Michela Khan

Elective Report: Obstetrics and Gynaecology at Mahamodara Hospital, Sri Lanka

What are the common obstetric emergencies in Sri Lanka? How do they differ from the UK?

Mahamodara maternity hospital is located in Galle, in the southern province of Sri Lanka. This area generally has more accessible health services than the northern and eastern sides of the island that have been more affected by conflict. In such areas delays in accessing emergency services are commonly responsible for preventable maternal deaths. Nationally, the maternal death rate has been steadily declining over recent decades as efforts have been made to develop the health care infrastructure. Despite the challenge of limited resources, Sri Lanka has a far lower maternal mortality ratio than similar countries. The lifetime maternal mortality ratio in Sri Lanka in 2013 was 29 per 100 000 compared with the UK which is 8 per 100 000. Sri Lanka also has relatively good maternal outcome indicators compared with other developing countries.

The common obstetric emergencies are similar to those found in the UK. Post-partum haemorrhage (PPH) and pregnancy induced hypertension (PIH) are the commonest complications of pregnancy that lead to maternal death in Sri Lanka. PIH is also the second leading cause of maternal mortality in the UK. PPH is the fifth commonest cause in the UK, with sepsis being first.

During my placement I noticed that gestational and type II diabetes were particularly common complications present on the antenatal ward. This surprised me as although I was aware that people of south Asian origin are at greater risk of developing diabetes, I thought that this would be countered by reduced nutrition and differences in diet.

How do maternity services in Sri Lanka differ from those in the UK?

Similarly to the UK, Sri Lankan health services are widely accessible and offered free of charge. There are also private hospitals available. Antenatal care is widely utilized, with the vast majority of pregnant women having attended at least four antenatal visits. The women at Mahamodara hospital also had a fetal ultrasound scan that detailed the fetal measurements.

During labour itself, 98% of women have a skilled attendant present. 24% are delivered by c-section. This is similar to the UK in which 26% of deliveries are by c-section. Unlike in the UK, there is no anaesthetist present on the labour ward at Mahamodara hospital. This meant that women are not routinely offered epidural for pain relief for vaginal deliveries. Instead pethidine is regularly used. Although we were told that nitrous oxide was available, this was a recent addition and we did not see it used.

I found that episiotomies were performed more frequently than in the UK. In the UK it is usually only done prior to an instrumental delivery or if a woman is likely to tear whereas at Mahamodara hospital it was routine.

The length of stay in hospital was generally longer than in the UK. Postnatal women would spend 1-2 nights on the postnatal ward to be assessed both mentally and physically. In the UK, in the case of an uncomplicated vaginal delivery, it is possible to return home within hours of delivery.

Explore views towards pregnancy and contraception in Sri Lanka

Obstetrics and Gynaecology is prioritized more highly in the curriculum of students from Ruhuna hospital than that of students in the UK. Their placement has a duration of eight weeks whereas we have only four. We were impressed by the quality of teaching the final year students received and noted that they were taught in greater depth the management of obstetric complications. This suggested that they would be less well supported when they start work than we are as Foundation doctors.

Pregnancy is viewed as a sign of successful marriage. It is rarer and less accepted to have a pregnancy outside of marriage than in the UK.

Family planning has been an important priority in improving maternal outcomes. The high contraceptive prevalence in Sri Lanka (around 70%) is in part responsible for the successes in women's health comparable to other developing countries. Nationally there is an average of 2.2 births per woman. Contraception is thought to be a woman's issue but is generally supported by husbands. The availability of various methods of contraception in Sri Lanka is comparable to that of the UK.

Legally, abortion in Sri Lanka is only permissible if there is a significant threat to the pregnant woman's life. Although clandestine clinics are available, they are of varying quality and pose a health risk for many women. It is therefore of even greater importance that contraception is not only readily available but it is also culturally acceptable

To develop clinical skills and to become more aware of cultural difference relating to health care

I was pleased to find there was plenty of opportunity to examine patients during the placement. This was somewhat dependent of the presence of a Sri Lankan medical student or doctor, however, due to the language barrier preventing us from asking for consent ourselves. Luckily the medical students were extremely accommodating and showed us how they examined pregnant women. They also taught us how to use the Pinard stethoscope which I had never seen be used in the UK. I found this interesting. This was routinely used in place of the hand held Doppler that we use in the UK.

The language barrier greatly limited communication with patients themselves. This is unfortunate as it meant that I was unable to take histories myself and generally ask them about their views of the health service. Fortunately the ward rounds were conducted in English and the medical students and some of the nurses spoke English.

Unlike in the UK, the students themselves were competent at suturing episiotomies. I only felt able to assist the doctor with suturing repairs. The students were given far more responsibility than we are permitted in the UK. They also appeared more competent with procedures than we are.

I was also able to develop my skills through the teaching that was provided for the medical students. This was taught very clearly with the use of models and it clarified for me some things that I had only been able to read about.

Generally on the ward I found that there was less privacy for the women as there were often no curtains around each bed. Even in the labour room the curtains did not reach all the way round to divide the patients that were placed in close proximity to one another. The women never appeared to be bothered by this and perhaps this reflects their different expectations to women in the UK. I also noticed that there was no hand sanitizer available for the doctors' use.

In many ways the provision of women's health services was very similar to that of the UK. The medical students used many of the same text books as those recommended by our lecturers, and attitudes towards health was also similar. The main difference was simply the limitation of resources. For instance there was far less use of disposable equipment and less reliance on technology and support from senior staff. There was also some overcrowding of the gynecology wards with patients resting on chairs due to the lack of available beds.

Overall I thoroughly enjoyed my placement at Mahamodara hospital. I was impressed by the skills of the medical students and they were extremely helpful and informative as was the teaching that we received from the doctors. The availability of maternal and gynecological health services exceeded my expectations and I would recommend this placement.

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