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NEONATAL

Electives Report

Objectives:

1. Describe the most prevalent complication of pregnancy in Sri Lanka and how this compares to the UK.
2. Compare the antenatal services available to women in Sri Lanka and women in the UK.
3. What are the infection control methods implemented in Sri Lankan hospitals?
4. Reflect on an interesting experience seen during your elective period. Describe the impact that had on you and what did you learn from this experience.

Write-up

Sri Lanka is a small island in the Indian Ocean with a total population 20,216,000 (estimated in 2008) spread over a land area of 65,610 Km^2. The population growth rate is 0.81% in 2008. Majority of the population is Sinhalese (approx. 74%) and the largest minority group is Tamil. It is a developing country but compared to other countries in the region it is relatively wealthier with areas of poverty still existing particularly in the estate sector. Approx. 25% of the population lives below the national poverty line. Majority of the population live in the rural areas. It is estimated that 93% of people have access to basic healthcare services. Healthcare in Sri Lanka is provided free of charge but over 50% of people use the private sector.

According to the World Health Organisation (WHO), although Sri Lanka is a developing country it has relatively good health indicators. The maternal mortality ratio per 100000 live births is 39. The infant mortality rate is 11.2 per 1000 live birth. These rates are relatively low compared to other countries in the region. The maternal mortality ratio in the UK is 12 per 100000 live births.

Approximately 25% of the population is women of child bearing age (15-44 years). Antenatal services in Sri Lanka are well developed and organised. Most of the couples are allocated a community midwife who visits the pregnant mother regularly and provides help and advice throughout their pregnancy. Most mothers are looked after by these community midwifes but all first pregnancies and high risk pregnancies are referred to a health facility with a consultant obstetrician. In the UK all uncomplicated/ low-risk pregnancies are followed-up by the general practitioner and the midwife-lead unit at the hospital. But as in Sri Lanka all high risk pregnancies are followed-up by a consultant obstetrician.

One of the differences in antenatal care between Sri Lanka and the UK is that routine scanning is not available to all pregnant mothers. Most patients often receive the dating scan but anomaly scan is not available. Also therapeutic termination of pregnancy for foetal anomaly is not legally allowed Sri Lanka and therefore screening foetal anomaly is not offered or performed. In Sri Lanka anomaly scanning is offered if there is a previous history or family history of foetal anomaly in order to reassure/prepare mother and family.

Over 90% of deliveries in Sri Lanka take place in health facilities with the support of skilled birth attendants. Birth attendants include doctors, midwives, nurses or community workers

with midwifery training. A referral system is in place to ensure transport to one of the 45 hospitals if any complications occur. These dedicates maternal services has helped to reduce maternal mortality to one of the lowest in the region. It fell from 520 in 1990 to 250 in 1998 and it has continued to decrease. It is now 60 per 100000. The maternal mortality rate in the UK is 7 per 100000 (2008).

The leading cause of maternal mortality in Sri Lanka is post-partum haemorrhage. Other causes include pregnancy-induced hypertension, early pregnancy loss, sepsis and other causes such as anaemia and deaths in patients with pre-existing heart disease during delivery. In the UK the commonest cause of death is thromboembolic disease. Other causes are pregnancy-induced hypertension, sepsis, amniotic fluid embolism, post-partum haemorrhage and ectopic pregnancies. Many measures are taken world-wide to prevent and reduce maternal mortality. In Sri Lanka, reduction in maternal mortality had been achieved with strong government commitment in improving healthcare, access to healthcare and education of mothers. In Sri Lanka there is good adult literacy rate with access to free education to all. The adult literacy rate among women is 88% which is one of the highest in the region. All these contribute to reduction in maternal mortality in Sri Lanka as women are better able to take advantage of family planning and maternal services.

Communicable diseases in this region of the world are common and greatly contribute to the mortality rate. In Sri Lanka, the mortality and morbidity due to communicable disease has declined but mortality and morbidity due to non-communicable disease is on the rise. Notable non-communicable diseases in Sri Lanka are cardiovascular and cerebrovascular disease, diabetes, tobacco and alcohol abuse and pesticide poisoning. Notable communicable diseases are: tuberculosis, dengue, Japanese encephalitis, diarrhoeal disease and acute respiratory infections. Incidence of malaria is low in Sri Lanka but it is still prevalent North Central and Eastern Provinces.

Many strategies are implemented in a community level to eliminate many of the communicable diseases such as dengue and other mosquito-born disease, TB and rabies. Strategies are implemented within hospital to prevent the spread of infection but there is no national policy on infection control in Sri Lanka. However the Sri Lankan Ministry of Healthcare and Nutrition and Sri Lankan College of microbiologist have published a Manuel on Infection Control. Some methods I observed in the wards are the availability of isolation units which isolates patients with possible communicable diseases from other patients. All beds and bed spaces are cleaned before allocating the bed to another patient. Staff are provided with disposable gloves for all contact with body fluids and other necessary times. Instruments and linens are sterilised and unsterilized items are kept in a separate area to sterilised items. Hand washing liquid/soap is available at most sinks but not all sinks.

Some difference compared to the UK is that sinks are not available in each bay. Also no alcohol gel provided in the hospital to enable hand-washing between patients. Also Sri Lanka has not implemented the bare-below the elbow rule practiced in all hospital in the UK. All medical students are expected to wear white coats.

Infection control methods in theatre are practiced strictly. For example all people attending theatres are provided with clean change of clothing, masks, hats and shoes. All theatre equipment are sterilised and kept in a clean sterilised area. Floors and operating tables are

cleaned in-between patients and all theatres are fixed with ventilation systems. All these infection control methods implemented within the hospital help to reduce spread of infection within the hospital. There are continuing efforts to improve their infection control methods in and out of hospital to reduce mortality and morbidity in and out of hospital.

During my elective period I was able to experience and observed the practice of different specialities. I thoroughly enjoyed the community medicine experience I have received. It enabled me to understand how the health system is exercised in Sri Lanka and gave me an insight into the efforts made to prevent diseases in Sri Lanka. I was able to attend one of the annual school checks with the medical officer of health. This was a very interesting experience for me as it was the first time I was able to take part in such an activity. I was able to actively participate and examine the students and help the MOH with giving the students vaccines, vitamin A capsules and worm-medication. This experience gave me an insight into the efforts made by the Sri Lankan health system to improve the health of their people by preventing disease and identifying problems early and providing treatment and advice. I have thoroughly enjoyed all specialities I have been able to participate during my elective period and the experience has given me some insight into the Sri Lankan heath system.

Reference:

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