

Presidential Address - 2017

Weerasekera D

INTRODUCTION

I would like to start this address by telling a story of two salesmen who went down to Africa in early 1900's from Manchester to find out whether there were any opportunities to sell shoes in Africa. They were asked to send telegrams to Manchester reporting the situation. First one wrote "Situation hopeless. They don't wear shoes." Other one wrote "Glorious opportunity. They don't wear shoes yet." I would be thinking as the same way as the 2nd one and consider I have got this opportunity to work towards achieving my goal of "SINGLE DIGIT MATERNAL MORTALITY" for Sri Lanka. There is a famous saying by Albert Pine "What we do for ourselves dies with us but what we do for others and the world remains and is immortal".

HISTORY OF SRI LANKA COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS.

The first association of "Obstetricians & Gynaecologist" was founded in 1953. This was called "Ceylon Obstetrics & Gynaecological Association" (COGA). Inaugural meeting of this association was held at the residence of Dr. May Ratnayake in Ward Place, Colombo. Dr. May Ratnayake was elected as the first president. The first journal of this association was published in 1954. It's editorial says "The association of obstetrics & Gynaecology is not a trade union nor does it exist for the main purpose of fighting for the rights and privileges of it's members. The only fight is that against maternal and infant mortality.

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In 1967 Prof. D. A. Ranasinghe suggested to form a new association and this was called "Association of Obstetrics and Gynaecology of Ceylon." The inaugural meeting of this association was held at the lecture theatre of De Zoysa Maternity Hospital" in 1967 and Prof. D. A. Ranasinghe was elected as the president. In 1970 the association was elevated to the status of a collage and became known as the "Ceylon Collage of Obstetricians and Gynaecologists." With Sri Lanka becoming a republic in 1972 the collage was renamed "Sri Lanka Collage of Obstetricians and Gynaecologists." In 1985 the 10th congress AFOG was held in Colombo and this is widely regarded as an elevation of the collage to international recognition. In 1992 the collage was 25 years old and this was celebrated with a grand silver jubilee congress in August. This is the year of Golden jubilee of the collage, this will be celebrated with a grand golden jubilee congress in August. This will be in association with FIGO, SAFOG & AFOG over 10 professional associations have confirmed their participation in the congress.

In 1992 the first seminar on "quality of care in safe motherhood" was held in Anuradhapura for family health workers. Myself being a young consultant at Anuradhapura had the distinction of organizing this event with my colleague Dr. Kapila Gunawardene. This programme gathered such momentum and later evolved into a college flagship event of "Safe motherhood program". This was during the presidency of Prof. Wilfred Perera and Prof. Harsha Seneviratne was the chairman of IPPF South Asian region and funds for the program was found by him. At the same time an official advisory committee to the health ministry was formed and approved by Dr. Joe Fernando, then secretary of Health. In 1994 the collage appointed a sub-committee to study and make suitable recommendations

to amend the existing abortion law which was completely out of date even at that time. It produced an excellent paper titled "termination of pregnancy" recommending to legalize 1st trimester abortions in cases of rape, incest and lethal fetal anomalies. This paper passed through the ministries of health and justice but when its presentation in parliament was imminent it was withdrawn for unknown reason. The situation regrettably remains the same today.

SLCOG HOUSE

Building our own house was a big dream of all of us for a long time. In 2003 SLCOG was handed over a 60 perch land on Model Farm Road behind Castle Street Hospital for Women. Unfortunately the land was occupied by a squatter who had constructed a house and a boutique in the centre of the land and then council members and the president Dr. Marlene Abeywardene donated money and constructed a small house and a boutique for the squatter to move out. In January 2005 the foundation stone for the new building was laid by Dr. Nalin Rodrigo who was the patron at that time. Today this magnificent building stands as a monument to all the hard work done by all the past presidents, their councils and all the members and fellows.

MY GOAL FOR 2017

My goal for 2017 is to achieve a single digit maternal mortality which is a realistic goal in near future. Scoring goals is not all that easy all the time. You need time, determination, dedication, hard work and application. Since 1985 maternal deaths has been a notifiable event in Sri Lanka. Notification Criteria includes all deaths irrespective of the cause of death in women in reproductive age group during the pregnancy period, and until one year after termination of pregnancy.



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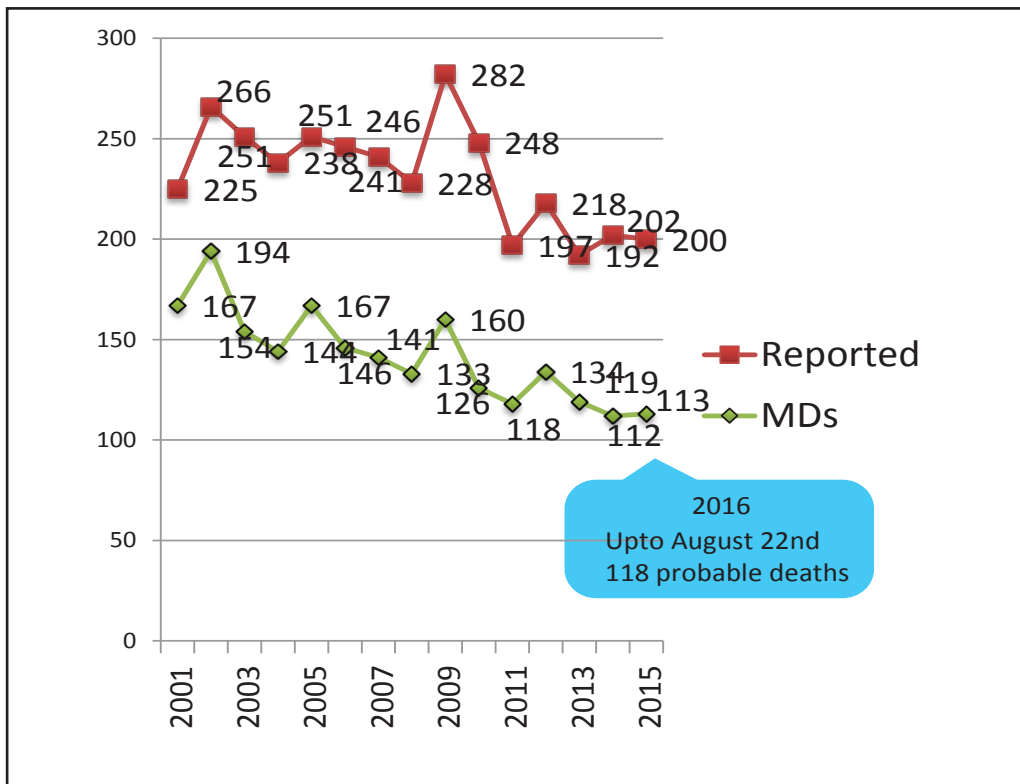
National Maternal Mortality Ratio 2015

• Maternal Deaths = **113**
 • Live Births = **334,821**
 (Registrar General's Dept)

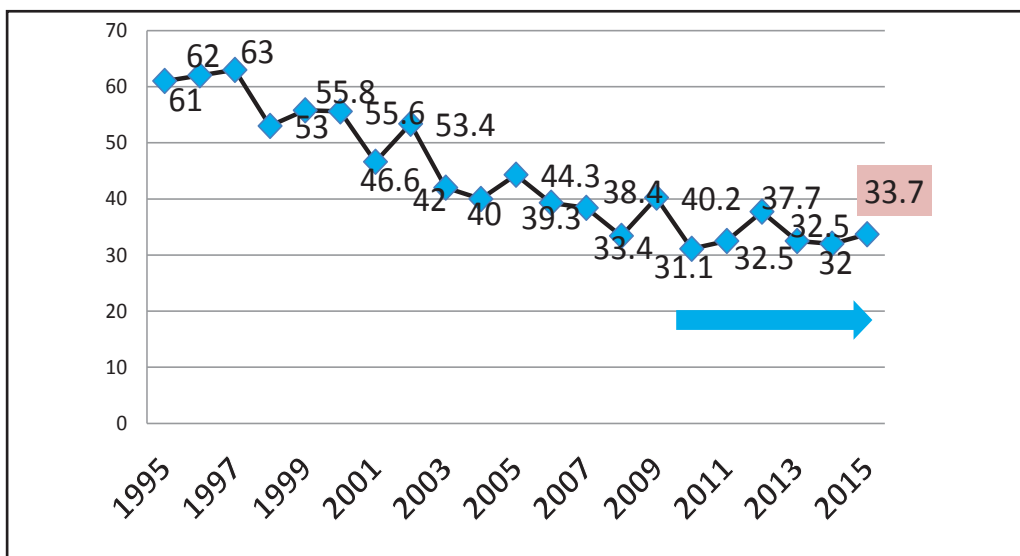
• $MMR = \frac{113}{334,821} \times 100,000$
 = **33.7 per 100,000 live births**

	2013	2014	2015
Live Births	365,792	349,715	334,821
		16077	14894

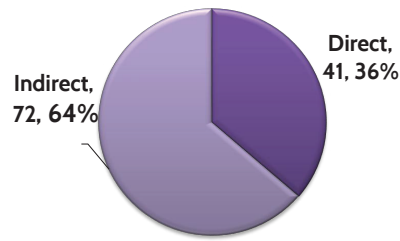
Number of Reported Deaths & Maternal Deaths (2001- 2015)



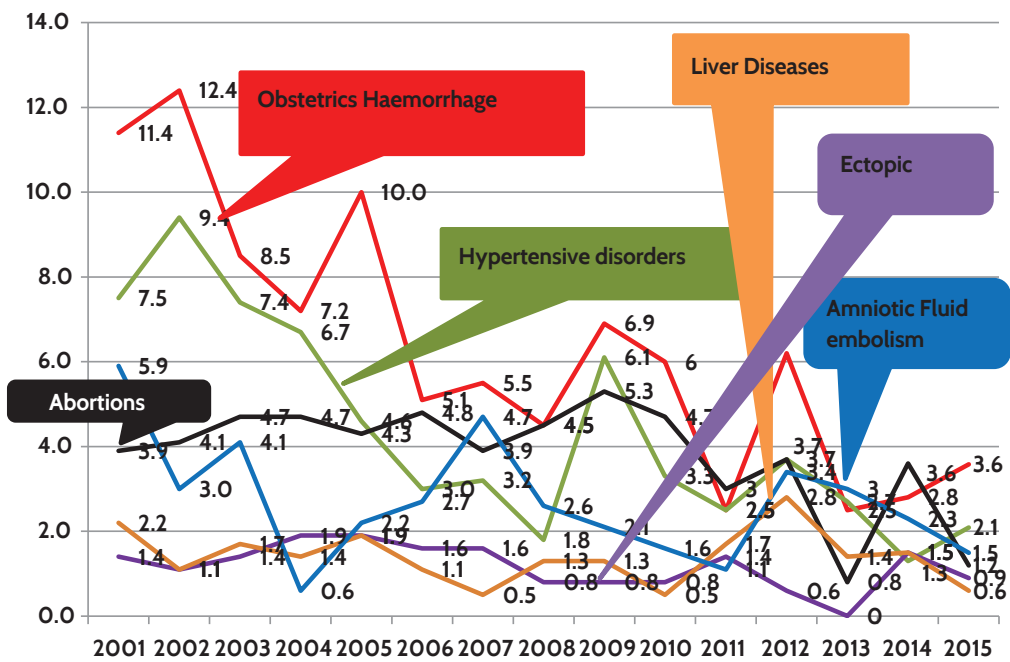
National Maternal Mortality Ratio 2015



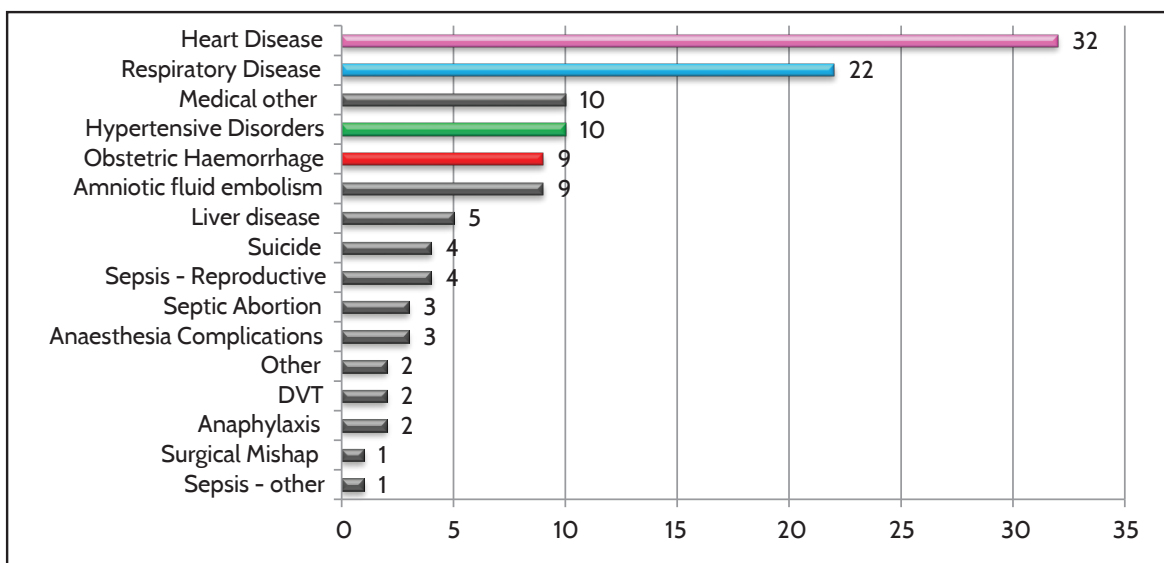
Categories of Maternal Deaths



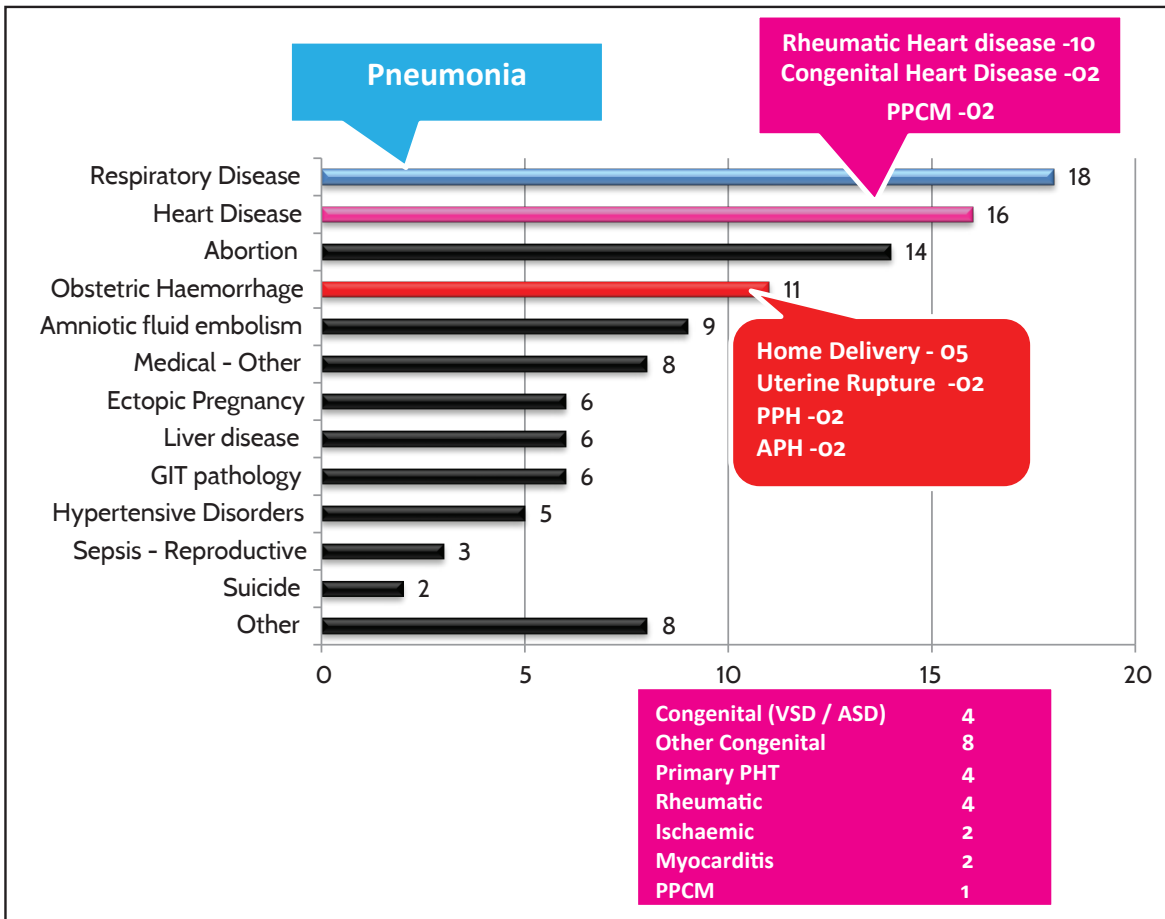
Cause - specific MMRs 2001-2015



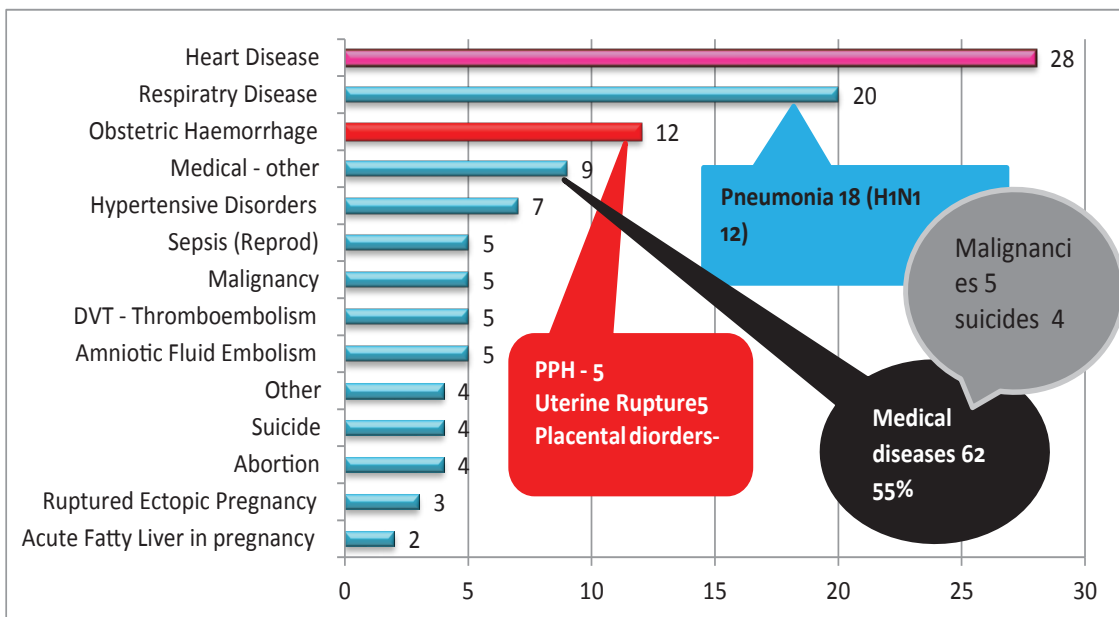
Cause of Deaths 2013



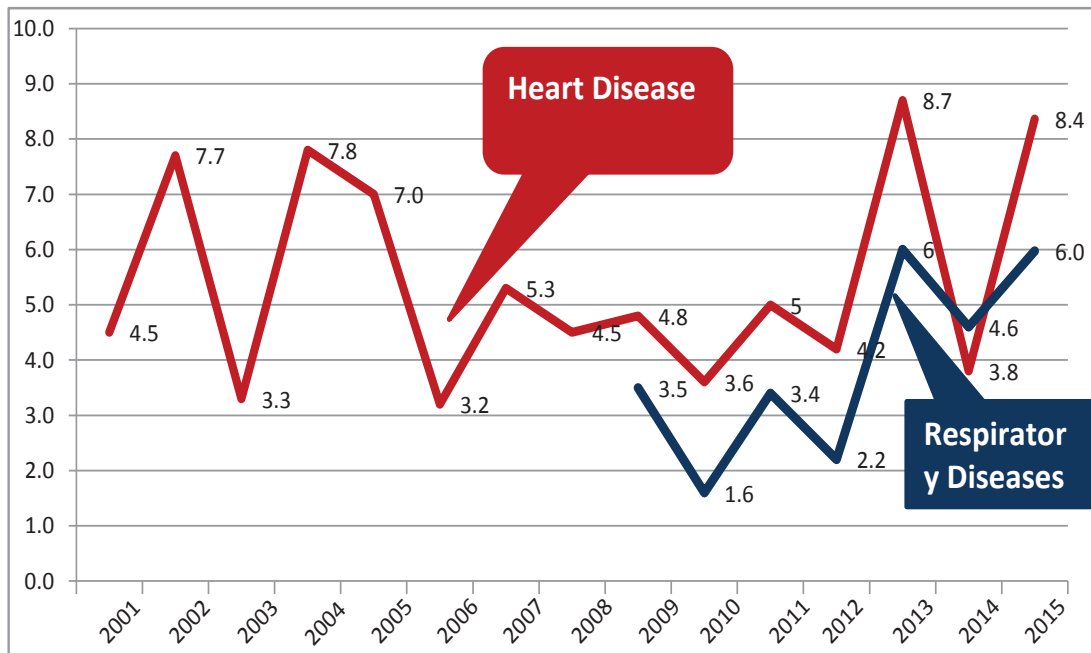
Cause of deaths 2014



Cause of deaths 2015



Cause specific MMRs 2001 -2015



Mandatory Post Mortem Examinations

Year	MDs	Done	%
2011	134	126	94%
2012	118	108	92%
2013	119	114	96%
2014	112	106	95%

Two Circulars:

- Ministry of justice to all coroners
- Ministry of health to all hospital heads

Maternal mortality ratio per 100 000 live births	Year	Proportion of maternal deaths among deaths of female reproductive age (PM %)
75 (65 - 90)	1990	3.5
70 (63 - 79)	1995	2.8
57 (52-63)	2000	2.4
43 (39 – 47)	2005	2.4
35 (31 – 41)	2010	2.3
30 (26 – 38)	2015	1.9

All Maternal deaths are reviewed at the district level with the participation of SLCOG representatives, Family Health Bureau officials, hospital and field staff involved. This data are utilized to formulate national strategies to reduce maternal deaths.

Deficiencies in this type of review meetings are that the patient is not there to tell her story, health care providers are psychologically affected as they feel that they are “guilty” and true story might not come out due to fear of litigation (for admitting fault in public) and patient notes are altered as a mechanism of defense.

MATERNAL NEAR MISS APPROACH

Maternal Near Miss is defined as “a woman who nearly died but survived a complication that occurred during pregnancy, child birth or within 42 days of delivery.” In practical terms women are considered near miss cases when they survive a life threatening condition (i.e. organ dysfunction). Women who survive life threatening conditions arising from complications related to pregnancy have many common aspects with those who die of such complications. Evaluation of maternal near-miss cases with maternal deaths gives a more complete assessment of quality of care. Criteria for identification of Near Miss Cases includes-

- Clinical criteria related to complication
- Management aspects e.g. Laparotomy, Blood transfusions, Admission to ICU etc.
- Organ system dysfunction e.g. Jaundice in pre –eclampsia , renal failure

A women presenting with any of these life threatening conditions and surviving a complication during pregnancy, childbirth or within 42 days of termination of pregnancy are considered as near miss criteria.

The WHO Near Miss Criteria:

- Globally Accepted
- Validated for Sri Lanka
- Objective Criteria

Dysfunctional system	Clinical Criteria	Laboratory Markers	Management base proxies
CVS	Shock Cardiac arrest	pH <7.1 Lactate > 5 mEq/ml	-Use of continuous vasoactive drugs -Cardiopulmonary resuscitation
Respiratory system	Acute Cyanosis Grasping Respiratory rate >40 or <6 bpm	Oxygen Saturation <90 % for 60mins, pO2/ FiO2<200mmHg	Intubation and ventilation not related to anaesthesia
Renal	Oliguria non responsive to fluids and diuretics	Creatinine ≥300µmol/l or ≥3.5 mg/dl	Dialysis for acute renal failure
Hematologic/ Coagulation	Failure to form clots	Acute severe thrombocytopenia (<50,000 platelets/ml)	Transfusion of ≥ 5 units of blood / red cells
Hepatic	Jaundice in the presence of pre eclampsia	Bilirbin >100 micromol /l or >6.0 mg/dl	
Neurological	Any loss of consciousness lasting for > 12 hrs , Strokes, Uncontrollable fits , Status epilepticus, Total paralysis		
Alternative severity proxies			Hysterectomy following infection or Haemorrhage

In the review of maternal near miss cases the woman is alive to directly tell the problems and obstacles that had to be overcome during the process of healthcare, investigating the care received may be less threatening to providers because the woman survived and health care workers will participate with a positive frame of mind.

STRATEGIES WHICH CAN HELP TO ACHIEVE A SINGLE DIGIT MATERNAL MORTALITY

Almost 50 % of maternal deaths are due to unmet need for contraception.

Strategies to improve family planning services

- All specialist hospitals should have dedicated family planning clinics from 8am – 4pm
- Have dedicated operating time for sterilizations
- Motivate field midwives to actively educate women on contraceptive methods
- Introduce family planning in school curriculum
- Introduce newer methods of family planning such as implants and postpartum IUD into the armamentarium of methods

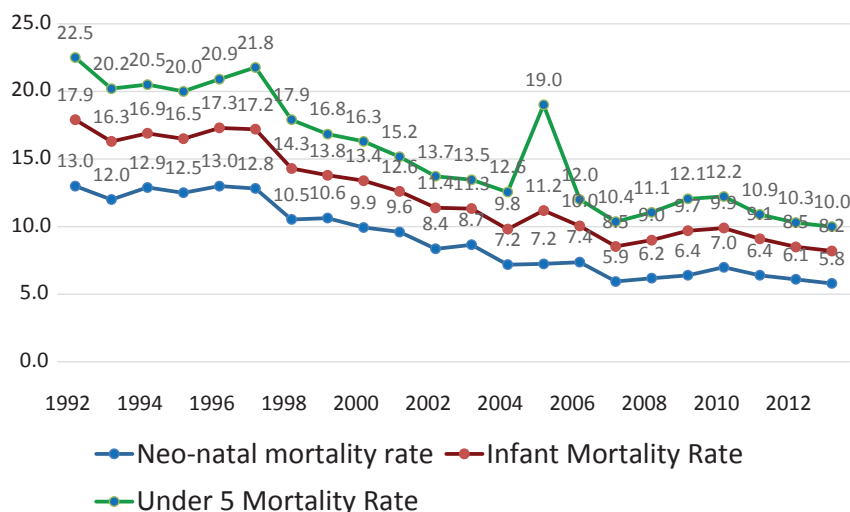
Strategies to reduce deaths due to pneumonia:

- Most of the maternal deaths due to respiratory causes are due to H1N1
- Immunization against H1N1 should be done routinely on all pregnant mothers during endemic periods
- Make Tamiflu available in all hospitals with specialists
- All pregnant mothers with fever and respiratory symptoms should be admitted and seen by a specialist

Strategies to reduce deaths due to cardiac diseases:

- Provide a training to all obstetricians to perform 2D ECHO cardiography
- Pregnant women with heart disease have to be assessed by a team consisting a cardiologist and an obstetrician.

Sri Lanka – Under 5, Infant and Neonatal Mortality Rates



- Establish super centres at Colombo, Kandy, Anuradhapura with all facilities to manage pregnant patients with complicated cardiac problems

Strategies to reduce deaths due to haemorrhage:

- Importance of correcting anaemia during antenatal period
- Promote active management of 3rd stage
- Expansion of availability of 24 hour blood bank services in all specialist hospitals
- Establish regional super centres to manage patients with morbidly adherent placentae

Strategies to reduce deaths due to septicemia:

- Making abortions safe
- Recommend to the government to legalize abortions when justified
- Minimum requirements in improving microbiology laboratories and appointment of a microbiologist to all specialist hospitals.
- Improve the availability of essential antibiotics to be used in patients with septicaemia

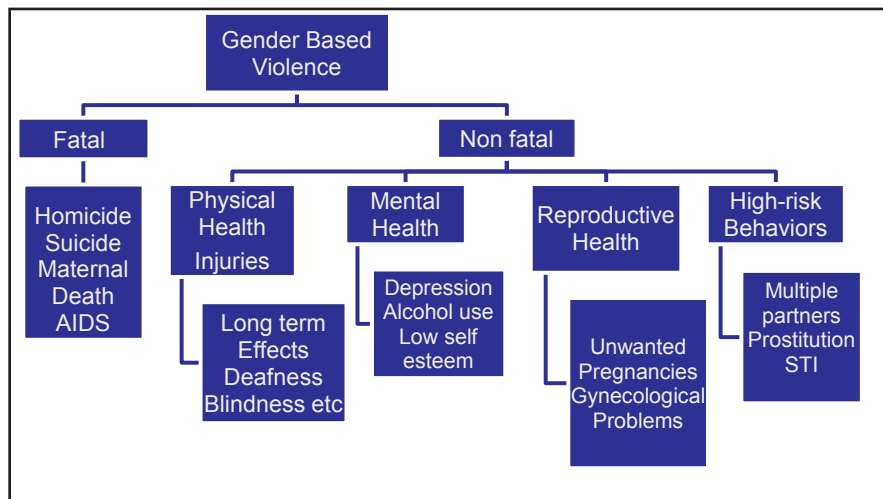
Strategies in infrastructure development:

- Improve facilities in labour rooms
- Have a national plan on providing ambulances
- Provide emergency telephone numbers to all pregnant mothers, e.g. Mobile phone number of the field midwife
- Field midwives should be able to contact the hospital and obtain advice

GENDER BASED VIOLENCE

WHO estimates 15 – 70 % women to be undergoing Gender Based Violence. Few studies done in Sri Lanka show a prevalence rate around 40%. There is adequate evidence to show the prevalence of Gender Based Violence particularly domestic violence is increasing. Healthcare professionals often fail to recognize the impact of Gender Based Violence on health. Many still consider it as a social and cultural issue that is not relevant to their work.

HEALTH OUTCOMES OF GENDER BASED VIOLENCE



Women who suffer from domestic violence are often fearful of their partners, denied access to family and friends, often feel guilty and experience reduced freedom. Violence can lead to negative pregnancy outcomes such as premature labour, miscarriages/abortions, antepartum haemorrhages, low birth weight, lack of antenatal care, substance abuse, depression and psychological effects. Reasons for not leaving an abusive relationship could be due to fear of further violence, lack of options such as safe shelter, lack of family support, concern about welfare of children, social stigma attached to a separate woman, being dependent of the partner, and belief that partner will change one day.

Strategies to prevent gender based violence:

- Establish SLCOG as a major stakeholder in the effort to reduce GBV
- Identify GBV as an important issue that has to be addressed very aggressively
- Establishment of dedicated service points within the health institutions
- Expand the concept of “Mithuru Piyasa”
- Development of training modules for field health staff

If a woman reveals that she is being abused by domestic violence provide her with support and relevant information, provide her with the assistance she needs, assess the risk to her and children, and help her to develop a safety plan. Even

in a resource poor settings health care providers can help women subjected to Gender Based Violence by reassuring the women that she is not to be blamed, raised women’s awareness about the health risks of violence, help her to get help before violence escalates and healthcare workers should not exert pressure on a survivor to do anything she does not wish to do.

Improving surgical techniques

Surgical techniques are rapidly improving worldwide and currently endoscopic surgeries have become routine in our surgical lists. Laparoscopy and hysteroscopy has become an essential tool in our surgical lists. With time to come we might move beyond endoscopic surgery.

Training programs in improving surgical techniques

SLCOG should take the leadership role in providing training for all doctors involved in performing surgeries, SHO training programs will have to be further strengthened and there should be a continuous programme of hands on training in modern surgical techniques for all obstetricians. Finally I would like to quote Professor Sir Sabarathnam Arulkumaran “Strong person will stand up for himself. The stronger person stands for others.”

Acknowledgements

I acknowledge Dr. Kapila Jayaratne of Family Health Bureau for providing the graphs and statistics on maternal mortality and morbidity.