FOGSI White Paper Recommendations
from
FOGSI INTERNATIONAL WOMEN'S HEALTH SUMMIT

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What is FOGSI

The Federation of Obstetric and Gynaecological Societies of India (FOGSI) is the professional organization representing practitioners of obstetrics and gynecology in India. With 245 member societies and over 33,000 individual members spread over the length and breadth of the country, FOGSI is probably one of the largest membership-based organizations of specialized professionals. FOGSI now has one International branch in London.

FOGSI engages in the organization of one Annual Congress in January each year and 4 regional yuva conferences (Zonal). FOGSI also organizes many social and awareness programs on women's health. FOGSI organizes many CMEs, workshops, skill enhancement simulator sessions, etc. at each of the member society.

Each year a new President is elected who carries on with the started projects, plus gives a new theme for direction of work.

FOGSI also has its own journal which is widely read and circulated and this offers a good platform for Indian research to be published.

FOGSI Mission

- The Federation of Obstetric and Gynaecological Societies of India (FOGSI) supports and protects the interests of practitioners of Obstetrics and Gynecology in India.
- FOGSI encourages dissemination of knowledge and education as well as research in the field of Obstetrics and Gynecology in India.
- FOGSI works to pilot and promote preventive and therapeutic services related to health care of women and children.
- FOGSI also serves to advocate the cause of reproductive and sexual health and rights.
- FOGSI considers the reduction of maternal mortality in India as its primary mission.

FOGSI Vision

"FOGSI to be the lead organization working towards advocating and promoting women's health and reproductive rights using scientific evidence and following the highest ethical standards through it's membership of committed professionals."

FOGSI's Theme Year 2018

"GIVE HER WINGS AND LET HER SOAR"

"पंख और परवाज दो, नारी को आकाश दो"

HER (Health, Empowerment and Respect) for Women of India

&

QED (Quality, Ethics and Dignity) for Medical Professionals

This theme, we at Federation of Obstetric and Gynaecological Societies of India (FOGSI) feel is very much, the call of the day, for women in our country and all around the world and focus on women's "Health, Empowerment and Respect" by our fraternity.

FOGSI came into formal existence in Madras on January 6, 1950 at the sixth All India Congress of Obstetrics and Gynaecology, when the obstetric and gynecological societies of Ahmedabad, Bengal, Bombay, Madras and Punjab resolved to form themselves into the FOGSI. It was further resolved that the Federation be registered and headquartered in Bombay. The launch of FOGSI as the national organization of obstetricians and gynecologists followed five earlier All India Congresses, the first of these held in Madras in 1936 and organized by the then existing three obstetric and gynecological societies at Bombay, Kolkata and Madras.

FOGSI exists to encourage and disseminate knowledge, education and research in the field of obstetrics and gynecology, to pilot and promote preventive and therapeutic services related to the practice of obstetrics and gynecology for betterment of the health of women and children in particular and the wellbeing of the community in general, to advocate the cause of reproductive health and rights and to support and protect the interest of practitioners of obstetrics and gynecology in India.

The Journal of Obstetrics and Gynecology of India is the official publication of FOGSI and is published bimonthly and circulated to every individual member. It contains articles and contributions on fundamental research and clinical practice as also case reports of clinical interest. With *www.fogsi.org* the official website, FOGSI has an important presence in cyberspace, which works to promote and fulfill the aims and objectives of the Federation.

The Indian College of Obstetricians and Gynaecologists is the academic wing of FOGSI with over 1010 fellows. It was established by FOGSI on December 21, 1984 to further promote the education, training, research and knowledge in obstetrics, gynecology and reproductive health.

The Federation continues to hold the All India Congress of Obstetrics and Gynaecology, its annual conference every year in January for four days. FOGSI also organizes Yuva FOGSI, four regional youth conferences to promote and showcase young talent each year. Besides these annual conferences many academic activities go on round the year throughout the country with twenty-seven subspecialty committees simultaneously working in their designated areas.

The Federation also collaborates with and partners the Government of India and is an invited reprehensive on all relevant policy-making bodies of the government on issues related to women's health.

FOGSI has close links and affiliation with international and regional organizations like FIGO, AOFOG and SAFOG, with many of its members having occupied prestigious positions in these organizations from time to time.

Each year FOGSI under the guidance the President selects a theme to highlight the importance of a particular issue related to women's health. This permits focus with the involvement of the large membership, FOGSI's greatest asset in addressing the challenge involving the particular issue. In recent years, the unidimensional theme has now evolved into a philosophical directive.

The Federation is always conscious of the responsibility it shoulders and the important role it has accepted to work not just for its members societies and professionals, but in working to advocate and improving the health of women in our country thereby contributing to the wellbeing of India.

In January 2018, Dr Jaideep Malhotra has taken over as President of FOGSI and besides the hundreds of CME's, Dr Jaideep has initiated four major social programmes:

ADBHUT MATRUTVA

Adbhut Matrutva is an initiative launched by FOGSI to provide holistic antenatal care to all pregnant women of India. Providing this changed approach to pregnancy care, it is expected to reduce pregnancy-related complications and deaths and also it is expected to have birth of healthier babies.

AKSHAYA JEEVAN

Seeing the deaths by cancer cervix in India, which is a preventable and treatable disease, we at FOGSI have initiated a pilot project for screening mother over 35 years and vaccinating daughters aged 9–14 years. The pilot project has started in Varanasi, Uttar Pradesh and if successful will make a huge impact on women's health in our country.

SAMARTH INITIATIVE

SAMARTH initiative is FOGSI's effort to train the paramedical staff working in private sector, small nursing homes, so that the monitoring can be done effectively with aim to provide quality maternity care and improve maternal health and reduce MMR. JHPIEGO has consented to partner in this initiative in Uttar Pradesh.

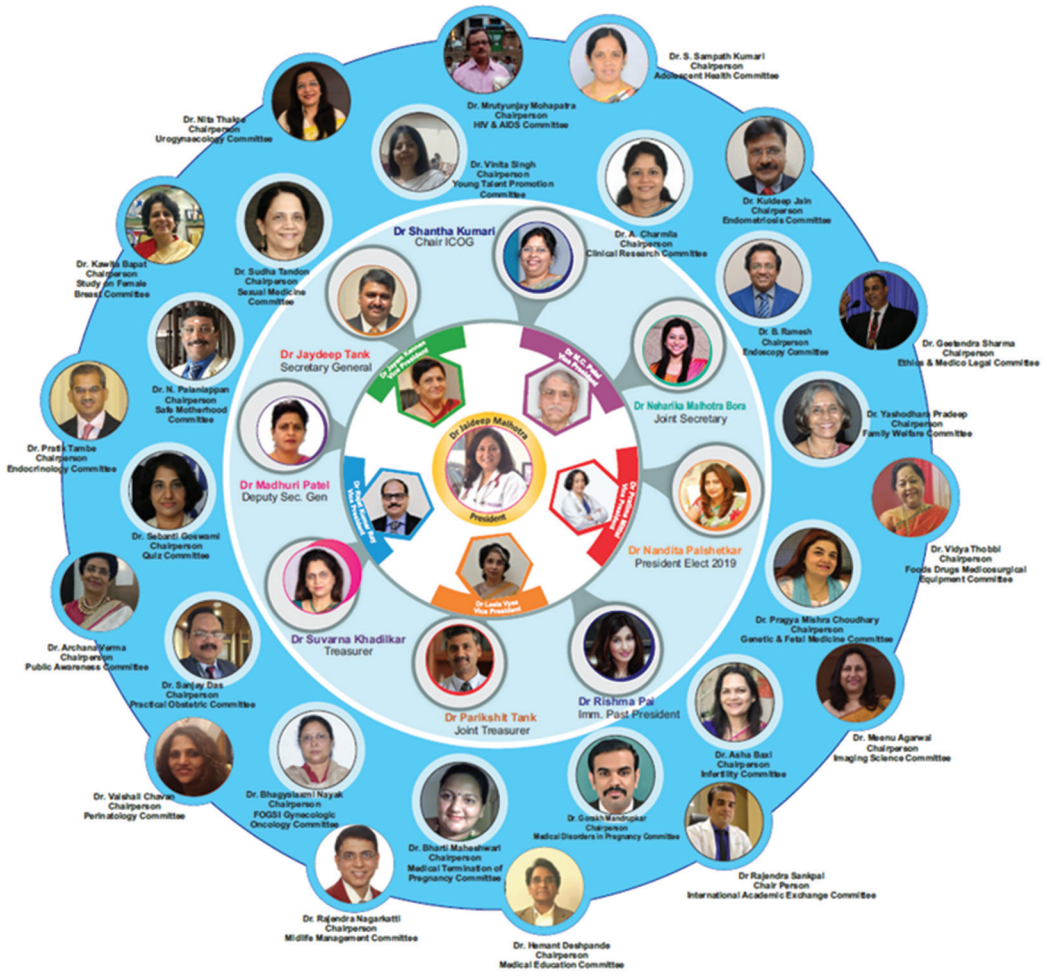
DIGITAL FOGSI–HEALTH-E-INDIA INITIATIVE

Understanding the need for obstetricians and small hospitals in record keeping and organized practice with data collection and data analysis, Health-E-India is FOGSI's initiative to give free software and mobile app to FOGSI members and to all patients for regular health tips.

Jaideep Malhotra
President FOGSI

FOGSI Office Bearers

FOGSI Committee Chairpersons



From the President's Desk

India is the biggest democracy and fastest moving economy of the world. We have the youngest population and we are adding 20 million every year to our 1.36 billion.

"We cannot all succeed, if half of us are left behind" Malala Yousafzai

It is important to understand that to make a difference in the health status of the women and children of our country, some very aggressive strategies need to be put in place. We are not far from achieving our MDGs, point is that we still have a long way to go. With the shortage of midlevel manpower in healthcare our Medical fraternity is bearing the brunt at both ends and our public expectations are galloping and our infrastructure and manpower are unable to keep pace with the growing demands. It really needs some serious thinking and strategies to be put in place so that a fast track road map is built with the existing infrastructure and manpower and also see that a build up is planned to meet the future needs. FOGSI (Federation of Obstetric and Gynaecological Societies of India) is an organisation of 36000 obstetricians and gynaecologists from 240 societies in our country and has the mission and vision of reducing Maternal mortality and looking after the interest of its members. Unless and until we have an integrated approach towards improving access to healthcare, we cannot achieve our goals.

Pandit Jawaharlal Nehru said,

"To awaken the people, it is the women who must be awakend, once she is on the move, family moves, village moves and Nation moves."

On 1st June an International Womens Health Summit was organized where representative from all over the world (WHO, ACOG, RCOG, IPAS, IAP, JPHIEGO, ASRM, FIGO, PSI, IAN DONAL, GOI, AOFOG, UNICEF, ISPAT, IMA, ISAR, SAFOM, RCPI, etc.) were involved to build the strategies and present to the Hon. Minister of Health and Family Welfare of India, Shri JP Nadda Ji, who graced the occasion. This booklet is a compilation of all points discussed, strategies planned and interventions are suggested on some key areas in India to improve maternal and Child Health Care.

"The health of a mother and child is measure of Nations state than any economic indicator"

Our aim is to provide 'Every mother regardless of race, religion in background a right to healthy pregnancy and childbirth.'

Hope the suggestions will be well received by the health ministry.

Jaideep Malhotra MD
President FOGSI

From Secretary General's Desk

Dear FOGSIANS,
Greetings and Regards!

It is my great pleasure to present to you all FOGSI White Paper Recommendations on important health issues of women of India. These were discussed in a Landmark event FOGSI INTERNATIONAL WOMEN'S HEALTH SUMMIT. This event was unique because for the first time FOGSI—Government of India—NGOs—PHARMA came under one winner with only one motive WOMEN'S HEALTH what we can be done.

We are proud of FOGSIANS of India, the choosen ones take care of women's health and in the last few years we have made a difference and that difference showing in the reduction of MMR and almost reviewing targets for SDGs.

Today the Government of India is proactively looking at FOGSI for advice on important issues and FOGSI aggressively contesting all issues and policies which we feel are not up to mark for patients and doctors.

FOGSIANS, I appeal to all of you with folded hands to practise with QUALITY, ETHICS and DIGNITY and DIGNITY for HER (Health, Empowerment & Respect). We hope these recommendations will form a basis of many health policies of our country.

Dr Jaydeep Tank
Secretary General FOGSI

30th May 2018

To,
Hon. Mr. JP Nadda
Minister for Health and Family Welfare
Government of India
New Delhi

Dear Hon. Naddaji

FIGO (International Federation of Obstetrics and Gynaecology) is the Apex body of all the Obstetricians and Gynaecologist's associations in the world representing 130 countries. It is the "Global Voice for Women's Health".

FIGO has a vision that women of the world achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives.

In 2015, when I took over as President of FIGO, I put forward three important areas of intervention.

(1) Reduction in Maternal mortality including that from Unsafe abortion.

India has made great strides in this direction but gaps still remain to be filled in providing universal health care especially in maternal health.

(A) In India control of NCDs, especially in diabetes in pregnancy afflicting 17% of women can be diagnosed by universal testing with 75 gm sugar anytime of the day as per FIGO recommendation for better compliance and early detection and treatment for hypertension in pregnancy with resultant mortality and morbidity in both mother and newborn need to be addressed nationally.

To improve short-term and long-term population health, NCDs must be addressed simultaneously alongside maternal health.

(B) A critical part of achieving the goal to improve women's health is increasing access to basic reproductive health services, including safe medical termination of pregnancy services. As you would be aware, many women and girls in India face vulnerabilities due to several legal and social barriers, such as lack of financial resources, cultural norms, lack of information and

stigma, that prevent them from accessing such timely and life-saving health services. Unsafe abortions pose undue risks to women's health, result in the deaths of many women and girls every year, and leave many more temporarily or permanently disabled.

Some of the key challenges that women face while accessing safe abortion include gaps in the Medical Termination of Pregnancy (MTP) Act, 1971, such as the 20-week gestation limit; the need for physician consent (one until 12 weeks of pregnancy and two from 12–20 weeks); and the limitation of these services to married women. These challenges often compel women to seek termination of pregnancies through unsafe means, which often have serious health repercussions and can also prove to be fatal. The amendments to the Medical Termination of Pregnancy Act, 1971, which will ensure equitable access and better health of women and girls in the country, have been pending with Ministry of Health & Family Welfare.

Access to Medical Termination of Pregnancy by oral medication in early pregnancy as advocated by FIGO and FOGSI must be provided nationally without any barriers.

(2) Contraception Services and Family Planning

You are aware that family planning is the major key element in reduction of maternal mortality.

FIGO has been actively involved in postpartum IUCD in India and elsewhere in the world and would like to see India take the lead and scale it up nationally. The other contraceptive in the basket needed to be made available is the injectable reversible contraception now approved by the government but still not available universally in the country.

Availability of contraception to adolescents who are not addressed and taken care of in family planning since they are not planning any family.

(3) Prevention and early detection of cancer cervix.

India faces a huge burden in this regard.

I believe:

Too often, women who are now being saved by the reduction in maternal mortality rates are instead dying due to cervical cancer "A preventable disease".

In the case of cervical cancer, many of the answers and tools are already available consensus on the target is emerging to eliminate cervical cancer as a public health problem through intensified vaccination.

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This year WHO has emphasised on all the issues we have taken up and India can be a champion in leading the way in the developing world countries by taking up these issues in right earnest.

FIGO is committed and would be glad to help in any manner that India wishes especially with me, an Indian, as President of FIGO.

Regards
Yours sincerely

Prof. CN Purandare
President, FIGO

President SAFOG
Prof. Rubina Sohail

Secretary General
Dr. Narendra Malhotra

Hon. Health Minister of India
Shri JP Nadda

30th May 2018

Greetings from SAFOG,

It gives me great pleasure to note that FOGSI International Women Health Summit is taking place in New Delhi from the first to third of June, 2018. The event becomes singularly important because of the interest the Ministry of Health is demonstrating for the event.

As you are aware that, for the last two decades the maternal mortality in the South Asian region has been almost stagnant. To reduce this burden, each of the countries of the region has adopted various measures. Approaches for handling the situation have varied from country-to-country and even state-to-state. This region is special as the countries share similar history, cultural norms and traditional values. The region also has the same issues of poverty, low literacy rate, women's health and women's right issues. Despite various interventions, most of the countries are still struggling with the issues of maternal health and rights and with lot of work needs to be done on urgent basis.

The huge population burden is a cause of great concern for the Government as it make the task of achieving universal health coverage even more daunting. Harnessing the population and improving contraceptive prevalence is a herculean task and needs joint efforts of all involved, in order to further the case of family planning and family welfare.

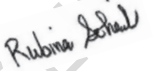
This event thus become even more important as it provides an opportunity for the experts and senior professionals of the region to have good deliberations and reach consensus after using the collective wisdom of all involved and to crystalize these decisions into practical concrete steps. The contribution of government officials will enrich the discussions and will help in the implementation of decisions of the Women Health Summit.

In order to improve things further and provide greater opportunities for collective work from the South Asian region, I request you to facilitate the travel and visa formalities for doctors in the region, so that they find more opportunities to convene and take the work forward. In this

regard, it also important that the Government plays a positive role in the process of acquiring a medical visa. This would help create more opportunities for patients of the region, seeking health care.

I congratulate you on your achievements and look forward to greater collaborative activity in the region.

Warm Regards,



Dr Rubina Sohail

Professor of Obstetrics & Gynecology
Services Institute of Medical Sciences, Lahore, Pakistan
President, South Asian Federation of Obstetrics & Gynaecology (SAFOG)
Member, FIGO committee on "Sexual Health and Human Rights"
Member Scientific Committee and Track Lead on Sexual Health &
Human Rights at XXII FIGO Congress
Vice President, Pakistan Menopause Society

Maternity Emergency Resource Network

The M.E.R.N. Childbirth Survival Protocol

Rotary | calmed

Background

Calmed (Collaborative Actions in Lowering of Maternity Encountered Deaths) is a rotarian initiated holistic evidence-based programme for reducing avoidable maternal and newborn deaths in low resource settings.

It had been implemented through two Rotary Foundation Global Grants (target population 3.2 million) supported by six Vocational Training Teams using training the team model (2013–2017).

It is a template of action with a modular constitution—the modules can be implemented together or separately, guided by priorities of the communities.

It has achieved its objectives of increasing skilled workforce number, raising community awareness and introducing important behavioural changes. It has generated a sustained impact.

Our challenge is for Rotary to adopt the SDG 3 Goals—reduce maternal mortality further and encourage equity in care. We wish to start in the remote areas, where access and mortalities are higher. We would wish to introduce low cost ambulance (E-ranger bike ambulance is based on a motor bike with a side car) and arrange basic resuscitation before transfer to the safety of hospital care—this practice saves mothers and babies during transfer.

MERN Concept

This is a validated resource for enhancing survival rates of mothers and newborn in emergency situations during transfer from distant communities—developed as a component of the CALMED programme. ***It involves a red flag alert in obstetric and newborn emergencies***.

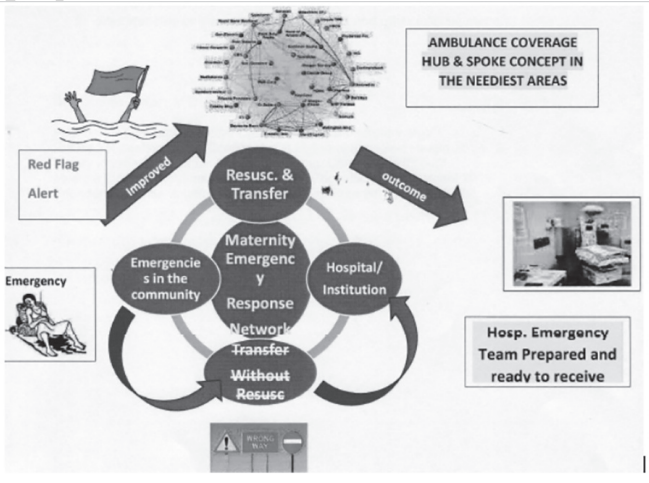
Maternity Emergency Resource Network

The M.E.R.N. Childbirth Survival Protocol

Rotary | calmed

Resuscitation and Stabilisation of Mother/Child with emergencies, prior to low cost Ambulance Transfer from remote areas to safety of hospitals.

Low cost Ambulance with Tracker, Consumables (TXA, Mag. Sulph., etc.) Equipment (Monitors, NASG, Thermal Blanket) and Training (for Ambulance Crew, base level health workers), Programme Manager



Maternity Emergency Resource Network

The M.E.R.N. Childbirth Survival Protocol

Rotary | calmed

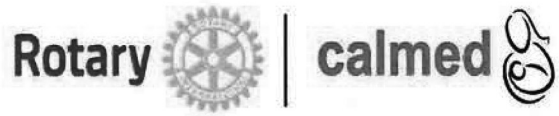
MERN Implementation—Further Action Required

1. **Rotary Partnership** with Government/private hospital—Polio legacy framework, identify target areas of need, publicity within and beyond, Rotary-social networking—Team Building
2. **Business Plan**—secure funding, collaboration/partnership, stewardship—Global Grant (3 years) for implementation in an agreed target area (2–3 million)
3. **Purchase** and assembly of consumables and equipment—in a Box
4. **Import/Production and assembly of E-Ranger Bike Ambulance** or similar locally available.
5. **Training** of Ambulance Crew, M. E. R.N. Care Manager, and basic health care workers; secure resources, trainers—training the trainer model, possibly based in a hospital.
6. **Create resources** for transfer to a "**Waiting Home**" near hospital before delivery date—for very remote areas—Matri Ghar (optional)
7. **Piloting the programme**—identify neediest areas, with Government/Hospitals/Rotary support and resources able to implement, implementation, data collection and evaluation.
8. **Free standing or integration** into Calmed 2 and other existing models.

MAY, 2018

Dr. Himansu Basu MD PhD
Founder, Programme Director, Calmed (www.calmedrotary.org)
Rotary Foundation Cadre Coordinator in Maternal and Child Health 2013–19
Rotary International Global Networking Group Committee 2017–20
Medical Director, Rotarian Action Group on Population Development 2010
Founder Chairman, International Fellowship of Rotarian Doctors 2002

TOOL KIT (RESOURCES) FOR MATERNAL AND CHILD MORTALITY REDUCTION PROGRAMMES IN LOW RESOURCE SETTINGS – A CALL FOR GLOBAL ACTION



Key Features

The Tool Kit is a resource to be used for guidance in planning and implementing an effective programme for reduction of preventable mother and child deaths in low resource settings, in collaboration with University of Geneva Hospital (HUG).

Background

Maternal and newborn mortalities in low resource countries, are largely preventable. These are related not only to medical issues, but also to public health and societal/cultural issues. We believe a holistic strategic action is needed, if we are to move towards reaching the SDG goals. For impact and sustainability, partnership of healthcare providers with Government, NGOs and civil societies is very necessary. We present a tool kit comprising of ideas and actions based on our experience, available evidence base and opinions/expectations of experienced players in these fields. lt is based on the PDCA (plan, do, check and act) principle. The components have been field tested in the Rotary Calmed programme (www.calmedrotary.org).

Rationale

These represent not only a dashboard view of but also a helicopter view of the problems in low resource settings, and their strategic solutions. These guidelines should be adapted and updated.

Maternal and Perinatal Mortality Reduction in low resource settings—Helicopter view

Indicators	*Problems*	*Solutions*
First delay in care—in the community	Lack of awareness in the community, of maternity and child care matters, and family planning	Training/Empowerment programme of community women's groups through pictorial charts, videos with subtitles in local language Group Antenatal Care training
Second delay in care—transport	Lack of emergency transport Lack of understanding re: basic resuscitation facilities at community/primary care level, before ambulance transfer	Low cost ambulance–E-ranger bike Maternity Emergency Response Network (ZMERN)—resuscitation/stabilisation prior to fast track ambulance transfer "Golden hour" concept

Contd …

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Indicators	*Problems*	*Solutions*
Third delay in care—in hospital facilities	Lack of trained professionals in hospital	BEmONC (WHO) training, through training the trainer model, aiming an extended skills trained workforce; Regular retraining
	Lack of supervision on site by trained seniors.	Improved availability/ supervision by senior doctors Telemedicine/Telehealth
Dysfunctional hospital	Lack of medicines, functioning equipment	Obstetric Quality Assurance and correction
Lack of governance, discipline, accountability, persistent failure of programmes	Preventable maternal and perinatal deaths	Training/implementation of MPDSR in partnership with Government and hospital providers, correction of deficiencies
Inequities in outcome in individual areas	Complacency/ignorance/lack of good data	Partnership with government regular review, MCH Programme manager-remunerated

Six pillars

We have divided the topics into 6 areas, based on our experience of the vocational team based training the trainer model in Calmed programme (www.calmedrotary.org) although there have been inevitable overlaps. Please put your comments, suggestions to drhbasumd@gmail.com—we will endeavour to adapt and enhance.

PROGRAMME DEVELOPMENT STRATEGY—HELICOPTER VIEW

S.1. International experience of preventable maternal and new born mortality in low resource settings, 3-delay model, MMR (maternal mortality ratio), life time risk (LTR).

S.2. CALMED (Collaborative Actions in Lowering of Maternity Encountered Deaths) programme basics—a template of successful action for reduction of preventable

TOOL KIT (RESOURCES) FOR MATERNAL AND CHILD MORTALITY REDUCTION PROGRAMMES IN LOW RESOURCE SETTINGS – A CALL FOR GLOBAL ACTION

maternal deaths—also reduce morbidities and child mortality. Introduced through Rotary Foundation Global Grants in India.

S.3. Partnership and collaboration with Governments, Academic bodies, Professional societies, and NGOs—for low cost resources, advocacy and empowerment.

S.4. Developing evidence base for Calmed and other related holistic programmes and individual components, for piloting and implementation.

S.5. Establishing a technical network of programme participants—Obstetricians, Paediatricians, Public Health Experts, Maternal and Child Health Champions, members of related Rotarian Action Groups and Rotary Fellowships.

PLANNING AND PREPARATION FOR VTT

P.1. Programme preparatory work—identifying the target area, assessing needs, abilities, priorities, adapting the Calmed template to combined resources and joint priorities. Preparatory work at programme site and international VTT (vocational training team) site (rehearsal discussions), communication network including Skype, working relationship between international and host committees.

P.2. Reconnaissance visit—meeting government—needs assessment, Rotarians, Professionals, Community leaders. Developing two teams; Agree on Checklist for programme preparatory partnership, training sites, hosting, administrative issues, funding and procuring resources, risk assessment of the team visit.

P.3. Funding-Rotary Global Grant application, establishment of funding structure, partnership, MOUs with partners, networking including local and global publicity network.

P.4. VTT Team selection—advertising, interview, selection, team building including communication and rehearsal (please see P.5.)

P.5. Trainee/Trainer selection in the host country—Government/Rotary/Professional Group/ Hospital staff partnership. A 2-3-year timed programme of training and retraining covering the entire target area. MOU for resources and required permission.

RESOURCES

R.1. Procuring Training Resources—Trainers' Manual, Trainee's manual, Community awareness training manual, presentation tools for lecture, breakout groups, pre- and post-test materials for assessment (knowledge, skills, and behavioural change), certificates,

charts, videos for training and publicity/awareness, simulators, loading flash drives, cell phones, computers.

R.2. Seeking resources within the country—equipment, pharmaceuticals and others for diagnosis, monitoring, treatment, and publicity.

R.3. Skills Lab set up—a resource for skills transfer training.

R.4. Funding an administrative set up for coordination of the holistic programme—hospital, community, public health and bridging the gaps and inequalities.

R.5. Telemedicine set up for management and Telehealth for awareness.

R.6. Maternity Emergency Response Network (MERN).

R.7 Group Antenatal Care.

MONITORING AND EVALUATION

M.1. WHO Checklist (modified)—please see T.4.

M.2. WHO signal functions.

M.3. Obstetric Quality Assurance (OQA)—please see T.15.

M.4. Maternal and Perinatal Death Surveillance and Response (MPDSR)—please see T.15.

M.5. Partnership, collaboration with Government—please see A.1.

M.6. Collaboration with NGOs, non-Governmental Private Hospitals—please see A.

ADVOCACY

A.l. Partnership with Government—please see M.5.

A.2. Collaboration with NGOs, Private Hospitals—please see M.6.

A.3. Bridging inequalities in service provision, within the target area.

A.4. Improving access to quality care—financial, geographic, cultural/social barriers.

A.5. Satisfying unmet needs of contraception, including reversible methods.

VOCATIONAL TRAINING TEAM-BASED PROGRAMME

V.1. Needs assessment in target areas to identify goals and resources needed.

V.2. Team Visit/Team Work—VTT Team organisation based on the Faculty working on training the trainer model—Team selection, Team briefing, Programme Director, Team Leader, Course Directors, Team members (Faculty), Administrators

TOOL KIT (RESOURCES) FOR MATERNAL AND CHILD MORTALITY REDUCTION PROGRAMMES IN LOW RESOURCE SETTINGS – A CALL FOR GLOBAL ACTION

V.3. Preparatory Day—unpacking and assembling the simulators, videos, charts, rehearsal for the training days, checklist for resources needed for lectures, breakout sessions, agreed template of action.

V.4. Programme Schedule—various training groups (for training, mentoring, etc.)—training the trainers, basic trainees, ASHA trainers, Emergency Responders (Ambulance workers, others) training; team briefing, de-briefing, return visits, arrangements for reporting, sharing monitoring and evaluation.

VOCATIONAL TRAINING COMPONENTS IN MATERNAL AND CHILD CARE

T.1. Training—Care of labour — normal labour, Postpartum care, new born care, resuscitation, examination of new born.

T.2. Training—Care of sick babies—resuscitation, preterm, hypothermia, hypoglycaemia, Kangaroo Mother Care (KMC).

T.3. Training—Partograph—normal, abnormal labour.

T.4. Training—WHO Checklist (modified)—please see M.1.

T.5. Training—Maternal resuscitation—structured approach.

T.6. Training—Shock and Hypovolaemia

T.7. Training—Antepartum Haemorrhage (APH).

T.8. Training—PET, Eclampsia.

T.9. Training—Postpartum Haemorrhage (PPH)—retained Placenta.

T.10. Training—Maternity Emergency Response Team—Stabilisation prior to transfer—training of Ambulance Crew, Nurses, Midwives, Emergency Box containing equipment, medication, E-ranger bike ambulance, cell phone based training, tracking device, Telemedicine assistance.

T.11. Training—Abnormal Labour—Twins, Breech, Cord prolapse, Shoulder dystocia, Mal-rotated Head, Obstructed labour.

T.12. Training—Sepsis in pregnancy, labour, puerperium

T.13. Training—Anaemia, HIV

Indian Society of Medical & Pediatric Oncology (ISMPO)

Hon. Health Minister of India,
Shri JP Nadda

Dated: 29 May 2018

Dear Honorable Minister,

It is a pleasure and privilege for the ISMPO to partner with the FOGSI & the present President of FOGSI, Dr. Jaideep Malhotra, at the International Women's Health Submit to be organized at the NCR in the first week of June 2018.

You would be aware that gynecological cancers form one of the major causes of morbidity and mortality in women in India. The majority of patients are first seen by a gynecologist and hence it is imperative to update and make aware the gynecological community regarding the early diagnosis and management of common gynecological cancers and the FOGSI, with its huge membership base, is the ideal platform for this activity.

Even though the incidence of Cervical Cancer is decreasing in our country, it still remains the commonest gynecological malignancy in rural India today. Epithelial ovarian cancer is the second most common cancer in women and usually diagnosed in late stage. Our group intends to focus on knowledge and advances in the early diagnosis and subsequent management of these cancers.

In the panel discussion planned at the summit, we plan to discuss various aspects of the diagnosis and treatment of advanced Ovarian and Cervical cancers and also come up with concrete recommendations for the practicing gynecologists as to how to approach a patient with these cancers. As per mandate of the meeting, planners we will also bring out a 10 point 'white paper' based on the consensus derived for the discussion between experts and the attendees.

We look forwards to this and many such activities under the auspices of the department of Health, Government of India and the Honorable Minister.

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From AOFOG (Asia & Oceania Federation of Obstetrics and Gynaecology)

Lessons to be Learned from Malaysia's Experience with Maternal Deaths
The Asia & Oceania Federation of Obstetrics and Gynaecology (AOFOG)

Malaysia, currently a "middle income" nation striving to become a "high income" nation by the year 2020, is a place where 32 million people from multiple religions, cultures, languages, and ethnicities reside. Despite competing demands of this diverse and aspiring population, Malaysia is well known as the country which has made significant strides in maternal health.

Confidential Enquiry into Maternal Deaths (CEMD) was known to be implemented only in the UK and Australia/NZ when Malaysia embarked on it in 1991. Over these last two decades, the maternal mortality ratio has declined from 44 to 22.3 per 100,000 live births in 2014.

Over these last 27 years, Malaysia has released 6 reports based on CEMD and the seventh one is in progress. The reports have been followed by various training manuals, case illustrations, guidelines and consensus statements. Policy changes at the national level, improved facility-based services, as well as enhanced home-based and primary maternal care were a result of these efforts. For example, pharmacological agents, e.g. prostaglandin F2a, Novo 7, Tractocile, Duratocin and others, were introduced into managing postpartum hemorrhage, as a result of the CEMD findings. Certain drugs (e.g. Dexamethasone, $MgSO_4$) were downgraded to allow the midwives to initiate therapy in case of preterm labor and severe pre-eclampsia/eclampsia from the moment of contact with the patients.

Midwives have now been trained to provide postpartum thromboprophylaxis to the high risk mothers. Similarly, patient referral and feedback mechanism were improved, and maternal and fetal surveillance equipment was updated when it was found that targeted cardiotocography (CTG) as well as Doppler ultrasound could allow us to better manage and optimise outcomes in high-risk pregnancies.

In order to ensure that some of these changes would be sustainable and the skills were passed on, Malaysia also introduced the Advance Diploma in Midwifery. This was in response to the findings of the CEMD and Maternal Death Surveillance and Response (MDSR) that the then midwifery training was lacking. With the new curriculum in place, there is an increased interaction between the midwifery students and clinicians. Maternal fetal medicine as a subspecialty was also advanced to optimise the care of the mother and fetus at risk.

Malaysia's success in reducing maternal deaths stems from a range of issues; many of which may not necessarily be unique to the country, but rather generic enough for other countries to draw from. We learnt that:

- It was important to start with achievable targets, maybe at a facility level and thereafter moving forward, rather than aiming for the entire nation to come on board at the very outset;
- The processes had to be nonpunitive with no naming, blaming or shaming;
- Engaging all the major stakeholders in the system, including from the public and private health services, academics, NGOs and the politicians, was crucial to make it work;
- A "top down" approach with a strong political will to see the change happen was necessary to push things through;
- Monitoring maternal deaths should receive priority from all quarters. For instance, maternal mortality ratios in Malaysia became a key performance indicator for the Minister of Health and the Director General of Health.

Whilst scarce "resources" is a reality for everyone, being discouraged by it did not help. Having a dedicated team of people with the passion to see our mothers live longer and willing to persevere for it was enough to start establishing the MDSR/CEMD. Mapping another country's success onto our own would not be the best way. Rather, tailoring the learning from other successes to suit our own needs is certainly recommended. Setbacks, brickbats and disappointments are all important ingredients towards achieving success in MDSR/CEMD.

The Malaysian journey has been far from being a bed of roses. We have stumbled, fallen, halted and even rejected along the way. But have picked up the pieces, dusted off the dirt and have moved forward. Success, as you can see, has followed.

Dr J Ravichandran R Jeganathan
National Head of Obstetrics and Gynaecologic Services, Chairman of the Confidential Enquiry into Maternal Deaths, Ministry of Health, Malaysia

Vaccination in Women: FOGSI IAP Joint Recommendations

Vaccination in Women [SATH-SATH (FOGSI – IAP)] Immunization (The Indradhanush Programme)

Vaccination should be offered to all women throughout their lifetime and should be an important intervention to be considered in the practice of obstetrics and gynecology. Vaccination before, during and after pregnancy helps protect women from serious infections. It can also help in improving the women's health in general. It is an important preventable measure which should be adopted rationally. FOGSI considers women's health in all the walks of life to be a responsibility and recommends vaccination in women in the appropriate context.

- FOGSI recommends vaccination counseling as a part of prepregnancy counseling (unvaccinated women). History of occurrence of vaccine preventable diseases, previous vaccinations administered and allergic reactions to vaccinations must be recorded.

Vaccination during the Adolescent Age Group

In this age group MMR, Hep B, Hep A, HPV, tetanus, diphtheria, influenza and VAR catch up vaccinations are recommended from 11 years onwards. Typhoid and cholera vaccination can be given seasonally. BCG, Oral Polio Vaccine and Triple (DPT) vaccine is usually given to all children. In addition vaccinations against Hepatitis B (Hep B), MMR (Mumps Measles Rubella), Hib (Haemophillus influenzae type b), varicella (VAR), meningococcal infections are also given during childhood. In case the vaccine has not been taken at the recommended age of 4–6 years, the catch up vaccination needs to be taken in the adolescent age group.

- FOGSI recommends administration of rubella vaccine to all adolescent girls as history of rubella infection is difficult to elicit. This is to prevent the incidence of congenital rubella syndrome (CRS) which occurs through vertical transmission if the woman is infected during the first 3 months of pregnancy. Antibody testing is not necessary before vaccination. Pregnancy should be avoided within three months of vaccination. However, if pregnancy occurs within 4 weeks of vaccination there is a small chance of the fetus being born with CRS and usually follow and close monitoring with ultrasonography (USG) is advised instead of

pregnancy termination. Immunization programs worldwide have made a major impact in the epidemiology of rubella both in the developed and several developing countries. In a study from Vellore, it is reported that congenital rubella constituted about 9.8% of all children born there with suspected congenital infections.

- FOGSI recommends HPV vaccination in all adolescents for protection against cancer cervix. This is best given as early as the age of 9 years or before commencement of sexual activity. Catch up vaccination is recommended in case of incomplete vaccination.
- Rubella, hepatitis B and varicella vaccination should be given preferably during postmenstrual period.

Postnatal Vaccination

Postnatal period is a good window of opportunity which should not be missed to protect the mother and her future progeny. Influenza vaccination of the pregnant and parturient woman reduces the risk of respiratory illness including laboratory-confirmed influenza in their infants up to 6 months of age as a result of both transplacental maternal antibodies, and increased anti-influenza antibodies in breast milk vaccines such as rubella can be safely administered in concurrence with postnatal contraception.

- FOGSI recommends postnatal rubella, hepatitis B, varicella, influenza, tetanus and HPV vaccinations to all nonimmunized postnatal mothers.

Vaccination in Adult and Elderly Women

HPV vaccine is licensed to be used up to 45 years of age. Unvaccinated adults of age 65 years and older be vaccinated by tetanus diphtheria acellular pertussis (Tdap) instead of tetanus toxoid if in close contact with an infant. Influenza vaccination prevents influenza illness amongst approximately 70–90% of healthy adults aged under 65 years.

- FOGSI recommends vaccination against HPV, tetanus, diphtheria and influenza for women of all ages.

Vaccination during Pregnancy

In contrast to developed nations where tetanus is rare, it remains endemic in the developing world. The incidence often increases following natural disasters such as earthquakes and tsunamis. In 2012, there were 2404 cases of tetanus reported to the WHO from India. Two doses of tetanus toxoid injection at least 28 days apart are to be given to all pregnant mothers

commencing from second trimester. If the subsequent pregnancy occurs within 5 years only one booster is given.

In the year 1997 and 1998 the number of diphtheria cases reported to the WHO from India were 1326 and 1378 respectively. Since then there has been a steady rise in the incidence of the disease. This has now plateaued over the last 5 years. In 2012, a total of 2525 new cases of respiratory diphtheria were reported from India. For reasons that are not well understood pockets of diphtheria are reappearing primarily in developing countries. Tdap vaccination can be considered instead of the second dose of tetanus toxoid to offer protection against diphtheria and pertussis in addition to tetanus. The regular pertussis vaccine is contraindicated in pregnancy. Tdap has to be repeated in every pregnancy irrespective of the status of previous immunization (with Tdap).

Both influenza A and B viruses are important as respiratory pathogens. Influenza occurs all over the world with the annual global attack rate estimated at 5–10% in adults and 20–30% in children. Most of the infections globally are caused by influenza A (HINI), influenza A (H3N2) and influenza B viruses. 'Antigenic drift' results in seasonal epidemics and is due to point mutations that occur during viral replication. The inactivated influenza vaccine (as opposed to live attenuated vaccine) is recommended in pregnancy. This offers protection to the mother (pregnant women are at a higher risk of ARDS) and to the newborn who cannot be vaccinated for the first 6 months of life. Higher rates of influenza associated complications recorded among pregnant women during the 2009 H1N1 pandemic resulted in recognizing pregnancy as a high risk group and therefore, vaccination is recommended in this group. Studies have demonstrated a 63% reduction in influenza illness among infants up to 6 months whose mothers received influenza vaccination during pregnancy. Influenza vaccination is recommended for mothers from 26 weeks onwards. In case of a pandemic the influenza vaccine can be given earlier to protect the mother.

- FOGSI recommends immunization against tetanus, diphtheria, pertussis and influenza during pregnancy.

IAP Immunization Timetable 2016

I. IAP Recommended Vaccines for Routine use		
Age (completed weeks/ months/years)	***Vaccines***	***Comments***
Birth	BCG OPV 0 Hep-B 1	Administer these vaccines to all newborns before hospital discharge
6 weeks	DTwP 1 IPV 1 Hep-B 2 Hib 1 Rotavirus 1 PCV 1	**DTP:** • DTaP vaccine/combinations should preferably be avoided for the primary series • DTaP vaccine/combinations should be preferred in certain specific circumstances/conditions only • No need of repeating/giving additional doses of whole cell pertussis (wP) vaccine to a child who has earlier completed their primary schedule with acellular pertussis (aP) vaccine-containing products **Polio:** • All doses of IPV may be replaced with OPV if administration of the former is unfeasible • Additional doses of OPV on all supplementary immunization activities (SIAs) • Two doses of IPV instead of three for primary series if started at 8 weeks, and 8 weeks interval between the doses • No child should leave the facility without polio immunization (IPV or OPV), if indicated by the schedule • See footnotes under figure titled IAP recommended immunization schedule (with range) for recommendations on intradermal IPV **Rotavirus:** • 2 doses of RV1 and 3 doses of RV5 & RV 116E • RV1 should be employed in 10 and 14 week schedule, 10 and 14 week schedule of RV1 is found to be more immunogenic than 6 and 10 week schedule

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Age (completed weeks/ months/years)	*Vaccines*	*Comments*
10 weeks	DTwP 2 IPV 2 Hib 2 Rotavirus 2 PCV 2	**Rotavirus:** If RV1 is chosen, the first dose should be given at 10 weeks
14 weeks	DTwP 3 IPV 3 Hib 3 Rotavirus 3 PCV 3	**Rotavirus:** • Only 2 doses of RV1 are recommended • If RV1 is chosen, the 2nd dose should be given at 14 weeks
6 months	OPV 1 Hep-B 3	**Hepatitis-B:** The final (3rd or 4th) dose in the Hep B vaccine series should be administered no earlier than age 24 weeks and at least 16 weeks after the first dose
9 months	OPV 2 MMR-1	**MMR:** • Measles-containing vaccine ideally should not be administered before completing 270 days or 9 months of life • The 2nd dose must follow in 2nd year of life • No need to give stand-alone measles vaccine
9–12 months	Typhoid Conjugate Vaccine	• Currently, two typhoid conjugate vaccines, Typbar-TCV® and PedaTyph® available in Indian market; either can be used • An interval of at least 4 weeks with the MMR vaccine should be maintained while administering this vaccine
12 months	Hep-A 1	**Hepatitis A:** • Single dose for live attenuated H2-strain Hep-A vaccine • Two doses for all inactivated Hep-A vaccines are recommended
15 months	MMR 2 Varicella 1 PCV booster	**MMR:** • The 2nd dose must follow in 2nd year of life • However, it can be given at anytime 4–8 weeks after the 1st dose **Varicella:** The risk of breakthrough varicella is lower if given 15 months onwards

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Age (completed weeks/ months/years)	*Vaccines*	*Comments*
16–18 months	DTwP B1/DTaP B1 IPV B1 Hib B1	The first booster (4th dose) may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose. **DTP:** • 1st and 2nd boosters should preferably be of DTwP • Considering a higher reactogenicity of DTwP, DTaP can be considered for the boosters
18 months	Hep-A 2	**Hepatitis A:** 2nd dose for inactivated vaccines only
2 years	Booster of Typhoid Conjugate Vaccine	• A booster dose of typhoid conjugate vaccine (TCV), if primary dose is given at 9–12 months • A dose of typhoid Vi-polysaccharide (Vi-PS) vaccine can be given if conjugate vaccine is not available or feasible • Revaccination every 3 years with Vi-polysaccharide vaccine • Typhoid conjugate vaccine should be preferred over Vi-PS vaccine
4–6 years	DTwP B2/DTaP B2 OPV 3 Varicella 2 MMR 3	**Varicella:** The 2nd dose can be given at anytime 3 months after the 1st dose. **MMR:** The 3rd dose is recommended at 4-6 years of age.
10–12 years	Tdap/Td HPV	**Tdap:** It is preferred to Td followed by Td every 10 years **HPV:** • Only 2 doses of either of the two HPV vaccines for adolescent/ preadolescent girls aged 9–14 years • For girls 15 years and older, and immunocompromised individuals 3 doses are recommended • For two-dose schedule, the minimum interval between doses should be 6 months • For 3 dose schedule, the doses can be administered at 0, 1–2 (depending on brand) and 6 months

II. IAP Recommended Vaccines for High-risk* Children (Vaccines under Special Circumstances)#

1. Influenza Vaccine
2. Meningococcal Vaccine
3. Japanese Encephalitis Vaccine
4. Cholera Vaccine
5. Rabies Vaccine
6. Yellow Fever Vaccine
7. Pneumococcal Polysaccharide Vaccine (PPSV 23).

**High-risk category of children:*

- Congenital or acquired immunodeficiency (including HIV infection)
- Chronic cardiac, pulmonary (including asthma if treated with prolonged high-dose oral corticosteroids), hematologic, renal (including nephrotic syndrome), liver disease and diabetes mellitus
- Children on long-term steroids, salicylates, immunosuppressive or radiation therapy
- Diabetes mellitus, cerebrospinal fluid leak, cochlear implant, malignancies
- Children with functional/anatomic asplenia/hyposplenia
- During disease outbreaks
- Laboratory personnel and healthcare workers
- Travelers
- Children having pets in home
- Children perceived with higher threat of being bitten by dogs such as hostellers, risk of stray dog menace while going outdoor.

For details see footnotes under figure titled 'IAP recommended immunization schedule (with range)'

Vaccination chart for pregnant women[3]

Vaccine	*Before pregnancy*	*During pregnancy*	*After pregnancy*	*No. of doses and route (IM-intramuscular, SC-subcutaneous)*
Hepatitis B	Catch up vaccine in those with no history or incomplete vaccination	Yes, if indicated	Yes, if indicated	3 doses (0, 1 and 6 months) IM
Human papillomavirus (HPV)	To be considered if not given earlier. In case of pregnancy next dose to be delayed	No	Recommended immediately postpartum if not immunized earlier	3 doses (0, 1or 2 and 6 months) IM
Influenza (Inactivated)	Yes	Yes	Yes	1 dose, IM
Rubella	Catch up vaccine in those with no history or incomplete vaccination. Pregnancy should be avoided within 3 months of vaccination	No	Recommended immediately postpartum if not immunized earlier	2 dose (0 and 1 month), SC

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Vaccine	*Before pregnancy*	*During pregnancy*	*After pregnancy*	*No. of doses and route (IM-intramuscular, SC-subcutaneous)*
Tdap	Yes, if indicated	Yes, vaccinate during each pregnancy ideally between 27 and 36 weeks of gestation	Recommended immediately postpartum if not immunized earlier	1 dose, IM
Tetanus	Yes, if indicated	From 2nd trimester	Recommended immediately postpartum if not immunized earlier	1 dose, IM
Varicella	Catch up vaccine in those with no history or incomplete vaccination. Avoid conception for 4 weeks	No	Recommended immediately postpartum if not immunized earlier	2 dose (0 and 1 month), SC

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Recommendations of FOGSI on Influenza Vaccination in Pregnancy

Objective

The aim of this committee is to have a detailed discussion on the proposed agenda, which will help the members of this committee to come to a consensus on the same and thereby assisting in framing the recommendations on influenza vaccination in pregnancy.

Proposal

To recommend "Influenza vaccination (quadrivalent) should be routinely given to all the women during pregnancy."

Background: Need of the Recommendation

Although routine vaccination of pregnant females against influenza with inactivated trivalent influenza vaccine is recommended, but none of the pregnant females had received influenza vaccination despite being pregnant in the influenza season. In absence of similar data from other parts of the country, the data more or less reflect the vaccination patterns across the country. Importantly, major deficits in the knowledge, attitude, and practices regarding vaccination against influenza have been observed in the healthcare providers, who are supposed to be the prescribers of vaccination to pregnant females.

Maternal immunization during the period of influenza virus circulation has been associated with statistically significant reductions in febrile respiratory illness among mothers and infants, higher mean birth weight in infants, and lower proportion of infants who were of small-for-gestation age, without any attributable adverse fetal, perinatal, or infant outcomes.

It has been only recently endorsed by the Federation of Obstetric and Gynaecological Societies of India (FOGSI).

However, despite ample evidence to the contrary, misperceptions regarding the safety and efficacy of influenza vaccination are common among healthcare providers in India. Thus, for advocating effective influenza immunization in pregnancy, educational interventions are needed.

Panel Discussion:	
Moderators	***Panelists***
Dr Pradeep Halder Dr Santosh Soans Dr Rajat Ray	Dr Pramod Jog Dr Ranjan Pejuvar Dr Shashwat Jani Dr Harshita Singhal Dr Astha Gupta

Ending Preventable Maternal Mortality and Morbidities Challenges and Opportunities for India

Lifetime risk of maternal death (1 in X) for India is 1 in 220 versus other countries. In India, approximately 121 women die of causes associated with pregnancy every day; 5 women in an hour.

Launch of RCH II/NRHM/JSY in 2005 was an attempt to increase institutional deliveries and reduce maternal mortality. At least 4.5% annual decline required from 2011 to achieve sustainable development goal (SDG) target of maternal mortality ratio (MMR) less than 70. **National 2020 MMR target: 100 and** SDG target: **MMR less than 70**

There is much disparity in the MMR between different states in our country.[1] It was discussed that certain states like Maharashtra, Kerala have achieved sustained decline in MMR already. This is due to processes of referral, audit and awareness. West Bengal is looking at the concept of "Obstetric mentorship" where remote area can be adopted for regular visits from central health facility.

High institutional birth proportions that Janani Suraksha Yojana (JSY) has achieved are of themselves inadequate to reduce MMR, other factors including improved **quality of care** at institutions are required for intended effect.[2] There was a discussion on training and creating a cadre of certified midwives who would help to bridge the gap to manage obstetric care especially for rural and outreach areas, with robust triaging for referral and intervention.

An analysis of data available on MDR Software for 8 States (2014–15) based on 2,021 reported maternal deaths found that **most women die either in transit (20% deaths) or in medical colleges (20% deaths), followed by deaths in district hospitals (DHs) (18% deaths), homes (16% deaths) and private hospitals (15% deaths).** Clearly, there is a strong need for the health system to strengthen referral/s transport and the care provided at health facilities.

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Ending Preventable Maternal Mortality and Morbidities—Challenges and Opportunities for India	
Moderators	***Panelists***
Dr Amrita Kansal, WHO India	Dr Ravi Chandran Dr Evita Fernandez, Fernandez Hospital Dr Jaydeep Tank, FOGSI Dr Asheber Gaym, UNICEF Dr Mahesh Gupta Dr Reena Wani

Dental Health in Pregnancy

The 2000 Surgeon General's report stated the: "***Poor dental health is a silent epidemic that affects the mankind of different race and ethnicity. Oral health includes the health of the gums, teeth and jaw bone is: mirror of general health and wellbeing*** "WHO recognizes that oral health is an important determinant for the quality of life. Dental health and its impact on the systemic health and vice versa has been extensively documented. The complications of periodontal disease, i.e. gum and bone disease in pregnancy and postpartum have been the prime area of concern. The proposal has also submitted the published research supporting the complications of periodontitis and its effect on pregnancy, maternal health and child birth, i.e. risk for adverse pregnancy outcomes, i.e. preterm/low birth weight (PT/LBW).

Rational of Dental Health in Pregnancy

Pregnancy brings in noticeable changes in the body including mouth. The oral changes include: pregnancy gingivitis (gum disease in pregnancy), pregnancy tumor/epulis, tooth mobility, tooth erosion, dental caries, and periodontitis/pyorrhea (gum and bone disease of the supporting structure of the teeth). **FOGSI recommends at least one oral cavity examination during preconception or early Antenatal period**. Apart from the routine oral changes in pregnancy, research has shown the complications of periodontitis and its effect on pregnancy, maternal health and child birth, i.e. risk for adverse pregnancy outcomes, i.e. pre-eclampsia, PT/LBW. Postpartum retrospective studies reveal prevalence rate of 53% periodontitis in LBW cases.

Prevalence of Periodontal Disease in Pregnancy

Pregnancy-induced gingivitis and periodontitis are two oral conditions with prevalence rates ranging from 30% to 100% and 50% to 60% respectively.

Proposed Dental Health Recommendations for GOI Maternal Health Policy

Rationale for Recommendations

1. To create awareness, education, significance and safety of dental health during pregnancy and postpartum.
2. Advise women that good oral health care significantly improves the women's general health throughout her lifespan.

Recommendations

1. **Incorporation and implementation of the oral health assessments chart during the antenatal/prenatal checks** (*to be done by dentist/ancillary healthcare providers).
   Oral health assessment: Clinical assessments and oral health questions (e.g. *pain in teeth, bleeding gums, bad breath, loose teeth or any other dental complaint)*, oral health maintenance and habits, e.g. brushing/flossing (e.g. *GOI MCP card for antenatal check*).
2. **Incorporation of Maternal and Child Dental Health Guidelines in GOI policy/ programs, etc. *e.g. GOI:*** *My safe motherhood booklet, GOI-PMSMA (Pradhan Mantri Surakshit Matritva Abhiyan)*, Janani Shishu Suraksha Karyakaram (*JSSK), JSY.*
3. To **reassure patients** that prevention, correct diagnosis and treatment of dental conditions are safe in pregnancy.
4. **Incorporation of the oral health screening questions by the OBGYN team during the antenatal visits** (e.g. in them patient history sheets) *This would be the first point of contact for understanding the oral health of the patient who may be later referred to the dentist for a detailed dental assessment.
5. **Knowledge transfer:** Allied CME programs (gynecologists and dental/periodontal specialists) for exchange of knowledge.
6. Healthcare providers as a part of routine counseling should **encourage women for scaling and prophylaxis** (professional cleaning of the teeth) during pregnancy and post-partum maintenance.
7. **Inform women** that dental procedures can be carried out safely during pregnancy [*dentist would appraise the pregnancy semester based (1-3RD trimester and postpartum)] dental treatment protocol.
8. **Free dental service**: At antenatal check-up visits.
   (*Access to dental care has been seen to be directly related to financial constraints predominantly. Other confounding factors complicating oral health in pregnancy are: lack of education, lack of dental care providers, poor nutrition, tobacco intake, etc.)
9. **Interprofession collaborations:** Between the OBGYN team and dental for cross referrals, refer patients for the mandatory oral health care as would be the practice to any medical specialist in pregnancy and postpartum.
10. **Reinforce oral health maintenance:** For example, limit sugary food and drink, brushing twice a day with fluoridated toothpaste and dental visit twice a year.

An Indian Society of Periodontology (ISP) Proposal submitted to FOGSI by:

Dr Sangeeta Dhir, National Convener
ISP Prenatal Periodontal Healthcare Committee

Prevention of Gynecological Cancers

1. The burden of gynecological cancers in India is increasing at an alarming rate.
2. The key to change begins with an awareness of the problem among the general population as well as the healthcare providers.
3. A well conceived and planned large scale gynecological cancer prevention program is cost effective and operationally feasible for India, however a sustained and reliable budget allocation is essential for implementation.
4. Being "breast aware" is the most potent method to empower women in the battle against breast cancer. "Breast awareness" implies familiarity with their own breasts, but it also implies an awareness of breast cancer and the changes it can cause.
5. Large-scale campaigns with interventions at all levels including national (mass media), regional (camps) and health facility (IEC materials) are required to raise awareness among the general population.
6. Clinical breast examination (CBE) can be an important tool if planned judiciously in our setting. Adherence to standard examination protocol and making CBE, an essential component of every visit to the health facility, can help in maximizing its impact as a screening modality. A policy of triennial CBE is preferable.
7. In settings where there are no resource constraints, a biennial mammography should be offered to all women at least between 50 years and 70 years.
8. Mammography before 50 years and after 70 years should be based on a shared decision making.
9. Cervical cancer prevention services, to be effective, need to be implemented in an organized program rather than current opportunistic approach.
10. India needs a rapid roll out of population-based human papilloma virus (HPV) vaccination program by incorporating HPV vaccine in National Immunization Schedule and universal screening to women in all districts and regions of India.
11. Enhance health system capacities to deliver HPV vaccination and screening services by reducing cost, including relevant policies, infrastructure, and skilled human resources.
12. Raise awareness about HPV vaccination, cervical cancer screening and treatment by engaging local leaders—such as members of local government, Accredited Social Health Activist (ASHA) workers and women's self-help groups. Empower them by regular training.

13. Develop tailored messages for the local context and target audience that address known reasons for poor acceptance of cervical cancer prevention services—these include fear of cancer, misconceptions about cancer, and safety of vaccine, support screening tests and the instruments/tools used.
14. Disseminate information through reliable channels, such as community meetings, door-to-door visits, and advertisements at health facilities. Involve media and disseminate information.
15. Develop a standardized protocol for treatment and follow-up. Ensure strong linkages within and between different levels of the healthcare system to ensure timely treatment, follow-up and referrals.
16. Establish a quality assurance plan that defines standards at different levels of care and implement the good practice.
17. Facilities for appropriate genetic counseling and testing should be made available for women at high risk of breast cancer, endometrial cancer and ovarian cancer, e.g strong family history.
18. FOGSI through Akshaya Jeevan initiative is encouraging seen mother and vacuum daughter.
19. FOGSI through Adbhut Matrutva is trying members to sensitize women through pregnancy for various preventive problems and preventive HIV vaccination in Postpartum period

Preventing Cancer in Women	
Moderators	***Panelists***
Dr Alka Kriplani Dr Bharati Dhorepatil	Dr Bhagyalaxmi Nayak Dr Aparna Sharma Dr Amresh Singh Dr Seema Singhal Dr Ruchi Pathak Dr Kirti Dhonde Dr Anurita Singh

FOGSI–JHPIEGO SAMARTH Initiative— Training of Nurses and Paramedics in Quality Care

1. SAMARTH Training Programme has been designed by FOGSI & JHPEIGO in collaboration. It is a useful program for skill enhancement of paramedics and nurses. Integrated approval especially for to preconception, ANC antenatal and postpartum care.
2. Private sector in India caters to 70% of healthcare system and the paramedics working there are less educated, qualified and trained but they are still a big support system of healthcare system.
3. Trained, qualified nurses in India are mostly in government sector, but according to their education, they are underutilized.
4. Training program like SAMARTH—are practical and goal oriented and we need to promote such courses so that, quality of health care is improved.
5. Not all duties need degree holder staff—lot of work can be done by physician assistant, trained midwives and care coordinate.
6. Nurses with college degree in Nursing (BSc/ANM/GNM) have knowledge but lack practical application.
7. There are no training courses for staff involved in health care in private sector, who form majority of support system.
8. Government and private partnership is needed to improve paramedic education and skill enhancement.
9. We have continuing medical education (CME) programs for constant improvement of doctors skills—similar education/learning program with practical tips are needed for nurses and paramedics.

10. Midwifery can be developed as an important course in India, like in many western countries.

FOGSI–JHPIEGO SAMARTH Initiative— Training of Nurses and Paramedics in Quality Care	
Moderators	***Panelists***
Dr Neeraj Agrawal Dr Shally Gupta	Dr RN Tandon Dr Amrita Kansal Dr J Ravichandran Dr Evita Fernandez BK Sister Husain Dr Shaheen Anjum Dr Reeta Dabrani Dr Somesh Kumar Dr Asha Sharma

Infertility Care in Indian Scenario

- **FOGSI strongly recommends GOI to include infertility management in all public and private sector.**
- Mother or nothing: the agony of infertility in Indian scenario. The social burden of a couple's failure to bear a child falls disproportionately and devastatingly on the woman.
- Infertility prevention and care rank very low on the public health agenda.
- It is a disease defined by the failure to achieve a successful pregnancy, after 12 months or more of appropriate, timed unprotected intercourse or therapeutic donor insemination.
- Earlier evaluation and treatment may be justified, based on medical history and physical findings is warranted after 6 months for women over age 35 years. (ASRM 2013d) (WHO 2009).
- Couples who can get pregnant, but unable to stay pregnant may also be considered infertile.
- Some features are special to Indian couples. Couple is not seen together. Husband semen analysis is lastly done. Investigations are done in piecemeal. Educated couples are also reluctant to get thoroughly checked up.
- About 77.8% prevalence of spousal physical/sexual violence among childless women compared with 6.1% among women who have children.
- India a mixed bag with early marriages as well as late marriages. So also no treatment with highest possible treatments. Poverty and malnutrition, early marriage and inadequate educational and health systems. Women have limited autonomy, make them face huge constraints on decision making, mobility and access to resources. Lack of awareness, lack of spousal intimacy and communication on sexual matters, if all these are avoided, this itself will reduce the need for infertility care.
- Apart from the basic need of a semen analysis, tubal patency testing and day 21 serum progesterone estimation, thyroid-stimulating hormone (TSH) and a transvaginal sono-gram are also recommended by the panel.
- Further testing if required, antral follicle count, follicle-stimulating hormone (FSH) followed by hysterosalpingogram (HSG), diagnostic hysteroscopy, diagnostic laparo-scopy with chromopertubation are recommended.
- For the male, semen analysis in detail, leukocyte count in semen, testicular biopsy if required are also recommended.

- Infections play a major role in infertility. Tubal factor has been found to be the most common cause followed by anovulation. Accessory gland Infection is the most common factor for men, women are vulnerable to infections, including sexually transmitted infections and reproductive tract infections. If north India is more of tuberculosis, south is more of endometriosis as a factor promoting childlessness.
- In view of the high prevalence of malnutrition, micronutrients, antioxidants and diet rich in proteins need to be advised at the first visit itself.
- In the new IT scenario, women successfully climb to hit the corporate ladder, she thinks she will hit the next milestone of having a baby. Five years gone, lacks spent still trying, aging 40, when science failed, she looks to home remedies in vain. She leaves her job, faces violence, get separated, not knowing what to do. Life ends in tragedy.
- Polycystic ovarian syndrome is the most common cause of anovulation in which after the first line of treatment with clomiphene citrate, letrozole is to be tried especially in obese category.
- In house, intrauterine insemination (IUI) should be done in infertility centers only.
- Thumb rule of controlled ovarian stimulation with IUI is effective in first 3–4 cycles, thereafter without wasting time counseling for in vitro fertilization needs to be addressed.
- Myomectomy is recommended for submucosal fibroids of any size and intramural fibroids 4 cm and above.
- Exercise, meditation are strong supporters of enhancing the success of achieving a pregnancy.
- Assisted reproductive technology with novel, less costly protocols with antagonists are suggested as cost effective measures. For fertility preservation during and preceding oncotherapy in young cancer victims, both boys and girls, cryopreservation of sperms, testicular tissues, immature and mature oocytes need to be well explained.
- Access to essential clinical examination, investigation, management and counseling services for infertility (Planning Commission 2002). The main development in the last 15 years or so has been a proliferation of infertility services in the private sector. This includes assisted reproductive technologies, which are mostly unaffordable, of varying quality and costs with low success rates and are usually accessed only by middle, and upper-class couples who can afford them.

- The role of the public sector in infertility management is weak as even basic investigations and services were limited or incomplete, infrastructure, management including time management, lack of information and training, absence of clear protocols at all levels.
- Preoccupation with other health issues and lack of regulation are the main problems mentioned by providers.
- Key recommendations are: realistic and low-cost management, streamlining and regulating services, counseling of couples, providing information and raising awareness of patients, health personnel and policy makers.
- Common mistake on the part of healthcare providers: what not to do is when the patient change doctors, the doctor insists on repeating all the test again, wasting the patients time, money and go down in the public image.
- Infertility is now a superspeciality with unprecedented revolution in the treatment of human infertility. Regenerative medicine using stem cell research, tissue engineering to achieve rejuvenation are all coming in very fatly.
- We, in India, should keep pace with the developed world more by prevention of preventable factors of infertility.

Strategy for Infertility Care for India	
Moderators	***Panelists***
Dr Sadhna Desai Dr Jayam Kannan	Professor Edgar Mocanu (Ireland) Professor David Adamson (USA) Dr Laxmi Shrikhande Dr SN Basu Dr Reeta Mahey Dr Anshu Jindal Dr Keshav Malhotra Dr Jyoti Bali

Advanced Carcinoma Cervix and Advanced Carcinoma Ovary

1. All postmenopausal females presenting with ascites and large pelvic mass should be suspected to have ovarian cancer, until proven otherwise.
2. Postmenopausal female suspected to have ovarian cancer should have complete work-up, including tumor markers, CA-125, CEA, and CA-19.9.
3. Contrast-enhanced computed tomography (CECT) of the whole abdomen is the preferred imaging modality to know the spread of disease, and nodal involvement.
4. If available, positron emission tomography-computed tomography (PET-CT) may be done, but is not mandatory.
5. All suspected or confirmed cases of ovarian cancer, early or advanced stage, should be operated by gynecologist/surgical oncologist to achieve optimum surgical results.
6. Primary debulking surgery, is preferred in advanced ovarian carcinoma, as compared to neoadjuvant chemotherapy (NACT) and interval debulking surgery, if R0 resection seems possible. Otherwise, NACT followed by surgery is a reasonable alternative.
7. The aim of primary surgery is to achieve maximal debulking to less than 1 cm residual disease or no macroscopic residual disease is possible.
8. However, if patient is poor surgical candidate, or if R0 does not appear to be possible, then NACT should be considered.
9. Conventional laparotomy is the preferred route of surgery. Laparoscopic resection or robotic surgery has no/minimal role.
10. Diagnostic laparoscopy may be considered in selected cases to assess whether debulking surgery is feasible and for confirming the histopathological diagnosis, especially when repeated cytological examination is negative.
11. Genetic counseling and testing is recommended for all women with epithelial ovarian cancer (this includes fallopian tube cancer or primary peritoneal cancer) and for individuals who have a personal or family history of breast cancer or ovarian cancer.
12. Good pelvic examination is the best method to assess for operability and stage of carcinoma cervix.
13. Magnetic resonance imaging (MRI) pelvis with contrast may be used if required.
14. PET-CT may be used in advanced cases, if available, especially to r/o para-aortic lymph node (LN) involvement.

Breast Cancer

- Increased Incidence
- Early detection leads to very high cure rates.
- Sensitizing women towards self examination and 3 yearly examination by an expert. Many cheaper screening devices available which can make screening easier and affordable.

15. Surgery is the primary mode of treatment for cancer cervix stages IA1, IA2, IB1, and IIA1.
16. For stages IB2, and IIA2, both surgery and concurrent chemoradiotherapy are treatment options. Stage IIB, and beyond are to be treated by concurrent chemoradiotherapy.
17. Neoadjuvant chemotherapy is not the standard of care in locally advanced carcinoma cervix.
18. Adjuvant treatment may be required postsurgery in cases of carcinoma cervix. Adjuvant pelvic radiotherapy is recommended in patients with large primary tumors, deep stromal invasion, and/or lymphovascular space invasion (LVSI).
19. Radiotherapy with concurrent chemotherapy is recommended for patients with positive pelvic nodes, positive surgical margins, and/or positive parametrium.

Treatment of Gynecological Cancers and Cancer Prevention Strategies	
Moderators	***Panelists***
Dr Hemant Malhotra	Dr Rama Joshi Dr Sabhyata Gupta Dr Shruti Bhatia Dr Manjeet Mehta Dr Bhagyalaxmi Nair

Contraception and Family Planning

As we all understand that there is need to position family planning/contraception as key aspects of reproductive rights. Promoting contraception can reduce in-intended pregnancies as well as safe abortions and hence contribute towards reduction of MMR to a great extent.

According to SDG, by 2030 India has to reduce the maternal mortality to less than 70/100,000 live births, we need to ensure universal access to sexual and reproductive health services including family planning (FP), information and education, and the integration of reproductive health into national strategies and program.

India accounts for 40% share in global commitment towards FP 2020, held in London summit, i.e. add 4.8 crore (48 million) new users by 2020. Family planning is an important component for achieving Universal Health Coverage. In spite of National Family Welfare Program for FP, there is still high unmet need for contraception both for spacing and limiting methods. Contraceptive prevalence rate is quite low as only 47%.

Some suggestions for inclusion in white paper:

1. **Public private partnership:** The National Health Mission, Government of Uttar Pradesh in 2015 came out with a creative solution and formally launched a program called '**Hausala Sajheedari'** in the state wherein the process of engagement with private sector has been simplified and made efficient through moving the entire process to a e-Governance based digital platform by creating a web-portal based interface '*www.hausalasajheedari.in*'. The Hausala Sajheedari program which was formally launched by the then Hon'ble Chief Minister in April 2015 provides an end to end online ICT linked solution to the entire process from online application for accreditation and empanelment, approvals and online MOU generation, maintaining digital data of FP beneficiaries on the portal by the accredited provider to submission of online claim invoice for reimbursement and online transfer of reimbursement claims to the providers using PFMS systems of Government of India (GOI).
    - **This system can be replicate in other states so that private sector participation can be increased.**
    - **Other family planning methods services (like Injectable) can be strategically purchased/included in web-portal. Currently, primarily sterilization services are included (both FST & NSV) as intrauterine device (IUD) reimbursement charges are too low, i.e. @ 75/month.**

- **Sensitizing the public through Multi Religious leaders is mandatory unless and until we all talk the same language success in family planning is far fetched for this all Doctors, paramedics of support staff need to be educated in helping couples to understand the benefits of spacing of choice of method to achieve this.**
- **Demand generation support, IEC to be facilitated by Government.**
- **Private members of Federation of Obstetric and Gynaecological Societies of India (FOGSI) can provide support in strengthening the capacity of State/District Quality Assurance Committee.**

2. **Increasing access to family planning (FP):** Private sector engagement is very important in reaching the unreached. Private providers who are members of FOGSI can devote one day exclusively for family planning may be like PMSMA.
3. **Family planning budget needs to be increased:** Meeting the basic human rights responsibility lies with Government, for poorest and marginalized population including adolescents.
4. **No practitioner should be missing the opportunity to counsel the client for FP, and provide the services as available:** Providing informed choice and method specific counseling/**structured counseling** is key towards increasing contraceptive acceptance and continuation. Because of shortage of time, **IT technology for counseling can overcome the barrier.**
5. **Increasing FP basket of choice:** The third and fourth generation of oral contraceptives are available but not used. DMPA sub Q will be rolled out soon by GOI.
6. **Civil Society Organization can develop champions** in this field for constant advocacy and action.
7. **Male engagement:** At the field level, ASHA is the only one responsible for all RH and other activities. Need more and more men involvement in promoting FP acceptance.
8. **Contraception services to be made available to adolescents without any judgmental attitude.** Social stigma needs to be addressed.
9. **Task shifting/Involving AUH (Ayurvedic, Unani and Homeopathy) providers:** Except for sterilization services all contraceptive services to be allowed for AUH providers both in public and private sector. Currently for IC only second dose onwards is allowed, but it can be allowed after proper training so that they can screen and counsel the client. **There is need to develop training guidelines for including private AUH providers for providing spacing methods. FOGSI can support in the process.**

10. Allowing **trained midwife** to provide all spacing method services including IUD insertion. Even Government can think of allowing them for FP clinics in unreached/ underserved areas by accrediting their facilities.
11. Motivating good FP service providers in various platforms by providing monetary/ nonmonetary incentives.

Contraception and Family Planning	
Moderators	***Panelists***
Dr Rishma Pai Dr Nozer Sheriar	Dr Ritu Joshi Dr Anjali Nayyar Dr Ravi Anand Dr Jyoti Vajpayee Dr Sanjay Pandey Dr Kiran Arora Dr Jyoti Bunglowala Mr Shankarnarayanan Dr Meera Agnihotri Ms Poonam Muttreja

Promoting Vaginal Delivery

1. Panel and expert communicates that rate of cesarean section across the population is around 25–30%, and varies according to type of institution and catering of low, moderate or high risk cases. However, there is need to reduce primary cesarean section rate due to increased immediate and future obstetric complications in relative indications.
2. There are multiple and combined factors for taking decision of cesarean and vaginal delivery and it is effected by obstetric demography, human and technical infrastructure, patient socioeconomic cultural status and pregnancy and delivery complications.
3. Robsons classification is a good and simple tool for self-auditing as well for linear analysis. Adoption of Robsons classification should be a positive step to improve obstetric care in healthcare system of all resource settings. Administrators should be proactive in documenting and auditing cesareans section as well vaginal delivery data with details of indication and obstetric outcome.
4. Conduct of safe vaginal delivery entails close maternal and fetal observation for 4–24 hours. Panel strongly recommends development of trained nurses and midwifery cadre who are trained and skilled in monitoring of labor, recognition of birth complications and routine neonatal care and resuscitation. There is felt dearth of this cadre. Government should take steps for quality education in nursing and midwifery and availability in public as well private settings from entry to in job. However, panel recommends doctor/specialist led and midwifery supported care rather than midwifery led care.
5. A good infrastructure is required in form of well, equipped labor room with back up of emergency C section capability. At present, good infrastructure is not available in majority of health facilities and that need to be developed for women and newborn safety.
6. Labor room protocol from admission to immediate postpartum care should be followed. Use of Partogram, Active Management of third stage of labor, watch for golden hour are few standard procedure. FOGSI has also framed 16 minimum essential safe labor room practices. Adherence to such protocols ensures quality obstetric care and promotes vaginal delivery.
7. Teaching and training of doctors for assisted vaginal delivery and obstetric maneuvers like version, breech delivery, shoulder dystocia should be implemented vigorously in undergraduate as well postgraduate curriculum. Professional organization should also come forward for skill enhancement regular workshops. Panel appreciate role of FOGSI, Indian Academy of Pediatrics (IAP) for many such initiative.

8. Birth preparedness needs to be addressed and Holistic management of pregnancy with the ADBHUT MATRUTVA modules on PCC, ANC, INC, postpartum care with lifestyle, Diet & Stress management emphasized.
9. Use of some obstetric practice like induction of labor, C section for cord around neck, nonassuring CTG, intrauterine growth restriction (IUGR) and medical problems should be reviewed thoroughly and if possible with 2 opinions for reducing primary section rate.
10. Medicolegal cases as well violence with labor room staff is on the rise throughout the country, and it leads to fear as well practice of defensive medicine. Doctors should be protected by laws in such situations and environment of confidence can help in increasing incidence of vaginal delivery.
11. Practice of antenatal classes for birth preparedness, antenatal exercise, availability of optimum nutrition, early recognition of pregnancy complications can help in increasing chances of vaginal delivery and they should be part of antenatal care. These supports can be conducted by separate paramedical workers who are trained for it.

    FOGSI, is all set to promote vaginal delivery yet enforcement of any compulsory rates can have negative impact on obstetric care of women. Creation of skilled midwifery care, adequate infrastructure for conduct of vaginal delivery, good antenatal care, skills for assisted vaginal delivery (AVD) for doctors, and protection of first level obstetric care providers are few strong recommendation by FOGSI. Education for the people for good diet and lifestyle birthing at prime age and community support for early recognition and referrals is equally important for creating positive environment for promoting vaginal delivery.

Promoting Vaginal Births and Role of Midwives	
Moderators	***Panelists***
Dr Shyam Desai Dr Sadhana Gupta	Dr Evita Fernandez Dr Rizwana Habib Dr AG Radhika Dr Shraddha Agarwal Dr Aarti Manoj Sharma Dr Anita Gupta Dr Mitra Saxena Dr Anita Vashisth Dr Anita Sharma Dr Krishna Kumari

Her Unspoken Problems of Midlife Crisis

Consensus Statement

1. Midlife is important as midlife population is increasing projected to be about 130 million by 2020. Life expectancy is increasing, so women are spending more than one-third of their life in midlife.
2. Women have become ambitious and productive in later years therefore her OOL issues are important.
3. She has right to decide for her body.
4. Her unspoken problems of urinary incontinence (UI), sexual dysfunction, pelvic organ prolapse (POP). Atrophic vaginitis with urogenital syndrome and other cosmetic issues should be addressed.
5. Need of day is creating awareness about these problems by keeping public information brochures in the OPD and awareness programs in public forums.
6. Way forward is to DO SKILL ENHANCEMENT AND CAPACITY BUILDING OF CLINICIANS.
7. More preventive strategies of hygiene and pulmonary function test (PFT) from antenatal should be part of antenatal care.
8. We should have dedicated clinics for midlife women in all the medical institutions and private clinics.
9. Their interpersonal issues should be addressed by counselors.
10. Specialties of reconstructive surgery, esthetic gynecology and female pelvic medicine should be evolved.
11. Special geriatric clinics and HCP dedicated to preventive and curative health care needs of women in this age group needs to be developed.

Midlife Crisis—Cosmetic Gynecology Her Unspoken Problems	
Moderators	***Panelists***
Dr Maninder Ahuja Dr Rajkumari Savana Chaungtham	Dr Ragini Agarwal Dr SN Basu Dr Malvika Sabharwal Dr Rashmi Chahar Khandelwal Dr Varsha Ladhe Dr Shashi Arora Dr Anita Sabharwal Mrs Neelam Gulati

Antenatal Care

The following points have emerged out of discussion and consensus:

1. Antenatal care and emergency obstetric care are a continuum and focus on only one cannot reap expected improvements in maternal and perinatal mortality and morbidity. Antenatal care sensitizes woman towards the right place and time to seek emergency obstetric care.
2. Various models of antenatal care (Conventional, WHO 2002, WHO 2016) were discussed and it was concurred that the latest World Health Organization (WHO) model with eight or more contacts provides optimum visits and is cost effective. It is evidence based and gives clear guidance on various aspects like micronutrient supplementation, etc. and can be adapted as per local needs.
3. It is important to focus on a positive pregnancy experience for a woman and antenatal care has to be refocused keeping this in mind. FOGSI initiative "Adbhut Matrutva" can go a long way in providing a spiritual and holistic approach to prenatal care.
4. PMSMA can be an invaluable tool to forge private public partnership and sensitize woman towards health care available. It is important to make protocols across the country and ensure common minimum standards and resources in PMSMA to ensure quality care.
5. Antenatal care must encompass screening for domestic violence which often goes unnoticed.
6. Provision of iron sucrose at healthcare facilities is a laudable step and can go a long way in treating anemia, which contributes to maternal mortality and morbidity.
7. In all the models of antenatal health care, focus has been on maternal wellbeing. The inverted pyramid approach with focus on screening for congenital malformations, pre-eclampsia is a new concept which needs validations.

8. We need to look at Antenatal care as a window of opportunity to not only manage the current pregnancy but utilize the interaction to educate families on many other aspects like lifestyle, stress, diet, birth prepared, breast feeding benefits, family planning, prevention of NCD, etc. for which this year FOGSI's project "ADBHUT MATRUTVA" shows a consolidated integrated approach towards pregnancy management and impacting maternal and neonatal outcomes.

Good Practice Recommendations for Antenatal Care	
Moderators	***Panelists***
Dr Shantha Kumari Dr Priya Bhave Chittawar	Dr Dinesh Baswal Dr Amrita Kansal Ms Pompy Sridhar Dr Veronica Yuel Dr Anubhuti Dr Sumedha Dr Reema Goel

Registries and Research: Need of the Day

1. Registries are necessary to understand the Indian phenotype, etiology to quantify and identify the causality and strategies interventions for prevention and treatment which will be indigenous.
2. This way we can have our own data and create Indian guidelines.
3. The three major bodies, Indian Medical Association (IMA), FOGSI and GOI should come together not only at the center but at the periphery to improvise women's health issues. If this is possible in case of the Aadhar or the Pre-Conception and Pre-Natal Diagnostic Techniques Act (PCPNDTA) why not for mother's life and morbidity.
4. Many clinicians and the people are unaware about MDR being maternal death reviews, SDG and MDG.The government and the societies should take measures to increase social awareness and clinicians' visibility of these important issues.
5. Uniform reporting systems through improvized digital medium and creating human resource of data operators are necessary to acquire important data.
6. Diseases such as anemia, pre-eclampsia, polycystic ovary disease (PCOD) and endometriosis need to be documented and digital base created to study these better.
7. The current MDR meetings are not conducted well and in Chennai, for example the private practitioners have instructed not to attend, so also is the issue related to Protection of Children from Sexual Offenses (POCSO) implementation where the police are not well informed and trained. The scope of Mother and Child Tracking System (MCTS) is not clear as in Aurangabad, for example the AA insists on medical termination of pregnancy (MTP) cases to be included in the MCTS.
8. In Patna many times illegitimate mothers are not documented in the records fearing questioning by the authorities and penalties. Also such women are not treated appropriately.
9. Many clinicians do not document for the fear of being judged and lack confidence.
10. West Bengal has a good system of MDR and the best system which is all inclusive is in Kerala and the data is accessible.
11. Telangana has devised a uniform form for documentation of pregnancy.

12. Revised strategies for improvization of maternal health are necessary.
13. DIGITAL FOGSI HEALTH E INDIA APP is thou if all are encouraged to document, then data analysis and registries will all be included.

Registries and Research: Need of the Day	
Moderators	***Panelists***
Dr Girija Wagh Dr Tarini Taneja	Dr Sumita Ghosh Dr Hema Divaker Dr Neerja Bhatla Dr Kuldeep Jain Dr Samita Bhardwaj Dr Neeta Dhabai Dr Neeta Singh Dr Asha Baxi Dr Sheela Mane

Role of Electronic Medical Record (EMR and EHR)

1. In India, most of the healthcare providers in the corporate sector and combined practices have accepted and implemented EHR, but not **interconnected through network**.
2. Most of the healthcare providers in private sectors have not accepted the EHR, which is a **need of time** because of **negative mindset**.
3. EHR is better in standards and beneficial than paper-based documentation as it improve care quality, safety, efficiency, privacy and reduce health disparities.
4. It has added benefits of clinical reminder alerts, clinical decision support (automated decisions) as well as patient registries (e.g. a directory of patients with diabetes) which can improve population and public health in epidemiology and clinical studies.
5. It also helps in electronic laboratory reporting for reportable conditions, immunization reporting to immunization registries, syndromic surveillance (health event awareness).
6. Less time consumption for documentations, fast review of medical data, increased portability and accessibility, working ease for all, less medical errors and comparatively eco friendly than paper work.
7. Storage needs small space and has (endless) maximum durability with easy access for any type of old data.
8. Implement drug-drug interactions and drug allergy checks, generate and transmit permissible prescriptions electronically, warning regarding repetition of same medications, maintain generic as well as active medication list, maintain active medication allergy list and decrease billing processing time and create more accurate billing system.
9. Personal Information Protection and Electronic Documents Act should be applicable.

10. Major threats (**Negative points**) are:
    - Software quality and usability deficiencies.
    - Lack of semantic interoperability.
    - Technical crash or hacking of data.
    - Needs extra training.
    - Initial cost, training cost, upgradation cost can cause negative impression.
    - Difficult to use local language as India is mixture of many languages.
    - Acceptance of digital data in the court of law is a question.
    - Encouraging use of APP and software will be very helpful.

Role of Documentation EMR	
Moderators	***Panelists***
Dr Dayanath Mishra Dr Girish Mane	Dr Bharat Bhushan Dr Prakash Gadgil Dr Rashid Rizvi Dr Dilip Dutta Mr Kishore Rajurkar Dr Priya Bhave Chittawar Mr Parvez Memon

Fetal Origin of Adult Disease

1. There is compelling evidence that many risks leading to chronic adulthood diseases (NCDs) originate in utero (Earliest stages of life).
2. Fetus is programmed early in life for developmental plasticity and developmental programming.
3. All diseases (NCDs) have a definite genetic component.
4. Epigenetics and environment play an important role in upregulating or downregulating the good and bad genes.
5. It is now established that fetal origins of adult noncommunicable diseases (NCDs) can be manipulated by interventions during pregnancy (Nine months window of opportunity).
6. Diet and nutritional interventions in preconception, pregnancy and postpartum play a big role in fetal health and future development of NCDs like diabetes, coronary heart disease (CHD) and hypertension.
7. Overnutrition and undernutrition are both harmful for the fetus (Dual teratogenicity).
8. Good thoughts, meditation, music, spirituality, stories, yoga, all have a beneficial effect on fetus, mother and future generation.
9. All obstetricians need to be aware of simple interventions during prepregnancy, pregnancy and postpartum period.
10. All obstetric units should follow a universal guideline under PMSMA and Adbhut Matrutva to ensure birth of healthy baby to a healthy mother.
11. Delivering safely and reducing MMR and NMR is our primary aim, but by integrating modules of ADBHUT MATRUTVA prevention of NCDs and reducing the burden of deaths due to these through ADBHUT MATRUTVA can be the beginning of another level of care.

Fetal Origins of Adult Disease	
Moderators	***Panelists***
Dr Narendra Malhotra Dr Prakash Trivedi	Mr Amit Bakshi Dr David Adamson Dr Sanjay Das Dr Pragya Mishra Choudhary Dr Nikita Sobti BK Dr Shubhada Neel Dr Rajlaxmi Walvekar Dr Vinita Diwakar

Environmental Health and Nutrition Consensus

Air Quality

Environment Disruptors

Strategies for Change Policy Level

A.

1. Take proactive steps based on air quality index like capping the number of vehicles on road or making public transport free.
2. Focus on renewable energy generation.
3. Public transport electrification.
4. Develop urban forestry (afforestation).
5. Support bag tax or bag ban.
6. Establish PYROLYSIS plants in the country.
7. Build PLASTIC roads from shredded plastic waste litter.
8. Establish plastic recycle plants.
9. Transparent auditing of industrial pollution by the pollution board.
10. Appeal environmental scientists, biologists, endocrinologists to develop life changing innovations.

B.

1. Prevent creation of waste rather than device ways to clean up afterwards.
2. Incorporate as much of the materials used in the process into final product (economise).
3. Design safer chemicals, products and processes.
4. Increase ways of energy efficiency.
5. Encourage use of renewable raw materials.
6. Design products to break down safely at the end of their function.
7. Choose substances that minimize the potential for accidents.

C.

1. Legislate for plain packaging of tobacco and alcohol products.
2. Ban direct and indirect advertising of tobacco and alcohol products.
3. Setting up of support groups for substance de addiction.
4. Develop a multisectoral cessation program.
5. Extend awareness and substance abuse prevention programs to schools and colleges.

Educating about environmental health and hygiene should start in the school itself. Infographics through media will help in educating others and Policies at Government level regarding reduction in use of environmental disruptors should be immediate strategy.

Environmental Health and Nutrition Consensus	
Moderators	***Panelists***
Dr Parikshit Tank Dr Neharika Malhotra Bora	Dr Prerna Keshan Dr Paapa Dasari Dr Bela Mohan Dr Atul Ganatra Dr Sneha Bhuyar Dr Shakunthala Kumar Mr Vinoj Manning Dr Shivani Chaturvedi

Domestic Violence Against Women and Empowering Women

Summary

- "Violence against women" is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, (1) Physical, (2) Sexual, (3) Psychological or (4) Economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in private life or public, domestic violence is part of it. The United Nations Declaration In 1993
- Domestic Violence Act (DVA) (2005)
  Appointment of Protection Officers and NGO's provide assistance to the woman w.r.t
  1. Medical examination
  2. Legal aid
  3. Safe shelter, etc.

  Offence under DVA is a cognizable and nonbailable and punishable.
  Punishment with imprisonment for a term which may extend to one year or with fine which may extend to twenty thousand rupees or with both.

Six "S" for Women Empowerment

Shiksha	=	Education
Swasthya	=	Health
Swavlamban	=	Self Reliance
Samajik Nyay	=	Justice
Samvedan	=	Sensitivity
Samta	=	Equality

Four 'S' for Women Survivors

1. Seeking Medical Aid
2. Seeking Police Protection
3. Seeking Shelter
4. Seeking Legal Advice

One in 3 women experience Domestic Violence, needs needs a change in education change in education and mindset at a very young age. Public Programs with families and religious leaders addressing it should be taken up.

In case of sexual violence against women and children, we need to be aware of the updates in legal provisions after Nirbhaya 2013 and the POCSO Act, 2012 where the definition of rape, aggravated assault, child (up to 18 years in POCSO) and onus of mandatory reporting being broadened to include anyone who comes across such events.

FOGSI through its STAR Program has prepared modules, booklet based on Ministry of Health and Family Welfare (MOHFW) guidelines to sensitize and train healthcare providers.

- As healthcare professionals, we must understand that providing emotional support is as important as taking care of the medicolegal aspects of rape.
- The physical wounds will heal but unless the survivor is given adequate psychosocial support in the right way from the first contact, the emotional trauma can last lifelong.
- If possible a mental health professional like a clinical psychologist and or counselor should form part of the team in the initial stage itself.
- If not possible, they should be at least be involved and referred to, for long-term rehabilitation of the survivor.

  Key to success and over power acts of VAW there is one and only one key and only one solution.

  1. Women empowerment
  2. Women protecting laws
  3. Strict implementation
  4. White paper to change the mindset of patriarchal society.

FOGSI through ADBHUT MATRUTVA initiative is encouraging families to maintain a congenital family atmosphere for facilitating healthy neurocognitive development of the children.

Conclusion

SDG Goal 3 of good health and well-being, and Goal 5 of gender equality will be achieved only if we work towards identifying, managing and hopefully preventing continued violence against women and children. We as healthcare providers need to be aware of the laws, standard protocols and be willing to do what it takes for this.

Domestic Violence Against Women and Empowering Women	
Moderators	*Panelists*
Dr Reena Wani Dr Meera Agnihotri Dr Mandakini Megh	Ms Upasana Arora Dr Sarita Agarwal Dr Roza Olyai Ms Sakshi Vidyarthi Dr Shantha Kumari Advocate Suneeta Krishnan Dr Shehnaz Taing BK Sister Damini Mehta Mrs Simran Bindra Mr Ravi Choudhary Ms Anju Choudhary

High-risk Pregnancy and Genetics 10 Points Recommendations

1. A woman with a high-risk pregnancy will need closer monitoring than the average pregnant woman.
2. Such monitoring may include more frequent visits with the primary caregiver, tests to monitor the medical problem, blood tests to check the levels of medication, serial ultrasound examination, and fetal monitoring, amniocentesis.
3. Testing should follow order of screening, diagnostic and confirmative tests.
4. The tests are designed to track the original condition, survey for complications, verify that the fetus is growing adequately, and make decisions regarding whether labor may need to be induced to allow for early delivery of the fetus.
5. Systematic identification of preconceptional risks through reproductive, family, and medical histories, nutritional status; drug exposures; and social concerns of all fertile women.
6. Provision of education based on risks.
7. Discussion of possible effects of pregnancy on existing medical conditions for both mother and the fetus and introduction of interventions.
8. Discussing of genetic concerns and referral, if appropriate and desired.
9. Determination of risks of infection and if indicated, testing and vaccination.
10. Doctors need to educate parents on new born screening (NBS). NBS can be done only by dried blood spot (DBS)—but NOT before 24 hours of birth. Urine is an unacceptable and incorrect specimen for NBS. There are NO indications NOT to perform NBS.

High-risk Pregnancy and Genetics 10 points Recommendations	
Moderators	***Panelists***
Dr Milind Shah Dr Ashok Khurana	Dr Ratna Puri Dr Edger Mocano Dr Manjeet Mehta Dr Preety Agarwal Dr Chanchal Singh Dr Vivek Kashyap Dr Komal Chavan

Building Healthy Future Generations

Adbhut Matrutva

A FOGSI - Eris Initiative

ADBHUT MATRUTVA

INCREDIBLE MOTHERHOOD

Prof. Dr. Jaideep Malhotra
(MD FICMCH FICOG FICS FMAS FIAJAGO FRCOG FRCPI)
President FOGSI 2018
Director Rainbow IVF

Motherhood is a unique experience which is uncomparable to anything in this world, our mothers are the creators of this world and are precious, so are our babies and both deserve the best of care, compassion so that this journey to motherhood is not only an experience in itself but is carried out in such a way that the journey is enjoyable and future generations are healthy.

It is from the history that we learn children conceived and born during famines especially the Famous Dutch hunger winter had many health issues in later life, many studies were done on this population and it was seen that depending on the time of exposure, suffered from infertility and those in first trimester had obesity and heart disease, and second trimester experienced airway disease and diabetes and in third trimester had insulin resistance and diabetes. In another study from a small village in Gambia showed that children born in the wet hungry season were ten times more likely to die prematurely than those born during the dry harvest season. They also had different levels of activity of a gene particularly regulating immune system. It was also shown that these babies had different weight and head circumference depending on the methylation patterns according to the seasons in which they were born.

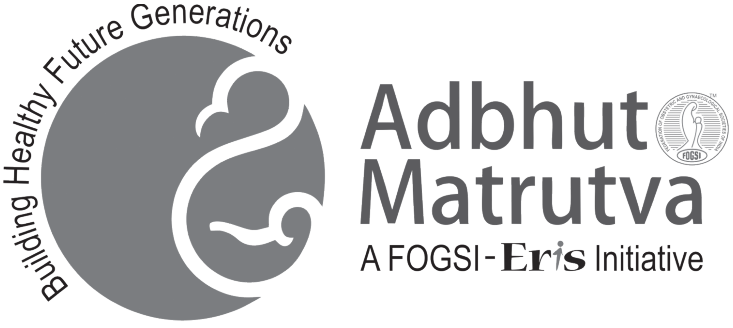
Adbhut Matrutva

A FOGSI - Eris Initiative

In Indian history, the Sanskrit word Garbh means fetus in the womb and Sanskar means educating the mind. So, Garbh sanskar essentially means educating the mind of the fetus. It is traditionally believed that a child's mental and behavioral development starts as soon as he/she is conceived. His/her personality begins to take shape in the womb, and this can be influenced by the mother's state of mind during pregnancy. This knowledge can be traced back to ancient scriptures and is included in the Ayurvedas been followed from time immemorial and a lot of traditional practices are now coming out with concrete scientific evidences, which the world is now researching on and today it is an emerging understanding that the origin of many adult diseases lies in utero and curbing the insults to the pregnant mother nutritionally, emotionally and bodily can have deep impact on the health, neurocognitive and many NCDs developing in later life.

Time has now come, where we as health care providers should not only be looking at provision, but quality and respectful, evidence based healthcare should be emphasized. With NCDs leading cause of death and India being the Diabetic capital of the world, with maximum numbers of preterm babies being born in our country, and Obesity on the rise definitely there are many things which we are not doing right.

As healthcare providers our major aim in the past few decades has been providing care and concentrating on institutional deliveries, but with 82% institutional deliveries our maternal and neonatal mortality rates have not come down as they were expected and our infant mortality rates have also not done any better. When you think of theories of fetal origin of adult diseases and Garbh sanskar and along with all the initiatives from preconception counselling, with directed good antenatal care, from first trimester to post partum period in a holistic combination, the outcomes will be far reaching on not only the mothers and the children, but the whole future generations. This is the concept of "ADBHUT MATRUTVA".



Aims and Objectives:

Future healthy generations

Components:

1. *Preconception counseling*
2. *Trimester wise focused antenatal care including:*
   - *Knowledge about growth and in utero events*
   - *Directed Investigations blood and Ultrasound scan with future impact*
   - *Preventive immunization*
   - *Directed diet with future impact*
   - *Lifestyle and meditation*
3. *Birth preparedness and delivery*
4. *Postpartum care including breastfeeding and contraception*
5. *Holistic approach in educating the whole family about pregnancy, health, preventive care, immunization, gender discrimination, domestic violence, lifestyle management and disease prevention.*

It will include Modules starting from:

Pregnancy and the changes in the mother and child during this period

When to start preparing for pregnancy and how

What is good directed antenatal care

What investigations to do and when to do

Nutrition and exercise play an important role in pregnancy outcomes

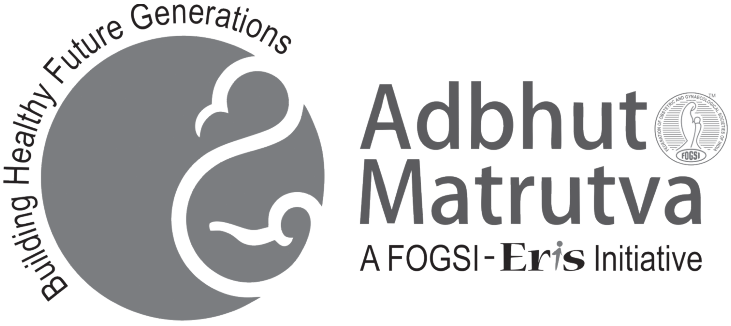
Mediation, Yoga and communicating with your child in utero important for neuro cognitive development

Immunization from womb to tomb

Preparing to deliver and allaying the fear of normal vaginal delivery

Breast fed is best fed

Spacing between children and counselling for various methods of spacing



Outcomes

Long-term studies can be started on outcomes of this on
NCDs
Impact on development of children
Increasing institutional deliveries
Reduction in preterm births and IUGR
Further reduction in maternal and neonatal mortality
Increasing faith in vaginal deliveries
Encouraging immunization acceptance
Decrease in domestic violence
Decreasing in gender discrimination
Preventing and reducing communicable diseases
Physical, mental, emotional and psychologically healthy future generations
Building doctor patient relationship

Need help from the Government to draw defined
Provision of antenatal and intranatal and postnatal care guidelines
Immunization recommendations for all age groups
Nutritional status and helping nutrition supplements
Videos on yoga and exercise recommendations for pregnant women
Music for meditation
Short documentaries on
Antenatal care and impact on future health
How to deliver normally
Post natal care is equally important
Breast feeding and benefits
Spacing and benefits
Congenial Home atmosphere is very important for good pregnancy outcomes
Husband and wife both are important for building up of future healthy families
Faith and trust in your doctor and healthcare provider is crucial.

A separate Document on Protocols of ADBHUT MATRUTVA is being prepared.