delivered to the community through the basic health unit located at the primary health centre (PHC) and it is entirely controlled and staffed by the Government under MCH and Family Planning Programme. All the basic health services are delivered to the community through the community health workers. The population living in villages at the periphery is largely underserved. Illiteracy, proverty, ignorance and difficult communication keeps this community in deep waters away from the under staffed health ser-

Accepted for publication on 2-7-80.

vices. The population which is thus most needy gets the least attention. Coverage of every individual is impossible under existing conditions. As MCH falls entirely in the field of obstetricians and Paediatricians, their organisations assisted by various voluntary organisations can achieve wide coverage. Thus if the Federation decided to enter the programme with its full strength and whole heartedly, our nation can count highly on the future generations.

(B) Role of Federation in Practical Organisation of MCH Services in Urban and Rural Areas

As the Federation of Obstetricians can participate in a limited range of MCH activities, certain action priorities have to be selected. Provision of prenatal, intranatal and postnatal care, care of children under 5 years, including advise regarding family limitation and adequate spacing of pregnancies alongwith care for unwanted pregnancies will be the main activities of the organisation. The Federation of Societies can be involved in these activities in the following manner:

(i) Defining Policies

The whole country should first be divided into different geographical areas. All societies in each geographical area should form an intermediate unit. Representatives of these units can form a central committee who will meet periodically to plan the programme. This central committee will decentralise itself into subcommittees, each having activities such as urban MCH services, rural services, training, evaluation and research, fund raising and allocation of resources and expansion etc.

(ii) a. Formation of an Infrastructure of Health Care Delivery

For effective delivery of health care services, creation of an infrastructure at three different levels is necessary from the centre to the periphery. Central level mainly concerned with administrative functions at one end and peripheral level concerned with execution of MCH services at the other end will have an intermediate unit which will be doing both the functions and will be a liason between the central and periopheral levels. Federation will be the central administrative unit for both urban and rural areas and the regional group of societies will form an intermediate unit. The peripheral unit in an urban area will be located at the dispensaries and hospitals which will be manned by the Medical Officers alongwith the visiting members of the society. In a rural area, PHCs and their subcentres will be the units and sub-units for MCH services, which will be managed by the local obstetric practitioners.

(ii) b. Development of Manpower

Expansion of the society to the peripheralmost area is necessary in order to build up manpower and for wide coverage of population. This can be done by (i) increasing the number of society members, (ii) by enrolling all the medical practitioners involved in Obstetric practice irrespective of their qualifications as Associate Members of the society and (iii) by enrolling other categories of paramedical personnel like nurses, midwives, 'dais' who are actively involved in delivery of Obstetric services as Affiliate Members. Such expansion of the society with considerable manpower will be entirely voluntary and hence will not involve any budgetary problems.

(iii) Organisation of Training Programme

For effective delivery of MCH care the small number of qualified society mem-

bers reluctant to leave cited will not be able to cover the demand of the population and hence educating and developing an accessory team is essential.

(a) Training of Affiliate and Associate Members

The primary health workers need training in main problems of concern to MCH services like nutrition and immunisation of a pregnant woman, safe confinement with minimum intervention along with care of newborn and its immunisation. Periodic short refresher courses should be organised for them, offering knowledge regarding recent trends in MCH care. High-risk approach to antenatal and intranatal patients, clearing misconceptions like hormonal diagnosis of pregnancy and many such subjects can be dealt with in such courses. Alongwith lecture-demonstrations, the society members should also arrange clinical discussions with the group, giving examples of mismanaged cases from the locality, stressing the avoidability of a death or morbidity. Once trained, these members can be a liason between the population at the periphery and the services at the nearby center.

(b) Training of Undergraduate and Postgraduate Students

The traditional case oriented teaching of Obstetrics should be modified into community oriented approach suited to the local problems. An Obstetric emergency instead of being viewed as a challenge to one's personal skills, should stimulate thinking to explore the social and environmental factors responsible for its occurrence, its overall prevalence in the community and preventive measures. Social aspects of Obstetrics should receive great importance in the teaching of Obstetrics. Present teaching stimulating undue interest in relatively uncommon but interesting clinical conditions needs to be modified with an emphasis on commoner Obstetrical problems and the practitioner should be well-versed with recognition of slightest deviations from normal in a pregnant, parturient and postnatal mother.

(c) Continued Education of the Society Members

The members of the society, most of whom are specialists also need reorientation. This sounds somewhat paradoxical, but it is essential. The integration of preventive, promotive and curative services must be emphasised on their minds through the orientation courses. The apathy shown towards MCH programme can be removed to some extent by direct involvement of the members in the programme.

(d) Defining Curriculum for Teaching

Traditional teaching procedures are largely adapted from the developed countries rather than identifying the local needs. Unfortunately, teaching institutions are not involved in planning of health services, hence education and training have become isolated and irrelevent to the national health needs. The Federation members should get an entry for making representation at the Universities, nursing councils and High School Boards to formulate our own educational system to meet the needs of our population.

(iv) Evaluation

A subcommittee appointed at the central level by the Federation will be involved in evaluation of the programme. Quantitative evaluation of health services and educational activities can be done by noting the actual number of pro-

gramme held and population covered. Qualitative evaluation can be done by noting the impact of educational activities on the population by way of knowledge attitude and practice (KAP) surveys, analysing the avoidable maternal and perinatal deaths etc.

(v) Encouraging and Assisting Research

The Federation should stimulate and assist research by society members. Research can be as related to health problems of mothers and children, as related to delivery of MCH care, as related to education and training in MCH, basic research or it can be related to social aspects of Obstetric problems.

(vi) Appreciation and Recognition for Performance

The Federation should utilise a part of its resources for recognising the efforts made by the various societies. Awards and trophies can be rewarded to the most dynamic society showing maximum output in the form of services, educational activities, expansion etc. The community participating to the maximum extent in the various services also should be recognised by prizes. The prize to be offered to the best community can be in the form of improving facilities at the health Centre in the locality. A part of annual convention of the Federation should be devoted to discussions on MCH activities and evaluation of the programme. Best research papers on MCH can also be rewarded at every congress.

(vii) Resources

Resources in the form of money and material will have to be made available for any systematically planned programme. In general, the resources should be collected from the community to be served. This will be easier by convincing the community leaders regarding the health needs of the population and also by giving priority to the problems which are of most concern to them. Grants and subsidees can be obtained from Government and Zilla Parishad. A sub-committee at the central level should explore the other ways of raising funds, through donations from private and social services organisations, charity shows, pharmaceutical firms etc.

(C) Practical Delivery of MCH Services

(a) Urban Area

The needs of a compact urban population are adequately provided for in the forms of various dispensaries, hospitals, etc. and hence manpower and resources can be better utilised in strengthening the existing services instead of starting new MCH centres. Visiting consultants, medical officers and other full time staff working in such centres can work in a team for effective implementation of MCH services.

(a) *Antenatal Care*: The present antenatal clinics which are impersonal 'Abdominal Palpation Clinics' with patchy and fragmentary services involving least rapport between the staff and the patient, can be changed into more personal clinics involving thorough consideration of a case as a whole, as a member of her family and as a member of the society, by active participation of society members attending these clinics voluntarily and in rotation and antenatal education could be combined with the services.

(d) *Intranatal Care*: A team of 6 members on call by rotation at Government sponsored or municipal maternity homes can supervise the subordinate staff conducting normal labour. Asepsis during labour, timing and nature of intervention etc. can be tought to them along

with some technical skills with an overall reduced maternal and perinatal damage.

(c) *Postnatal Care and Family Planning*: Education regarding family planning measures should be a part of routine management and need not be delivered in a separate clinic. The patient can also be made aware of the possibility of a legal termination of an unwanted pregnancy in its safe limits.

(d) *Care of Children 'Under Five'*: Assessment of growth and development of a child and its protection from communicable diseases can be arranged at a well baby clinic with the help of visiting paediatricians.

(e) *Health Education*: Overall public in an urban area being more of literate and educated type, can respond to the educational media like exhibitions, newspaper articles, radio talks, interviews on televisions etc. Such activities by enthusiastic society members can bring about education of the lay public in the lacality.

(ii) Rural Area

This is more difficult task to undertake as the rural population is scattered, communication is difficult, consists predominently of agricultural workers (hence not available at home). Illiteracy and lower levels of education make them unaware of the facilities, thus making them more apathetic. Social and religious tabooes, beliefs, customs and traditions have got deep seated roots which again affect the maternal health adversely. To solve these, a long term educational plan must be implemented for making every family aware of the various aspects of MCH. However, the immediate results can be obtained by a short term plan wherein facilities will be provided in the patient's own environment i.e. at her home. Thus the services given by the peripheral units will be partly in the field area i.e. at the subunits and partly at the MCH clinics, which will be housed in the PHC. The subunit situated farthermost from the Federal body will run well organised ANC, PNC and immunisation programmes which will be conducted by the affiliate members of the society and will be supervised by the associate members living in the vicinity of the MCH unit at the PHC.

At the MCH unit, similar services will be made available and will be supervised by the local associate members on voluntary basis. The unit will also run a small well equipped hospital with facilities of conducting labour and simple operative procedured such as MTPs, tubectomies etc., with the help of visiting specialists from the intermediate unit.

The workers will be trained in conducting deliveries with aseptic precautions and with minimum interventions. They will also be made aware of their limitations and about recognising the risk factor in labour (Premature rupture of membranes, failure to progress in labour etc.). Such problem cases should be referred in time to the PHC unit and if necessary even to the intermediate unit. While referring they would be taught to follow certain principles of referral system. The intermediate unit located in urban area should provide facilities for the referral and care for problem cases that cannot be managed at the peripheral units. Thus it can serve as a teaching hospital for co-ordination of all MCH activities in the periphery with careful supervision.

Enthusiastic young specialists may be persuaded to spend a few days at a time amongst the primary health workers at the peripheral unit to demonstrate and supervise the conduct of normal and ab-

normal labour. Another way of helping the peripheral population will be by developing 'flying squad' by which the patient at the periphery can be resuscitated on spot and then shifted to the center in an improved condition. Considering the expenditure involved, it will have to be kept as a goal for achievement in future.

The rural centres can be offered antenatal, postnatal, family planning and immunization services. Knowledge regarding legal and safety aspects of MTP and general health can also be imparted in a manner similar to that suggested for urban centres. Initially, that can be provided at the homes of the populace and later shifted to the PHCs and health units.

Rural population being illiterate and more or less scattered, health education will have to be planned more in the form of person to person communication. It should be a part of every service being offered. Orientation and training camps can be organised by the society members for the local leaders, teachers and other respected members in the population. Use of locally accepted entertainment programme like Lokanatya or Tamasha can be utilised effectively for imparting health education.

Record Keeping: Records related to births, deaths, naming the newborns and other MCH activities will be maintained regularly by the primary health workers. These records and the concerned work thereby can be supervised by the associate members of the respective health units and later by the intermediate unit.

In Conclusion: A large network of personnel at the Federal, intermediate and peripheral level needs to be mobilised on voluntary basis. Existing sites and resources when geared up and put to a full use should no doubt give satisfactory results. The present trend is to work in spurts in an attempt to fulfil targets given by the central and State Governments. This should be replaced by a continuous effort and this can be achieved only if all members of all societies mobilise their resources and pledge to uplift the motherhood of Indian woman.