THE 30TH ALL INDIA OBSTETRIC AND GYNAECOLOGICAL CONGRESS

Presidential Address

by

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At the very outset I express my gratitude to the members of the Federation of Obstetric and Gynaecological Societies of India for electing me to the exalted post of the President of the Federation of Obstetric and Gynaecological Societies of India for the year 1987-88. I consider it a great honour and privilege. At the same time I am conscious of my limitations particularly when I think of my predecessors who were all distinguished people with great achievements at the background. However, I can assure you that I shall spare no pains to prove myself worthy of the trust you have placed on me.

Ladies and Gentlemen. I really feel thrilled in having the opportunity to meet you in the historic city of Ahmedabad renowned all over the world for the beauty and extensive architectural remains. This year of 1986 is the Golden Jubilee year—a very memorable year for the host Society—Ahmedabad Obstetric and Gynaecological Society where there is added zeal and enthusiasm to the satisfaction of all. The Portugese traveller Barbosa described this city "as very rich and well-embellished with good streets and squares supplied with houses of stone and cement". In Sir Thomas Rose' time (AD 1615) "it was goodly city as large as London". From AD 1411 when it was founded by Ahmed Shah to the decline of the Moghul Empire and the ascent to power by the British rulers, old Ahmedabad has seen many ups and downs. But unruffled by the ravages of time, today the modern city stands on river Sabarmati reasonably proud of magnificent achievements not only in the textile manufacturing and numerous other big and small manufacturing industries but also in exquisite handicraft which have won international markets.

I have always had a respect and soft corner for the people of this state of Gujarat who have made their place in the heart of our country men not only for their inclination to hard work for the sake of livelihood but also for their enormous contribution in the national struggle for freedom under revered leadership of Mahatma Gandhi and Sardar Vallabbhai Patel. I have had opportunities to have glimpses of the rich cultural and literary genius of people of this state when these were presented in cultural meets and festivals in different parts of India. Last but not the least is the commendable progress that medical scientists and educationists connected with different medical colleges and research institutes of this state has made in the field of medicine blazing the golden trail left by the illustrious leader of the profession and the great national leader like Dr. Jivaraj Mehta.

I hope many of you have come across these famous lines of Shakespeare:

"Some are born great, some achieve greatness and some have greatness thurst upon them"

The great poet and dramatist must have met many a person in his life time holding high positions who squarely fitted in the third kind of greatmen described by him. I was neither great nor did I achieve greatness, but my troubles have been greater because greatness has been thurst on a small man like me. I am quite aware that it is an uphill task for a member of our learned Federation like me to prove worthy successor of doyens of the profession who adorned this highest office of our organisation before me. Let me pay my respectful tribute to my illustrious predecessors like Sir Lakshmanswami Mudaliar, Dr. Chamanlal Mehta, Dr. N. A. Purandare, Dr. Subodh Mitra, Dr. Jhirad, Dr. V. N. Shirodkar, Dr. K. M. Masani, Dr. P. C. Das, Dr. M. K. Krishna Menon, Dr. B. N. Purandare, Dr. V. N. Purandare, Dr. C. G. Saraiya, Dr. P. K. Devi, Dr. A. D. Engineer, Dr. C. L. Jhaveri, Dr. R. Nadkarni, Dr. R. D. Pandit, Dr. C. S. Dawn, Dr. M. N. Parikh and Dr. R. V. Bhatt and many others who have made our organisation what it is today.

It is befitting that I begin with the primary thing—our organisaton which assembled all of us here from different corners of our country. The FOGSI Congress first came into existence in 1936 is now having 30th Session. With a total membership strength of about 7000 and with about 86 member-bodies affiliated to it, it has become a formidable forum of the obstetricians and gynaecologists of our country. Today any organised body of professional men and women can make themselves heard to the Government, to the people or even to the fellow professionals only when they talk from strength. In our vast country the number of practising obstetricians and gynaecologists is estimated at three times more than our total membership strength. Unfortunately we are associated with different local societies of our speciality with different names and despite the meritorious service rendered by these local bodies in different regions of the country, we often either go unnoticed by the Government or fail to command the weight that should be attached to our views in matters of health care, particularly on the vital issues like maternal and child health, family welfare and perinatal mortality.

This experience should have led us to a serious heartsearching in recent decades. Unite we must, we must come closer to each other if we have to make the existence of our organisation felt to all concerned and at the same time get our working condition improved for the sake of the health and longivity of the two most vulnerable sections of the population with whom we deal—the mothers and the infants.

Esteemed delegates to this congress will be really happy to know that the urgency of uniting at the state level by the obstetricians and gynaecologists scattered in the fold of societies with different nomenclatures was deeply felt by an eminent builder of our organisation in Gujarat—Dr. Raman Nadkarni. Dr. Nadkarni took a bold initiative in 1981 to bring together the members of our speciality functioning under different societies in Gujarat and formed the State Organisation of obstetricians and gynaecologists (SOGOG). The host

society—Ahmedabad Obstetric and Gynaecological Society is also incorporated in it. The purpose of such unified state organisation is to stimulate various societies incorporated in it to take up scientific activities and to coordinate M.C.H. Care and Family Welfare services to the community. I earnestly hope that leaders of our organisation in other states, where we have not yet been able to close up our ranks by forming one state-level society comprising all hitherto separately functioning societies, would emulate the example of the state of Gujarat. This step, I am sure, would augur a brighter future for the organisation.

With consolidation of our professional unity comes the question of our role. I hope you would kindly excuse me for my opinion that we sometimes forget or underestimate the role that we are capable of playing as teachers and practitioners of our particular discipline in the health status of our nation. I hope all of you are conversant with the broad picture of maternal and child-health in our country. While general mortality has declined due to public measures and programmes for control or communicable diseases, maternal and infant mortality rates continue to remain high. According to an analysis of mortality based on the census of India 1981 figures, female death rate in the pack reproductive age-group 20-29 years is consistently higher than male death rate in both rural and urban areas, primarily due to hazards of pregnancy and child birth and secondarily due to discrimination in health care and nutrition against females in our society. The figures for infant mortality rate per 1000 live births as computed by the vital Statistics Division, New Delhi for the period 1970 to 1980 show that while the national average stood at 114 in 1980, interstate variations have been wide. In 1980 the three highest ranked IMR states were Uttar Pradesh (159), Orissa (143) and Madhya Pradesh (142), while Kerala (40), Karnataka (71) and Kashmir (72) ranked as the lowest three.

In between the States having an IMR of over 100, namely, Assam (103), Gujarat (113), Haryana (103), Rajasthan (105), stood Maharasthra (75), Himachal Pradesh (87), Panjab (89) and Tamil Nadu (93). Infant mortality in India as we all know is linked with the nutritional status of pregnant women, high birth rate, frequency of births, lower maternal age and factors like ante-natal care, institutional care during delivery, infant care after birth and socio-economic support for the family. As we are more concerned with perinatal mortality, let us also look at the figures for infant death within 7 days of birth per 1000 live-birth, the source being the same Vital Statistics Division. Quoting the figures, the UNICEF publication—"An analysis of the situation of children in India", says—"Perinatal mortality rate was around 48 per 1000 live births during 1968-1978". There was clear rural-urban differences, the rural being more than twice 53:27 in 1977 and 52:23 in 1978.

It is hard to estimate precisely the neonatal deaths in our country because most births, especially in rural areas, are domiciliary and conducted by untrained attendants or family members. According to the 1979 survey of the Registrar general some 75 per cent births in rural areas are attended by untrained medical practitioners and traditional mid-wives as compared to 33 per cent in urban areas. The analysis concludes that "the predominance of domiciliary

child-birth in rural area is a critical factor in post-partum complications leading to maternal and perinatal mortality".

Our problems in MCH/Family Welfare are that if we have to play any worthwhile role in reducing maternal and perinatal mortality, we must know our limitations as well as our capabilities for supplementing the efforts of the Government in this field. That is to say, we need to be very clear about the major constraints, of developing country with a large population like ours for effective MCH and Family Welfare care. In our country the reality is that large segments of the population have very limited access to medical care while high quality services are available to small section of the population. The universal coverage of health care, as the WHO assessed the situation about developing countries in 1978, is clearly limited by lack of money and of trained manpower.

In a country of nearly 800 million population where about 60% of the people live below poverty line and about 70% are unlettered, where only 12% of the employed people are covered by the Central Health Service Scheme and where there are only about 50,000 hospital beds to cater to the need for institutional health care, the limitations regarding coverage of health care are not difficult to understand. On the other hand, we have roughly 80,000 physicians, trained in modern medicine including 60,000 general practitioners and 20,000 specialists and about 90,000 trained nurses to look after the health care of our vast population. I am not belittling the role or contribution of the qualified practitioners of indegenous system of medicine, but since authentic information about this number and scientific assessment of the merit of these systems are not readily available I refrain from referring to them. Anyway, the position regarding coverage of health care remains much the same as before and though the introduction of health auxiliaries like the multipurpose health workers and community health guides have helped the people to become health conscious to some extent and narrowed the communication gap in the health care delivery system of the Government, its impact on the improvement of maternal and child health care or on the family welfare programme has not been impressive enough for various reasons.

As obstetricians and gynaecologists, we are coming across sizeable number of cases of anaemia, poor maternal health, frequent pregnancies, undernourishment, and low birth weight.

An I.C.M.R. study on MCH care was carried out in recent years in 3 urban centres (Delhi, Calcutta, Madras) and 3 rural areas (Chandigarh, Hyderabad and Varanasi) to identify high-risk families, low birth weight and perinatal and infant mortality and morbidity. Preliminary analysis of the data available from the 1-year follow-up of 6500 mothers and their newborns showed that the incidence of low birth weight was higher (about 45%) than the generally accepted estimate (about 30%). It was also found that over 15 per cent of urban and 75 per cent of rural women of low income group were anaemic, particularly during the third trimester of pregnancy. The picture of utilization of MCH service too is not bright according to the findings of another study carried out by the I.C.M.R. In the Union territory of Delhi itself the utilisation of MCH service was found to be only 23 per cent in the urban slums.

Underutilisation of the available family welfare service has also been revealed from another study launched by I.C.M.R. in the state of Gujarat, Rajasthan and Uttar Pradesh to 'develop strategies for improving the delivery and continuation rates and developing the socio-cultural as well as professional factors that influence to acceptability and continuation rate of various existing methods'. The baseline data obtained from the study indicated underutilisation of available health services in most instances and the reasons appeared to be a sporadic and inadequate supply of drugs and contraceptives, the long distance to be covered by the people to reach PCH, illiteracy and lack of awareness of the availability and inhibition due to traditional practices and believes.

Alterative Open To Us

The fruitfulness of our MCH and FW care services cannot be achieved without removing these snags. But something has to done now. Let us think of the alternatives. In the health strategy called the risk strategy or risk approach which the WHO has prescribed for the developing countries where universal health coverage is limited by lack of money and trained manpower, the emphasis is rightly on optional use of existing resources for the benefit of the majority particularly through the use of the Primary Health Centre approach. Plainly, the strategy means to base the organisation of health services in such a manner as that while trying to provide health services for all, special attention can be paid to those who are at the special risk namely, the pregnant mothers and the infants. I think, I need not dwell upon the universal risk factors for Indian women like early first pregnancy, high parity, too frequent pregnancies, malnutrition etc. which increase the chances of poor outcome of pregnancy. as these are already well known to you. You also know the chain relationship that governs the fate of the infants in our country: (1) Poverty, (2) illiteracy of mother, (3) low birth weight, (4) gastro-enteritis, (5) marasmus, (6) infant death. My point is that the vicious cycle of relationship between the risk factors and the defined outcome has to be broken.

The obvious question is how this is to done? Here comes the very important and crucial role of obstetricians and gynaecologists "as scientists, apex teacher and leaders in furthering the much needed manpower development" to quote the words of Dr. U. Koko, Director of South East Asian Region of WHO, who inaugurated our 27th All India Obstetric and Gynaecological Congress at Madras. In the present socio-economic conditions of our country we have positive role to play to bring down the maternal and child morbidity and mortality. And in my opinion, reorientation of education in obstetrics and gynaecology to implement the risk strategy, the combined efforts of qualified practitioners of our speciality, the auxiliary nurse, midwives and traditional birth attendants. (T.B.As) who have been trained for safe child birth, can achieve the objective to a great extent.

Reorientation of Education in the Discipline

Coming to discuss the first requisite, namely, reorientation of the education in obstetrics and gynaecology, I cannot resist the temptation of quoting from the Presidential Address of an illustrious past president of our Federation, Prof. S. N. Upadhyay. He said at the Agra Congress in 1974. "We are tempting