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Editorial

PERINATOLOGY

Perinatology is closely related to Social Obstetrics. Most of the socio-economic factors discussed in contributions on Social Obstetrics in this Journal also apply to Perinatology. There are every day, 4000 perinatal deaths for over 57,000 deliveries, or annually, 104 million perinatal deaths and 100,000 maternal deaths for over 20 million births (Mehta and Jayant, Obstet. Gynaec. India, Volume 31, page 183, 1981).

Prenatal care is the most important factor in reducing perinatal mortality. The quality of antenatal care available is as important as the number of antenatal visits. By vigilant supervision anaemia, and other high-risk factors during pregnancy are detected early and treated. Timely professional intervention to secure favourable pregnancy outcome for the mother and the infant is achieved when the patient is under constant antenatal supervision. Obstetric institutions in cities have successfully lowered the perinatal mortality, but the problems of rural India, as at present, are formidable. The Government of India has launched an ambitious programme for training 'dias' which should lead to an improvement in pregnancy outcome but there should be a parellel increase in regional centres in rural areas where emergencies can be adequately treated. Mehta and Jayant (1981) in their extensive survey state that institutions with 40 or more per cent emergency admissions exhibit perinatal mortality of 80 and 90/1000. Simultaneously, communications and quick transport from village to hospital must improve. It is all too well known to Obstetricians of India that long, hazardous journey is the precipitating cause for maternal and perinatal mortality.

The relationship of age and parity in developing countries has been brought out by Oman and Standley. "Too early, too late and too narrow spaced, pregnancy are known to exhibit and increase the risk of perinatal mortality (Oman and Standley: Family Formation Patterns and Health-Review of the evidence. WHO, Geneva, 1976). From this it is apparent that conception planning is the most important preventive measure in decreasing perinatal mortality.

Rural pregnant women, women with monthly income of 200 rupees and less, pregnant women with very low educa-

tion, pregnant women employed in manual occupation, advanced reproductive age and grand multiparity are at very high risk of perinatal death.

It is unfortunate that medical education in India is urban based where co-operation between Obstetrics, Paediatrics, Intensive Baby Care units and research in reproduction is available in cities and rural problems are entirely neglected. No purpose will be served in increasing referral centres if rural oriented medical personnel is not available.

Now that all the problems facing rural population are well documented in pains taking studies, the implementation aspect should receive urgent attention. Despair that these unfavourable rural problems will remain unsolved for decades is not the answer. FOGSI should play an important role by getting the Planning Commission to give high priority and sizeable funds should be set apart for rapid amelioration of problems such as transport, rural universities, large number of referral centres, and training of 'dias'. International Organisations should study these problems on the spot and give practical and monetary help in solving them. Until the Health and Family Planning departments at the Centre and the States give urgency it deserves, despair will continue to haunt the rural population. Let us hope and pray that the Indian Society consider their unfortunate rural population as their brothers and sisters and give moral and maternal help to uplift them.

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