Commentary

Presidential address – 2011

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Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for some women it is associated with suffering, ill-health and even death. Figure 1 shows the contributions made by the Sri Lanka College of Obstetricians and Gynaecologists towards improving maternal health in Sri Lanka.

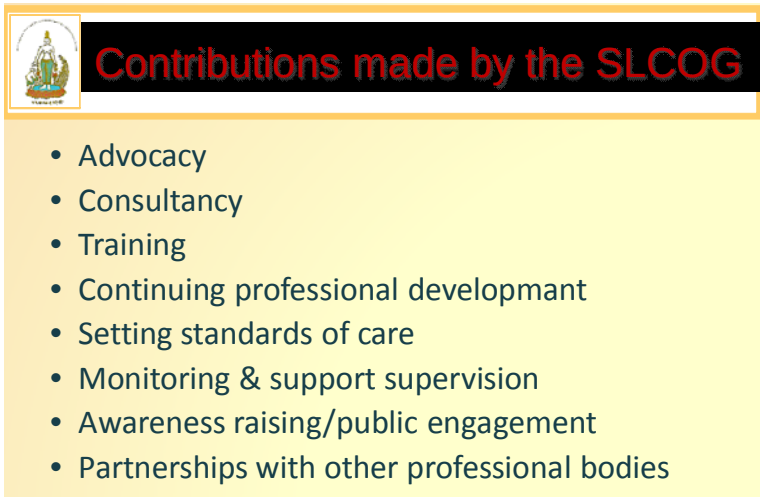

Figure 1

Figure 2 shows how the maternal mortality has decreased over the years in Sri Lanka.

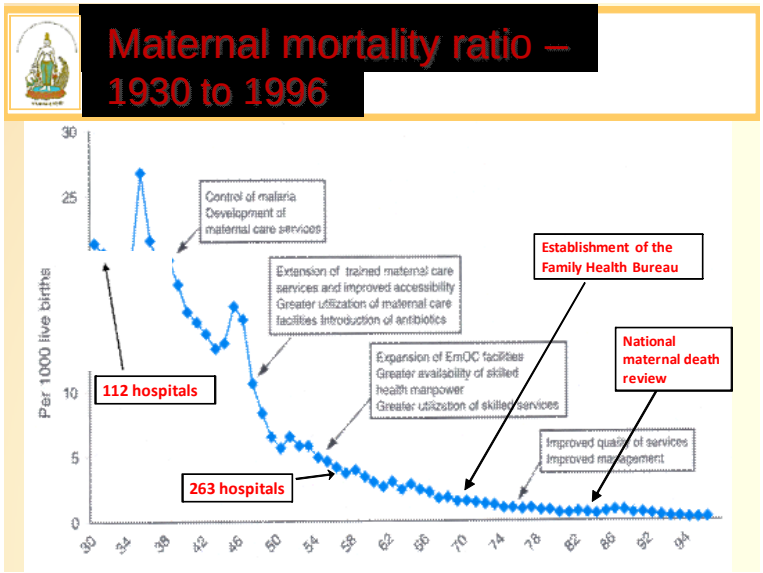

Figure 2

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[1] *President, Sri Lanka College of Obstetricians and Gynaecologists.*

Sri Lanka enjoys a reasonable position in the world map in relation to maternal mortality. Figure 3 shows maternal mortality ratio by country and here Sri Lanka is among the second best group.

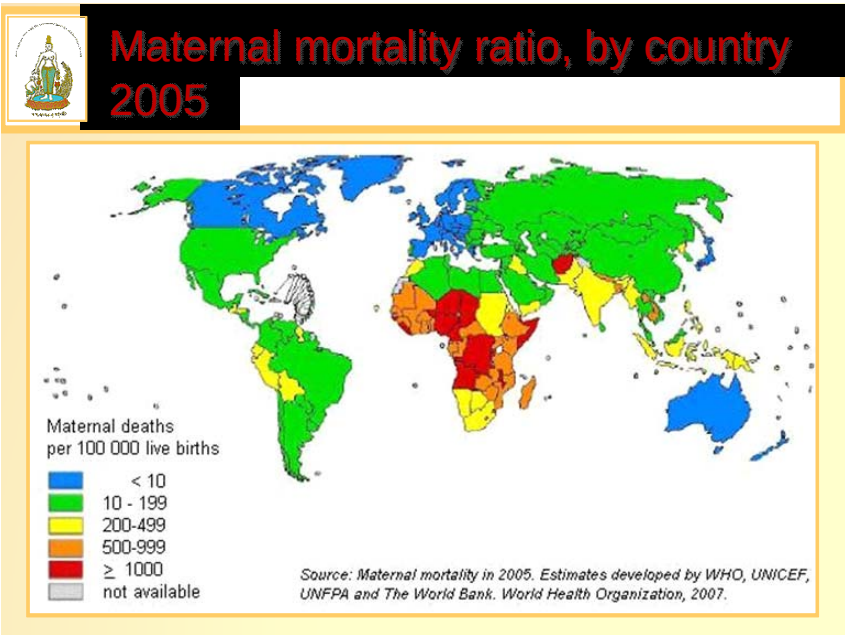


Figure 3

Sri Lanka has achieved this low maternal morbidity and mortality due to sheer commitment and dedication of care givers. High antenatal clinic attendance and high institutional deliveries contributed to the lowering of the maternal morbidity and mortality. The credit should go to the field staff in the community and the Family Health Bureau who supervises and guide them. Most of these deliveries take place in the consultant based units where college members serve. The services provided with limited facilities by them should be greatly appreciated. Figure 4 shows how base, provincial and teaching hospitals are scattered in Sri Lanka.

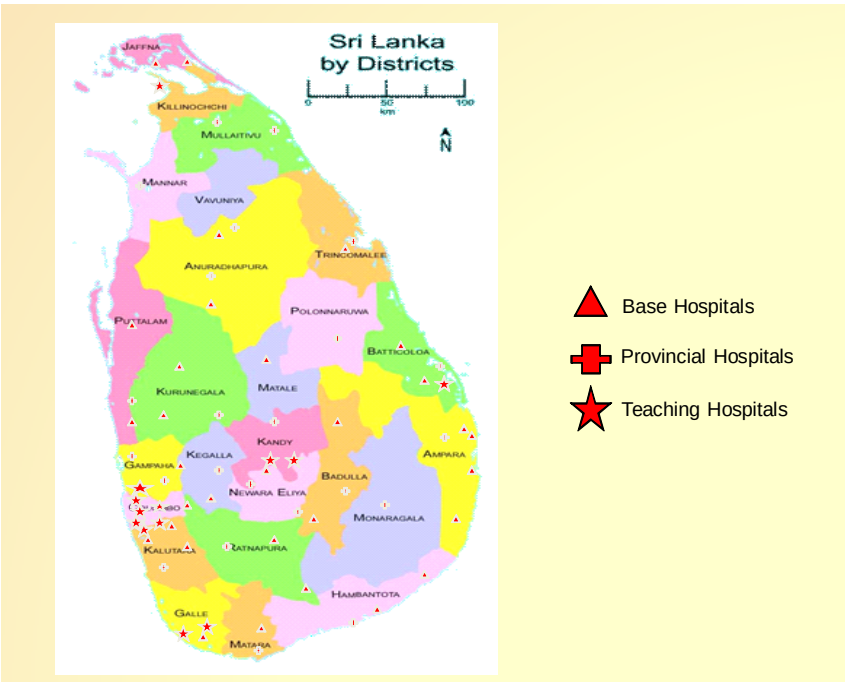


Figure 4

However, the maternal mortality rate (MMR) has remained somewhat static over the past couple of years as shown in Figure 5.

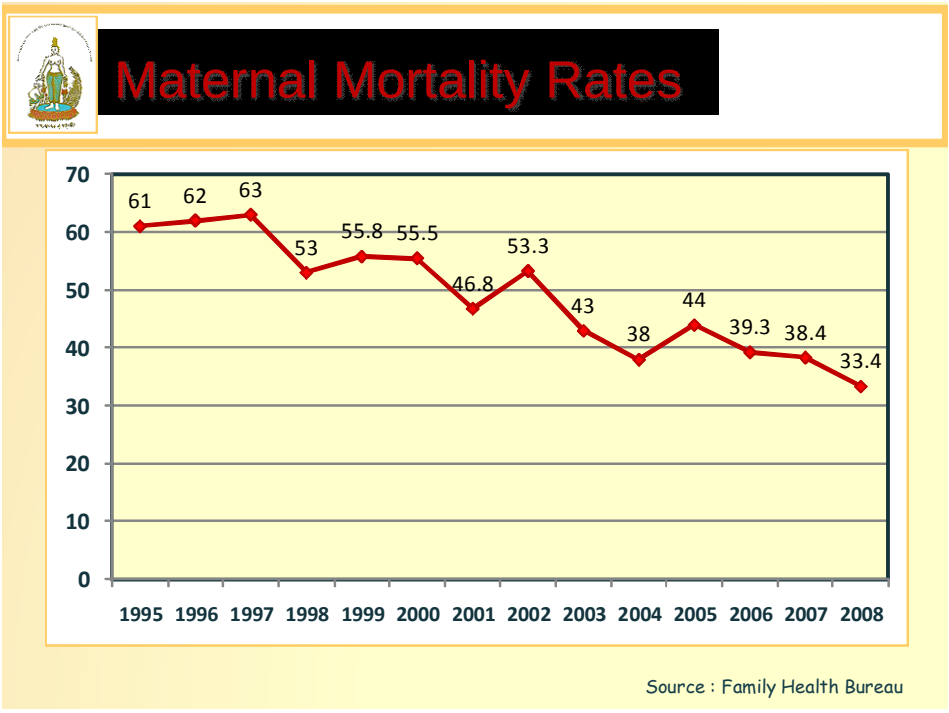


Figure 5

Main causes of maternal deaths remain more or less the same in the recent past. Figures 6 and 7 shows how the major causes of maternal deaths have contributed to the MMR over the past two decades.

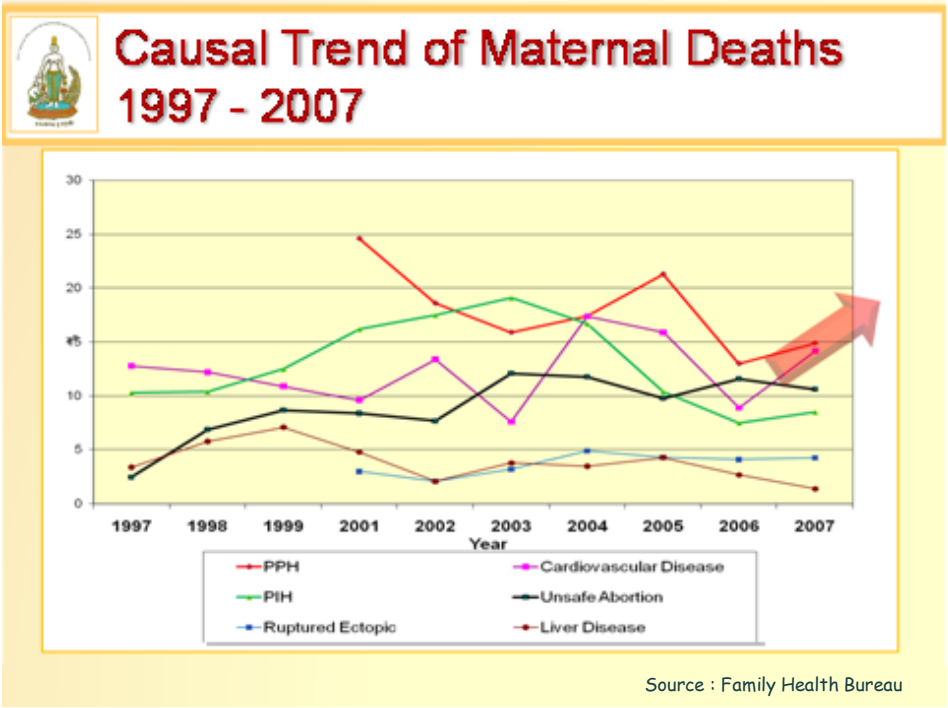
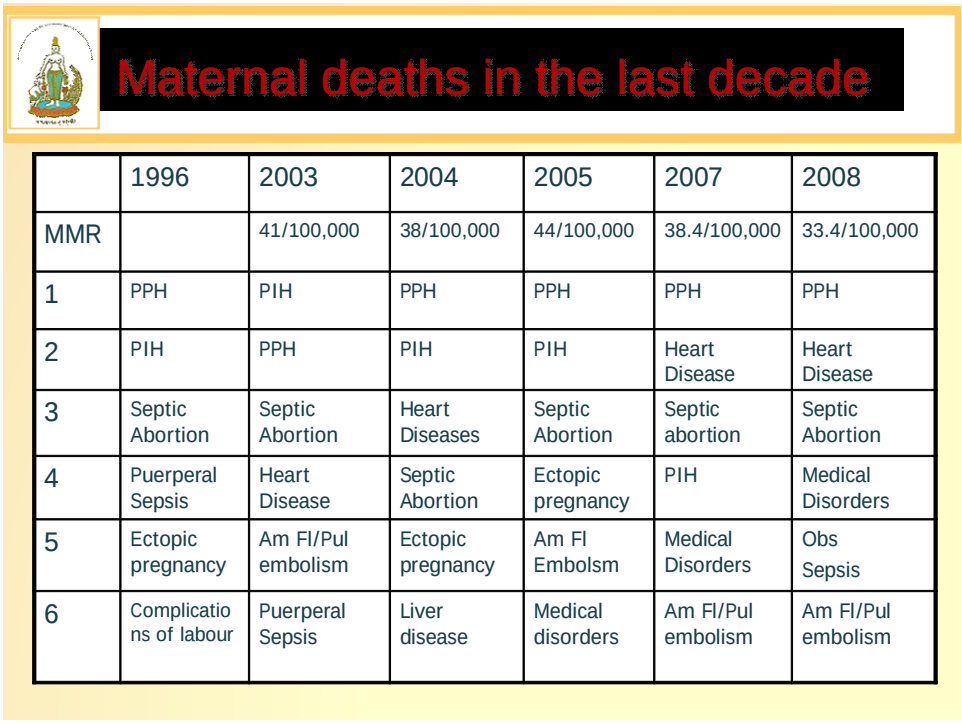


Figure 6



	1996	2003	2004	2005	2007	2008
MMR		41/100,000	38/100,000	44/100,000	38.4/100,000	33.4/100,000
1	PPH	PIH	PPH	PPH	PPH	PPH
2	PIH	PPH	PIH	PIH	Heart Disease	Heart Disease
3	Septic Abortion	Septic Abortion	Heart Diseases	Septic Abortion	Septic abortion	Septic Abortion
4	Puerperal Sepsis	Heart Disease	Septic Abortion	Ectopic pregnancy	PIH	Medical Disorders
5	Ectopic pregnancy	Am FI/Pul embolism	Ectopic pregnancy	Am FI Embolsm	Medical Disorders	Obs Sepsis
6	Complications of labour	Puerperal Sepsis	Liver disease	Medical disorders	Am FI/Pul embolism	Am FI/Pul embolism

Figure 7

It is important to look into the ways to bring down the maternal morbidity and mortality rate further. New strategies need to be developed to improve further. Analysis of maternal deaths according to the three delays model shows that the care given in the institution and in labour could be further improved. This is to minimize the maternal deaths related to the 3rd delay. Figure 8 shows the percentages of delay in each category.

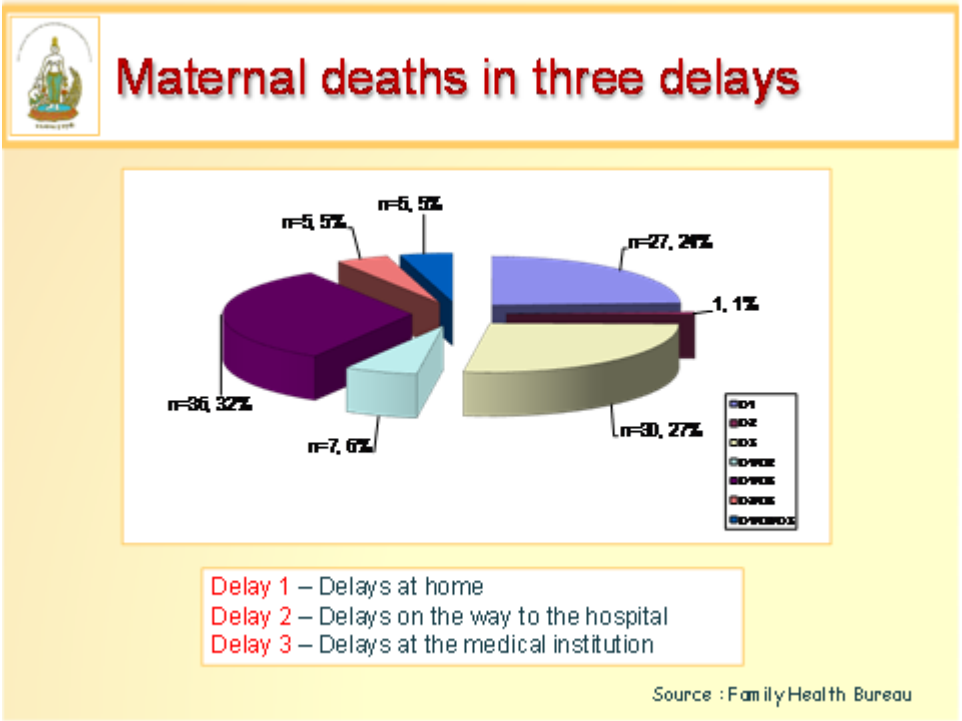


Figure 8

The increasing rates of caesarean sections (CS) and the related long term complications over the past two decades are of some concern. Figure 9 shows how the caesarean section rates have been increasing over the past years.

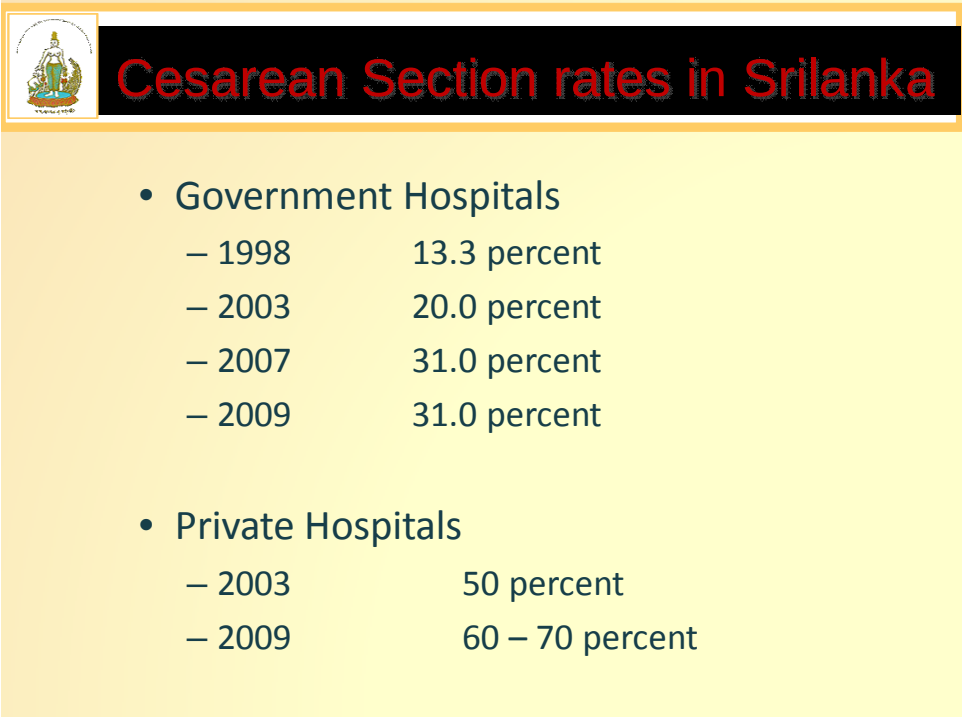


Figure 9

Another area which needs focusing is gynaecological cancer and related morbidity and mortality.

Keeping the above facts in mind it is important to strengthen the CPD activities to address these main issues during the coming year.

1. Reduce maternal morbidity and mortality related to antepartum and intrapartum management.
2. Adopt strategies to reduce CS rates.
3. Address the unmet need for contraception, unwanted pregnancy leading to an unsafe abortion and its complications.
4. Reduce deaths related to gynaecological cancer. Special emphasis on cervical cancer – where we can take action to prevent and control disease and complications.

Most maternal deaths are avoidable, as the health care solutions to prevent or manage the complications are well known. Since complications are not predictable, all women need care from skilled health professionals, especially at birth, when prompt decision making and rapid treatment can make the difference between life and death.

These women are seen and assessed by the intern medical officers and the middle grade officers (Registrar or the SHO's). Registrar is a postgraduate trainee and going through a structured training programme working with a carreer goal. Majority of them have good theoretical knowledge as well as surgical experience. However, some of the SHOs may not have sound theoretical knowledge. Their surgical experience also may be inadequate. Global Survey Asia 2007 showed that SHOs perform 72.7% of the caesarean operations. Figure 10 shows the analysis of the skill level of the operator in CSs.

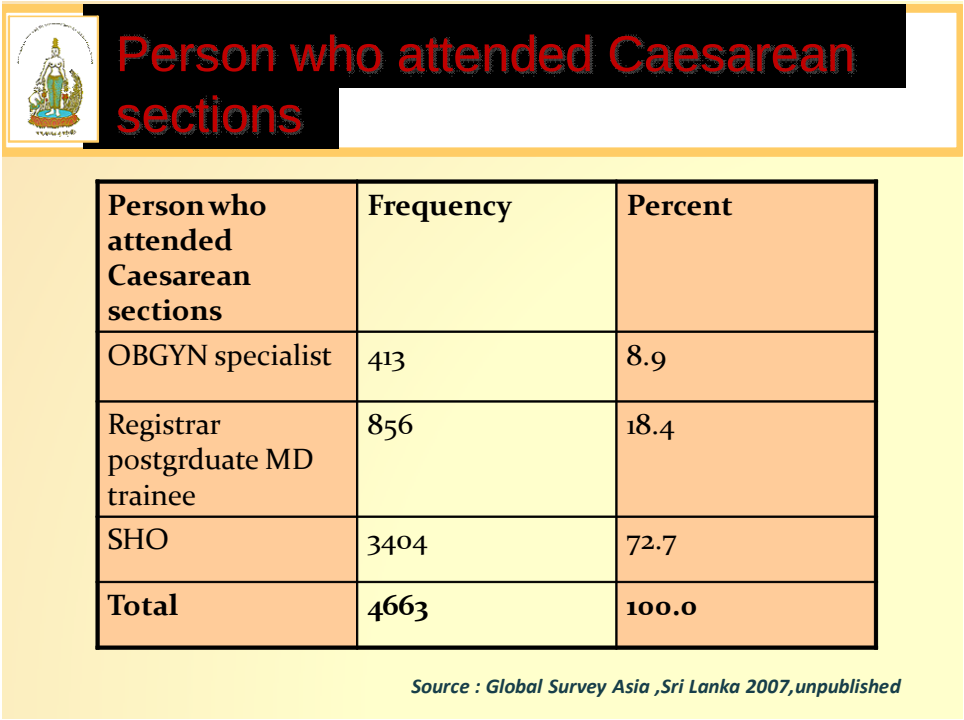


Figure 10

Improving the skill level of the least trained category may help to further improve the maternal mortality rate. Therefore we propose to have training modules mainly for SHOs in:

Intrapartum management, with special emphasis on maintaining partogram

Emergency obstetric care

Correct Interpretation of CTG

Hands on training to improve surgical skills

WHO recognizes the quality improvement among the middle grade health professionals in view of

Infection control

Surgical safety

Blood transfusion safety

Importance of risk management in a more organized manner should be recognized. We have to develop a safety culture including recognizing, reporting, learning and evaluating.

"Quality is never an accident. It is always the result of high intention, sincere effort and intelligent direction"

Training in management of labour and correct interpretation of CTGs will reduce the prolong labour, obstetric sepsis and associated complications. It will also reduce unnecessary caesarean sections.

Training in surgical skills will improve the quality of surgery done as well as reduce the complications.

PPH management using condom tamponade will be life saving. It saves a lot of money too by utilizing low cost methods and avoiding major surgery. As shown in picture 1 articulating a condom catheter is a simple procedure.

Picture 1

"I believe through learning and application of what you learn, you can solve any problem, overcome any obstacle and achieve any goal that you can set for yourself." – Brian Thomas

Safe Motherhood Programmes

Training sessions for peripheral staff as safe motherhood programmes are important. Identified areas with high maternal mortality should be selected to conduct these workshops.

Sepsis following unsafe abortions has remained a leading cause of maternal deaths. Figure 11 shows a detailed analysis of causes of death in year 2008.

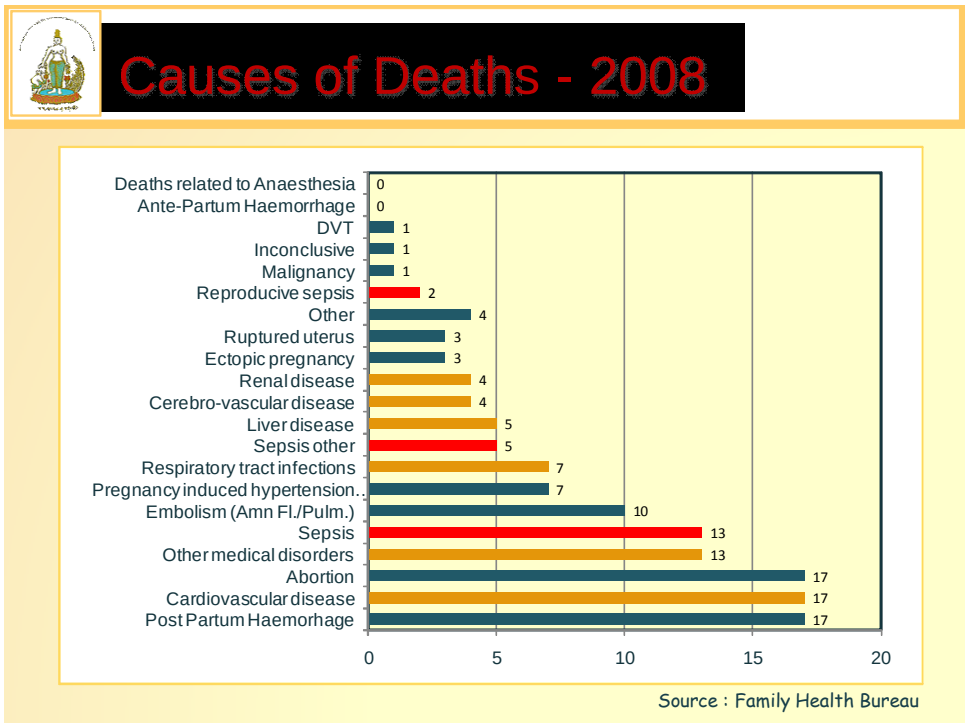


Figure 11

"The first step for avoiding maternal deaths is to ensure that women have access to family planning and safe abortion. This will reduce unwanted pregnancies and unsafe abortions."

As abortions are not legalized in Sri Lanka we cannot do much in terms of providing safe abortions. Family planning services should be freely accessible to all.

Present family planning clinics in hospitals are held once weekly or fortnightly for one session from 8 am to 12 noon. Few from 8 am to 4 pm.

Most of the field family planning clinics are held for half a day weekly, fortnightly or monthly which is highly unsatisfactory.

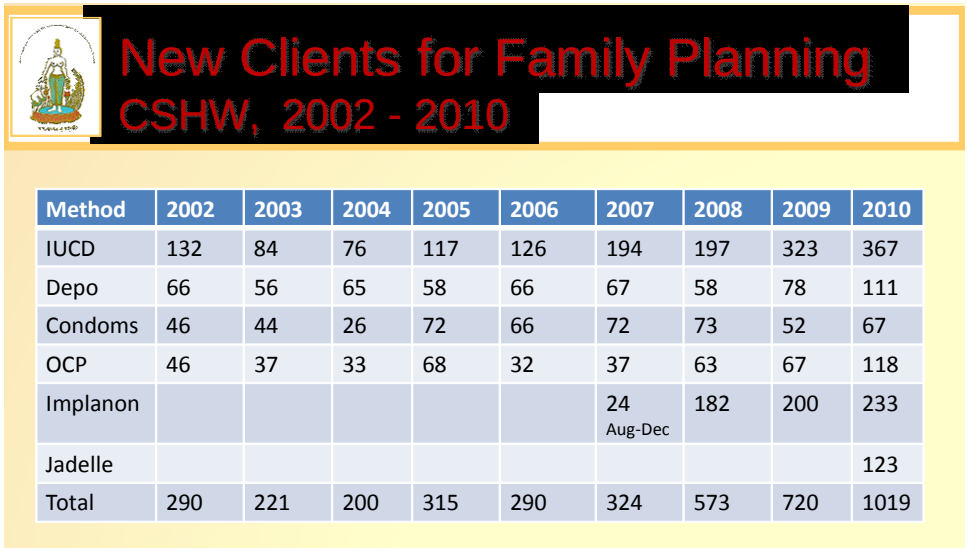
As most of the mothers deliver in hospitals they prefer to come to hospital for family planning advise, insertion of IUCD, insertion of implants etc. These clinics sould function from 8 am to 4 pm including the lunch hour. That means even during hospital visiting hours this clinic can offer services. It is important to have dedicated staff and a dedicated place in the hospital to conduct the clinic.

Family Planning Clinic at the Castle Street Hospital for Women

Figure 12 shows how the Family Planning Clinic at the Castle Street Hospital for Women has become popular over the past decade.

Figure 12

Figure 13 shows how the different procedures have become popular in this Clinic over the past years. This clinic also functions as a subfertility clinic (performing IUI and counselling) and as a well woman clinic offering cancer screening, pap smear, transvaginal and abdominal scanning services. It provides emergency contraceptive advice. All teaching hospitals, general hospitals and district general hospitals could establish family planning clinics of this nature with dedicated staff to offer these facilities.



Method	2002	2003	2004	2005	2006	2007	2008	2009	2010
IUCD	132	84	76	117	126	194	197	323	367
Depo	66	56	65	58	66	67	58	78	111
Condoms	46	44	26	72	66	72	73	52	67
OCP	46	37	33	68	32	37	63	67	118
Implanon						24 Aug-Dec	182	200	233
Jadelle									123
Total	290	221	200	315	290	324	573	720	1019

Figure 13

Severe acute maternal mobidity study

Maternal deaths in teaching hospitals are few in number.

But we see a lot of mothers who are critically ill and recover. Earlier we called them as near miss but now we identify them as cases of severe maternal morbidity. If we can study them on an institutional basis this will provide enormous data to improve our patient management.

CS audit - standardized according to Robson's criteria. This will help to identify the ways and means to reduce the CS rates. Figures 14 and 15 show Robson's classification into groups.

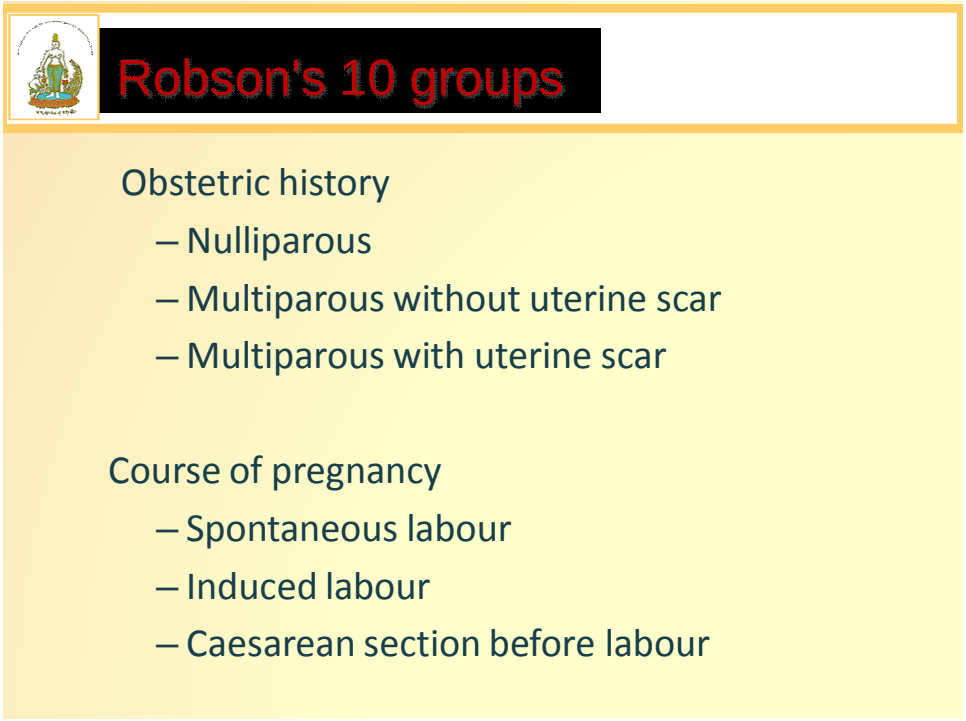


Figure 14

Robson's 10 groups

group	Women Included
1	Nulliparous with single cephalic pregnancy, ≥37 wks gestation in spontaneous labour
2	Nulliparous with single cephalic pregnancy, ≥37 wks gestation who either had labour induced or were delivered by CS before labour
3	Multiparous without a previous uterine scar, with single cephalic pregnancy, ≥37 wks gestation in spontaneous labour
4	Multiparous without a previous uterine scar, with single cephalic pregnancy, ≥37 wks gestation who either had labour induced or delivered by CS before labour
5	All multiparous with at least one previous uterine scar, with single cephalic pregnancy, ≥37 wks gestation
6	All nulliparous women with a single breech pregnancy
7	All multiparous women with a single breech pregnancy including women with previous uterine scars
8	All women with multiple pregnancies including women with previous uterine scars
9	All women with a single pregnancy with a transverse or oblique lie, including women with previous uterine scars
10	All women with a single cephalic pregnancy ≤36 wks gestation, including women with previous scars

Figure 15

Gynaecological cancer screening - deaths due to gynaecological cancers can be reduced by improving the existing programme to enlarge the coverage of pap smear screening while incorporating new ideas like HPV testing. Taking measures to make the vaccines available, establish colposcopy clinics and organize training.

It is important to maintain a gynaecological cancer registry.

Safety and welfare of obstetricians

Litigation against medical profession is gradually increasing. Quality care ensuring patient safety and adherence to ethical practices are the main deterrent.

In USA out of 33.6 million admissions to hospitals in 1997, 44000 died as a result of medical misadventures.

62% of claims for obstetric cases while 38% on gynaecology care.

They have changed their obstetric and gynaecological practice based on litigation and claims.

Further interviewing of specific changes made showed the seriousness of the impact on O&G practice.

8.3% stopped obstetric practice altogether

2.1% stopped surgery

32.7% stopped practicing vaginal birth after CS

33.1% stopped accepting high risk obstetric patients

37% increase in caesarean deliveries

In this respect the WHO Jakartha Declaration on patients for patient safety is a way forward.

It is important to work towards achieving the following goals:

1. Functioning quality and patient safety systems in every health care facility.
2. Adherence to guidelines that are evidence-based and ethical.
3. Avoidance of irrational treatments such as unnecessary medicines, investigations and surgical procedures.
4. CME for health care professionals.
5. Patients safety concepts integrated into pre- and in-service training.
6. Rational load of patients in each health care facility.
7. This will help to minimize legal actions against doctors.

CME activities

An effective CME programme should be established. However, there should be incentives for the members to participate such as promotions, considering CME points for scholarships and selecting members to attend international or local congresses to improve their professional competency.

Some people want it to happen, some wish it would happen, others make it happen.

Hopefully we will be in the last category.