"Towards excellence in maternal and reproductive health care"

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(This article is based on the presidential address delivered at the induction of the 33rd President of the Sri Lanka College of Obstetricians and Gynaecologists on 06th January 2019)

Looking back to the history of the Association and the College, it is with respect and gratitude that I observe the contributions made by many great personalities who sacrificed their time and energy to bring the College to its present status. I take this opportunity to remember and thank them all. At this moment it may be appropriate to revisit the editorial of the first journal of the Association published in 1954.

I quote "The Association of Obstetrics and Gynaecology is not a trade union nor does it exist for the main purpose of fighting for the rights and privileges of its members. The only fight is that against maternal and infant mortality"[1].

We as the Obstetrics and Gynaecology fraternity, are continually challenged to provide the best evidence-based, safe and quality healthcare to the diverse Sri Lankan female population while setting an example for maternal and reproductive health care delivery.

It has been the tradition of the College to orient its activities each year conforming to a meaningful and practically implementable theme formulated by the newly elected President. After carefully considering the multitude of challenges our profession is encountering today, my choice of the theme for the coming year is "Towards excellence in maternal and reproductive health care"

If I may briefly elaborate on the technical meaning of the two most important clauses of the theme;

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period while reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of reproductive disease or infirmity.

Reproductive health deals with the reproductive processes, functions and system at all stages of life.

Having introduced the terms maternal and reproductive health let me move on to the quality of care. According to the WHO definition, quality of care is "the extent to which health care services provided to individual patients and populations improve desired health outcomes"[2].

In order to raise the quality of care to a higher level it must be

- ***Safe*** – delivering health care that minimizes risks and harm to service users, including avoiding preventible injuries and reducing medical errors

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• ***Effective*** – providing services based on scientific knowledge and evidence-based guidelines

• ***Timely*** – reducing delays in providing and receiving health care

• ***Efficient*** – delivering health care in a manner that maximizes resource use and avoid waste

• ***Equitable*** – delivering health care that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status

• ***People-centered*** – providing care that takes into account the preferences and aspirations of individual service users and the culture of their community[2].

Our journey towards excellence in care obviously begins with the individual obstetrician and gynaecologist. In this endeavor, skills that one requires go well beyond traditional technical skills. They should be armed with a multitude of leadership qualities of which soft skills play a major role. Undoubtedly these skills will be necessary to effectively work as a team with all our stake holders including the Ministry of Health and the Family Health Bureau.

There are many unresolved and unattended issues in the area of Maternal and Reproductive Health care in our country today. Although the time constraints will not permit me to address all of these, I take this opportunity to draw your attention to a few important areas.

Therefore, I will focus on those issues which will form the foundation of my work plan for the next year: especially in relation to:

1. Providing better fertility care in state hospitals and introducing the relevant regulations
2. Reducing maternal deaths due to heart disease
3. Providing better care during labour and reducing deaths due to haemorrhage
4. Confidential inquiries in to maternal deaths
5. Clinical governance and
6. Providing more opportunities for post graduate education and continuous professional development

Provideing better fertility care in state hospitals and introducing the relevant regulations

Motherhood happens to be the most cherished dream of every woman. This dream sometimes get shattered due to infertility leading to psychological, social, financial, marital and many other problems. All these will eventually affect the performance at work, confronting her with another set of issues and problems and the cycle continues.

Very often ill effects of these will manifest as depression. If I may throw some light on to this with the latest statistics, researches carried out all over the world have shown that 25-65% females who are subfertile suffer from depression[3]. The research studies carried out in Sri Lanka show a similar trend[4].

Infertility has been identified as a significant disability in the report on disability by the World Health Organization (WHO) and the World Bank. It is stated in the report that infertility generates disability, and thus access to health care falls under the convention on the Rights of Persons with Disability. An estimated 34 million women, predominantly from developing countries are infertile due to different causes[5]. Further, Infertility in women has been ranked as the 8th highest serious global disability among populations under the age of 60 (WHO)[5].

Many countries in the world have taken meaningful steps to address the issue of infertility with modern scientific knowledge[6]. Unfortunately, in Sri Lanka infertility prevention and care is yet to receive its rightful place. Currently the government health sector is able to provide only basic level subfertility care. Only a handful of them provide secondary level treatment such as intrauterine insemination. At present none of the government hospitals provide tertiary level treatment such as In-vitro Fertilization and embryo transfer. Because of non-availability of such services many women with average financial resources are denied the opportunity of realizing their cherished dream of motherhood. However the situation in the private sector is somewhat different. When receiving treatment in the private sector a couple may have to spend Rupees 10000 - 25000 for one intrauterine insemination cycle. Tertiary level fertility treatment such as In-vitro Fertilization and embryo transfer is available at an exorbitant cost of around Rupees 800,000 for each cycle. But, how many patients can afford this prohibitive cost? It is heartening to note that some countries provide complete or partial state funding for Assisted Reproduction Treatment (ART)[6].

ART was introduced to Sri Lanka in 1998 with the assistance of foreign experts in the field. In 2001 a Sri Lankan team of doctors and scientists was able to provide this treatment on their own[7]. However this was limited to the private health sector and the attempts to commence this treatment in the state health sector was a failure. Numerous efforts to establish an ART unit in the government health sector during the past 15 years did not succeed[8]. Currently there is an initiative to establish an Assisted Reproduction Treatment (ART) unit at Castle Street Hospital for Women. My sincere wish is that this initiative will become a reality soon. Our college will extend its fullest support to the Ministry of Health in this endeavor and I hope the country would be able to see its first ever state ART unit soon.

I wish to draw your attention now to a related but an alarming trend on provision of fertility care prevailing in the country. While appreciating the work of many private sector health organizations for the responsible manner of providing the services, I should also point out that extreme commercialization with unacceptable and unethical practices have started to occur.

Instances of misguiding the patients giving unrealistic expectations of 100% success in the treatment for quick financial gains are emerging. This is when even countries like the United Kingdom report much lower success rates[9]. Some of the methods advertised and used in such instances are not supported by proper scientific studies though the treatment cost is exorbitant. Nevertheless, this is a worldwide phenomenon observed even in the United Kingdom, as highlighted in some studies carried out at the University of Oxford and published in the *British Medical Journal*[10,11]. As a responsible organization the Sri Lanka College of Obstetricians and Gynaecologists (SLCOG) should not ignore such negative and unethical developments.

Efforts to introduce a regulatory body related to infertility treatment were initiated in 2003. A detailed document was prepared by an eminent panel of specialists with the intention of presenting it to the parliament in 2005. It is sad to note that even after 15 years it has not been possible to introduce these regulations. The need and importance of a regulatory body has also been highlighted in international publications such as in the article by a senior academic from the University of Durham, UK[12].

The lack of appropriate guidelines and regulations in Sri Lanka is a serious drawback in efforts to improve the quality of the fertility services provided. In the absence of national legislation, health professionals are faced with the challenge of implementing some form of self-regulation. However relying on self-regulation only is not sufficient. There is a long overdue need to introduce guidelines and regulations for management of subfertility. These will safeguard not only the patients but also the respected qualified practitioners. During the coming year the council will work with the Ministry of Health, Family Health Bureau and other stakeholders towards introduction of relevant regulations.

Reducing maternal deaths due to heart disease

Over the years Sri Lanka has been proud of being a country with a low maternal mortality[13]. While being content of the reported low maternal mortality figures we have to be concerned about the almost static nature of the figures over the years[13].

In fact, we should analyse whether the interventions introduced recently are effective or they should be revisited. I believe that we should address this issue in a constructive manner.

Heart disease complicating pregnancy has been the leading indirect cause of maternal death for the last 15 years in Sri Lanka[13]. Heart disease has also contributed to severe maternal morbidity. The number of pregnancy terminations in situations where the continuation of the pregnancy poses a serious threat to the mother's life is also on the rise.

Further prevention of maternal deaths and other ill effects due to heart diseases could only be improved by providing better quality care. One important aspect of better quality care is provision of access to vital information prior to pregnancy. Every attempt should be made to avoid the pregnancies that are of high risk through appropriate counselling and also by provision of appropriate contraception. However preventing such pregnancies in a mother with heart disease in a way is a challenge. This problem can be effectively addressed by two different approaches. The first is by educating the general public about heart disease complicating pregnancies and associated risks. The second is the establishment of a network through which Obstetricians, Cardiologists and other relevant persons exchange information and provide care benefiting the women with heart disease.

Further, it is essential to implement appropriate guidelines in screening and management of heart disease complicating pregnancy. Establishment of clinics with a multidisciplinary team approach and establishment

of highly specialized centers are positive approaches towards this goal. We are yet to see the results of these activities.

As I indicated earlier a focused approach is required by a group consisting of Cardiologists, Physicians, Anaesthetists and Obstetricians. I suggest that the SLCOG establish a task force to address this issue. Participation of the Ministry of Health and the Family Health Bureau is vital in formulating the strategies and I welcome their contribution.

Providing better care during labour and reducing deaths due to haemorrhage

A significant number of maternal deaths and a substantial proportion of pregnancy related life threatening conditions are attributed to complications that arise during labour and the immediate postpartum period. Quite often this situation arises as a result of haemorrhage, or sepsis[13].

An emerging challenge is the increasing number of patients with morbidly adherent placenta. Early recognition of the high risk patients and managing at centers with facilities and skill is important to save maternal life and prevent serious complications.

The maternal death review carried out most recently classified that 69% of the maternal deaths as preventable[13]. Deaths due to haemorrhage had contributed to the above percentage. In present day maternal care, mothers should not die of haemorrhage. It is mandatory that adequate 24 hour blood bank facilities and 24 hour anaesthetic services are available in every hospital with an obstetrician. Regional centers should be established with rapid blood transfusion facilities to support the management of morbidly adherent placenta.

In Sri Lanka 99.9% deliveries occur in hospitals with skilled birth attendants[14]. Intervention through updating the knowledge and improving the skills of all categories of staff will certainly have a positive impact on care during labour. As the President of the Perinatal Society in 2015, I initiated a successful training programme in labour management for all levels of labour room staff.

This year I propose to commence a well-structured training programme in management of labour to further update the knowledge and skills of the labour room staff.

Access to labour and childbirth care facilities only, may not guarantee good quality healthcare. It is also necessary to recognize and abide by what is mentioned in the publication titled, WHO recommendations Intrapartum care for a positive childbirth experience[15]. It specifies the factors for women to have a right to a positive childbirth experience. These factors include,

- Respect and dignity
- Choice of a labour companion
- Clear communication by labour room staff
- Pain relief
- Mobility in labour

Fellows and members of the college are the best professionals who are capable of taking the leadership in providing the best experience for women during labour. In the coming year the SLCOG will take the leadership to promote this.

Confidential inquiries in to maternal deaths

One of the drawbacks of the present system of maternal death inquiries is the lack of confidentiality which promotes a defensive attitude from the health care workers. This has led to an inability to get adequate information regarding the root causes of deaths and thus appropriate preventive measures cannot be put in place. Since 2012, the College had several discussions with the Ministry of Health to initiate a process to introduce confidential inquiries. In response to a proposal made by the SLCOG the Family Health Bureau and the Ministry of Health agreed in principle to initiate confidential enquiries with legal indemnity based on the practice followed in developed countries. We are very much hopeful that this task will be accomplished within the next 2 years.

Clinical governance

No system will be successful unless it is properly managed, accountable to the clients and work towards continuous improvement. In order to design and implement such a system successfully, all fragments related to quality improvement have to be taken into account. This is very much applicable to the health sector too.

Clinical governance is defined as "A framework through which organizations are accountable for continuously improving the quality of their services and safe-guarding high standards of care by creating an environment in which excellence in clinical care will flourish"[16].

Some important aspects related to clinical governance include,

(1) An adequate and accredited work place that has required equipment and facilities;

(2) Optimal and well trained staff based on the recommendations

(3) The availability and use of evidence based guidelines

(4) Multi professional training to unify practice and enhance team work

(5) Clinical audit to make sure that the guidelines are followed and the clinical outcome for women and newborn babies are the best;

(6) Incident reporting and risk management to identify risk incidents based on frequency and severity and to institute steps to minimize such incidents

(7) Monitoring of complaints to distinguish those due to clinical deficiency from those due to system error or those due to behaviour or communication issues[16].

From what I have mentioned it is clear that work culture aligned to a system plays an important role in reaching excellence in patient care. Thus all of us as individuals have a responsibility in making clinical governance work and through that improve the health system in our country.

Post graduate education and continuous professional development

Professional Development and lifelong learning is growing importance in all sectors of education. Having got involved in post graduate education as a teacher and as an examiner over the last two decades I have witnessed how young doctors are transformed from being novices to knowledgeable and skilled professionals.

Good postgraduate education is the key to reach excellence in clinical care. A comprehensive education and training programme have already being finalized by the College. The SLCOG will work with the Postgraduate Institute of Medicine and the Ministry of Health to make this a success in the coming year.

Dear Colleagues,

Our college is rich in human resources with growing numbers with clinical skills and up to date knowledge. Quite often we deliver the best possible health care under the most difficult circumstances with minimum resources. However, health care providers are criticized often when things go wrong but only rarely the hard work is appreciated.

We have to recognize and appreciate that a diverse female population throughout our country is expecting the best possible services in the field of maternal and reproductive healthcare. Such a service can only be achieved by continuous improvement of our systems and by dedicated team work.

As the newly elected President of the College I hope that the membership will rally around the College and work towards achieving “Excellence in maternal and reproductive health care”.

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