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Safe Motherhood Initiative

A Silent Revolution

Editor
Sadhana Gupta

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Sabaratnam Arulkumaran
Hema Divakar



Under the aegis of
Safe Motherhood Committee (2011–2013)
Federation of Obstetric and Gynaecological Societies of India



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3



Safe Motherhood Initiative in Sri Lanka: A Success Story to Share

Hemantha Parera

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INTRODUCTION

Every day almost 800 women die in pregnancy or child birth. Every loss of a mother shatters a family and threatens the well-being of surviving children. All women deserve the care they need to be safe and healthy throughout the pregnancy and child birth which is termed Safe Motherhood. It could be regarded as a right of every mother. However in the backdrop of social and cultural factor, including political governance, health system and health policy, there is huge inequality of care received by mother across the globe.

In a last decade there has been a lot of progress towards a better understanding of problem of maternal mortality. However only a few South Asian countries could make significant strides towards a safe motherhood. Sri Lanka is in the forefront of these countries. This chapter gives glimpse to their road map towards success.

Historical Perspective of Sri Lankan's Maternity Care

Sri Lanka has a long history with objective evidence to it running into over 2550 years. There have been following facts noted in history of Sri Lanka notifying sensitivity and measures for safe motherhood in Sri Lanka from the beginning:

1. *Pre-Europe era:* A long chain of kingdom encouraged Buddhist way of living, which preaches mother to be the most sacred of all. Sri Lanka had established system of health care including hospital as far back as 9th century AD. Traditional nature medical care, later supplemented by Ayurveda from India was cornerstone of health delivery system.

2. *European era*: Sri Lanka, than Ceylon was under Portugal, Dutch and then since 1815 to 1947 till independence was under British rule. Followings are few landmarks at his period.
   - Western system of medicine was introduced by Portugese in 1506
   - The foundation of present health system was rooted by British in 1858 with creation of civil medical department
   - Registration of birth and death under Registrar general began in 1887 and made compulsory in 1897
   - Maternal mortality was included in the annual report in special section as way back as 1921
   - Universal health coverage of all including women was introduced as way back as 1931 in Sri Lanka, only 3 years after UK well ahead of its neighbor like India (1950), Nepal (1951), Pakistan (1956), Bhutan (1953), Bangladesh (1972).

Registration of midwives and training of nurses and midwives was made compulsory from 1897, A separate maternal and child health department was started in 1906, and trained midwives were made available in Colombo city municipality. Figures 1 and 2, show data of MMR in Sri Lanka from 1930 to 1996.

It shows marked reduction of MMR from 2200 death/100,000 live birth in 1920 to 34 death/100,000 live births, in present time one of lowest in developing factor despite general poverty still prevalent in country.

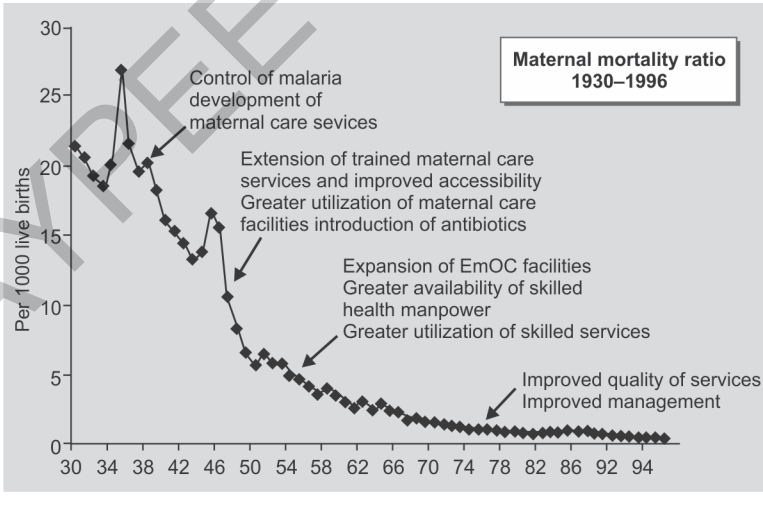

Fig. 1 Maternal mortality ratio in Sri Lanka from 1930–1996

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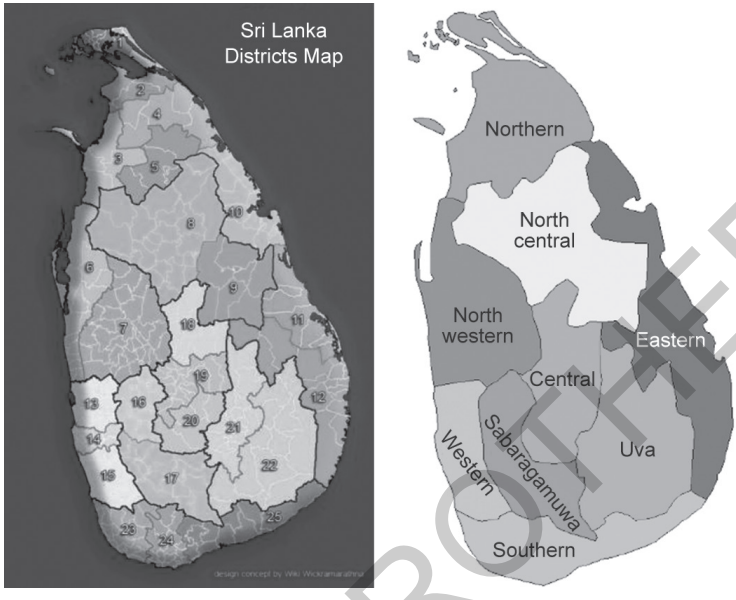

Fig. 2 Political demography of Sri Lanka *(for color version see Plate 1)*

Postindependence Period

- In 1948, village hospitals (Peripheral units) were introduced to provide easy access to curative care
- In 1968, a coordinated body for maternal and child health (MCH) services were established. Same year every district of country was provided with a medical officer of MCH. Central line monitoring of maternal mortality (MM) was initiated with a team sent to regional maternal mortality meetings.
  Figure 2 shows the administrative political demography of Sri Lanka.
- Since 1989, the administration of country was decentralized with birth of provincial council. A provincial director of health service was appointed to each of the 09 provinces.
  Flow charts 1A and B show health delivery system in Sri Lanka.

SUCCESS STORY OF SRI LANKA

There are many factors behind success of Sri Lanka in achieving one of best maternal heath indicators in Sri Lanka. The few important factors are as follows:

- Government's historical emphases on meeting the basic needs of its population in area of infrastructure—health and education, with the

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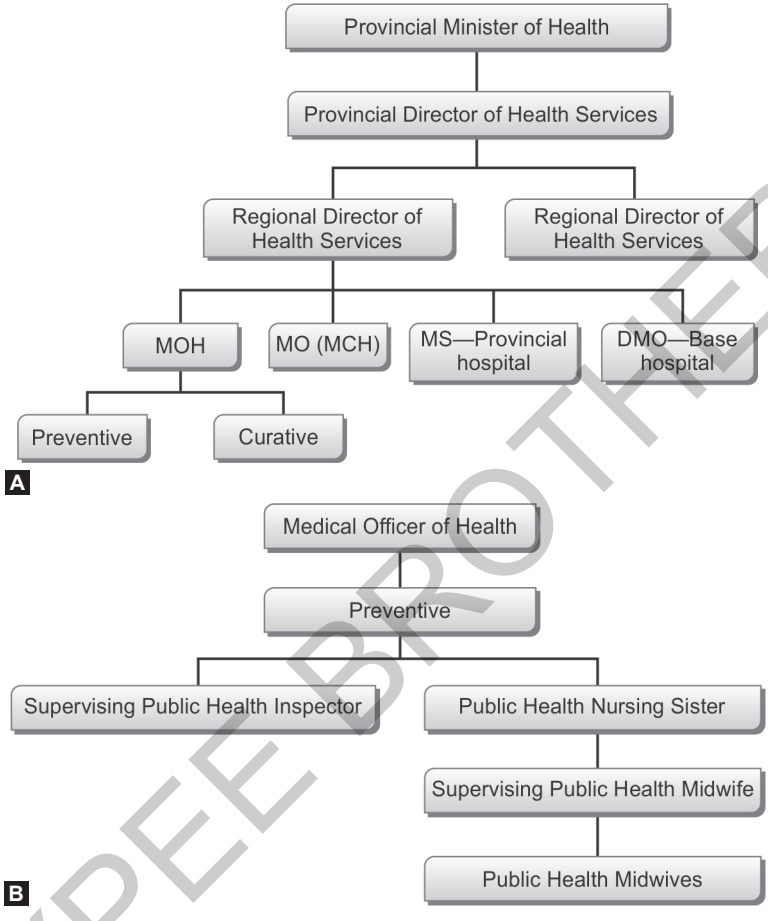

Flow charts 1A and B Health delivery system in Sri Lanka

Abbreviations: MS, Medical Super in tendent; DMO, District Medical Officer; MOH, Medical Officer of Health; MCH, Maternal and Child Health

relatively high status of women in society. High female literacy, free education and opportunity for girls and increased age at marriage for girls (25.1 year in 1993) has substantiated the improvement in women health

- A comprehensive and high quality family planning program which offer contraception through wide range of channel. As a result contraceptive prevalence rate is 66 percent, fertility rate is 2.3 birth/women

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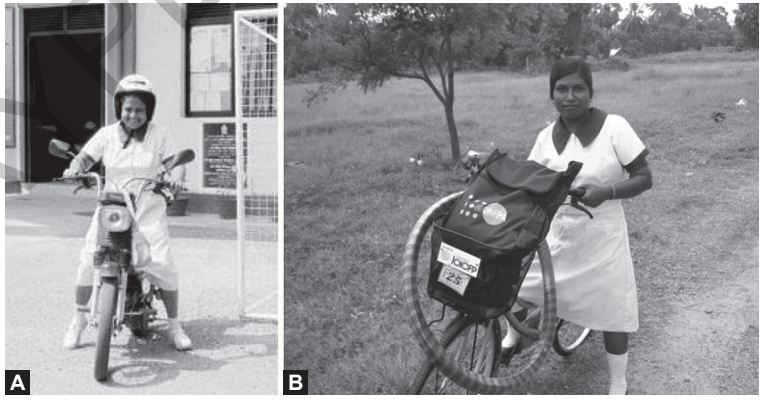
- Focussed environment in health intervention generally and maternal health services specially
- A good road network, community local maternal child health free services, integration of family planning with maternal and child health services, institutional delivery up to 90 percent, and use of appropriate technology like home-based mother's record and partograph are few implemented focussed interventions in Sri Lanka.
- *Literacy in Sri Lanka:* Education in Sri Lanka has history of 2300 years. Today there is free education for all and literacy rate for with male and female has reached nearly 100 percent.

Health master plan, November 2003: The clear demarcation of the preventive and curative section of the health system from the beginning was instrumental in service delivery and recognition of priorities for health expenditure. Having trained birth attendant in form of government midwives, posted to every village was the first major step in bringing down MMR. Midwives were divided into the preventive and curative sections with interchange for regular exposure to all aspect of maternity care.

On preventive side medical officers of health (MOH) were appointed to every district, based on the population ratio and apex preventive health officer was provided to every MOH to supervise and oversee the midwifery team appointed to the field service.

There are MOH officer per district and 5725 public health midwives working in community level.

Midwives role has been broadened to encompass a major preventive role like early booking of pregnant mother, contraceptive service delivery and vaccination (Figs 3A and B)



Figs 3A and B Midwife role in MCH care is broadened

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Box 1 Decrease in domiciliary delivery from 2007 to 2012 in Sri Lanka

Percentage of home deliveries	2007	0.5
	2008	0.4
	2009	0.3
	2010	0.2
	2011	0.1
	2012	0.1

On curative side, maternity homes were built in every village and with trained midwives, there was a rapid transition from home delivery to institutional deliveries, creating an immediate impact on MMR.

Box 1 shows marked reduction in home deliveries from 2007 to 2012 in Sri Lanka.

There were smaller hospitals in the periphery called peripheral units with a medical officer-in-charge and a labor room with midwives as a mandatory component.

The referral system: It was planned with expenses of specialist care centers as well as planning of the obstetrician was and gynecologist to cater to ever increasing need based on demographics.

SOCIOCULTURAL AND DEMOGRAPHIC IMPROVEMENT

This improvement added to improvement in maternal child health. The good registration system and statistics gives very clear objectivity to the planning, implementation and analysis of health services.

Figures 4 to 6 mark the distribution of specialist care center, peripheral units in district and health institutions in Sri Lanka respectively.

PROFESSIONAL BODIES IN SRI LANKA

The first association of obstetric and gynecologist was founded in 1953, called Ceylon Obstetrical and Gynecologist Association (COGA).

The editorial of the first journal (1954) is testimony of its aim and high principles.

'The association of obstetric and gynecologist is not a trade union, nor does it exist for main purpose of fighting for the right and privilege of its members. The only fight that figures in our aim is that against maternal and infant mortality.'

In May 1970, the association was elevated to status of college and became known as Ceylon College of Obstetric and Gynecologist (CCOG), which was renamed Sri Lanka College of Obstetrician and Gynecologist as it stands today with 1972 constitutional reforms of Sri Lanka. Today the college with 245 members stands out among rest as a beacon in

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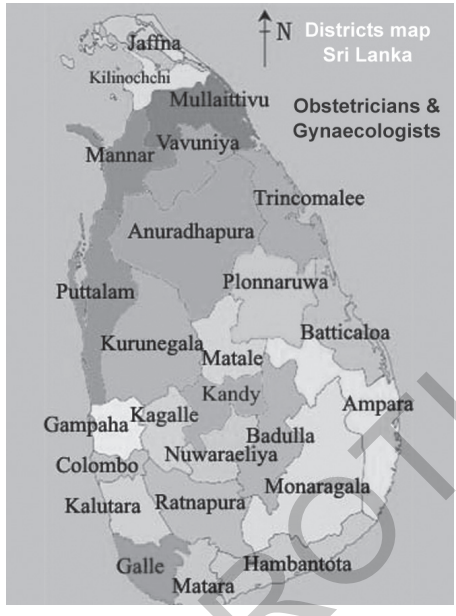

Fig. 4 Specialist care centers in Sri Lanka *(for color version see Plate 1)*

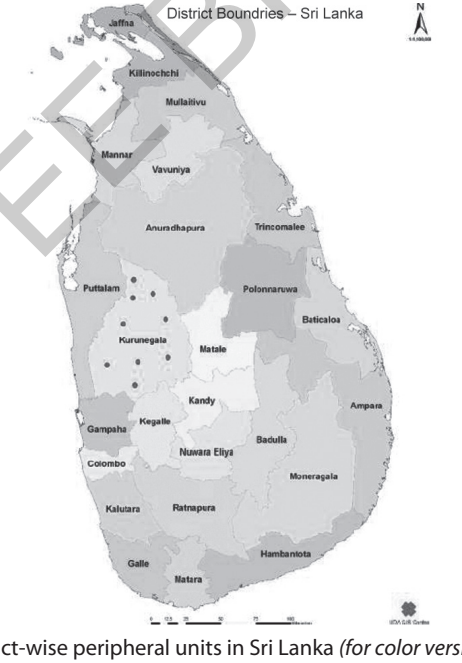

Fig. 5 District-wise peripheral units in Sri Lanka *(for color version see Plate 2)*

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Fig. 6 Health institutions in Sri Lanka *(for color version see Plate 2)*

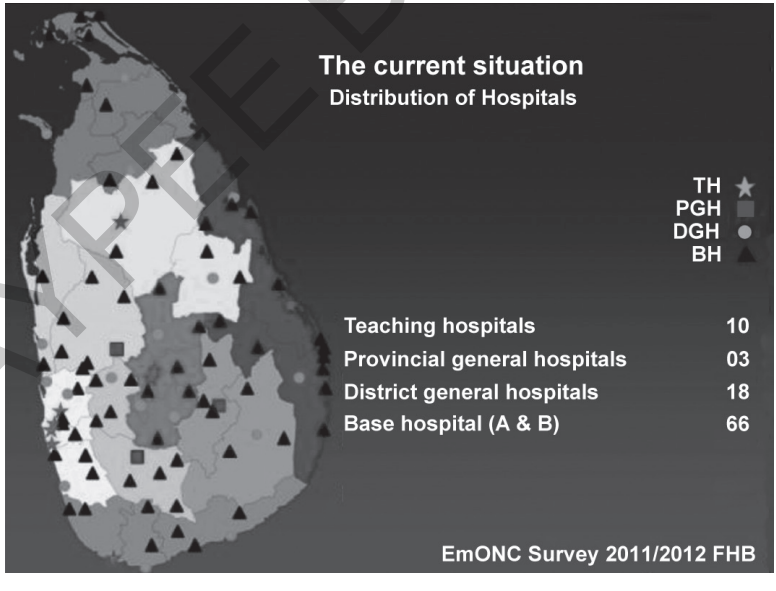

Fig. 7 Current distribution of hospitals in Sri Lanka *(for color version see Plate 3)*

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directing the maternal and child health services in country. Its members work in 68 hospitals, along with a fully fledged private sectors, providing the women care of a caliber with the country could be proud of (Fig. 7)

SCOG was geared to action by the very first international initiative at Nairobi, Kenya in 1987. In 1985 both AOFOG conference held in Colombo with major lead by doctor Shiva, Chimathamby and Professor S Ratnam. AOFOG supported Island wide workshops on maternal and perinatal health with tag quality of care in safe motherhood. First was held in Colombo 1989 and second at Ratnapura 1993. Over the years this single aspect of action of SCOG has remained constant with workshops held in various parts of Island prioritize on regional MMR.

The objectives were broadened with changing causes as well as reduction of MMR. With very high institutional delivery, the focus has shifted to EMOC as well as reduction of maternal morbidity, perinatal morbidity and mortality. Hands on training on essential emergency obstetric procedure have been incorporated into the workshop. As a step of galvanizing the next generation of obstetrician to need of quality of care in obstetrics as well to expose the different facilities and the need of different regions of the country, all the postgraduates are expected to take part in these intense workshops. Figure 8 shows author and members of SCOG providing skills and training to health care providers.

SCOG has come to an understanding with Ministry of Health (MOH) as to need to update any health attendant who comes across a laboring mother on the management of obstetric emergencies. Further development of program is expected with the assistance of RCOG, with whom the SCOG signed a historic MOU in 2012. Box 2 summarizes the purpose of this partnership.

Box 2 SCOG and RCOG partnership

The purpose of this partnership is to:

- Strengthen knowledge and clinical skill development by:
  - Facilitating placement of trainees from Sri Lanka to participate in the RCOG sponsorship scheme.
  - Facilitating short-term placement of Board certificated specialists serving in Sri Lanka on their own funding in pre-arranged centers in the UK with the objective of updating knowledge and skills.
  - Exchanging of trainees to gain knowledge and skills including medical elective placements.
  - Establishing active and genuine collaboration inclusive of other professional and professional bodies involved in health issues of women, newborns and reproduction, such as the organization of joint conferences, development of guidelines and exchange of opportunities.

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Fig. 8 SCOG training workshop

SCOG plan for 2012 to 2016: In 2012, a strong effort was made by SCOG to make the MOH to initiate confidential enquiry into maternal death as well as to maternal morbidity, SCOG plans to develop mechanism for it, coordinate legal authorities, to obtain indemnity of participants, provide assessors and scrutinize the final report and ensure it's publication within a year. Beside SCOG and MOH wishes to have many more health initiatives like universal sexual and reproductive health education, independent adolescent and youth friendly clinics, universal contraceptive availability, comprehensive abortion services

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Box 3 Strategic goal of SCOG

Strategic goal 4	By 2015 we want all children, adolescents and youth to have mandatory sexual and reproductive health education
Strategic goal 5	By 2017 we want independent adolescent and youth-friendly reproductive health services
Strategic goal 6	By 2014 we want contraceptive services to be available, accessible and be utilized by all sexually capable people irrespective of age, parity and marital status
Strategic goal 9	By 2014 we want all eligible for parenthood to receive satisfactory preconception care
Strategic goal 10	By 2014 we want all pregnant mothers to receive antenatal, intrapartum, postnatal care and emergency obstetric care at an appropriate standard set by the SLCOG
Strategic goal 11	By 2014 we want postabortion care to be delivered at an appropriate standard set by the SLCOG
Strategic goal 12	By 2014 we want all single mothers to receive equal care and assistance
Strategic goal 15	SLCOG stands for eradication of Gender Based Violence (GBV) from Sri Lanka. By 2015 we want women victims of GBV to be managed in an appropriate manner safeguarding the principles of human rights.
Strategic goal 16	To mobilize necessary resources to assist women undergoing psychological repercussions of obstetrical and gynecological and other women ralated life events
Strategic goal 17	By 2013 we want all maternal death inquiries to be carried out in the internationally accepted standard confidential reporting format
Strategic goal 18	By 2015 we want severe acute maternal morbidity inquiries to be carried out in the internationally accepted standard confidential reporting format
Strategic goal 19	We want to incorporate and promote evidence-based practice into the undergraduate and postgraduate curriculum and the clinical practice of obstetrics and gynecology

and eradication of gender based violence. Box 3 summarizes strategic goal of SCG in coming years.

CONCLUSION

Sri Lanka has shown a remarkable improvement of quality of maternal health care over the years from the colonial era to present time. Sri Lanka is a country which achieved remarkable reduction in level of

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maternity during second half of 20th century, despite total expenditure on maternal health care (recurrent and capital expenditure) average 0.23 percent of GDP or around 12 percent of total government expenditure on health. Cost were higher at the beginning of the program during 1950 and gradually decreased at a result of combination of increased efficiency and growth of private sector.

The universal and free of cost health care, women-friendly sociocultural, demographic and political influences introduced to country have given benefits to multitude of women in the country. A mother in Sri Lanka is safer than most of her counterpart in the region and in many part of the world. She could be safer further and continual address of the objective of safe motherhood initiative will be way forward.

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Safe Motherhood Initiative
A Silent Revolution

This is a unique book which encompasses vastness as well as depth of complex issues of Safe Motherhood at international and national levels. Galaxy of learned and experienced authors, leaders and ground root public health people have contributed to the book. In international section, readers will find global and historical perspectives of Safe Motherhood Initiative as a whole as well as nationwise data and stories of success, difficulties and failures. Indian section will give you deep insight into every possible knowledge and information of Safe Motherhood Programs in India right from ancient times to modern era of National Rural Health Mission and success story of Kerala. Innovations section will introduce the readers to present and future tools and program to achieve safe motherhood.

This book will be highly beneficial for teaching institutions, public health administrators, NGOs and obstetric caregivers (obstetricians, non-specialist doctors, nurses and midwives), who are working in difficult geographical areas and having passion and interest for crucial and critical issues of safe motherhood. It will sensitize and inspire the young generation of doctors to ground root realities and optimizing their role in achieving safe maternity at their work place.



Sadhana Gupta MS (Obs & Gyne) MNAMS FICOG FICMU FCMCH has incepted, edited and published *Safe Motherhood Initiative—A Silent Revolution* under her chairmanship of Safe Motherhood Committee of Federation of Obstetric and Gynaecological Societies of India (FOGSI). She is well-known for her persistent and ground root clinical, organizational and academic work. She is strong advocate of women equality, empowerment and also the righteousness and compassion in health delivery system at national and international forums. She is author of many books, editor FOGSI Publication—Safe Motherhood Bulletin, an innovative research worker has been proud recipient of many prestigious academic, social and service awards including Padmabhushan Kamlabai Hospet Award to reduce maternal mortality. This book will prove a landmark in the field of Safe Motherhood.

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