Ashvina Chouhan

Elective report

University of Ruhuna and Mahamodara maternity hospital

1) What are the most prevalent O&G conditions in Sri Lanka? How does this differ from the UK?

I undertook my elective in Mahamodara maternity hospital in Galle, Sri Lanka. The range of conditions I saw in gynaecology clinics were similar to those I have seen in the UK. For example, dysmenorrhoea, subfertility and menstrual irregularities. The menstrual irregularities were often due to uterine fibroids, PCOS or thyroid disease, as they are in the UK. Vaginal discharge and, in older women, prolapse is also common here - as it is in the UK.

In anetanal clinics, I observed that a greater proportion of women here suffer from gestational diabetes or type II diabetes than in the UK. I was aware of the strong ethnic and genetic link with type II diabetes in those of Asian origin. However, a lot of the food here is fried in ghee and sweets are very popular – diet is a major contributing factor.

More women here are also anaemic during pregnancy, consequently blood transfusions are more common. In general the patients attending this government hospital in Sri Lanka are poorer and and less able to afford a balanced diet; additionally more patients than in the UK are vegetarian. This may partially account for the higher incidence of iron deficiency anaemia. The midwives delay clamping the cord for longer than in the UK (>1 min) to help prevent anaemia in the neonate.

2) How are O&G services (antenatal, delivery and post-natal) organized and delivered in Sri Lanka? How does this differ from the UK?

Antenatal care in Sri Lanka is similar in structure to the UK. It takes place in the community (health clinics or midwife led home visits) unless a woman is identified as being high risk, in which case her care is transferred to the hospital (however some women pay for hospital based antenatal care privately). Nearly every pregnant woman receives antenatal care. They usually have one visit/appointment during the first trimester, then two to three visits during each of the second and third trimester (6-7 in total). In the UK, most miltigravidas receive 10 and primigravidas receive 13.

The booking visit is similar to the UK, with measurement of maternal height and weight, blood pressure, urine dipstick and blood tests (checking for group, rhesus status, anaemia, diabetes, syphilis, Hepatitis B and HIV). The dating scan and fetal wellbeing scans take place but the triple test for Downs syndrome does not. The antenatal examinations are similar to the UK, although Pinard stethoscopes rather than hand held Dopplers are used to locate the fetal heart beat.

The patients in labour ward received a very good standard of care. Cardiotocography (CTG) is available, and partograms are used to monitor progress of labour, as in the UK. Caesarean sections are far less common than in the UK, partly due to limited availability of epidural anaesthesia. All Primigravidas receive an episiotomy (mediolateral), whereas in the UK women only receive it if they are about to tear.

Oxytocin is used for active management in the third stage (as in the UK) to reduce rates of post partum haemorrhage.

One of the most striking differences in labour between the UK and Sri Lanka relates to pain management. In the UK every woman receives Entonox (gas and air) and many have an epidural. Generally Sri Lankan women give birth without pharmacologic pain management. If they do, pethidine (IM injection) is the most common drug given for pain relief during labour. Entonox has recently become available at Mahamodara hospital, but I did not observe any women using and it has proved unpopular. Epidurals were unavailable. There is also less privacy in labour room than in the UK, partly because many beds are in close proximity and only separated by ward curtains. However, I also noticed that clinicians and medical students were quite lax with closing curtains around beds when patients are exposed in front of other patients and staff. However, the patients seem used to this and do not seem to mind.

Women spend one to two nights in the postnatal ward after uncomplicated vaginal delivery, where they are given advice on breast feeding and contraception and monitored for complications. This is a bit longer than in the UK where most women go home after a few hours, the same day.

3. Is there less medicalisation of pregnancy in a developing country such as Sri Lanka?

Antenatal care is similar to the UK. In terms of pain relief in labour, there is less medicalisation in Sri Lanka. As mentioned above epidurals are not an option and entonox has only recently become available. This is probably due to limited availability of anaesthetists but there is likely also a cultural element, as most women decline the entonox even though it has recently become available. Non pharmacological techniques for pain control such as breathing exercises are preferred.

Although medical intervention in terms of Caesarean sections are less common, I would not say that instrumental deliveries (ventouse or forceps) are significantly more or less common than the UK, and the indications remain the same.

I did notice other in-hospital differences from the UK, which relate to Sri Lanka being a developing country. For example, the huge volume of beds in the antenatal and post natal wards, which are quite basic and not electronic, as in the UK. Alcohol gel is also not available on the wards to sterilize hands before and after examining each patient. Washbasins are also quite scarce. There is also less disposable equipment than in the UK, such as speculums and operating theatre instruments – it all tends to be sterilized and re-used. The patient notes were all on paper, whereas in the UK they would also be computerized.

Despite these differences I do not think the standard of care in Sri Lanka is significantly less than the UK. The clinicians are highly skilled (in fact we learnt that many of the obstetricians complete their higher training in the UK) and whilst less money is available it is well prioritized.

4. To develop my clinical skills by performing practical procedures (under supervision) and clerking patients on the maternity ward and in theatre.

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I was able to assist in both theatre (gynae and obstetric) and labour ward (stitiching up perineal tears and episiotomies) during my stay here. However, the most useful part of the elective was the opportunity to perform numerous antenatal examinations, as I had only performed a few in UK clinics.

The Sri Lankan medical students were invaluable in encouraging me to get involved on the wards (especially when a language barrier exists with patients) and were also keen to teach and supervise, giving feedback on my examination and presentation skills. Their responsibilities are much greater than those of medical students in the UK; they have a role similar to foundation doctors in the UK. They are also more proficient at performing procedures, such as suturing. For instance the finalists were expected to be able to suture up episiotomies and 1st and 2nd degree tears without supervision.

Overall, I thoroughly enjoyed the placement, and found all the staff and students extremely helpful and friendly. I would highly recommend this placement to future students.