INTERNATIONAL WOMEN'S DAY 2022

FOGSI FOR ALL, ALWAYS
DHEERA
STOP VIOLENCE AGAINST WOMEN

Dear Friends,

It is a pleasure to connect with you in the historic month of March when we celebrate International Women's Day on the 8th and essentially through the month.

I wish you all a very happy International Women's Day 2022.

The official theme on International Women's Day (IWD) this year is **'GENDER EQUALITY TODAY FOR A SUSTAINABLE TOMORROW'** highlighting the gender disparity which continues to exist both in our country and globally. Just knowing that bias exists is not enough and action is needed in all sectors to level the playing field. As President of FOGSI which works for Women's Health, I urge you all to use the month effectively and make a positive difference to women around you.

As we all know, despite India being a populous country, ART has flourished in the country because of the social ramifications of female infertility. Having a child is a social necessity in addition to being a personal requirement for every couple. There is a no bigger example of gender inequality than female infertility in India. ART, therefore, is a boon for this 12% of couples. However, a lot of malpractices have crept in under the garb of ART. It was realised as early as 2005, while ART was still in its infancy in India, that protocols and regulations were required to make this an organised sector. ICMR did issue guidelines but this did not help to streamline this segment. Nearly two decades later the acts have finally been passed. Assisted Reproductive Technology (Regulation) Bill and the Surrogacy (Regulation) Bill passed on January 25th 2022 aims to bring thousands of ART and surrogacy clinics under the ambit of the law. These bills passed by the Indian Parliament will positively influence Indian women's reproductive rights and health. The purpose of the Bill is to "regulate" and "supervise" assisted reproductive technology (ART) clinics and surrogacy and curb unethical practices like sex selection, etc. However, the acts still come with many ambiguities that need to be sorted if proper functioning is desired and the aims and objectives of the bills are to be met. Welcoming the acts, as the President FOGSI I, along with our Secretary General, Dr Madhuri Patel, and others, had the opportunity meet the government authorities and explained our point of view and also sought clarification on certain points. Till the rules and regulations are framed, it is important for gynaecologists to go through the acts in order to understand their limitations. Those conducting IUI's in their clinics may also need to register under this act. It should be clear to every gynaecologist that they comply with the law. There are major changes in third party reproduction which include the donor and surrogacy programmes. Hence every gynaecologist must know when to refer a patient to an ART centre in such cases. ART and Surrogacy centres must understand the bill completely and follow it. The aim of every FOGSIan is to bring gender equality and justice to every woman in the country and we must strive for the same.

The special bulletin on Maternal Mortality in India 2017-19 (Sample Registration System -from Office of Registrar General Of INDIA) has been released and it is now 103 maternal deaths per 1,00,000 live births. It is heartening to note that the MMR is decreasing and I am sure that we will be able to reach the SDG Goals 2030. I take the opportunity to thank all the Obstetricians of our country for working hard to achieve this reduction.

Caesarean section in modern Obstetrics is an invaluable tool in the armamentarium of the obstetrician to save precious maternal and fetal lives. Worldwide there has been an exponential rise in caesarean births and India has followed suit (1). The factors responsible for this rise are many. The National Family Health Surveys 4 and 5 are the logical reference points to trace the magnitude of this rise. The same data when scanned microscopically can help enlighten us regarding the labyrinth of causes associated with the rise in Caesarean Section rate (1, 2).

A reference to the table below suggests that the rates of caesarean all over the country have escalated from around 17% in the 2015-16 survey to more than 21% in 2019-20. As highlighted in **Table 1**, the rise in the private sector (approx. 7%) is more than the overall increase (approx. 4%) and that in the public sector (approx. 2.3%)). The highest rates have been recorded by five states that include Telangana (60.7%) followed by Kerala (42.4%), Andhra Pradesh (42.4%), Lakshadweep (31.3%), erstwhile Jammu and Kashmir (41.7%), and Goa (39.5%). UP, Bihar and Rajasthan have witnessed the lowest rates. (3)

Table 1: Comparison of rates of caesarean section in NFHS 4 and NFHS 5 (1, 2)

	NFHS – 5 Urban	NFHS – 5 Rural	NFHS – 5 Total	NFHS -4 2015-16
Overall	**32.3 %**	**17.6%**	**21.5%**	**17.2%**
Private Sector	**49.3 %**	**46 %**	**47.4 %**	**40.9 %**
Public Sector	**22.7 %**	**11.9 %**	**14.3 %**	**11.9 %**

The possible justifications for this rise are multifactorial, encompassing socioeconomic and biomedical factors both. Maternal age at birth has shown an association with higher odds of caesarean birth in the age group of 40-49 years (OR 1.7; CI[1.52-2.05]) and in 30-40 years (OR 1.39; CI [1.32–1.48]) when using 15-20 years as reference. Women in rural areas (OR 0.84 CI [0.82–0.86]) are less likely to undergo caesarean births compared to those in urban areas. The more educated the parturient, the higher the chances of caesarean birth (OR 1.64; CI [1.60–1.76]). Birth in a private hospital is more likely to end up in an abdominal route as compared to public sector institutions. [(OR 4.45; CI [4.34, 4.57]). (3)

Interestingly, women falling in the middle wealth index category are more likely to have a caesarean birth (OR 1.62; CI [1.55–1.66]) followed by those with those more endowed (OR1.46; CI [1.41–1.52]) when compared to the poor women. Paradoxically women who have more than five antenatal visits are more likely to deliver via caesarean section compared to those with fewer or no visits (OR 2.10; CI [2.04–2.17]) as are overweight women compared to those with a normal BMI [(OR–CI, 2.45 [2.36–2.55]) (3). The rise in infertility and artificial reproductive techniques (ART) have undoubtedly contributed to the inflation in caesarean births.

Is every caesarean a manifestation of Obstetrician's profit-motive or their medico-legal fears, in addition to being a valid medical option? Do the absence of skilled Birth attendant, round-the-clock anaesthesia and labour analgesia services across the country also contribute to the rising Caesarean Section rates? These are pertinent queries in the minds of all of us. If participation, counseling, and shared decision making are encouraged in modern obstetrics, then should the cross of increasing caesarean births be borne only by the doctor?

While it is easy to unify the dots of obesity, higher literacy, multiple antenatal visits, increasing maternal age at birth with urban areas, an important area where potential change can steer a more judicial approach to clinical decision making, is clinical leadership and organizational factors. Incentivizing lower caesarean rates and providing state sponsored insurance cover to obstetricians can be possible solutions that need further deliberation. Standardized operating protocols for admission to the labour ward, induction, oxytocin administration, management of fetal heart rate abnormalities and other obstetric scenarios can be instrumental in optimising labour outcomes without resorting to operative interventions. Training and rotation of labour room staff should be more judiciously planned to ensure more experienced personnel in the labour area.

Auditing Nulliparous Term Singleton pregnancies in Cephalic presentation (Robson's groups 1 and 2) can be a good first step as a national initiative, making it mandatory for all hospitals to submit monthly data which can then be methodically audited. Training of junior cadre, universal availability of labour analgesia and anaesthesia services will be effective steps to increase vaginal deliveries. Group practice can offer an effective solution to physician availability that sometimes becomes responsible for caesarean births(4). While it is imperative to impose judicious restrictions on this ever-growing rate of interventions in a process that is inherently physiological, it is equally imperative to understand the rates of caesarean birth are affected by the quantum and nature of maternal morbidity and the compelling need to optimize feto-maternal outcomes. WHO in its 1985 statement last century suggested, *"There is no justification for any region to have CS rates higher than 10- 15%"* (5). The statement from the same authority in the next century is *"Every effort should be made to provide caesarean sections to women in need, rather than striving to achieve a specific rate"* (6) the goal is to achieve the SDG Goal 2030. This change in the stand of the world's largest medical body reflects the changing perspectives and priorities of the health care system and the society at large. FOGSI has an identical stand on the issue while accepting the need to generate more data. There is no ideal caesarean section rate and we have to take into account all factors for the well being of our Mothers and babies. Having a national birth registry compiling and monitoring data on a monthly and annual basis shall bring us all to a common denominator as a country. I conclude by emphasizing that the promotion of gender equality is the need of the hour. Ethical practices preserving the interest of women, especially pregnant women, infertile patients, and surrogate mothers will definitely play a contributory role in improving the health of the country as a whole. As President FOGSi it is my earnest request to all my dear FOGSIans to work for the best of women's health.

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