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*Newsletter of The Indian College of Obstetricians & Gynaecologists*

# ICOG campus

## Advancing Standards of Education and Healthcare Practices

ICOG Office:
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605, Bapurao Jagtap Marg,
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Mumbai 400 011.

# Message from Vice Chairman, ICOG

**Dr. Uday L. Nagarseker**
**Vice Chairman, ICOG**
uday_goa@sancharnet.in

Dear Friends,

"I was privileged to attend and give a lecture at the Inaugural Conference of South Asian Federation of Menopausal Societies ( SAFOMS ) at Colombo. Our incoming Chairman, Dr. Behram Anklesaria was elected there as the 'President of SAFOMS' for the next 2 years. Let us congratulate him on this great achievement.

The online quiz on Infertility is already on our website-www.icogonline.org. We want all of you to participate and get fabulous prizes! So why wait? Register online and answer the quiz!

FOGSI-ICOG Good Clinical Practice Recommendations (GCPR) Core committee met at Pune recently and more topics like Induction of Labour, Thyroid in Pregnancy, Medical Termination of Pregnancy etc were discussed. The accepted recommendations will be displayed on our website.

More and more Societies are applying for ICOG CREDIT POINTS to be allotted for the programme like workshop, conference, CME etc, that they are organizing. We want all the Societies who will be doing these type of programmes in future, to apply through a mail with a detailed scientific Programme and names of speakers with time allotted to each faculty.

100 ICOG Credit Points will help many of you to get MICOG/FICOG when you fulfill all the criteria sans Publications. "

**Dr. Uday L. Nagarseker**
**Vice Chairman, ICOG**

# Bulletin Board

*To,*
*The Chairman,*
*Indian College of*
*Obstetricians and Gynaecologists,*
*Mumbai.*

*Dear Madam,*

*It has been a great privilege to be associated with ICOG, Mumbai, for the ICOG certificate course. I learnt the scientific way of approaching the patients of infertility. The structured curriculum of this programme helps to stimulate individual thinking and imbibes the confidence.*

*This training is helping me to become more astute in my clinical practice.*

*Thank you.*
*Dr. Anjum Mulla*

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Hubli - 30, Karnataka.
09901052087

**LAUNCHED**

The ICOG-FOGSI **Online Quiz – Infertility** on the website **www.icogonline.org**

**New Memberships open**

To become a **new Member or Fellow** of ICOG... please log on to **www.icogonline.org** for details.

Your feedback will also be appreciated by e-mail – **chairman.icog@gmail.com**

**To all Organizers of Conferences, Workshops and Training courses.**

Awarding Credit through Training Courses and Conferences.
If you determine that your course, seminar or conference qualifies for credit points, please send details to **secretary.icog@gmail.com**

CURRENT OPINION
EVIDENCE
ETHICS
EXCELLENCE

## CONFERENCE ANNOUNCEMENT

March 18-20th, 2011
Leela Kempinski, Goa, India

**Please send the registration form to the ICOG office, Mumbai**

**Email: icogcampusnews@gmail.com**

# ICOG Chairman's Address

**Dr. Duru Shah**
**Chairman ICOG**
chairman.icog@gmail.com

## The Perfect Moment

Dear Friends,

In the third issue of the ICOG Campus I was happy to announce the release of the first document of the ***"Guidelines for Accreditation of Private Health Facilities for Providing SBA Training"*** which were developed by ICOG for the Ministry of Health, Govt. of India. I am happy to inform you that the second document on ***"Guidelines for Accreditation of Private Health Facilities for Providing RCH Services"*** has just been released, bringing to fruit the 18 months of efforts which ICOG put in, between Jan 2007 and June 2008.

I do feel extremely proud that ICOG has been able to develop the Accreditation Criteria for the Govt. of India on the basis of which all Private Health Facilities (Nursing homes of FOGSI members) will be accredited by their local District Health Societies. We have made it mandatory that the District Health Society must include an ICOG or a FOGSI member on the Committee! It is truly satisfying to see that our tireless efforts have been responsible for recognition of private health facilities by the Ministry of Health in their maternal health program. After the nursing homes get accredited based on our accreditation criteria, they would be able to display the NRHM logo on their premises, and will be approved for all benefits which are available to patients who go to a Govt. Hospital. Hence women would prefer to utilize the services of private facilities, getting the dual advantage of receiving the incentives which the Govt. offers and the best of care as offered by our FOGSI members. **The silver lining to this massive exercise will be that every accreditatied facility of a FOGSI member will not need any separate MTP or Tubectomy certification! What a relief to those FOGSI members who have been struggling to obtain these certificates, sometimes for years together!**

**Reproduced ahead are 3 excerpts from the Document** "Guidelines for Accreditation of Private Health Facilities for Providing RCH Services" Maternal Health Division, Ministry of Health and Family Welfare, Government of India, April 2010, which will be of immense value to our members.

**"Accreditation of PHFs for MTP and FP services by the District Accreditation committee shall be done as per the existing rules and regulations laid down for provision of these services. Hence no other registration/certification would be required by the PHFs for rendering the services under these heads".**

**"Such accreditated facilities will be deemed to be accreditated for Central Government Sponsored Schemes under Maternal and Child Health and also Reproductive Health such as JSY, MTP, and Family Planning etc".**

**"A Private Health facility, which gets accredited for RCH services will receive a Certificate of Accreditation and will be authorized to display the NRHM logo. The certificate will mention the type of services and the level for which accreditation has been done".**

**The detailed Document is available on the ICOG website on www.icogonline.org in the Accreditation Section.**

We, as a team, worked with our Ministry of Health. We offered a very subsidized fee for deliveries for "Below the Poverty line" (BPL) patients at our private facilities, in return of which, we got the above. Of course, the volume of work will increase, the revenues will also increase, but what will remain the same is the immense passion within us to contribute our expertise, towards reducing the maternal mortality in this country!

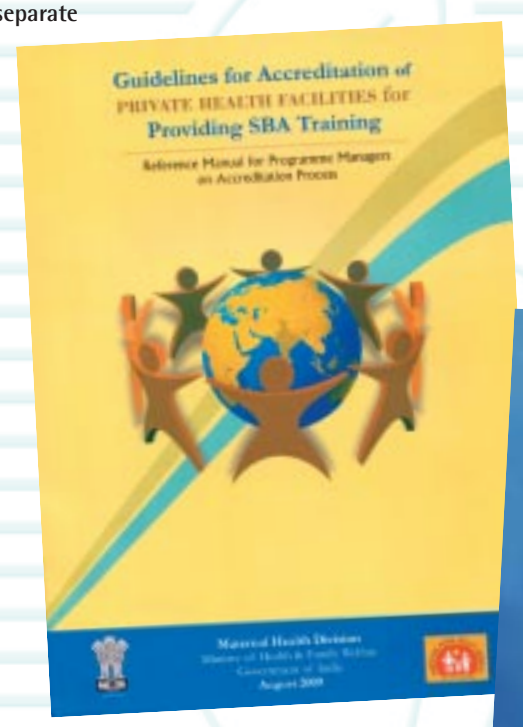
I must acknowledge the excellent efforts of the ICOG team, Sanjay Gupte, Hema Divaker, and Hara Patnaik who assisted me in this endeavour, my heartfelt gratitude to all the local Co-ordinators who assisted in the various stakeholder meetings: Madhuri Chandra, Hephzibah, Adarsh Bhargav, Suneeta Mittal, Usha Saraiya, Manjugita Mishra and Alok Debdas. And of course Dr. Himanshu Bhushan, Assistant Commissioner, Maternal Health, Ministry of Health & Family Welfare, for his untiring efforts towards this cause.

I wish I see the day of mushrooming NRHM centers, headed by our FOGSI members at every small village and town. This will be the quickest way to deliver safe labour practices to the underprivileged women in rural areas of our country, thus reducing maternal mortality to levels which have never been attained before!

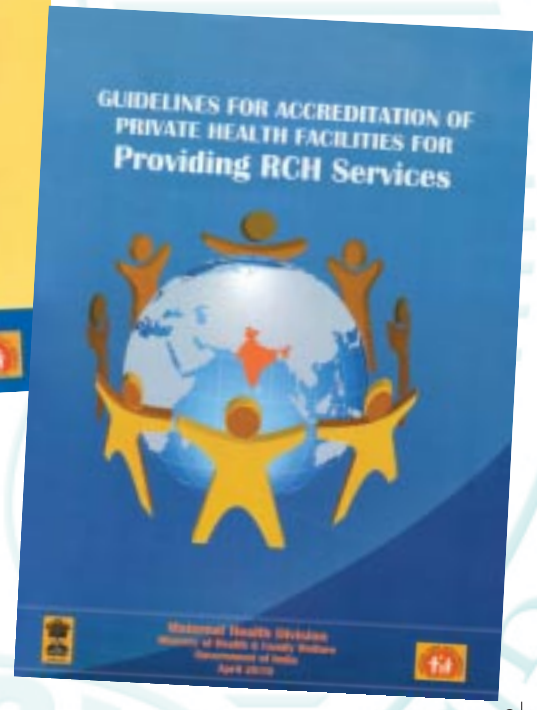
**Without doubt, this is the perfect moment for FOGSI's intervention, we must not lose it!**

Wishing you all a very Happy New Year. From all of us at ICOG.

**Duru Shah**
**Chairman – ICOG**




Guidelines for Accretitation of Private Health Facilities for Providing RCH Services




Guidelines for Accreditation of Private Health Facilities for Providing SBA training

**Dr. Duru Shah**
Chairman ICOG

**Dr. Hema Divakar**
Secretary ICOG

**Dr. Safala Shroff**
Correspondent

**Dr. Ameya Purandare**
Correspondent



# ICOG Secretary Speaks...

**Dr. Hema Divakar**
**Hon. Secretary, ICOG**
secretary.icog@gmail.com

**Dear friends and collegues**,

"Actions speak for themselves "

You will find a very brief note from me this time, focussing on the academic work that has been crystallised into the write up on **GDM ANALYTICS** .

**ICOG Study Hours**, conceptualised by our chairman, Dr. Duru Shah, provides a unique platform for academic leaders and participants all over India, to conduct a vibrant discussion aimed at reaching consensus in the various fields of gynecology and obstetrics. Debates, discussions and lectures facilitated this academic dialogue on the four theme topics chosen for the year. This aims to bridge the gaps between the expansion of information and its implementation in clinical practice.

An update on one of the most pressing issues facing clinicians today, **Gestational Diabetes Mellitis** is being shared with you in this issue of the Campus – focussing on Screening and Diagnosis of GDM, influencing the development of INDIAN Guidelines.

**This is just the Beginning**
"Should we accept the IADPSG recommendations? Can FBG be used as a screening tool? Oral hypoglycemic drugs for all in GDM? Long acting insulin analogues – are they safe? Is there a role for new oral hypoglycemic? How to define well glycemic control? Is there a role for ultrasound evaluation for the decision of treatment?"

Several and more issues need to be discussed and will be done in due course of time... We gratefully acknowledge the efforts of Drs. Uday Thanawala, Mandakini Parihar and Jaideep Malhotra in the making of Questionnaires and excecution of Study hour session.

**VOICES OF YUVA – is a novel deliberation** on making of the guidelines and Good Clinical Practice Recommendations. This session was conducted by me, for the first time at the WEST ZONE YUVA congress where a set of bright young postgraduates participated and voiced their opinion on current practices and exsisting standards in management of GDM and participated in **a mock discussion in the making of practice recommendations for "Anaemia**" The Yuva gained Insights into the challenges of "agreeing to disagree" and reaching a "consenses from controversies".

I remind you once again, to visit our website www.icogonline.org to

- apply for the ICOG CME sponsorship and
- also for a special session at YUVA congress.
- apply for membership/fellowship / certification courses/ skill transfer programmes & avail of the opportunities which ICOG has laid before you.

*Apart from academic feasts at ICOG,*
*I also Wish that you and your family enjoy the festivities of the New Year*
*and we look forward to meeting you at the ICOG Convocation 2011 at Hyderabad*

Warm regards

**Dr. Hema Divakar**
**Hon. Sec. ICOG**

# ACADEMICS – ICOG STUDY HOURS
# GDM ANALYTICS

Please log on to **www.icogonline.org** under Academics/ Research to fill a form & contribute towards such clinical research through ICOG.

The inputs for this study is from ObGyns all over the Country and represents the knowledge, attitudes and practices on GDM – both in private and public institutions

| | |
|---|---|
| Attached to Public Hospital | 51.45 % |
| Attached to Private Hospital | 18.68 % |
| Private Practice | 70.25 % |

**Whom do they screen?**
The prevalence of GDM is approximately 3.8% in the western world. Comparative figures in India indicate prevalence around 15 %. The Indian ethnic population is considered to be AT RISK and UNIVERSAL SCREENING has to be offered in the antenatal period.

| | |
|---|---|
| All my antenatal patients | 64.9 % |
| Only high risk antenatal patients based on past history | 14.88 % |
| Only if they develop history of GDM during antenatal period | 2.91 % |
| Do not screen any antenatal patients for GDM | 0.11 % |

About 15% of practitioners are offering the tests only based on risk factors and previous history. Hence, they would miss a number of cases of GDM

**Recommendation – TEST ALL ANTENATAL PATIENTS**

**Perceived prevalence**
Multicentric studies in India have shown an incidence of 15 to 17 %. Only 10 % of practitioners in our study, seem to indicate a prevalence of 10-15 %. 60 % have reported an incidence of 1 to 5 % They may be missing many GDM cases in many centers owing to the practice of not offering the screening test universally and not doing the right kind of tests for diagnosis.

**Which test?**
The study reveals a variety and inconsistency in performing the standard tests

The following tests were used as screening tests in the study.

| | |
|---|---|
| Urine sugar | 25.95% |
| Fasting blood sugar | 19.35% |
| Post prandial blood sugar | 16.68% |
| Fasting and post prandial blood sugar | 23.15% |
| Random blood sugar | 25.73% |
| 50 gm Glucose challenge test | 28.97% |
| 75 gm Glucose and 2 hour reading | 14.54% |
| Oral Glucose challenge test | 4.47% |
| Other | 1.57% |

**For screening, the recommended test is a two-step test**

1. GCT with 50 gm glucose irrespective of the time of last meal, and a one hour venous sample for glucose estimate. If the reading is more than 140mg% , it is declared as screen +ve
2. OGTT 100 gm OR 75 gm (WHO) Oral Glucose Tolerence Test with fasting, one hour, two hour and three hour samples.

ONE STEP TEST called the DIPSI test is established by Dr. Seshiah and group in INDIA and has been validated and published and included in INDIAN GUIDELINES for GDM (2009)

Irrespective of the last meal, 75 gm glucose is given and a two hour venous sample is drawn for glucose estimates. If values are > 140 mg%, patient is labeled as GDM.

This avoids multiple visits and multiple pricks and analysis of multiple samples. This is a simple single step test both for screening and diagnosis.

**If GCT +ve – what next?**
Either of the methods can be followedbut the cut offs are different and criteria for diagnosis are different.

| | |
|---|---|
| Fasting,75gms glucose, 1hr, 2hr, 3hr reading. | 56.94% |
| Fasting,100gms glucose, 1hr, 2hr, 3hr reading. | 41.26% |
| Other2 | 2.68% |

**When to do perform the tests?**
It is unwise to delay the testing beyond 28weeks, since late detection reflects a lost opportunity for control.

| | |
|---|---|
| First antenatal visit/even if it is in 1st trimester. | 64.32% |
| At 26 weeks. | 19.91% |
| After 26 weeks. | 7.05% |
| Only if urine shows sugar. | 2.8% |
| Repeat at 26 weeks even if normal reading earlier. | 37.36% |
| Other. | 0.22% |

Even if the first trimester tests report normal, the test should be repeated between 24 to 28 weeks of gestation, since the maximum incidence of flare up and development of GDM occurs in this phase of pregnancy.

It is wise to offer the Single step DIPSI test in every trimester. 17 % of cases are picked up before 16 wks of gestation indicating the significance of early testing and initiating early control for a better outcome.

**What is considered as normal for OGTT?**
Respondents considered the following as normal for OGTT:

| | |
|---|---|
| Carpenter &tCoustan criteria | 73.49% |
| NDDG criteria | 27.74% |
| No criteria | 0.45% |

**Expert Group says:**
In Indian ethnic population, which is at high risk, it is advised to follow Carpenter and Coustan criteria in a OGTT interpretation - this is a stricter criteria demanding lower values for cutoffs.

Using NDDG criteria would miss 27% of GDM who would have otherwise be picked up from the same set antenatal patients if C & C were applied (published 2008 Divakar H &tManyonda IT)

**When is it an abnormal test?**
Respondents considered the following as abnormal OGTT:

| | |
|---|---|
| One reading abnormal | 27.4% |
| More than one reading abnormal | 70.25% |
| All readings abnormal | 2.8% |

**Expert Group says:**
66% of clinicians opine that more than one value has to be abnormal - and seem to ignore those with only one value abnormal.

But even if one value is abnormal, we label her as gestational glucoseintolerance and maintain a strict follow up for a better outcome. This group should not be ignored.

**What do you do if only one reading is abnormal?**
Respondents considered the following if only one reading was abnormal:

| | |
|---|---|
| Repeat tests every trimester | 53.8% |
| RepeatPLBS everymonth | 41.39% |
| Consider test as normal | 6.26% |

**Expert Group says:**
The choice between repeating tests every trimester or every month needs to be individualized. Either way, one needs to keep track!

**What is to be done for all abnormal OGTT patients?**
Respondents advised the following management all abnormal OGTT patients:

| | |
|---|---|
| Diet control only | 23.49% |
| Start insulin myself | 12.42% |
| Try oral hypoglycemic agents | 3.8% |
| Start insulin only if fetal macrosomia | 3.13% |
| Refer to a specialist | 73.38% |

**Expert Group says:**
5 % of clinicians are using oral hypoglycemics - not yet in the recommendations for glycemic control.

While, 73 % would refer to the specialist - if such option is available and a multi specialty approach would bring in the best control.

**How should patients on Insulin be followed up?**
Respondents followed up patients on Insulin with the following management options

| | |
|---|---|
| Home self monitoring of glucose | 53.58% |
| PLBS at regular intervals | 53.13% |
| Other | 6.94% |

**Expert Group says:**
Home monitoring is ideal when patient is on insulin.

A significant number of clinicians seem to think this is difficult for the patients and advise PLBS at the visits to the hospital. These visits have to be as frequent as once or twice a week.

# Strategies to Reduce Health Issues In Rural Women – What do I do?

**Dr. Usha Krishna**
Consulting Obstetrician
& Gynaecologist
drushark@sify.com

There are some special problems rural women have and they are largely due to malnutrition, delay in diagnosis and decision making. Most of them could be avoided by education, awareness and understanding. The community and family support is most essential and if women are treated with love & respect, there will be a great change in the status of health.

Every girl child should be a wanted child and given the very best of nutrition and preventive healthcare. The last National Family Health Survey (NFHS) indicates that 41% of women and 18% of men age 18-49 have never been to school and only 22% of women have completed 10 or more years of education. The attitude towards family life education in school makes a great deal of difference. Just under ½ (49%) of women think girls should learn about contraception compared with 65% of men. However, 63% of women feel that they need to learn about HIV & AIDS. It is the 'son preference' which leads to larger families and neglect of girls. The contraceptive prevalence rate among the currently married women is 56%. Female sterilization accounted for 71% of contraception use in NFHS 2 report which now accounts for 66% of contraceptive use. The discontinuation rates for temporary method are quite high, 30-45%. There was very little improvement in full vaccination coverage between NFHS 2 & NFHS 3. Full vaccination coverage has been 42% & 44% respectively in NFHS 2 and 3. Polio vaccination improved by 63% to 78%. Less than half the women receive antenatal care during first trimester and just over half of the mothers had 3 or more antenatal visits. Though 65% women received iron and folic supplements, only 23% consumed the same. 3 out of 5 births take place at home and only 37% of mothers get postnatal care. Thus, anaemia and osteoporosis and pregnancy related complications and infections could be avoided by prophylactic care. Septic abortions, STD infections as well as HIV and even social problems such as domestic violence, teenage pregnancies, could be prevented by education and awareness.

My involvement increased by being Family Planning President, where we could work in sensitive acceptable manner by educating the adolescents, as well as the medical officers, counselors, and para medical workers. The medical officers of Tonk district (Rajasthan) were trained to give better antenatal and Intrapartum care and provide safe abortion. There are many training programs all through the year for medical and paramedical workers.

I realized that it has become extremely essential for women of villages to perform multiple roles and responsibilities, acquire knowledge and confidence through training programs. I could then set up a collaboration of KEM Hospital Research Centre, Pune, with Larsen & Toubro public charitable trust and set up a project at PABAL, a village 30 km. from Pune. This was initially set up by Dr. Banoo Coyaji, a pioneer in empowering rural women. We could revive the project 5 years after she passed away. We met the school dropouts or semi literate women and adolescent girls from socio economically backward classes and had discussions with opinion leaders from 30 villages around PABAL. After surveying technical feasibility, we set up courses for computer skills for home nursing and food processing and have now added classes on spoken English, health and hygiene, etc. to achieve holistic development and empowerment of rural women. By now 167 trainees have successfully completed the courses and even got jobs in local nursing homes and hospitals and started small business of food products. We have involved gram panchayats and elderly women and received their cooperation. We have dynamic workers like Mr. Ram Deshpande from L&T, Mr. Pingle and Dr. Padbidri from KEM Hospital, to manage these projects. Our team therefore works to remove discrimination, domestic violence, child labour and prostitution, STD and HIV and develop healthy outlook in rural women.

Our government is giving tremendous support to encourage rural women to get the necessary medical help. FOGSI has organized excellent schemes to teach emergency obstetric care and many NGOs are working in various areas to achieve our goal.

**References**

- National Family Health Survey (NFHS-2 and 3)
- International Institute for Population Sciences, Deonar, Mumbai 400 088
- KEM Hospital Research Society Newsletter

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Maternal Health is Global Health. It is universally agreed that the health of the community as whole is tied with the health, illness and death of women. More than 2/3rd our of our population reside in rural areas and even less than 1/3rd of the total health care facilities are accessible to them. The major health issues concerning to rural women are Maternal Mortality, teenage marriage & pregnancy, malnutrition & anaemia, poverty, illiteracy, gender bias, violence against women and the HIV/AIDS pandemic.

People from high Maternal Mortality sectors have started realizing that death is not an inevitable risk of child birth and no woman should die while giving life to the mankind. It is heartening, hot and a huge achievement, we have to strike in right place in the right time. The most important strategies include access to contraception to prevent unintended pregnancies (each of which multiplies the risk of Maternal death), skilled care before & after child birth and emergency obstetric interventions when complications arise. Mobilising the community and health systems to reduce the three delays (in decision to take help, the time taken to reach help and the waiting time in health facilities) can play a large role in saving lives of our rural women. Maternal death Audit should be carried out at every hospital and Health Centre in order to indentify the cause as to why the woman died and what measures needed to prevent such deaths. The health systems needs to be more decentralized and strict discipline of accountability should be enforced.

Education on safe motherhood seems to be a quite rational approach. Gramsat facilities should be ultilised optimally by means of teleconferencing enabling active interaction in the community level to overcome the constrains and bottlenecks existing at that level. Individual constrains can be prioritized with openness in mind in order to empower them with the provisions already existing or anything extra that can be done in special situations. Promotion of public awareness in both electronic & print media always holds positive advantage to sensitise the community. Exploring the possibility of health insurance schemes particularly for BPL families can be of tremendous advantage in situations like malignancies and HIV/AIDS. The Govt. of Orissa has allowed all benefits under BPL Card to PLHAs which can be taken as an exemplary initiative.

WHAT I DO – As a responsible member of FOGSI, I carry out regular health camps in rural areas in association with different community based civil organizations. In every health camp, I conduct one hour counseling programme on Safe Motherhood, contraception and different aspects of healthy & positive life style. The issue of teenage marriage and teenage pregnancy has always pinched me. At present I am highly concerned regarding the high risk behaviors and prevalence of HIV in adolescents. Conducting regular life style education programmes in schools & colleges and adult education programmes in remote villages have been my fancied and satisfying approach. On FOGSI designated days, I contribute write-ups in both print and electronic media to sensitise the community. I have been contributing write-ups, preparing programmes in TV & AIR on every safe motherhood days for last five years where I emphasize on cent percent institutional deliveries. Promotions of public awareness and media advocacy have been my commitment in my self-made continuous Public Awareness Programmes (CPAP).

**Dr. Dilip Kumar Dutta**
M.D., PHD, FICOG

India, the 2nd most populous country of the world, has fast changing socio-political-demographic patterns that have been drawing global attention in recent years. Approximately 1/4th of all pregnancy and delivery related maternal deaths worldwide occur in India.

**Why India is drawing world attention?**

Since independence, a number of urban and growth-oriented developmental programmes have been implemented. The policies implemented so far, which concentrate only on growth of economy not on equity and equality, have widened gap between urban & rural and haves and have-nots. Nearly 70% of all deaths and 92% of deaths from communicable diseases, occur among the poorest 20% of the population.

**Current health scenario in rural India**

The health status of Indians, is still a cause of grave concern, especially that of the rural population. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live birth) and maternal mortality rate (438/100000 live birth). Reasons? Beside-direct, indirect, and coincidental causes, there are also logistic causes that are failure in the health care system, lack of transport, lack of manpower and apathy towards patient care. To improve this, the problem has to be addressed both at the district, regional (micro) state and national (macro) level.

**Steps to reduce health issues in rural women**

Working for last couple of years at grass root level at rural area, following steps have been formulated by me for prevention of maternal mortality and morbidity rate. Woman health issues were divided into three 'C' i.e. Crisis, Care and Cure.

**Objective**

**STEP – I CRISIS** Every woman should know about the crisis (Problem) that may come to her life from pre-reproductive period to post reproductive period.

**STEP – II CARE** Having knowledge about the crisis - care (Prevention) should be instituted (a) to protect against child hood and adolescent health issue (b) To prevent complications of pregnancy through early detection and treatment. (c) To provide clean and safe delivery (d) To promote the implementation of family planning programme (e) Predicting the early diagnosis of post reproductive disease. (f) cent percent encouragement for Institutional delivery

**STEP – III CURE** Immediate action is to be immediately implemented (a) To promote action and management of puberty and adolescent problem if any. (b) early diagnosis of complications of pregnancy and prompt management (c) To ensure clean and safe vaginal delivery (d) To ensure immediate step to prevent third stage complications.

**Action plan**

To ensure success – the following important steps are to be formulated.

1. To involve the neonatologist, paediatrician and physician - to ensure that child's family must have knowledge about their blood Group, Rh Factor and girls should have at least >14gms haemoglobin and devoid of malnutrition, UTI and RTI.
2. To involve the gynaecologist - to prevent and treat PCOS, endometriosis and infections in adolescent girls before marriage.
3. To inform head of family - marriage of girl should be > 20 years of age.
4. To involve head of the family and husband-before pregnancy wife should have at least above 14gms of haemoglobin, no abortion without proper knowledge of blood Group and RH Factor.
5. To involve obstetrician, midwife and paramedical staff - to find out any complications of pregnancy and prompt treatment.
6. To involve govt., NGO, FOGSI, IMA - for awareness programmes at school/ college/ media/ religious places/ marriage functions -regarding reproductive healthcare/ sex education/bad effects of drugs/ smoking/alcohol.
7. To involve health care staff- to perform community studies, household survey, sisterhood measures and reproductive age mortality surveys.
8. To involve office staff-to maintain hospital data, data from other sources and other health records.
9. To involve DM, SDO, BDO and Panchayat Sabadipati - to initiate action plan and generate economic resources for implementation of this programme.

**Self- investigated Result**

Since 2007, involvement of obstetricians from Kalyani Obstetric and Gynaecological Society, IMA, NGO and stepwise implementation - to improve access to adolescent health problem (anemia, infection), pregnancy related health services and timely interventions during intra and postpartum care, 50% to 75% maternal death and morbidity has been prevented at tertiary level hospital (JNM hospital) Kalyani, Nadia, WB (8 to 10 thousand deliveries per year). Observation showed that maternal mortality 738/1000000 live births during 2006 was found to be drastically reduce to 389 (2007), 280(2008), 211(2009) and 284 (2010 upto 31st Oct) after implementing plan of action.

**Conclusion**

Strategies to improve coverage of effective interventions during pre-reproductive period by involving doctor and Govt and others manpower could reduce the incidence of health related complications or mortality and morbidity at rural India.

Early intensive efforts to improve family planning ,to control of fertility choices, to provide safe abortion and integrated maternal health services - were the most important interventions to reduce pregnancy related mortality i.e. 150,000 maternal deaths-could be prevented in next 5 years.

---

**Dr. Ramaraju**
H.E MS(OBG)
Assistant Professor in OBG
Dept of OBG ,VIMS, Bellary, Karnataka

"However much a mother may love her children, it is all but impossible for her to provide high-quality child care if she herself is poor and oppressed, illiterate and un-informed, anaemic and unhealthy, has five or six other children, lives in a slum, has neither clean water nor safe sanitation, and if she is without the necessary support either from health services, or from her society, or from the father of her children" - Vulimiri Ramalingaswami, The Asian Enigma

It sums up rural women in India. India's maternal mortality is one of the highest and carcinoma cervix with its late diagnosis is a nightmare for our rural women. This rate is high due to lack of political will, administrative and managerial failures rather than absence of expertise. - WHO Magazine 2008.

Health indicators like, assistance during delivery by TBA, unmet need for family planning, knowledge of HIV prevention methods expose inequities between rural and urban women SRH Services. We need to take drastic steps and actions at both social and medical aspects of problem of WEEEEP (Women Education, Empowerment, Employment and Environmental Problems).

Planning for reducing health issues in rural women:

1. Improve of social status of women: must be a high priority. Female literacy and education including vocational training with better employment opportunities help in delaying the age of marriage and promoting smaller families. Social leaders and mass media can play a vital role in making it a reality.
2. Better Family Health Education: by practicing contraception, unwanted pregnancies could be avoided. Safe abortion facilities and counselling must be available even in periphery.
3. Comprehensive Perinatal care including Risk: Screening - each planned pregnancy be supervised by a nearest health worker & booked for delivery with the trained person or an institution well before term. Members of the community and TBAs trained to recognize signs of high risk pregnancies and complications and accompany them to the nearest health centre. Tetanus immunization for all ANC women. Prophylaxis with IFA tab from 2nd trimester till 6 months post partum. At each visit she should be screened carefully and those identified as high risk are referred to appropriate higher level of care. Maternity waiting homes or villages should be available close to the FRU where high risk women like previous CS, BOH. H/o PPH, retained placenta not needing hospitalization can await onset of labour instead of arriving late from villages as emergency.

Domiciliary delivery for all uncomplicated cases but back up support should be available to the health worker in case of unforeseen complications. The staff at the community level should work as a team for the success of this programme.

4. Establishment of First Referral level centre: the current practice of centralization of emergency care at the district level hospital in India leads only for over crowding but also some maternal deaths due to undue delay in reaching there. Therefore, FRC should be developed closure their homes. Each district may need 5- 6 centres (1/50,000 population) well staffed and equipped, to perform essential obstetric functions (WHO 1986). Some of our existing taluka hospitals and community health centres can be strengthened to function as FRC The staff here need not be specialists but should be specially trained to promptly treat common obstetric emergencies.

*Continued on page 14*

# Strategies to Reduce Health Issues In Rural Women – What do I do?

**Dr. Usha Krishna**
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There are some special problems rural women have and they are largely due to malnutrition, delay in diagnosis and decision making. Most of them could be avoided by education, awareness and understanding. The community and family support is most essential and if women are treated with love & respect, there will be a great change in the status of health.

Every girl child should be a wanted child and given the very best of nutrition and preventive healthcare. The last National Family Health Survey (NFHS) indicates that 41% of women and 18% of men age 18-49 have never been to school and only 22% of women have completed 10 or more years of education. The attitude towards family life education in school makes a great deal of difference. Just under ½ (49%) of women think girls should learn about contraception compared with 65% of men. However, 63% of women feel that they need to learn about HIV & AIDS. It is the 'son preference' which leads to larger families and neglect of girls. The contraceptive prevalence rate among the currently married women is 56%. Female sterilization accounted for 71% of contraception use in NFHS 2 report which now accounts for 66% of contraceptive use. The discontinuation rates for temporary method are quite high, 30-45%. There was very little improvement in full vaccination coverage between NFHS 2 & NFHS 3. Full vaccination coverage has been 42% & 44% respectively in NFHS 2 and 3. Polio vaccination improved by 63% to 78%. Less than half the women receive antenatal care during first trimester and just over half of the mothers had 3 or more antenatal visits. Though 65% women received iron and folic supplements, only 23% consumed the same. 3 out of 5 births take place at home and only 37% of mothers get postnatal care. Thus, anaemia and osteoporosis and pregnancy related complications and infections could be avoided by prophylactic care. Septic abortions, STD infections as well as HIV and even social problems such as domestic violence, teenage pregnancies, could be prevented by education and awareness.

My involvement increased by being Family Planning President, where we could work in sensitive acceptable manner by educating the adolescents, as well as the medical officers, counselors, and para medical workers. The medical officers of Tonk district (Rajasthan) were trained to give better antenatal and Intrapartum care and provide safe abortion. There are many training programs all through the year for medical and paramedical workers.

I realized that it has become extremely essential for women of villages to perform multiple roles and responsibilities, acquire knowledge and confidence through training programs. I could then set up a collaboration of KEM Hospital Research Centre, Pune, with Larsen & Toubro public charitable trust and set up a project at PABAL, a village 30 km. from Pune. This was initially set up by Dr. Banoo Coyaji, a pioneer in empowering rural women. We could revive the project 5 years after she passed away. We met the school dropouts or semi literate women and adolescent girls from socio economically backward classes and had discussions with opinion leaders from 30 villages around PABAL. After surveying technical feasibility, we set up courses for computer skills for home nursing and food processing and have now added classes on spoken English, health and hygiene, etc. to achieve holistic development and empowerment of rural women. By now 167 trainees have successfully completed the courses and even got jobs in local nursing homes and hospitals and started small business of food products. We have involved gram panchayats and elderly women and received their cooperation. We have dynamic workers like Mr. Ram Deshpande from L&T, Mr. Pingle and Dr. Padbidri from KEM Hospital, to manage these projects. Our team therefore works to remove discrimination, domestic violence, child labour and prostitution, STD and HIV and develop healthy outlook in rural women.

Our government is giving tremendous support to encourage rural women to get the necessary medical help. FOGSI has organized excellent schemes to teach emergency obstetric care and many NGOs are working in various areas to achieve our goal.

**References**

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- KEM Hospital Research Society Newsletter

**Dr. Durga Shankar Dash**
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Safe Motherhood Consultant & Family Health Physician
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Maternal Health is Global Health. It is universally agreed that the health of the community as whole is tied with the health, illness and death of women. More than 2/3rd our of our population reside in rural areas and even less than 1/3rd of the total health care facilities are accessible to them. The major health issues concerning to rural women are Maternal Mortality, teenage marriage & pregnancy, malnutrition & anaemia, poverty, illiteracy, gender bias, violence against women and the HIV/AIDS pandemic.

People from high Maternal Mortality sectors have started realizing that death is not an inevitable risk of child birth and no woman should die while giving life to the mankind. It is heartening, hot and a huge achievement, we have to strike in right place in the right time. The most important strategies include access to contraception to prevent unintended pregnancies (each of which multiplies the risk of Maternal death), skilled care before & after child birth and emergency obstetric interventions when complications arise. Mobilising the community and health systems to reduce the three delays (in decision to take help, the time taken to reach help and the waiting time in health facilities) can play a large role in saving lives of our rural women. Maternal death Audit should be carried out at every hospital and Health Centre in order to indentify the cause as to why the woman died and what measures needed to prevent such deaths. The health systems needs to be more decentralized and strict discipline of accountability should be enforced.

Education on safe motherhood seems to be a quite rational approach. Gramsat facilities should be ultilised optimally by means of teleconferencing enabling active interaction in the community level to overcome the constrains and bottlenecks existing at that level. Individual constrains can be prioritized with openness in mind in order to empower them with the provisions already existing or anything extra that can be done in special situations. Promotion of public awareness in both electronic & print media always holds positive advantage to sensitise the community. Exploring the possibility of health insurance schemes particularly for BPL families can be of tremendous advantage in situations like malignancies and HIV/AIDS. The Govt. of Orissa has allowed all benefits under BPL Card to PLHAs which can be taken as an exemplary initiative.

WHAT I DO – As a responsible member of FOGSI, I carry out regular health camps in rural areas in association with different community based civil organizations. In every health camp, I conduct one hour counseling programme on Safe Motherhood, contraception and different aspects of healthy & positive life style. The issue of teenage marriage and teenage pregnancy has always pinched me. At present I am highly concerned regarding the high risk behaviors and prevalence of HIV in adolescents. Conducting regular life style education programmes in schools & colleges and adult education programmes in remote villages have been my fancied and satisfying approach. On FOGSI designated days, I contribute write-ups in both print and electronic media to sensitise the community. I have been contributing write-ups, preparing programmes in TV & AIR on every safe motherhood days for last five years where I emphasize on cent percent institutional deliveries. Promotions of public awareness and media advocacy have been my commitment in my self-made continuous Public Awareness Programmes (CPAP).

**Dr. Dilip Kumar Dutta**
M.D., PHD, FICOG

India, the 2nd most populous country of the world, has fast changing socio-political-demographic patterns that have been drawing global attention in recent years. Approximately 1/4th of all pregnancy and delivery related maternal deaths worldwide occur in India.

**Why India is drawing world attention?**

Since independence, a number of urban and growth-oriented developmental programmes have been implemented. The policies implemented so far, which concentrate only on growth of economy not on equity and equality, have widened gap between urban & rural and haves and have-nots. Nearly 70% of all deaths and 92% of deaths from communicable diseases, occur among the poorest 20% of the population.

**Current health scenario in rural India**

The health status of Indians, is still a cause of grave concern, especially that of the rural population. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live birth) and maternal mortality rate (438/100000 live birth). Reasons? Beside-direct, indirect, and coincidental causes, there are also logistic causes that are failure in the health care system, lack of transport, lack of manpower and apathy towards patient care. To improve this, the problem has to be addressed both at the district, regional (micro) state and national (macro) level.

**Steps to reduce health issues in rural women**

Working for last couple of years at grass root level at rural area, following steps have been formulated by me for prevention of maternal mortality and morbidity rate. Woman health issues were divided into three 'C' i.e. Crisis, Care and Cure.

**Objective**

**STEP - I CRISIS** Every woman should know about the crisis (Problem) that may come to her life from pre-reproductive period to post reproductive period.

**STEP - II CARE** Having knowledge about the crisis - care (Prevention) should be instituted (a) to protect against child hood and adolescent health issue (b) To prevent complications of pregnancy through early detection and treatment. (c) To provide clean and safe delivery (d) To promote the implementation of family planning programme (e) Predicting the early diagnosis of post reproductive disease. (f) cent percent encouragement for Institutional delivery

**STEP - III CURE** Immediate action is to be immediately implemented (a) To promote action and management of puberty and adolescent problem if any. (b) early diagnosis of complications of pregnancy and prompt management (c) To ensure clean and safe vaginal delivery (d) To ensure immediate step to prevent third stage complications.

**Action plan**

To ensure success – the following important steps are to be formulated.

1. To involve the neonatologist, paediatrician and physician - to ensure that child's family must have knowledge about their blood Group, Rh Factor and girls should have at least >14gms haemoglobin and devoid of malnutrition, UTI and RTI.
2. To involve the gynaecologist - to prevent and treat PCOS, endometriosis and infections in adolescent girls before marriage.
3. To inform head of family - marriage of girl should be > 20 years of age.
4. To involve head of the family and husband-before pregnancy wife should have at least above 14gms of haemoglobin, no abortion without proper knowledge of blood Group and RH Factor.
5. To involve obstetrician, midwife and paramedical staff - to find out any complications of pregnancy and prompt treatment.
6. To involve govt., NGO, FOGSI, IMA - for awareness programmes at school/ college/ media/ religious places/ marriage functions -regarding reproductive healthcare/ sex education/bad effects of drugs/ smoking/alcohol.
7. To involve health care staff- to perform community studies, household survey, sisterhood measures and reproductive age mortality surveys.
8. To involve office staff-to maintain hospital data, data from other sources and other health records.
9. To involve DM, SDO, BDO and Panchayat Sabadipati - to initiate action plan and generate economic resources for implementation of this programme.

**Self- investigated Result**

Since 2007, involvement of obstetricians from Kalyani Obstetric and Gynaecological Society, IMA, NGO and stepwise implementation - to improve access to adolescent health problem (anemia, infection), pregnancy related health services and timely interventions during intra and postpartum care, 50% to 75% maternal death and morbidity has been prevented at tertiary level hospital (JNM hospital) Kalyani, Nadia, WB (8 to 10 thousand deliveries per year). Observation showed that maternal mortality 738/1000000 live births during 2006 was found to be drastically reduce to 389 (2007), 280(2008), 211(2009) and 284 (2010 upto 31st Oct) after implementing plan of action.

**Conclusion**

Strategies to improve coverage of effective interventions during pre-reproductive period by involving doctor and Govt and others manpower could reduce the incidence of health related complications or mortality and morbidity at rural India.

Early intensive efforts to improve family planning ,to control of fertility choices, to provide safe abortion and integrated maternal health services - were the most important interventions to reduce pregnancy related mortality i.e. 150,000 maternal deaths-could be prevented in next 5 years.

"However much a mother may love her children, it is all but impossible for her to provide high-quality child care if she herself is poor and oppressed, illiterate and un-informed, anaemic and unhealthy, has five or six other children, lives in a slum, has neither clean water nor safe sanitation, and if she is without the necessary support either from health services, or from her society, or from the father of her children" - Vulimiri Ramalingaswami, The Asian Enigma

It sums up rural women in India. India's maternal mortality is one of the highest and carcinoma cervix with its late diagnosis is a nightmare for our rural women. This rate is high due to lack of political will, administrative and managerial failures rather than absence of expertise. - WHO Magazine 2008.

Health indicators like, assistance during delivery by TBA, unmet need for family planning, knowledge of HIV prevention methods expose inequities between rural and urban women SRH Services. We need to take drastic steps and actions at both social and medical aspects of problem of WEEEEP (Women Education, Empowerment, Employment and Environmental Problems).

Planning for reducing health issues in rural women:

1. Improve of social status of women: must be a high priority. Female literacy and education including vocational training with better employment opportunities help in delaying the age of marriage and promoting smaller families. Social leaders and mass media can play a vital role in making it a reality.
2. Better Family Health Education: by practicing contraception, unwanted pregnancies could be avoided. Safe abortion facilities and counselling must be available even in periphery.
3. Comprehensive Perinatal care including Risk: Screening - each planned pregnancy be supervised by a nearest health worker & booked for delivery with the trained person or an institution well before term. Members of the community and TBAs trained to recognize signs of high risk pregnancies and complications and accompany them to the nearest health centre. Tetanus immunization for all ANC women. Prophylaxis with IFA tab from 2nd trimester till 6 months post partum. At each visit she should be screened carefully and those identified as high risk are referred to appropriate higher level of care. Maternity waiting homes or villages should be available close to the FRU where high risk women like previous CS, BOH. H/o PPH, retained placenta not needing hospitalization can await onset of labour instead of arriving late from villages as emergency.

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ICOG CME

# Prevention and Medical Management of Post-Partum Hemorrhage (PPH)

## Tackle PPH by PPH (Predict, Prevent/Prepare and Handle)

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Goal of United Nations was to reduce maternal deaths by 3/4 from 2000 to 2015. To achieve this, postpartum hemorrhage related deaths should be prevented as most of the PPH related deaths are preventable. It is essential that health care providers need to know medications (evidence-based guidelines on the safety, quality, and usefulness of the various interventions) used and the necessary skills to use the procedures that prevent the PPH. They also must have easy access to these medications. This article is aimed to provide updated practical information on medications used for PPH and procedures that prevent PPH along with tips for resuscitation and referral.

Prevention: No pregnant woman is immune to postpartum hemorrhage as it is noted that 2/3 of the cases of PPH occur in cases without risk factors. Health care provider must anticipate PPH in every woman in labor. **It is important here to note PPH for PPH i.e. tackle Post-Partum Hemorrhage by Predict, Prevent/ Prepare and Handle.** It is important for all of health care providers to keep in mind the risk factors for PPH and other low risk cases who can develop this complication. This is one of the obstetric emergencies that needs immediate attention as occurrence to death interval is just two hours. Hence it is essential to diagnose, treat and manage including referral at the earliest as these are the three delays that kill the woman in PPH.

It is proved beyond doubt that Active Management of Third Stage of Labor (AMTSL) has reduced the incidence PPH as proved by the multi-centre randomized trials and World Health Organization (WHO) has already endorsed the same. It is essential for all the health care providers to note this change as some of the obstetricians/health care providers still think that active management of third stage of labor means anterior shoulder methyl ergometrine. Active management of the third stage is an intervention to facilitate the delivery of placenta by enhancing uterine contraction & retraction to prevent atonic postpartum hemorrhage.

The three components of AMTSL are

1. **Provision of (Uterotonic) Oxytocin 10 IU intramuscularly (IM** within one minute after the delivery of the baby (Ensuring there is no second baby inside by palpation)
2. **Controlled Cord Traction** (after delayed cord clamping,If no contraindications for delayed clamping)
3. **Uterine massage:** Palpation of the uterus every 15 minutes after the delivery to ensure that uterus remains well contracted and retracted during the observational period.

AMTSL: ***From AText PPH By C.B.Lynch et.al pages 6-7***

**Uterotonics: Oxytocin** is preferred over others as it acts faster after injection (within 2-3 minutes) and has minimal side effects so that it can be used in all women. It needs storage between15-300c and should not freeze.

If oxytocin is not available other uterotonics like **Ergometrine 0.2mg** IM (storage at 2-80c protect from light and from freezing), **Syntometrine** (Ergometrine 0.2mg+ Oxytocin 5IU) both are contraindicated in pregnancy with high blood pressure (PIH and hypertension).

**Misoprostol** 400-600 mcg orally, Misoprostol oral use is reserved where safe administration and or appropriate storage conditions for injectable oxytocin and ergot alkaloids are not possible. Misoprostol can be stored at room temperature in closed container.

**Controlled Cord traction:** How to perform controlled cord traction ?
Clamp the cord close to the perineum (once pulsation stops in a healthy newborn) and hold in one hand. Place the other hand just above the woman's pubic bone and stabilize the uterus by applying counter-pressure during controlled cord traction. Keep slight tension on the cord and await a strong uterine contraction (2-3 minutes). With the strong uterine contraction, encourage the mother to push and very gently pull downward on the cord to deliver the placenta. Continue to apply counter-pressure to the uterus. If the placenta does not descend during 30-40 seconds of controlled cord traction, do not continue to pull on the cord:- Gently hold the cord and wait until the uterus is well contracted again; with the next contraction, repeat controlled cord traction with counter-pressure. Never apply cord traction (pull) without applying counter-traction (push) above the pubic bone on a well-contracted uterus. As the placenta delivers, hold the placenta in two hands and gently turn it until the membranes are twisted. Slowly pull to complete the delivery. If the membranes tear, gently examine the upper vagina and cervix wearing sterile/disinfected gloves and use a sponge forceps to remove any pieces of membrane that are present. Look carefully at the placenta to be sure none of it is missing. If a portion of the maternal surface is missing or there are torn membranes with vessels, suspect retained placenta fragments and take appropriate action.

**Uterine Massage: How to perform uterine massage?**
Immediately massage the fundus of the uterus until the uterus is contracted. Palpate for a contracted uterus every 15 minutes and repeat uterine massage as needed during the first 2 hours. Ensure that the uterus does not become relaxed (soft) or 'boggy' after one stops uterine massage.

Note: Out of the three components of AMTSL only use of uterotonic has sound evidence and other two components are not so well supported by evidence and are under evaluation.

**What to do during Antenatal period?**

1. Treat and prevent anemia
2. Identify high-risk cases
3. Counseling for institutional deliveries
4. Arrangements for emergency transport

**Intranatal:**

- Judicious induction of labor
- Identify high risk cases
- Use partogram to prevent prolonged labor
- Keep the emergency tray and equipments necessary for the management of PPH
- AMTSL for all cases
- Skilled birth attendant at every birth

**Diagnosis Of PPH:**
It is important to diagnose PPH. Blood loss following delivery is most commonly estimated by visual method which over estimates when the blood loss is less and

**Fig 1. Weighing of swabs**

**Fig 2. Soakage pattern of sponges of fixed sizes**

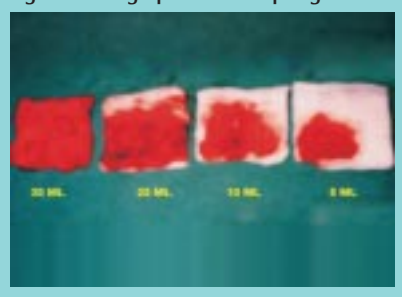


**Fig 3. BRASSS-V blood collection drape**

under estimates when it is more. It is the change in the hemodynamics (i.e Pulse and the blood pressure changes) that alerts the clinician (fast low volume pulse and hypotension), by then more than 25% of the blood volume is lost as shown in **Table 1 (From A Text PPH By C. B. Lynch et.al page 36).**

**Techniques used for post partum blood loss measurement.**

1. Mostly Visual estimation
2. Direct collection of blood into bedpan or plastic bags/ Kelly's Pad
3. Gravimetric method
4. Weighing sponges before and after use
5. Determination of changes in hematocrit and hemoglobin
6. Plasma volume changes
7. Measurement of tagged erythrocytes
8. BRASSS-V blood collection drape - easy and reliable method and used in most of the recent PPH related studies.

**See Figs 1, 2, 3**

It is important to note that the blood loss continues during the course of treatment, it goes unnoticed and these small but simple methods helps to keep the track of lost blood and thus helps to alert the person in management. Once there are hemodynamic changes it is always better to refer to higher health facility as it needs well equipped provider with close monitoring along with blood transfusion.

**Medical management Of PPH:**

It is important for one to know the correct dose, route of administration, maximum dose, precautions and contraindications for every drug that is used in the management.

Table 2 - Drugs used in the management of PPH (WHO guidelines 2009).

**Other Uterotonic Drugs:**

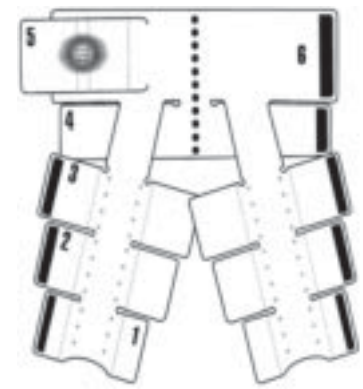
**Carbetocin:** It is an oxytocin analogue, it is more effective than syntometrine and the dose recommended is 100mcg, presently not available. Though it is expensive but side-effects are less.

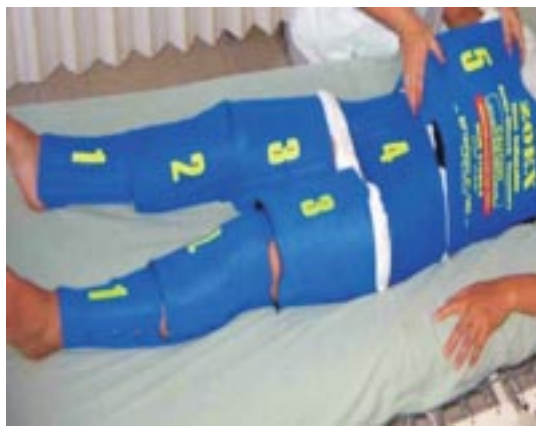
**Misoprostol:** PGE1 analogue it is to be used only when injectable uterotonics are not available or where the injectable uterotonics cannot stored effectively. Dosage ranges from 400-800mcg. Higher the dose more the side effects (Pyrexia, shivering, vomiting and diarrhea). It is also used with different dosage with sublingual and rectal route. This drug should be tried (1000mcg rectally) before surgical management. The present evidence suggests that it is less superior to injectable uterotonics. The advantages are it can be kept at room temperature and has a higher safety margin and ease of administration.

Though each drug has its maximum dose and interval between the dosage has to noted as in presence of active bleeding where every minute counts (150ml /Min) the decision to wait for such duration has to be taken cautiously.

It is essential to maintain the hemo-dynamics of the woman with PPH during referral and while preparing / shifting to surgery in order to avoid irreversible shock,renal failure and related complications. It is essential to maintain hemo-dynamics by mechanical methods while transferring to higher health facility or while waiting for arrangements for surgery.

1. Ballon condom Catheter by S.Akther et.al
2. Sengstaken-Blakemore tube
3. Bakri balloon
4. Rüsch hydrostatic balloon catheter
5. Non inflatable anti shock garment (Suellen Miller et.al)



**Resuscitation**

Resuscitation is an important and vital step in the management PPH. It is important use the drugs and right solutions correctly with proper monitoring. Initially an intravenous line with wide bored (16-18 gauze) branula must be started with either normal saline or Ringer lactate and once the blood is available blood should used to resuscitate. One must keep the correct record of infusions/transfusions to avoid fluid infusion related complications otherwise it is better to have CVP catheter in situ.

Every institute/birth place must have this Emergency Tray/ Crash kit with all the essential items of resuscitation. This ensures all care providers to be present for resuscitation with the woman who has PPH and avoids personnel to leave the site to get the items for resuscitation. The one which is used at our institute is given below with following items.

**Crash Kit (Emergency Tray)**

**{JN Medical college hospital labor Room (actually it has other items also for other emergencies like Eclampsia.)}**

**Brannula** (16 ,18 ,20), drip sets, Bulbs for blood grouping and cross matching, venesection set, syringes, gloves, roller gauze / mops, sticking plaster, scissor, Foley's catheter, I.V. Fluids- RL, DNS, colloidal solutions, intubation materials, Uterotonics-Oxytocin, ergometrine PGF2 alpha,Misoprostol,PGF2alpha Ergometrine ,Oxygen with mask, injections hydrocortisone, Calcium Gluconate, Deriphylline , Atropine, Adrenaline, Dopamine, Dobutamine along with CVP /Swan -Gange Catheter.

Intravenous fluids: (From AText PPH By C.B.Lynch et.al page 51)

Table 3.Intravenous fluids

**Referral of a case PPH:**

Timely referral to a proper place is important to save the woman's life in PPH. Following tips are helpful.

- To proper place where blood and equipped provider is available
- Prior information to the place of referral
- Inform the blood group of a woman
- Foot end elevated with procedure that maintain hemodynamics
- With I.V. drip
- Blood samples (For grouping & cross-matching) as it helps to arrange blood early
- Paramedical staff / medical personnel with emergency drugs
- With a note (Diagnosis & treatment given)

***Attenders - Young adults (for blood) for replacement and donation of blood.***

This usually ensures the woman with PPH to reach the referral hospital in a stable hemodynamic condition and thus prevents irreversible shock.

**Conclusion:**

PPH has to be managed by PPH (Predict, Prevent/prepare and Handle). To prevent the complications related to PPH, awareness, education and commitment are the key issues at all the three levels (Community, provider and system).Together with proper care during antenatal, intra-natal period along with good transport, communication network and availability of well equipped provider with adequate skills, it is possible to reduce PPH related mortality to a great extent. It also ensures prevention of PPH related morbidity.

*Continued on page 10*

# Prevention and Medical Management of Post-Partum Hemorrhage (PPH)

Table 2 – Drugs used in the management of PPH (WHO guidelines 2009)

| Type of fluid | Advantages | Disadvantages |
|---|---|---|
| ***Crystalloids*** | | |
| Saline | cheap; easily available; long history of use | produces a hyperchloremic acidosis; small procoagulant effect |
| Hartmann's | no risk of anaphylaxis; minimal direct effect on the base deficit; easlily available | mildly hypotonic |
| 5% dextrose | no place in acute expansion of the intravascular space | hypotonic; no significant expansion of the vascular space; rapid distribution to intracellular and extracellular spaces |
| Hypertonic saline | rapid expansion of the intravascular space in excess of the volume of infused; possible beneficial effects on red cell and endotheial edema and capillary blood flow | insufficient data; uncertainty regarding possible adverse effect such as on the immune system |
| ***Colloids*** | | |
| Gelatins | largely remains in the intravascular space for 2-4 h | risk of anaphylaxis; no clear survival advantage over crystalloids |
| 4% human albumin | more physiological than gelatins; remains predominantly in the intravascular space for 12 h | expensive; no clear survival advantage over crystalloids |
| Hydroxyethyl starch | remains in the intravascular space for 12-24 h | risk of coagulopathy, renal injury and reticulo-endothelial accumulation |

Table 1 Classes of hemorrhage

| | Class I | Class II | Class III | Class IV |
|---|---|---|---|---|
| % Blood loss | 15 | 20-25 | 30-35 | 40 |
| pulse (beats/min) | normal | 100 | 120 | 140 |
| systolic blood pressure (mmHg) | normal | normal | 70-80 | 60 |
| Mean arterial pressure (mmHg) | 80-90 | 80-90 | 50-70 | 50 |
| Tissue perfusion | postural hypotension | peripheral vasoconstriction | pallor, restlessness, oliguria | collapse, anuria air hunger |

Table 3. Intravenous fluids

| | Oxytocin | Ergometrine/ Methyl-ergometrine | 15-Methyl Prostaglandin F2a |
|---|---|---|---|
| Dose and route | IV: Infuse 20 units in 1L IV fluids at 60 drops per minute | IM or IV (slowly): 0.2 mg | IM: 0.25 mg |
| Continuing dose | IV: Infuse 20 units in 1L IV fluids at 40 drops per minute | Repeat 0.2 mg IM after 15 minutes<br>If required, give 0.2 mg IM or IV (slowly every 4 hours) | 0.25 mg every 15 minutes |
| Maximum dose | Not more than 3L of IV fluids containing oxytocin | 5 doses (Total 1.0 mg) | 8 doses (Total 2 mg) |
| Precautions/ contraindications | Do not give as an IV bolus | Pre-eclampsia, hypertension, heart disease | Asthma |

## Questions for CME Credit Points

(More than one answer may be correct. Please refer to the answers which will be printed in the following issue of the newsletter. Credit Point Max 2 1 for attempt; 1 for answers > 50% correct) **Mail your answers to ICOG office at icogcme@gmail.com**

**1. What is the goal of United Nations by 2015 in relation to maternal deaths ?**
**a.** Reduce by 25%
**b.** Reduce by 50%
**c.** Reduce by 75%
**d.** Reduce by 100%

**2. PPH occurs only in high risk cases**
**a.** True
**b.** False

**3. Write the three components of AMTSL**
**a.** _____
**b.** _____
**c.** _____

**4. Name the uterotonic recommended in AMTSL**
**a.** Methyl ergometrine
**b.** Misoprostol
**c.** Oxytocin
**d.** PGF2 alpha

**5. What is the recommended route of administration of uterotonic in AMTSL**
**a.** Intravenous
**b.** Intra muscular
**c.** Sub cutaneous
**d.** Intra myometrial

**6. Which of the following components of AMTSL has sound evidence base ?**
**a.** Uterotonic use
**b.** Controlled cord traction
**c.** Uterine massage

**7. With what percent of blood loss changes in the hemodynamics (pulse and blood pressure )occur.**
**a.** 10%
**b.** 15 %
**c.** 20 %
**d.** 25%

**8. Which of the following methods of blood loss estimation is followed in most of the recent PPH related studies**
**a.** Visual estimation
**b.** Weighing sponges before and after use.
**c.** Determination of changes in hematocrit and hemoglobin
**d.** BRASSS-V blood collection drape -

**9. Write the maximum dosages for the following uterotonics ?**
**a.** Oxytocin
**b.** Methyl ergometrine
**c.** PGF2 alpha
**d.** Carbetocin

**10. Which of the following IV fluids should not be used for resuscitation ?**
**a.** Ringer's lactate/Normal saline
**b.** 5% dextrose
**c.** Colloids
**d.** Normal saline

**Answers: Issue 6 CME MCQ on Individualizing Contraceptive Choices (Credit Points: 1 for attempt; 1 for answers > 50% correct)**

**1.** E **2.** E
**3.** E **4.** E
**5.** B **6.** D
**7.** D **8.** D
**9.** C **10.** C

# Placenta Accreta – A Dreaded Complication

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Abnormally adherent placenta is a dreaded complication which invariably leads to severe maternal morbidity & mortality. In the last 2 decades, there has been a ray of hope if conservative treatment procedures are utilized. But these procedures are available only in well equipped tertiary care centers at considerable cost. This condition needs attention as the incidence of which is on the increase.

Abnormally adherent placenta includes placenta accreta, increta, percreta & those with bladder invasion. It is defined as an abnormal attachment of a part or the entire chorionic plate to the myometrium, secondary to a defect in the deciduas basalis or fibrinous Nitabuch layer.

American College (ACOG)[1] warns of a rate of 40% accrete in Placenta Praevia with more than 2 previous Caesarean Sections & in cases of anterior or central placenta Praevia. The risk factors are, increased caesarean section rate, higher maternal age & smoking.

Therefore, Asim Kurjak[2] in June 2010 emphasized that "Prenatal Diagnosis with Imaging Modalities is necessary for good outcome."

**Case Report**

Mrs. S. R., a 37 year old nurse in a tertiary care hospital registered for delivery at 18 weeks. She had undergone a LSCS, 2 years earlier. The 18 week scar showed a normal foetus with a low lying placenta covering the os. The placenta did not move up as expected but remained anterior, covering the scar & the internal os. She was also a case of persistent breech presentation. She never had any episode of bleeding. Family was informed about the risks of placenta being accreta & that the delivery had to be planned well in advance & the possibility of caesarean hysterectomy. A repeat scan with color doppler at 35 weeks reconfirmed the finding. There was some doubt regarding bladder invasion so was advised to undergo an MRI examination. In case of bladder invasion, referral to another hospital where uterine artery embolisation was considered.

She was scheduled for surgery at 36 week with an Urologist as part of the team.

MRI reported that there was no bladder invasion. About 4 hours after the MRI test, patient started painless profuse bleeding. The foetal heart sounds were good. She was given a blood transfusion & taken up for surgery.

Photograph 1: MRI picture shows lack of decidual space & Photograph 2: MRI showing clear interphase between placental edge & bladder.

Under general anesthesia, a midline sub umbilical incision was taken instead of going through the original Pfannensteil incision. The uterus was incised through the lower segment transverse scar & baby which was breech floating was delivered. It was in a good condition. No time was wasted in trying to remove the placenta. The edges were clamped with multiple Green Armitage forceps. Caesarean hysterectomy was performed. The bladder was edematous & slightly difficult to separate. But it was done gently with a moist swab. Two bottles of blood were transfused.

The urine was blood tinged for 2 hours after surgery, then cleared up. Patient made a good recovery.

Photograph 3: Histopathology section showing abnormal migration of trophoblast into the myometrium.

In this patient, there were 2 risk factors previous Cesarean & advanced maternal age. She was not a tobacco user.

**Discussion**

In uteri where there is placenta praevia, cesarean section scar, excessive curettage or exposure to radiation or chemotherapy; there is primary deficiency of deciduatisation.

Secondly, there is over invasiveness of the trophoblast. There is a strongly positive EGFR (Epidermal Growth Factor Receptor) and a reduced VEGFR - 2 & Tie 2 (Vascular Endothelial Growth Factor).

Thirdly, the radial & arcuate arteries show loss of muscular & elastic tissue - making them unresponsive to vasospasm leading to torrential haemorrhage. This change could be age related or caused by smoking.

A report from Biswas[3] of PGI Chandigarh compares placental biopsies from 50 cases each of placenta praevia & normal placenta. It revealed that the trophoblastic cells in placenta praevia were more aggressive.

**Diagnosis**

Antenatal Imaging is the key to diagnosis which must be made between 32 - 34 weeks. So as to plan for delivery by 36th week.

Gray Scale Imaging gives about 51% Positive Predictive value & Colour Doppler 47% Shih J. C. et al.[4] It improves significantly with 3D Power Doppler to 76%. It is the multiplanar imaging & dynamic assessment of uterine wall, bladder interphase & the study of vascular network which gives an accurate diagnosis. Recognisable 3 D photographs assist the Obstetrician.

MRI plays a significant role. It gives additional information in equivocal cases. It is particularly useful in anterior Placenta Praevia. According to Warshak CR, Eskande R et al[5], USG followed by MRI optimizes diagnostic accuracy.

**Management**

Elective delivery is preferred to emergency Surgery. In Institutes with good neonatal support 34-35 weeks of gestation is most suitable. Multidisciplinary approach in an Institute with all facilities would give the best results.

The patient may be offered Conservative Treatment and or Caesarean Hysterectomy. In women who have not completed their family, conservative approach with the Urologist on the team is to be considered. This would include,

1. Leaving placenta totally or partially in situ
2. Uterine artery embolisation
3. Stepwise uterine devascularisation
4. B Lynch or Cho sutures.

These procedures are more risky & may lead to severe morbidity.

The first few cases of Conservative treatment were reported in 1996 - 1997, since then the number of cases has increased significantly.

In 1996, Mathews & Macowan[6] reported from Australia a case of Placenta Praevia with bladder invasion, where placenta was left in situ. Internal iliac artery Embolisation was done 9 days later. Hysterectomy was safely performed 55 days later.

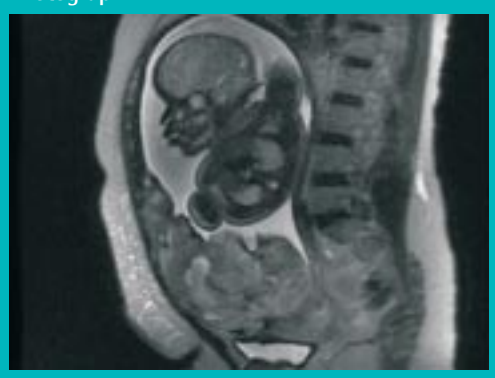
In 1997, Silver & Hobet[7] reported similar cases where Hysterectomy was performed 2-4 weeks later.

In January 2010, Warshak, Ramos et al[8] reported a series of 99 cases of Placenta accreta. Prenatal diagnosis was possible in 62/99 cases. At 34-35 weeks. Enblock Hysterectomy was planned without removal of placenta. Maternal morbidity due to haemorrhage decreased & neonatal morbidity was unchanged.

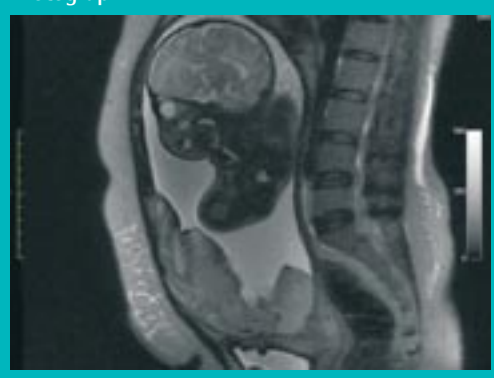
In March 2010, Maternal outcome after Conservative Treatment of Placenta accreta was reported as a multicentive study from 40 University tertiary hospital centers in France[9]. Out of 311 cases of Placenta Accreta, 167 women were treated. The rest had extirpative approach. They conclude that conservative treatment in cases of placenta percreta with bladder involvement may have the advantage of avoiding a difficult hysterectomy fraught with risks including urologic complications, in an acutely bleeding patient.

*Continued on page 14*

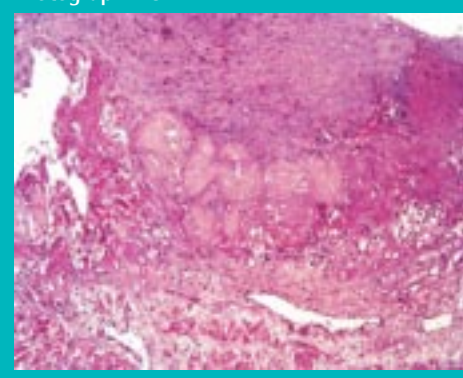
**Photograph - 1**



**Photograph - 2**



**Photograph - 3**



# Nuances of Vaginal Surgery

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Surgery is a fine art, which includes not only science but all the subtle variations within the scientific framework that one does for the good of patients. Subtle variation or nuance, provides challenge and opens the door for better outcomes. Nuance literally means finer or subtle variation. This is important in improving surgical practice in the best interests of patients. Vaginal route provides a natural avenue for gynecologists to vary surgical art in subtle way.

### I. HYSTERECTOMY

Performing a hysterectomy, by the abdominal route either opening the abdomen or use of laparoscopy when the same could be achieved via the vaginal route is like performing a Caesarean delivery when the same could have been achieved as a vaginal delivery.

When scientific crystallization, from Cochrane data and evidence based studies have distinctly concluded vaginal hysterectomy (VH) has the best outcomes and that when vaginal hysterectomy is not possible, laparoscopic hysterectomy has advantages over abdominal hysterectomy[1,2].

### 1. UTERINE PROLAPSE / NO PROLAPSE

The route of hysterectomy is an issue only when there is absence of uterine descent, not in a case where the uterus is dangling out of the introitus. Unfortunately the surgeons depend on descent for opting for the vaginal route and reflect their surgical competence. No available English literature mentions uterine prolapse as a pre requisite for performing hysterectomy via the vaginal route and its absence as a contraindication to vaginal hysterectomy.

### 2. UTERINE FIBROID(S) / ENLARGED UTERUS

Just as the mere presence of fibroids does not necessitate, surgery, neither does their size and presence dictate the route. Scientific norm befits that uteri less than 12 weeks size or volume less than 250 - 300 cubic cm, whether due to fibroids or adenomyosis or myohyperplasia should and can be operated through the vaginal route. Not to perform AH or LAVH / LH if VH can be achieved is the goal of subtle variation.

What guides success is pelvic factor in form of uterine decent on traction including 'give' obtained after progressive severance of lateral connections, tissue suppleness and available uterus-free space. As a rule fibroids will be easily accessible when uterus volumes less than 250-300 cm3 or is 12 weeks or less in size and enucleation makes uterus smaller. Larger the myoma smaller becomes the size of uterus to be dealt with and as a rule myoma becomes easily accessible to debulk, if required. Uterine volume is a greater facilitator and anxiety reducer than obstetric based measured uterine size.

**Debulking:** Debulking is gratifying surgical art, easier in a myomatous uterus rather than an adenomyotic uterus and with posterior wall myoma than anterior. This deviation can change impossible to possible or contraindication into a pleasing indication. Preoperative GnRH for selective women has a role.

### 3. HISTORY OF CAESAREAN SECTION(S) IN PAST

Gynecologist of the near future will have increasingly to confront the problem of hysterectomy in patients with one or multiple previous Caesarean Sections. To determine the technique of hysterectomy from mere history of pelvic surgery in the past is to be resisted. In the absence of a contraindication, history of a cesarean in the past should never deter the operator from taking the vaginal route. Sizzi and Rossetti (laparoscopic surgeons)[3] state that in cases of hysterectomy in patients with severe adhesions and multiple cesarean sections "A safer approach is from the lateral part of the cervix from a space firstly described as the uterocervical broad ligament space for the vaginal approach to hysterectomy in uteri with previous cesarean sections"[4] [Figure 1]. If doubt or anxiety persists and not undertaking VH even as 'TRIAL VH'[5] despite favourable findings under anaesthesia and/or after laparoscopic evaluation is a subtle variation.

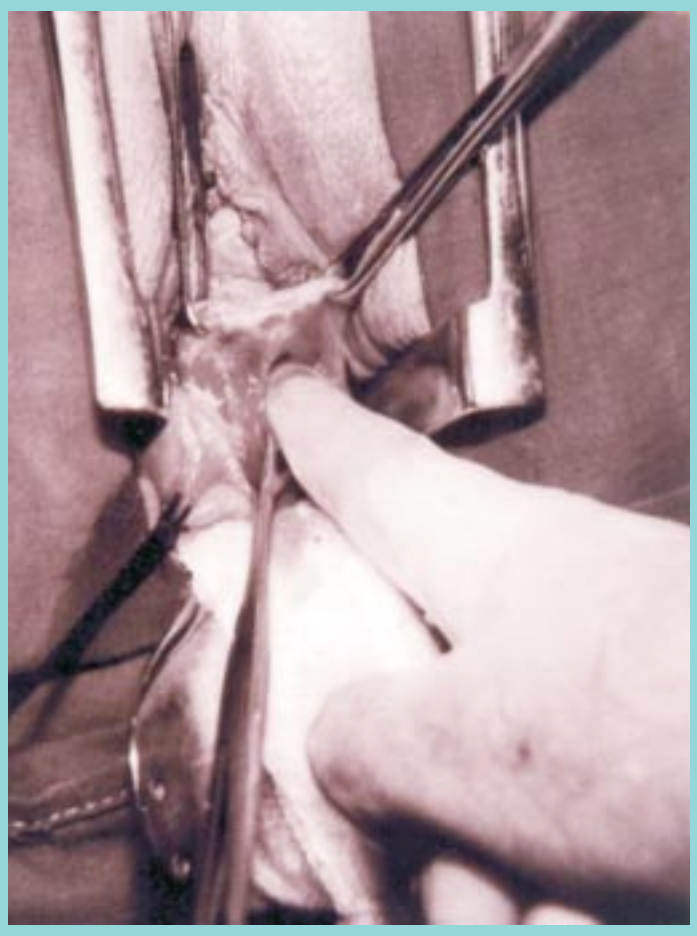

Figure 1. At vaginal hysterectomy, the finger is on the uterocervical surface, with the bladder antero-medially, as it insinuates further between the two leaves of the broad ligament. (From Sheth SS. An approach to vesicouterine peritoneum through a new surgical space. J Gynecol Surg 1996;12:138)

### 4. NULLIPARITY

The misfortune of having learnt vaginal hysterectomies on prolapsed uteri in multiparous patients, leads most gynecologists to have a mind set against vaginal route in nulliparous women without such laxity. Although there is no doubt about, laxity and descent, aiding the vaginal route, the absence of such laxity but not without presence of physiological descent in nulliparous does not preclude the vaginal route. Agostine[6] showed a 96% success rate in performing VH in nulliparous women.

Non Descent Vaginal Hysterectomy (NDVH) is a gimmicky term, since in absence of pelvic pathology there is no cervix that does not physiologically descend on adequate traction. If hysterectomy can be performed vaginally in women with intact hymen, nulliparous state cannot be a hindrance but a fine variation.

### 5. ADHESIONS

So long uterus is freely mobile, adnexa are normal and without contraindicated size of uterus; variation lies in more often adhesions are in operator's mind and not in pelvis[7]. In the initial learning curve, one may take refuge in the laparoscopic evaluation. The art is in overcoming obstacles and not creating them. (In ones mind).

Laparoscopy could clarify the situation when in doubt and tackle the situation though in reality, though sometimes what looks difficult following a laparoscopic evaluation can be achieved easily vaginally.

### 6. OBESITY

UK, USA and Canada have now a significant and increasing obese population. Besides intra operative difficulties, post-operative complication rates are increased in obese women, including pulmonary compromise, venous thrombosis, wound infection and dehiscence.

Unfortunately in obese women, method commonly used is one which is more invasive of abdominal opening or laparoscopic route, with its attendant morbidity. In fact, in the absence of contraindications for vaginal hysterectomy, operator should strongly consider obesity as subtle variation[8] for the vaginal route and a contraindication for taking the dissuading abdominal route either for laparotomy or laparoscopy[7].

**7. INSPECTION OF ABDOMINO-PELVIC ORGANS**

Unless there is genuine reason or indication which demands inspection, more often it is a chronic excuse for avoiding vaginal route, a subtle variation.

**8. CARCINOMA IN SITU OF CERVIX**

When required, severe dysplasia or carcinoma in situ of cervix or cervical intraepithelial neoplasia (CIN) grade III should be by the least invasive method i.e., via the vaginal route. Navratil emphasizes that the vaginal route offers excellent cuff and provides a significant advantages in the treatment of carcinoma in situ[7].

**9. ENDOMETRIAL CARCINOMA**

The high cure rates in stage I endometrial cancer suggest the regular use of VH in patients with early endometrial carcinoma, if it is well differentiated, particularly when the woman is morbidly obese and/or has impaired cardio respiratory status[7].

**EXAMINATION UNDER ANAESTHESIA (EUA)**

This can change any number of planned LAVH / LH or TAH to VH, if done carefully with intention of performing VH and in absence of contraindication for VH. Examination under anaesthesia performed just before the start of hysterectomy with patient in lithotomy position and not otherwise, should serve as gold standard in decision making on route and technique of hysterectomy[5, 7]. Similarly, selective laparoscopic evaluation can be of immense value in choosing vaginal route or otherwise.

The ACOG Committee concluded that vaginal hysterectomy (VH) is associated with better outcomes and fewer complications than laparoscopic (LH) or abdominal hysterectomy (AH)[9]. But in spite of this 70-75% of hysterectomies are still abdominal or 3-15% laparoscopically.

**10. CONCOMMITANT SURGERY AT VH**

**i. Oophorectomy at Vaginal hysterectomy**

A report in 2002 shows that in the age group 55-60, oophorectomy was done in 92% at abdominal hysterectomy, 96.6% at LAVH and only 9.4% at vaginal hysterectomy. Call it partiality or deficiency.

ACOG Guidelines recommend use of laparoscopic assistance only for difficult oophorectomy at vaginal hysterectomy[10]. Let one not make removal of ovaries at all VH difficult. Technique used in more than 1500 women, is detailed earlier elsewhere with 3-4% failure rate[7].

One can learn in select cases to add fine or subtle variation in providing better outcome by crossing barriers and undertaking.

**ii. Benign adnexal pathology at vaginal hysterectomy**

**iii. Ovarian endometrial cyst at VH**

**iv. Broad ligament fibroid removal at VH**

**11. SUBTOTAL HYSTERECTOMY**

Subtotal hysterectomy is a subtle variation though Dr. Parker, teacher of Howard Jones once commented that supra-cervical hysterectomy was an operation devised by and made for incompetent surgeons[11], which should be relegated to the history books. Paradoxically, in 21st century, with laparoscopic surgeon's incidence of supracervical - subtotal hysterectomy is mounting, being 20% + in California, USA[11]. This is totally subtotal management. Subtotal or supracervical hysterectomy should be offered when[1] ureters and/or colon are at risk of trauma because of dense adhesions;[2] anaesthetist request to quickly complete the surgery in interest of patient;[3] woman is keen to preserve her cervix.

**II NUANCES OF VAGINAL SURGERY ..... BEYOND HYSTERECTOMY**

**1. Vesico vaginal fistula (VVF) / Rectal vaginal fistula (RVF):**

For the vast majority of fistulas VVF or RVF vaginal is the ideal route for suffering women. However, since bladder and/or rectum are involved, patient may land up with urologist or colorectal surgeon, who'll then repair via their routes.

We suggest not being lead by urologist's opinion as they will never perform repair vaginally and always perform repair via abdominal route which for a patient is more invasive and morbid. They may often, pre-operatively, find ureters not far from the fistula site and cause anxiety. For the choicest management, careful Examination under anaesthesia will be of immense help.

**2. For operable cancer cervix**, a vaginal surgeon may care to perform Schauta's radical vaginal hysterectomy with laparoscopic lymphadenectomy and similarly radical trachelectomy for select women with cancer cervix wanting to have fertility preserved.

Though more than subtle variation, both have definitive place in modern day surgery. Prior laparoscopic lymphadenectomy showing normalcy paves the way for radical trachelectomy via vaginal route. After arrival of laparoscopic lymphadenectomy, Schauta's operation is revived by countable vaginal surgeons as it is much less invasive than opening the abdomen for it.

**3. SURGERY VIA POUCH OF DOUGLAS (POD)**

Vaginal route can be a great alternative in some situations, when abdominal access is an accepted primary route but can fail or is risky[11].

a. Ovarian cyst via pouch of Douglas
b. Oophorectomy via the pouch of Douglas
c. Myomectomy via pouch of Douglas
d. Tubal ligation or Sterilization
e. Creating pneumo-peritoneum
f. Culdoscopy

There are adequate references / literature for subtle variations and provide benefits to the patients but vital is to make attempt to do so.

**"Man learns as he lives and experience is the greatest teacher in the world"**

***Swami .Vivekananda***

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## Strategies to Reduce Health Issues In Rural Women

*Continued from page 7*

5. Role of Professional societies: societies like FOGSI not only train at national and state level but also participate in training of non specialist doctors for the FRC. They should educate the community leaders and women social service organizations about the need for promoting maternal health care in their areas (WHO, FIGO 1988).

6. Training Midwives; train in large number of midwives: expand midwifery training to include range of skills necessary at the community and FRCs.

7. Vital Statistics - Collecting Information Maternal audit and confidential enquiries into maternal deaths at state and national levels are useful to find out their causes and recommend proper preventive measures. These activities contribute to reductions of maternal deaths (Bhatt 1988)

Participate in National eclampsia and cancer cervix registries to have our own data to formulate necessary interventions

Aim of Safe Motherhood: As per MDG 5 MMR should be reduced by 75% by 2015

We have seen in the past Green revolution, White revolution, recent Communication revolution But Need of the hour is the Healthcare revolution.

Train 24X7 medical officers in Emoc services. MgSO4 For Eclampsia, I.V Iron Sucrose for Anaemia, Effective Contraception services, Safe abortion - Medical abortion, MVA Procedures.

Introduce Health issues like Maternal Mortality and Morbidity Health education in School and college curriculum.

Conduct school health programmes on nutrition, imp of Blood donation in saving mothers lives, form youth groups avail huge manpower of youths in educating the community towards various health issues

Contribute actively in Writing in Public media, TV, Radio shows Save Girl child and Save Mothers Involve celebrity's services as brand ambassadors to drive home the message of safe motherhood and save the girl-child initiative.

Educate women regarding the burden of disease, symptomotology and effective screening procedures to detect Ca Cx at earliest by PAP smears. VI Cx, VILI, and Colposcopic evaluation prompts. Public awareness programmes with prompt referral services to higher centres.

Conclusion: Improving the health status of women should be the responsibility of not only the Govt, Health care provider but it should be the responsibility every citizen, women themselves.

## Placenta Accreta – A Dreaded Complication

*Continued from page 11*

The study concludes that conservative treatment for placenta accreta is a valuable option with a success rate of 78.4% & a severe maternal morbidity rate of 6.0%.

Take Home Messages

We must concentrate on

1. Good training of PG Students
2. Liberal use of Imaging to make a diagnosis by 32 weeks
3. Good liaison with Sonologists & Referrals Centress
4. FOGSI/ ICOG can take the lead & perhaps initiate a multicentral study like France

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*Advancing Standards of Education and Healthcare Practices*

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