



SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

FEBRUARY 2018, VOLUME 11, ISSUE 02



Cover Story
Page 10

SLMA Monthly Clinical Meeting
Page 05

A Universal Truth: No Health Without a
Workforce
Page 11

SLMA Guest Lecture
Page 21



www.slma.lk

AUGMENTIN[®]

amoxicillin/clavulanate potassium



THE ORIGINAL

Zinacef[™]

Cefuroxime sodium injection



Zinnat[™]

Cefuroxime axetil



GlaxoSmithKline Pharmaceuticals (Pvt) Limited
121, Galle Road, Kaldemulla, Moratuwa, Sri Lanka.
Tel: +94 11 2636 341-2 Fax: +94 11 2622 574 Web: www.gsk.com
A procedure for reporting of adverse event Email: lk.pharmacovigilance@gsk.com Tel: 2636341
For the use of medical professionals only.

CONTENTS

01 PRESIDENT'S MESSAGE

Page No. 04

02 SLMA MONTHLY CLINICAL MEETING

Page No. 05

03 REVISED GUIDELINES FOR THE MANAGEMENT OF SNAKE-BITE IN HOSPITAL

Page No. 05

04 YOU AND YOUR MEMORY - KEEP YOUR BRAIN TICKING

Page No. 06

05 SLMA REGIONAL MEETING

Page No. 10

06 A UNIVERSAL TRUTH: NO HEALTH WITHOUT A WORKFORCE

Page No. 11

07 CHANGING THE STORY OF PREGNANT MOTHERS: A BROAD-BASED APPROACH

Page No. 12

08 ABSTRACT SUBMISSION

Page No. 20

09 SLMA GUEST LECTURE

Page No. 21

10 FROM DENNIS TO CHRISSIE, TILL WE MEET AGAIN

Page No. 22

SLMA Theme 2018

Shifting Focus from
Diseases to Patients:
Today's Vision,
Tomorrow's Reality

OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

NO. 6, WIJERAMA MAWATHA, COLOMBO 7.

TEL: +94 112 693324
E MAIL: OFFICE@SLMA.LK

SLMA News Editorial Committee 2018

EDITOR IN CHIEF

Dr. Amaya Ellawala

EDITORIAL COMMITTEE

Dr. Achala Balasuriya
Dr. Sarath Gamini de Silva
Dr. Achala Jayatilleke
Dr. BJC Perera
Dr. Sankha Randenikumara

Cover Page by

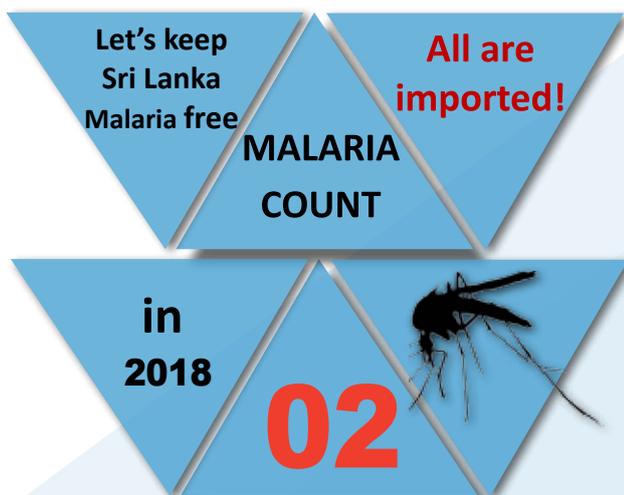
Dr. Lahiru Rajakaruna

Our Advertisers

ANTI-MALARIA CAMPAIGN.
GLAXOSMITHKLINE PHARMACEUTICALS LTD.
HÄFELE DESIGN CENTER.
JLANKA TECHNOLOGIES (PVT) LTD.
THIS SOURCE (PVT) LTD.
TOKYO CEMENT COMPANY (LANKA) PLC.

Publishing and printing assistance by:

This Source (Pvt.) Ltd,
No 136 D, Ruhunupura,
Robert Gunawardene Mawatha, Battaramulla.
Tel: +94 71 119 4825
Email: info@thissource.com



President's Message

Dear Member,

Your Council has been in office for the past one month. I am pleased to inform you that we are progressing steadily in our efforts to organize the 131st Anniversary International Medical Congress and the SLMA Run and Walk 2018. The Co-Chairs of the Steering Committee for both events are the Vice-Presidents of the SLMA. They would welcome your active contribution in finalizing the programmes and the logistics of both events. 31st March 2018 has been set as the dead-line for submissions for the seven prestigious orations awarded annually by the SLMA as well as for abstract submissions, proposals for research awards and travel grants. Please log on to our website (<http://www.slma.lk>) for further details. Our e-Bulletin also carries details of same. If you do not receive the bi-weekly e-bulletin and are desirous of receiving it, please contact the SLMA office and request to be included in our e-mailing list.

As you probably know, the driving force of the SLMA are its Committees. More importantly, it is the platform offered to our members to get actively involved with SLMA activities and thereby contribute their expertise, interest and enthusiasm towards setting and maintaining high standards for the profession in Sri Lanka. The Committees and our members, who serve in them voluntarily, make it possible for the SLMA to play its apex role as the academic, professional, ethical and moral guardians of the entire medical profession in Sri Lanka. As per tradition we have advertised for new members for the SLMA Committees and the application form appeared in the January 2018 issue of the SLMA Newsletter. The deadline for such applications is 1st March 2018. On behalf of the Council, may I please urge you to submit your duly completed application for consideration by the Council for inclusion as a member of the listed Committees.

In the preceding month we had a very constructive meeting with the newly

appointed Director General of Health Services, Dr. Anil Jasinghe, on the 9th of January 2018. He reiterated the support of the Department of Health Services towards on-going collaborations between the Ministry of Health and the SLMA. The NIROGI Lanka project on which the SLMA has collaborated with the Ministry for many years and has set the standard for collaborative projects between the MoH and Professional Associations and Colleges, came in for praise by the DGHS. The collaborative activity on Palliative Care which was initiated in 2017 was reviewed critically. The SLMA noted that the Guidelines for Palliative care have been developed along with a Guide Book and is awaiting dissemination throughout

For the strength of the Pack is the Wolf, and the strength of the Wolf is the Pack

the country through the Ministry. The long overdue implementation of the Continuous Professional Development (CPD) for state sector doctors was discussed once again. The SLMA brought to the notice of the DGHS that his predecessor had initiated a draft circular for implementation of CPD activities for doctors of the Ministry of Health and urged the DGHS to use his good offices to follow up on making the draft circular operational as soon as possible.

We held the first of our regional meetings for the year in Kadugannawa. The Kandy Society of Medicine (KSM) under the Presidency of Prof. Samath Dharmartane and The Ministry of Health Central Province under the leadership of Dr. Shanthi Samarasinghe (Provincial Director of Health Services, Central Province) collaborated with us in organizing the regional meeting under the theme 'Paediatrics for Primary Care'.

We were also able to organize a Guest Lecture by Prof. Mala Rao, Senior Clinical Fellow at Imperial College, London, on the topic 'Primary care-centred health services for universal health care- Sri Lanka leading the way' which was in keeping with our

theme of 'Shifting Focus from Diseases to Patients: Today's Vision, Tomorrows Reality'. The event, held on 12th February 2018 was followed by the SLMA hosting Prof. Rao to a sit-down lunch in the old Council Room (now renamed as the SLMA Meeting Room after extensive refurbishment in 2017) thanks to the efforts of our dynamic social secretaries Drs Pramilla Senanayake and Preethi Wijegoonewardene. Resources permitting, we intend making this the norm for lunch time guest lectures.

The SLMA commemorated its founding day, the 26th of February 1887, by hosting the Dr. C G Urugoda History of Medicine Lecture on 25th February 2018 at the Lionel Memorial Auditorium of the SLMA. The lecture was delivered by Dr. Sankha Randenikumara, MBBS, PgDTox, PDAR on the topic 'Hospital Architecture in Sri Lanka: A Historical Review'. This

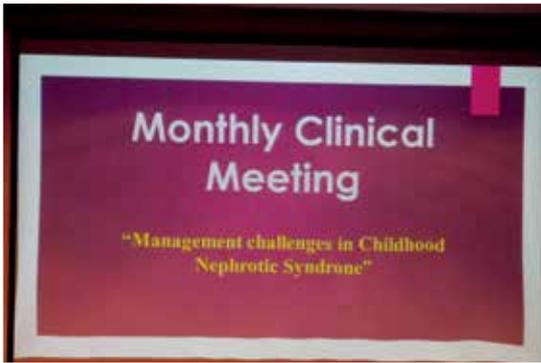
year our founding day celebrations had an added bonus as the SLMA also launched the book, History of Medicine in Sri Lanka; 1948 - 2017. This book is the continuation of the land mark book also published by the SLMA, A History of Medicine in Sri Lanka – From the earliest times to 1948 by Dr. C G Urugoda. Both books which have limited print runs are available for sale at the SLMA Office.

I wish to conclude this message by quoting Joseph Rudyard Kipling, English journalist, short-story writer, poet and novelist. In his novel The Jungle Book, Kipling writes 'For the strength of the Pack is the Wolf, and the strength of the Wolf is the Pack'. If I may be permitted to draw an analogy it is you the individual member who makes the SLMA strong and relevant to the medical profession in Sri Lanka. During this year and the years ahead I know the SLMA can count on your strength in order to maintain its undisputed role as the academic, professional, ethical and moral guardian of the Sri Lankan medical profession.

With kind regards

Ruvaiz Haniffa
President SLMA

SLMA Monthly Clinical Meeting



Dr. Sajith Edirisinghe,
Assistant Secretary-SLMA

The monthly clinical meeting of the SLMA for January, 2018, organised in collaboration with the Sri Lanka College of Paediatricians, was held on 16th January, 2018 at the SLMA Auditorium.

The lecture was delivered by Dr. Randula Ranawaka, Consultant Paediatric Nephrologist on the topic, 'Management Challenges in Childhood Nephrotic Syndrome'. The meeting also comprised of interactive case discussions, an MCQ discussion and a question and answer

session, conducted with the assistance of registrars and senior registrars in Paediatrics. The meeting was chaired by Professor Ariarane Gnanathan, Professor in Medicine, Faculty of Medicine, University of Colombo.

Now on SLMA website!

Revised Guidelines for the Management of Snakebite in Hospital

Dr. Malik Fernando
Convenor, Snakebite Committee

The Snakebite Committee has been engaged in revising the Guidelines for the Management of Snakebite in Hospital. We are happy to announce that this is now available on the SLMA website ([slma.lk/Committees/Expert Committees/Snakebite Committee](http://slma.lk/Committees/Expert%20Committees/Snakebite%20Committee)).

Many sections have been extensively revised, such as the procedure for performing the 20WBCT, use of antivenom and management of antivenom reactions. Most of the changes are evidence based - the revision relying on the WHO guidelines of 2016 and on the published work of Sri Lankan researchers. The website also lets you access the 24-hour Hotline telephone numbers for advice on coping with treatment dilemmas and the document for Prevention and First Aid of Snakebite that is also available in Sinhala and Tamil. Many persons have served on the committee over the years. The current

Co-Chairs and members who have been involved in drafting the Management Guidelines 2017 are listed below in alphabetical order of the surname:

- Prof. Kolitha Sellahewa – Co Chair
- Prof. S. A. M. Kularatne – Co Chair
- Dr. Vinya Ariyaratna
- Mr. Anslem de Silva
- Dr. Shantha de Silva
- Dr. Udaya de Silva
- Dr. Christo Fernando
- Dr. Malik Fernando – Secretary
- Prof. Indika Gawarammana
- Dr. Kalana Maduwage
- Dr. Namal Rathnayake
- Dr. Anjana Silva
- Dr. S. Sivansuthan
- Dr. N. Suganthan

We welcome suggestions for making this site more useful. E-mail your comments to the SLMA "For attention Snakebite Committee".

Now that's some serious family planning!

Roger Federer born on the 8th August 1981 is a Swiss professional tennis player. Many commentators and players regard Federer as the greatest tennis player of all time.

He has two sets of identical twins, two girls and two boys.

The youngsters when they grow up can play in all forms of the game and keep it within the family.

Men's Singles
Women's Singles
Men's Doubles
Women's Doubles
Mixed Doubles

THIS IS CALLED GRAND SLAM PLANNING!

Extracted from an e-mail received by Dr. BJC Perera



You and your memory - Keep your brain ticking

Extracted and reproduced from

<http://1960medicalbatchcolombo.blogspot.com/2010/09/you-and-your-memory-dr-jb-peiris.html>

by Dr. B.J.C.Perera

With permission from:

Deshamanya Vidyajyothi

Dr. J. B. Peiris MBBS, MD, FRCP, FRCPE,
FRCP&S, Honorary FRACP

Senior Consultant

Neurologist Dr. J.B.

Peiris suggests some simple ways to keep your mental faculties healthy.

A while ago a friend of mine asked me how best to remember names. Having faced the problem myself (possibly, a familial trait) I could not think of a suitable answer immediately. So, I did some thinking, reading and surfing and here are some interesting facts, myths and food for thought.

By the time you are 65 years, your brain is not what it used to be; you will start to notice the signs: you forget people's names and you cannot remember where you left your keys or mobile phone. Clearly not everyone ages in the same way. Reaction time is slower and it takes us longer to learn new information. Sometimes it takes longer to retrieve information, resulting in that tip-of-the-tongue phenomenon where you almost have that word or that thought. That's typical of the middle-age brain.

There is a good reason why our memories start to let us down. At this stage of life we are steadily losing brain cells in critical areas such as the hippocampus - the area where memories are processed. This is not too much of a problem at first; even in old age the brain is flexible enough to compensate.

At some point though, losses start to make themselves felt. It's true that by midlife

our brains can show some fraying. Brain processing speed slows down. Faced with new information, we often cannot master it as quickly as our younger peers. And there's little question that our short-term memories suffer.

There are, however, some brain functions which improve with age. We actually grow smarter in key areas in middle age which, with longer life spans, now stretches from our mid 40s to our mid to late 60s. In areas as diverse as vocabulary and inductive reasoning, our brains function better than they did in our 20s. As we age, we more easily get the "gist" of arguments. Even our judgment of others improves. Often, we simply "know" if someone or some idea is to be trusted. We also get better at knowing what to ignore and when to hold our tongues.

Fresh thinking about the brain

An old myth in neuroscience is that once a brain cell dies off you can't replace it. But many studies have now shown, that there is, in fact, brain cell growth throughout life. It continues to develop, and even continues to grow new brain cells. So the brain can continue to learn throughout the middle age years and beyond.

Plasticity of the brain

The brain can be changed or moulded to suit the needs. The concept of "Plasticity" which relates to changes by adding or removing connections, or adding cells. Research has shown that in fact the brain never stops changing through learning. In a study referred to as "your brain on Google," healthy, middle-aged volunteers, all novices on the computer, were taught how to do a Google search. They were told then to practise doing online searches for an hour a day, for seven days. After the week's practice, the volunteers came back into the lab and had their brains scanned while doing a Google search. The scans revealed significant increases in brain activity in the areas that control memory and decision-making.

The area of the brain that showed the

increase was the frontal lobe, the thinking brain, especially in areas that control decision making and working memory.

With practice, a middle-age brain can very quickly alter its neuron-circuitry; can strengthen the neuron circuits that control short-term memory and decision making. It is also known that other areas of the brain also increase in size with usage. For example, the finger area in the motor cortex in Braille readers and professional string instrument players is more extensive than in a normal individual. The ability of the brain to change with learning is what is known as Neuro-plasticity.

Remembering names and numbers

Let me now try to answer the question I posed at the beginning "how to remember names and numbers". Repeat it 7 seconds later. Train your mind frequently by repeating to yourself anything you need to remember as quickly as you learn it. This is very useful especially when remembering phone numbers and dates. Repetition is a simple system on how to improve memory power, but it works even for long term memory. Recall it after 7 seconds to store it in memory. One could also write it down. Let the paper remember for you. The point is to have use of the information later, and if that's more easily done by way of an "external memory device" like pen and paper, why not take advantage of these tools?

Also, writing things down is another way to more strongly "fix" something in our minds.

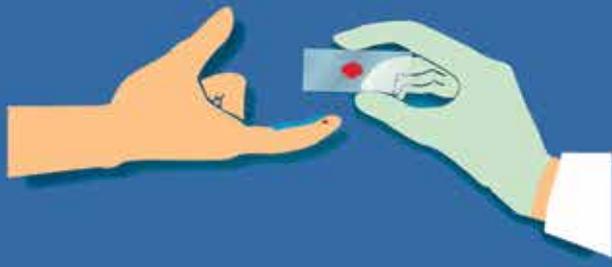
Imagine the future use

If you think about how you will use information, you're more likely to remember it. For example if after learning a new algorithm in a math class you imagine using it during a test, you'll probably remember it better, particularly when taking a test.

How to improve brain fitness

Consider the brain a muscle. Variety and curiosity is the basis.

CONTD. ON PAGE 08



Reduce the Delay

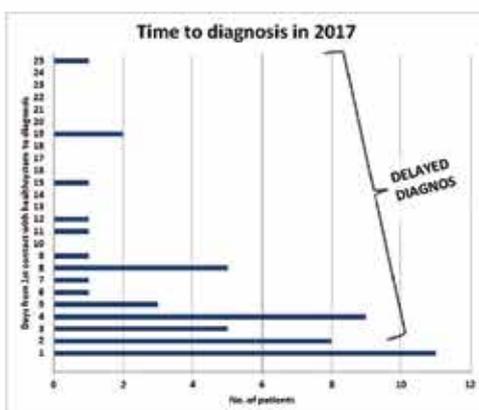
in diagnosing imported **Malaria**

Every single day that a malaria patient is left untreated,

- * His/her chances of survival decreases, &
- * He/she can transmit the disease to others & re-introduce malaria to Sri Lanka



Therefore **malaria should be diagnosed within 24 hours of onset of fever**



Your role:

For all fever patients, always check **travel history** at first interview. If patient has travelled to a malaria endemic country recently, **test for malaria**.

Anti Malaria Campaign Headquarters
Public Health Complex, 3rd floor, 555/5,
Elvitigala Mawatha, Colombo 05
Tell: 011 2 588 408/ 011 2 368 173/ 011 2 368 174
Email : antimalariacampaignsl@gmail.com

Call now for free advice, treatment and drugs
011 7 626 626
www.malariacampaign.gov.lk

Your and your memory...

When anything you do becomes second nature, you need to make a change. If you can do the crossword puzzle in your sleep, it's time for you to move on to a new challenge in order to get the best workout for your brain.

Brain aerobics

What exactly constitutes a brain aerobic exercise?

To qualify as a brain aerobic exercise, the activity needs to

- Involve two or more of the senses
- Break a routine activity in an unexpected and non-trivial way

Play games

Sudoku, crosswords, playing chess or bridge, dancing regularly and electronic games can all improve your brain's speed and memory. These games rely on logic, word skills, math and more. These games are also fun. You'll get more benefit by doing these games a little bit every day, spend 15 minutes or so, and not hours at it.

Meditation

Daily meditation is perhaps the single

greatest thing you can do for your mind/body health. Meditation not only relaxes you, it gives your brain a workout. By creating a different mental state, you engage your brain in new and interesting ways while increasing your brain fitness.

Turn off your television

Television can stand in the way of relationships, life and more. Turn off your TV and spend more time living and exercising your mind and body.

Exercise your body to exercise your brain

Physical exercise is great brain exercise too. By moving your body, your brain has to learn new muscle skills, estimate distance and practise balance. Choose a variety of exercises to challenge your brain.

Read something different

Branch out from familiar reading topics. If you usually read history books, try a contemporary novel. Read foreign authors, the classics and random books.

Learn a new skill

Learning a new skill works multiple areas of the brain. Your memory comes into play, you learn new movements and you

associate things differently. Learning a new language or becoming computer literate is equally good. Reading Shakespeare, learning to cook and building an airplane out of toothpicks will challenge your brain and give you something to think about.

Make simple changes

We love our routines. We have hobbies and pastimes that we could do for hours on end. To really help your brain stay young, challenge it. Change routes to your destinations, use your opposite hand to open doors, eat dessert, shave, brush teeth, texting and using the computer mouse. Writing with the other hand is a useful way of using the non-dominant hemisphere to do a component associated with speech "usually" located in the dominant hemisphere.

The brain is an organ like no other. You can exercise it in many different ways and this is the best way to make the best use of it.

"Use it or lose it", is true of the brain; importantly you can use it in many different ways.

Now let's exercise our brains!

Word Ladder

Change just one letter on each line to go from the top word to the bottom word. Do not change the order of the letters. You must have a common English word at each step.

ROSE

BUDS

Puzzle

Which of the numbers should replace the question mark?

A	B	C	D
3	5	1	9
2	0	4	6
7	1	0	8
2	3	1	?

8	2	9
1	4	6

Answers available on page 22

Extracted from 'Boost your IQ' and 'Word Puzzles'.

SLMA Newsletter | February 2018



LIVE
VERY
HÄFELE

Häfele brings to you
Smooth Sliding Solutions

Insect Screen

Fold 70 F



Classic 100 F



Häfele Design Centre - Colombo
No. 52, Nandana Gardens, Colombo 04
(On Duplication Road), Sri Lanka.
Phone: 0094 112 500 501
Fax: 0094 112 500 553

Häfele Design & Training Centre - Moratuwa
448, Galle Road, Rawathawatta, Moratuwa,
Sri Lanka. Phone/Fax: 0094 112 644 600

Häfele Boutique - Kandy
747A, Sirimawo Bandaranayake Mawatha,
Mulgampola, Kandy, Sri Lanka.
Phone/Fax: 0094 812 223 338

Customer Care No.:
011 20 55 55 8

SLMA Regional Meeting

Dr. Shihan Azeez, -
Assistant Secretary, SLMA

Dr. Sumithra Tissera -
Assistant Treasurer, SLMA

The first SLMA regional meeting – ‘Paediatrics in Primary Care’, organized in collaboration with the Ministry of Health, Central Province and the Kandy Society of Medicine (KSM), was held at the Kadugannawa Regional Training Centre on 24th January 2018 with the attendance of approximately 50 participants. The programme commenced with the speakers and participants being welcomed by Prof. Samath D. Dharmaratne, President KSM, Dr. Ruvaiz Haniffa, President, SLMA and Dr. Iranga Madushan, MO Planning on behalf of the Provincial Director of Health Services, Central Province.

In the first session chaired by Prof. Samath Dharmaratne and Dr. Ruvaiz Haniffa, Dr. Shehan Perera, Consultant Paediatric Cardiologist, Lady Ridgeway Hospital, Colombo, spoke on ‘Congenital Heart Disease made easy – all I need to know in a



nutshell’ and Prof. Rasanayake Mudiyanse, Professor in Paediatrics, Faculty of Medicine, University of Peradeniya, delivered a lecture on ‘Effective Communication with Patients.’

The second session was chaired by Prof. Rasanayake Mudiyanse and Dr. Neelamani Hewa g e e g a n a g e , President, College of Medical Administrators, Sri Lanka. This session comprised lectures by Dr. BJC Perera, Consultant Paediatrician and Past President, SLMA on ‘Bacterial lower respiratory tract infections in children’; Dr. Jagath Munasinghe, Consultant Paediatrician,

Sirimavo Bandaranayake Specialized Children’s Hospital on ‘Is it a seizure or not a seizure? – working with uncertainty’ and a joint presentation by Dr. Malik Fernando, Past President, SLMA and Professor SAM Kularatne, Senior Professor of Medicine, Faculty of Medicine, University of Peradeniya, titled ‘Introduction to the snakebite website.’

The meeting concluded with the vote of thanks by Dr. Anura Rajapakse, Deputy Director Training – Regional Training Centre, Kadugannawa.

The lectures were highly interactive with ample time for discussion and were appreciated by all present. All participants were awarded a certificate of participation with CPD points.

The meeting was sponsored by Ceybank Asset Management Limited.



A Universal Truth: No Health Without a Workforce

This article is based on the workshop conducted on the same theme by a panel of experts from WHO on 28th of November 2017, at the SLMA Auditorium. The experts from WHO included Dr. Mclsaac Michelle & Dr Zurn Pascal (World Health Organization – Head Quarters, Geneva), Dr. Zapata Tomas (WHO – SEARO) and Dr. Padmal de Silva (WHO – Sri Lanka).

The health workforce plays a central role in achieving Universal Health Care (UHC) coverage. With the rising burden of non-communicable diseases there is increasing need for greater access to appropriately trained health workers. The importance of the health sector is growing and the demand for health workers is expected to double by 2030 (WHO, 2017).

Investment in the health workforce comprises the largest component of health investment needed to achieve the health Sustainable Development Goals (SDGs); requiring over a third of the resources. It is estimated that the cost of meeting the health SDGs is between 1-4 trillion USD over the next 15 years, with 36% of this needed for an additional 23.6 million health workers (Stenberg et al., 2017). The Global Strategy on Human Resources for Health: Workforce 2030 which is based on a threshold of 4.45 skilled health professionals per 1,000 population suggests a shortfall of 17.4 million health workers by 2030. The estimated shortfall for the South-East Asia region is 4.7 million and the projected shortfall of doctors

in the region is 1 million doctors (World Health Organization, 2016).

Having the appropriate quantity of skilled health workers accelerates progress on health-related SDGs. Increasing the supply of health workers with the appropriate skill mix needed to meet demand is important in order to meet the growing demand for health services. As such, having responsive education and training facilities, sufficient continuing education and career opportunities are essential. Equally important is having a recruitment and deployment strategy that ensures an equitable distribution.

Globally, health is a leading economic driver and a large employer as a sector. The unique position of the health sector, as both its own industry as well as an input into the productivity of other industries gives it a multiplier effect in terms of economic growth. The health and social sector contributes to economic growth with the total global expenditure on health estimated at over US\$ 7 trillion per year worldwide (World Health Organization, 2014), making it a leading economic driver. The health and social sector is also a major employer, comprising 11 percent of total employment in OECD countries (OECD, 2016).

However, there remain underexploited additional benefits to investing in health

workers; investing in the health and social workforce stimulates poverty reduction (SDG1), gains in quality education (SDG 4), gender equality (SDG 5) and decent work and inclusive growth (SDG 8).

There is an increasing body of evidence pertaining to the value of investing in the health workforce. The socioeconomic dividends of investing in the health workforce are strong. Investing in health sector jobs has generally seen large increases in female labour force participation. In Sri Lanka alone, female workers make up approximately 60% of the health workforce, whereas they comprise only about 35% of all employment in Sri Lanka (Sri Lanka Bureau of Foreign Employment, 2015). Investing in the health workforce is likely to have enduring effects in the face of structural changes in sectors due to the high level of resiliency to automation.

Social workers dealing with substance abuse, audiologists, occupational therapists, orthotists and prosthetists, healthcare and social workers, oral and maxillofacial surgeons, dieticians and nutritionists, physicians and surgeons, psychologists, and dentists are all ranked in the 20 least likely jobs to be replaced by automation (Frey and Osborne, 2013). These constitute half the jobs in the latter category.



CONTD. ON PAGE 12

A Universal Truth...

Nevertheless, the growing shortfall of health workers suggests that there remains a pervasive underinvestment in health worldwide.

On average, across the globe, around 10% of the gross domestic product was spent on health in 2014. Sri Lanka's total health expenditure was 3.5% of GDP in 2014, which is comparatively lower than India at 4.7% and Nepal at 5.6% (World Health Organization, 2017).

This underinvestment also affects the dynamics of health workforce international mobility. In high income countries, demand for health workers is outstripping domestic supply, resulting in an increasing reliance on international migration of health workers. In 2013 in OECD countries the average share of foreign trained doctors was 17.3% (OECD, 2015).

In addition to a need for more investment in the health workforce in many countries, a lack of evidence-based health workforce planning can result in inefficient investments, impairing progress towards UHC and attaining the SDGs. Improving the understanding of the health labour

market can assist with informed policy making, guide resources and investments, and facilitate effective health workforce planning taking into consideration contextual factors that influence the country's health system.

References

Frey C, Osborne M, (2013). *The Future of Employment: How Susceptible Are Jobs to Computerization* Oxford Martin School, Oxford, UK.

OECD, (2015), *Health at a Glance 2015: OECD Indicators*, OECD Publishing, Paris. http://dx.doi.org/10.1787/health_glance-2015-en

OECD, (2016), *Health Workforce Policies in OECD Countries – Right Jobs, Right Skills, Right Places*. OECD Publishing Paris. <http://dx.doi.org/10.1787/9789264239517-en>

Sri Lanka Bureau of Foreign Employment (2015), *Annual Statistical Report of Foreign Employment -2015*. <http://www.slbfelk/page.php?LID=1&MID=213>

[slbfelk/page.php?LID=1&MID=213](http://www.slbfelk/page.php?LID=1&MID=213)

Stenberg K, Hanssen O, Edejer T, et al. (2017), *Financing transformative health systems towards achievement of the health Sustainable Development Goals: a model for projected resource needs in 67 low-income and middle-income countries*. *Lancet Glob Health*, 5, pp. e875–e887

World Health Organization, (2014), *Global health expenditure atlas*. September 2014. <http://www.who.int/entity/health-accounts/atlas2014.pdf?ua=1>

World Health Organization, (2016), *Global strategy on human resources for health: Workforce 2030*. http://www.who.int/entity/hrh/resources/global_strategy_workforce2030_14_print.pdf?ua=1

World Health Organization. (2017). *Global Health Observatory data: Total expenditure on health as a percentage of gross domestic product (US\$)*. http://www.who.int/gho/health_financing/total_expenditure/en/

Changing the story of pregnant mothers: A broad-based approach

Dr. Kapila Jayaratne, Consultant Community Physician, National Program manager – Maternal & Child Morbidity & Mortality Surveillance, Family Health Bureau – Ministry of Health

Based on the Nicholas Attygalle Oration delivered on 27th October, 2017 at the Lionel Memorial Auditorium, SLMA.

The loss of a pregnant mother is a tragic event. There were 303,000 maternal deaths worldwide reported by the World Health Organization (WHO) publication on maternal mortality estimates in 2015.

Maternal deaths

We define a maternal death as 'Death of a woman while pregnant or within 42 days after termination of pregnancy due to direct or indirect causes'. The

Maternal Mortality Ratio (MMR) –number of maternal deaths per 100,000 live births, is a strong social indicator since it reflects the living conditions of women, the level of population development and the quality and level of the health system organization.

Out of 303,000 estimated maternal deaths in the world, developing regions account for 99% (302 000). The world MMR is 216 per 100,000 live births. It ranges from 12 in developed regions to 239 in developing regions. The global worst MMR is reported from Sierra Leone with 1360 deaths per 100 000 live births in 2015. The global best MMR of 3 was reported from 5 countries (Greece, Finland, Iceland, Kuwait and Poland). More than one third of all estimated global maternal deaths

are reported from Nigeria (58000) and India (84000). The disparity is wide –the estimated risk of a woman dying from pregnancy-related causes in high-income countries is 1 in 3400 while in low-income countries the same risk is 1 in 52.

Maternal Death Surveillance & Response

Each maternal death is a sentinel event. For each maternal death, we want to know 'Why it happened'. Review of maternal deaths is recognized as a best practice for reducing such deaths. WHO in 2004 introduced a guide, *Beyond the numbers—Reviewing maternal deaths and complications to make pregnancy safer* to initiate maternal death reviews & response systems (MDSR).

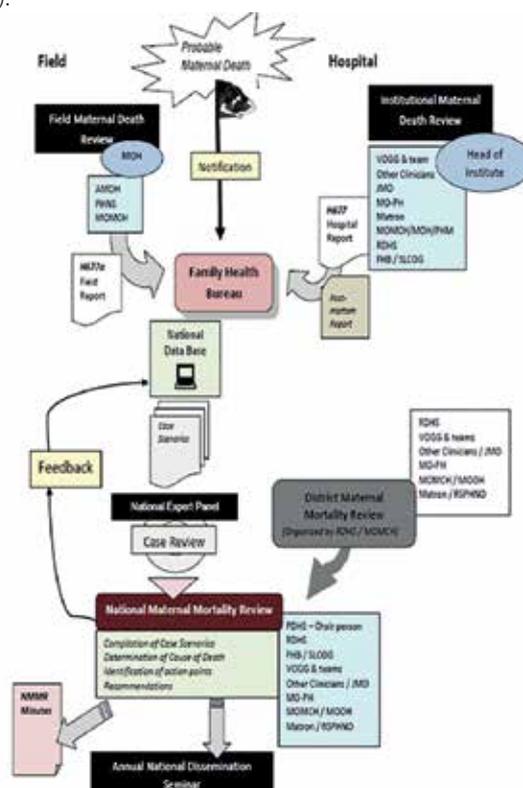
WHO facilitated a review of the status of MDSR implementation in five countries—India, Indonesia, Myanmar, Nepal and Sri Lanka in the SEARO region in 2013. The specific objectives of the review were to document the experiences of MDSR initiatives being implemented in these countries, to identify lessons learnt, and to share country experiences with other countries in the region. In each country, we reviewed documents and reports, had key informant interviews and where possible observed the MDR process.

In this study, we found that Sri Lanka started reviewing maternal deaths way back in 1985. The review process evolved over the years with the addition of quality dimensions. In 1985, the gazette regulation on mandatory notification of probable maternal deaths was issued. In 1995, structured review of deaths was started by the Family Health Bureau (FHB). In 2000, a national maternal death database was established. Maternal death investigation formats were revised in 2006. In 2009, Ministry of Justice issued a circular to all coroners on compulsory post-mortems on maternal deaths. It was further reinforced by the circular issued from Ministry of Health in 2010. In 2010, the review process was revolutionized with the addition of compilation of case scenarios and a desk review by national level experts from professional colleges of obstetricians, anaesthesiologists, community physicians, forensic pathologists and pulmonologists. MDSR guidelines were introduced. Minutes were made and disseminated to a wider group of stakeholders. Several mechanisms, including two technical committees and a national committee on family health were introduced, to translate lessons learnt into action. Maternal death data were shared with the Registrar General's Department –the gold standard source for maternal mortality statistics (Figure 1).

We published the outcome in *British Journal of Obstetrics & Gynaecology*

(BJOG) in 2014- *Maternal death review in selected countries of South East Asia Region*. In this paper, our MDSR system was recognized to be the best organized and structured. This was further acknowledged at the highest international level when we published Sri Lanka's MDSR experience in *The Lancet* (2014) and presented it at the *World Health Summit in Berlin* in 2014 and at the *Royal College of Obstetricians and Gynaecologists (RCOG) Annual Congress, Brisbane* in 2015. We have showcased the country's MDSR at the recent *WHO Regional meeting to strengthen capacity on MDSR* in Maldives this year. As a role model mechanism, representatives from several countries (Maldives, Nepal, Afghanistan, DPR Korea, Bangladesh and Timor Leste) had hands on exposure to our MDSR system over the last few years.

Figure 1 – MDSR Mechanism of Sri Lanka



Reviewing maternal deaths *per se* will do nothing. Translating lessons learnt into policies, programmes and practices is also of utmost importance. We have performed a multitude of actions as lessons learnt out of maternal deaths. From addressing human resource issues and provision of logistics to care for the critically-ill

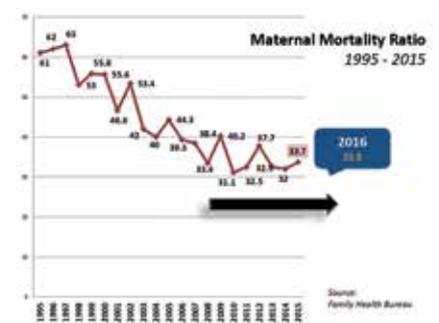
pregnant mother at intensive care units (ICU). MDSR contributed significantly in reducing maternal deaths in Sri Lanka. The maternal care service delivery is so successful that the country has a maternal and child health record that is the envy of South Asia. Nowhere is this better reflected than in the MMR. Figure 2 shows how MMR has declined over the years in Sri Lanka.

Figure 2 – Maternal Mortality Ratio – Sri Lanka (1911 – 1995)



In 1948, 1700 women died when 100,000 babies were born alive (reported by Registrar General's Department). The reduction in maternal deaths as reported by FHB after a structured MDSR was implemented is depicted in Figure 3.

Figure 3 – Maternal Mortality Ratio – Sri Lanka (1995 – 2015)



Now we capture almost all maternal deaths. In the year 2016, Sri Lanka had 112 maternal deaths and 331000 live births to report a MMR of 33.8 per 100,000 live births. In other words **'34 women die when 100,000 babies are born alive'**. This success is inspiring when compared with other countries in the region and the global worst (Figure 4).

Changing the story...

Figure 4

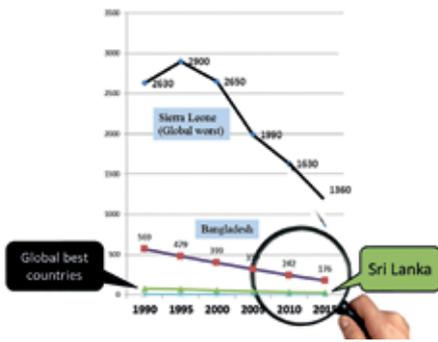
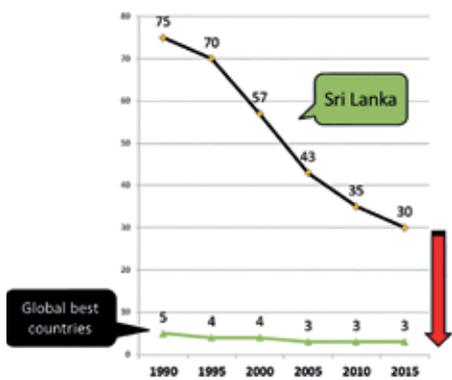


Figure 5



We are well-placed along with global best MMR countries (Finland & Greece) and other comparative countries (eg. Thailand and Malaysia) as seen in Figure 4. When we magnify further however, it is not really so (Figure 5). With Sri Lanka's current MMR status in comparison with the global best and countries with similar socio-economic levels, we have a long way to go to achieve a single digit MMR.

Still 112 women are dying in this country just because they are pregnant. Our media, community groups, politicians and even healthcare professionals talk of 48 dengue deaths, 24 rabies deaths or a possible Zika virus epidemic. Maternal deaths often go unnoticed because they are dispersed and occur mostly in rural and remote settings. In 2015, ¾ of these women were either from rural or estate sectors, most possibly poor. A significant proportion (10%) were 'not married'. The majority were socially-stigmatized pregnancies.

Referring again to Figure 4, since 2007, the country's MMR has been fluctuating at the same level. A significant reduction is not evident. This is despite a background

of 99% antenatal care, 99.9% hospital deliveries (94% in an institution where an obstetrician is available) and 91% post-partum domiciliary care.

The global context is also similar. The global MMR declined significantly, dropping from 385 in 1990 to 216 in 2015 (an approximate 43% reduction in maternal deaths). Despite a secular worldwide trend towards social development and maternal mortality reduction, the original target of global MMR for Millennium Development Goals (MDG), 95, could not be achieved. This, in part could be explained by the phenomenon of 'Obstetric Transition' – gradual changes that countries experience in their pathway towards elimination of avoidable maternal deaths.

Obstetric Transition

The Obstetric Transition Model has been recognized to be a theoretical framework to examine the dynamic process of maternal mortality reduction. As seen in Table 1, the model includes a shift of maternal deaths from direct obstetric causes to indirect causes; from communicable to non-communicable diseases; from a younger

maternal population to an older one; and a decrease in MMR, along with an increase in institutionalized maternity care, and at the end, over-medicalization.

In a context of global focus on reducing the global MMR below 70 by 2030 to achieve Sustainable Development Goals (SDG), it is important to test whether the proposed features of the Obstetric Transition Model are observed at a country level. We analyzed a large, multi-country, maternal and perinatal health database, WHO Multi-country survey on Maternal and Newborn Health (WHO-MCS), for this purpose.

WHO Multi-country survey on Maternal and Newborn Health (WHO-MCS)

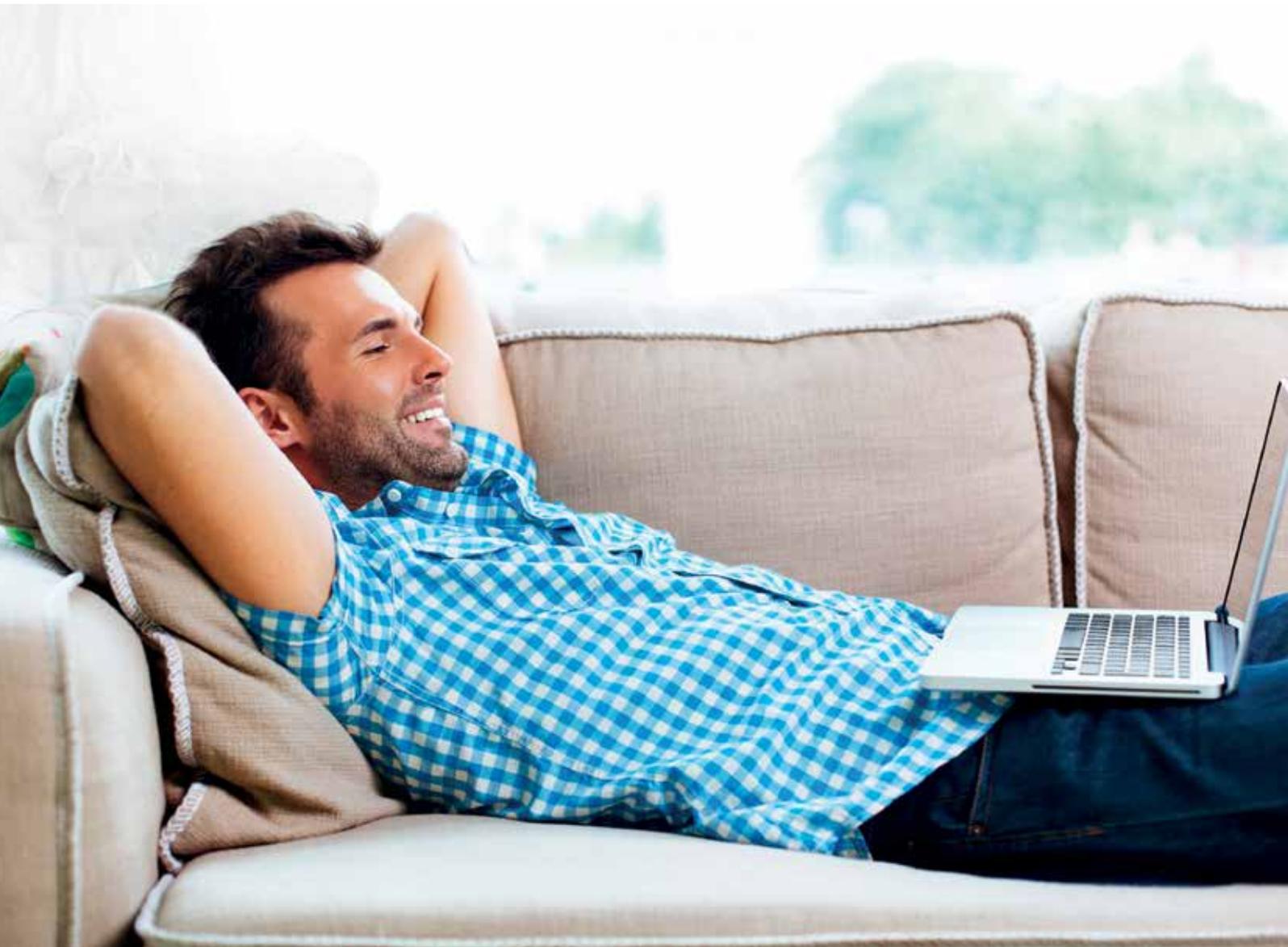
The WHO-MCS was a cross-sectional study conducted in health facilities in 29 countries from Africa, Asia, Latin America, and the Middle East. A stratified, multistage cluster sampling strategy was used to select countries, provinces and health facilities randomly. Health facilities were eligible only if they reported at least 1000 deliveries per year and had the capacity to provide caesarean section.

Table 1: Obstetric Transition Stages

Stage	MMR	Causes	Service Provision
Stage I	> 1 000 Very high MMR	<ul style="list-style-type: none"> • ↑↑ fertility • ↑↑ direct maternal deaths • ↑↑ communicable diseases • A situation close to the natural history of pregnancy and childbirth 	<ul style="list-style-type: none"> • ↑↑ do not receive professional obstetric care • ↑↑ do not have access to health facilities
Stage II	999 - 300	<ul style="list-style-type: none"> • ↑↑ Mortality and fertility pattern of causes similar to Stage I 	<ul style="list-style-type: none"> • ↑↑ women seek and receive care in health units
Stage III	299 - 50	<ul style="list-style-type: none"> • Variable fertility • ↑ direct maternal deaths 	<ul style="list-style-type: none"> • Access continues to be an issue for a large part of the population • ↑↑ arrive at health services • Overburdened health services • Quality of care -main determinant of outcome
Stage IV	< 50	<ul style="list-style-type: none"> • ↓ fertility rate • ↓ direct ↑ Indirect causes • ↑ Chronic-degenerative diseases 	<ul style="list-style-type: none"> • ↑↑ access to care • ↑↑ medicalization as a threat to the quality and improvement of health outcomes
Stage V	< 5	<ul style="list-style-type: none"> • ↓↓Fertility • ↑↑ Indirect obstetric causes • ↑ chronic-degenerative disorders • All avoidable maternal deaths are prevented 	<ul style="list-style-type: none"> • The main challenges - consolidation of advances against structural violence (eg. gender inequalities), • Effective management of vulnerable populations • Sustainability of excellence in quality of care

Time to sit back and relax!

Speak to us for turnkey publishing solutions.



Changing the story...

All women who delivered at participating facilities and women with severe maternal outcomes (SMO) were the study population. Data for all eligible study participants was obtained from hospital records at hospital discharge, transfer, or death up to 7 days post-partum. Data collection was done for a period of two months in facilities that had at least 6000 deliveries every year and for three months in facilities with fewer than 6000 deliveries every year to minimize variation in cluster size. Data were entered into a web-based data management system. Data was collected for 314,623 women from 359 health facilities in 29 countries, including Sri Lanka, between May 1, 2010, and December 31, 2011. This study was approved by the WHO ethical review committee and the relevant ethical clearance mechanisms in all countries. As the principal investigator for the Sri Lankan component and a member of the WHO-MCS research network, the orator was involved in the coordination of the study. The methodology was published in BJOG 2014 -*The World Health Organization Multicountry Survey on Maternal and Newborn Health project at a glance: the*

power of collaboration.

We did a secondary analysis of WHO-MCS data to discuss the dynamic process of maternal mortality reduction using the same model as a theoretical framework. We utilized data on 314,623 women admitted for child birth in 359 hospitals in 29 countries. WHO estimates of MMR were used to stratify participating countries into obstetric transition stages. Stage I, the most primitive stage, and Stage V, when all preventable maternal deaths are eliminated, were not considered as they are practically not seen in the present context. Characteristics of obstetric transition were evaluated through available variables and proxies. The results are presented in Table 2.

The Obstetric Transition Model and results allow identification of a country's current obstetric stage. After country stratification by obstetric transition stage, based on country-level MMR estimates, we found that as the stages of obstetric transition increased, women tended to have fewer children, have the first child at an older age, and experience increased medicalization

of childbirth. The frequency of uterine rupture, used as a proxy for avoidable morbidity and mortality, decreased as the obstetric transition stage increased. The frequency of severe maternal outcomes (both near-miss and mortality) decreased in the study facilities as the obstetric transition stage increased.

This shows that the model also provides an insight in to which strategies should be used to make further improvements. Because the Obstetric Transition Model considers specific features of the maternal population (such as fertility, medicalization of pregnancy and childbirth, age of maternal population, and causes of maternal morbidity and mortality), it moves beyond human development index classifications and previous transition models. The outcome of application of this model at global and country levels can provide guidance to public health decision makers on implementation of appropriate, dynamic, and efficient programmes at the global, regional, and national levels. We published the outcome of the analysis in *Pan American Journal of Public Health 2015 - Obstetric transition in the World Health Organization Multicountry Survey*

on Maternal and Newborn Health: exploring pathways for maternal mortality reduction.

Table 2 - Obstetric transition stages and their characteristics in WHO-MCS

Characteristic	Stage II	Stage III	Stage IV
Maternal mortality			
Intra-hospital MMR (per 100 000 LB)	279	134	13
Number of maternal deaths	268	211	7
Fertility (proxy)			
Parity	3.0	2.0	1.8
Medicalization (proxy)			
Cesarean section rate	15.3%	33.9%	36.7%
Inductions of labor rate	7.1%	9.8%	18.8%
Age of maternal population (proxy)			
Age of nulliparous in years	22.3	23.4	25.8
Avoidable morbidity & mortality (proxy)			
Ruptured uterus per 100 000 LB	178	80	34
Number of ruptured uterus	171	127	18

Preventing Preventable

Maternal Deaths

Are we doing the maximum? Not really. In-depth analysis of maternal deaths shows that nearly 30 -35% (one third) of deaths could have been averted had we promoted proper family planning. The analysis of 720 maternal deaths, 2006 – 2010, revealed that 92% were preventable. This was 61% in 2011 – 2013 (out of 372 deaths) and for the year 2014 (112 deaths) it was 62%. Preventing Preventable Maternal Deaths is a challenge the world over.

NEW LOOK, NEW OFFERINGS, UNCOMPROMISED QUALITY, GUARANTEED.



TOKYO SUPERLIGHT
LOW WEIGHT | HIGH STRENGTH



LIGHT WEIGHT CONCRETE BLOCK



ORDINARY PORTLAND CEMENT • PORTLAND POZZOLANA CEMENT • CELLULAR LIGHTWEIGHT CONCRETE
INTERNAL & EXTERNAL PLASTER • SELF LEVELLING FLOORING COMPOUND • PREMIXED CONCRETE
WATERPROOFING SOLUTION • TILE ADHESIVES • BLOCK MORTAR • SCREED MORTAR

www.tokyocement.lk



TOKYO CEMENT GROUP

☎ 077 395 1513 / 0112 558 100 / 0112 500 466 / 0112 592 308 @ sales@tokyocement.lk

Changing the story...

Once a country, achieves a low level of maternal deaths, further reductions are difficult. Despite the high significance of the issue, maternal deaths are relatively rare events in individual facilities, complicating the assessment of effects of care on mortality. Lessons learnt are limited due to low sample size. But, countries have achieved single digit MMRs. No quick fix exists to reduce maternal mortality. Micro-level approaches are crucial in further reduction.

MMR in Sri Lanka has fallen from close to 100 in 1990 to 34 in 2016. Despite such an impressive reduction, especially when comparing with regional countries, we could not achieve the MDG target for MMR – 23 per 100,000 live births. However, capitalizing on the momentum generated by MDG 5, the Sustainable Development Goals (SDG) provides a transformative new agenda going much further than the MDGs.

Sustainable Development Goals

On September 25th 2015, at a historic UN Summit at UN headquarters in New York, world leaders adopted a set of 17 goals to end poverty, protect the planet, and ensure prosperity for all as part of a new sustainable development agenda. SDGs address root causes of poverty and a range of social needs including education, health, social protection, and job opportunities, while tackling climate change and environmental protection that work for all people. Each goal has specific targets to be achieved over the next 15 years. Goal number 3 of the SDGs focuses on 'Good Health & Wellbeing'. In ending preventable maternal

deaths; target 3.1 of SDG 3 is to reduce the global MMR to less than 70 per 100,000 live births by 2030. For Sri Lanka, to achieve 10 MMR by 2030.

In this background, to face the phase of obstetric transition, 'Moving beyond maternal deaths' is inevitable.

Two strategic plans, Every Newborn: An Action Plan to End Preventable Deaths (ENAP) and Ending Preventable Maternal Mortality (EPMM), aim to catalyze global action to eliminate wide disparities in the risk of death and end preventable maternal and newborn mortality and stillbirths within a generation. The detailed strategic guidance, specific targets, interventions, and milestones of this paper provide guidance for countries to use in their formulation of national health plans and funding priorities.

Moving beyond maternal deaths to improve care for pregnant mothers, two most important mileposts in the challenging road ahead include maternal

near-misses and coverage of essential interventions.

Maternal Near-misses

The next layer in the iceberg below maternal deaths, is severe maternal morbidity. With low MMR and a direct obstetric case fatality rate (0.151%) well below international threshold (1%), maternal near-misses are highly implicated in Sri Lankan settings. Severe maternal complications are described as "potentially life-threatening conditions". Pregnant women who develop severe acute complications share a common pathway with many pathological and circumstantial factors. Those who narrowly escape death are termed 'maternal near-misses'. The WHO maternal near-miss criteria is based on clinical criteria, laboratory markers and management based proxies categorized according to dysfunctional organ systems. A woman presenting with any of these life-threatening conditions and surviving a complication during pregnancy, childbirth or within 42 days of termination of pregnancy is considered a maternal near-miss case.

Figure – 6 The WHO maternal near-miss criteria

Dysfunctional system	Clinical criteria	Laboratory markers	Management based proxies
CVS	Shock Cardiac arrest	pH<7.1 Lactate >5 mEq/mL	Use of continuous vasoactive drugs Cardio-pulmonary resuscitation
Respiratory	Acute cyanosis Gaspings Respiratory rate >40 or <6 bpm	Oxygen saturation < 90% for ≥ 60 mts PaO ₂ / FiO ₂ <200 mmHg	Intubation and ventilation not related to anaesthesia
Renal	Oliguria non responsive to fluids or diuretics	Creatinine ≥300µmol/l or ≥3.5 mg/dL	Dialysis for acute renal failure
Haematologic/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	Bilirubin>100 µmol/l or >6.0 mg/dL	
Neurologic	Any loss of consciousness lasting >12h, Stroke Uncontrollable fit / status epilepticus Total paralysis		
Alternative severity proxy			Hysterectomy following infection or haemorrhage

The orator was involved in the development of the WHO near-miss approach for maternal health to evaluate the quality of care for severe pregnancy complications as a member of the WHO Multi-country Survey on Maternal and Newborn Health Research Group in 2011. This was published by the WHO: *Evaluating the quality of care for severe pregnancy complications, The WHO near-miss approach for maternal health* (http://apps.who.int/iris/bitstream/10665/44692/1/9789241502221_eng.pdf). Guidelines were further improved at the consultative workshop on 'WHO Maternal Near-Miss Approach and Quality of Care: Research and Implementation' January, 2015, Istanbul, Turkey. The orator contributed as a temporary advisor to WHO representing Sri Lanka at this technical consultation.

By studying women with severe maternal outcomes (SMO) much can be learnt about the processes and the findings can be translated in to policies, programmes and practices to improve the care of pregnant women.

With this background, we carried out a survey, covering severe maternal morbidity (maternal near-misses) in a global network of health facilities as part of WHO-MCS described earlier.

WHO-MCS is the largest study to date assessing management of severe complications and the prevalence of maternal near-miss by use of standardized definitions in a global context. Our analysis specifically aimed to describe maternal characteristics and perinatal outcomes and to assess the prevalence and severity of complications related to pregnancy.

We obtained data from hospital records for all women giving birth and all women who had a SMO (maternal death or maternal near miss). We computed the frequency of women with potentially life-threatening conditions, the maternal near-miss ratio, the severe outcome ratio and the intra-hospital MMR.

The results showed that the majority of women with organ dysfunctions were identified through clinical criteria. Laboratory based criteria were the single identifiers only in a minority of cases. Potentially life-threatening conditions were noted in 23,015 (7.3%) women and 3024 (1.0%) developed an SMO. Post-partum haemorrhage (n=808, 26.7%) and pre-eclampsia/eclampsia (n=784, 25.9%) were the two most frequent obstetric complications noted in women with SMO. Cardiovascular, respiratory, and coagulation dysfunctions were the leading organ dysfunctions. The prevalence of SMO in a country increased as maternal mortality ratio increased. Women with SMO in countries with a low MMR had a reduced severity of illness compared with other groups.

We published the outcome in *The Lancet: Moving beyond essential interventions for reduction of maternal mortality (the WHO Multicountry Survey on Maternal and Newborn Health): a cross-sectional study* in May 2013.

WHO-MCS Sri Lanka Component

We carried out the WHO-MCS in Sri Lanka to determine the incidence of severe maternal outcomes in the Western, Southern and Eastern provinces. From 14 health facilities in seven districts, 18,129 women were recruited and 17,988 live births were reported. Mean age of the study sample was 28.3 (SD 5.7) years. Of the women studied, 862 (4.8%) reported at least one major pregnancy complication and out of them, 75 (8.7%) had organ dysfunctions. Obstetric haemorrhage was the most common complication (n=354, 2%), followed by hypertensive disorders in pregnancy (n=233, 1.3%) and heart disease (n=124, .68%). Maternal near-miss ratio and intra hospital maternal mortality ratio (limited to 7 days postpartum) was 405.8 and 16.7 per 100,000 live births. The estimated severe maternal outcome ratio was 423 (95% CI 328-517) per 100,000 live births.

Results cover the information on the incidence of pregnancy complications.

Direct obstetric causes, although not seen in maternal death data, are readily visible in maternal near-miss cases. For every maternal death reported there were approximately 11 cases of maternal near-misses with a projected total of 1400 per year. This study provided solid evidence for implementing the use of the near-miss concept in maternal care evaluation.

We published the findings as the *WHO-MCS Country Report – Sri Lanka* in 2015 and shared the outcome with national level stakeholders. We also did presentations at FIGO-SAFOG-SLCOG 2014 –International Conference in Obstetrics & Gynaecology, Colombo, Sri Lanka 2014, WHO Maternal Near-Miss Approach and Quality of Care: Research and Implementation Workshop Istanbul, Turkey 2015 and at the RCOG World Congress in Brisbane Australia 2015.

Coverage of essential interventions

In Sri Lanka, commonly required interventions for pregnancy-related complications (n=862) were oxytocin for post-partum haemorrhage (n=201, 23.3%), transfusion of blood products (n=183, 21.2%), and admission for ICU care (n=125, 14.5%). The survey provides a comprehensive evaluation of the implementation status of critical life-saving interventions in the continuum of maternal and perinatal care in the Sri Lankan context. However, the National Emergency Obstetric and Neonatal Care Needs Assessment Survey (EmONC) – 2012 reported that oxytocin was given only in 80% immediately after delivery at tertiary care hospitals.

Objective assessment and benchmarking of the management of severe maternal morbidity with essential interventions, opens pathways for the reduction of maternal mortality. Such information has considerable advocacy value for promoting policy actions and mobilizing professional and civil societies to improve the quality of care for pregnant women.

Changing the story...

These findings, were published in The Lancet: *Moving beyond essential interventions for reduction of maternal mortality (the WHO Multicountry Survey on Maternal and Newborn Health): a cross-sectional study* in May 2013.

The way forward

For moving beyond maternal deaths in achieving SDGs, it is essential to translate outcomes into policies, programmes and practice. A majority of the lessons learnt are achievable. We are focusing on the areas highlighted in Figure 7 to change the story of our pregnant mothers.

Team work is an indispensable dimension in improving service delivery for pregnant women. Within a heterogeneous group of stakeholders, working productively together across professional boundaries will pave the way for better outcomes.



1. Maternal near-miss surveillance – Translating lessons learnt into action
2. Caesarian Sections –Use of C-Model electronic calculator -to assess, compare, and drive C-section rates, at facility level and nationally.
3. Establishment of Super centres to manage medically-complicated pregnancies
4. Maternal death review and perinatal death surveillance
5. Family Planning
6. Social inequity and regional disparities
7. Reach every women –Register of Eligible women in Danger (RED book)
8. Focus on mother-baby dyad
9. Address health system issues
10. Harness power of civil society



131st Anniversary International Medical Congress Sri Lanka Medical Association

26th – 29th July 2018
The Galadari Hotel, Colombo

“Shifting Focus from Diseases to Patients: Today’s Vision, Tomorrow’s Reality”

Abstract submission deadline

31st March 2018

Visit www.slma.lk for online abstract submission

**SUBMIT YOUR ABSTRACTS
TODAY!**

SLMA Guest Lecture



Dr. Sumithra Tissera
Assistant Treasurer, SLMA

The first guest lecture for the year was held on 12th February, 2018 at the Lionel Memorial Auditorium of the SLMA. The lecture was delivered by Prof. Mala Rao, Senior Clinical Fellow at Imperial College, London, who spoke on the topic "Primary care-centered health services for universal healthcare: Sri Lanka leading the way". Approximately 80 participated in the event. The lecture was followed by a lively discussion. The session was chaired by Dr. Palitha Abeykoon, Past President, SLMA.

Important notice:

Professor Wilfred SE Perera Travel Fund

Please note the following amendments to the criteria for application:

Applications are called from life members of the SLMA, requiring financial support to attend an academic conference, provided an abstract has been selected for presentation at the event. Five copies of the application should be submitted. Two travel awards will be granted during 2018

Closing date: extended till 30th June 2018.

A message from the Editor

We invite the membership of SLMA to contribute to **SLMA News** with articles, poems, cartoons, quizzes etc. We also welcome your views regarding the content of the newsletter. Please forward them to:

e-mail: nleditor.slma@gmail.com
amayaellawala@gmail.com

Postal: Editor-in-chief *SLMA News*,
Sri Lanka Medical Association,
6, Wijerama Mawatha,
Colombo 7.

From Dennis to Chrissie, till we meet again

Dr. Dennis Aloysius, Past President, SLMA

I met you so many years ago, at a picnic you were there when I saw you
My heart went pang, little realizing I had started a journey long
I walked up to you to see you smiling and you looked at me with mischievous eyes
And handed me a cup of tea,
This was the first of billions of cups you would hand me, my love

It took some time to realize the pang was love, and my first love
It was my greatest joy to hear you say Dennis I loved you at first sight.
But the romance was taboo and many tried to break our bond
It was then that we realized our strong bond would never die

When they would not compromise, we left to face the world together
When you left them Chrissie, you were crying, but never did you look back my love
Your pain would not die because you lost so much my love
But I proved strong and so did you, we withstood the storm together
Later I became the best son-in-law her dad had and the rest accepted us
Now all united and happy as could be, love had won again

My mother Ann met us at the door, she listened and she gave her blessing
She asked Chrissie are you hungry dear, while Chrissie ate she stitched a gown
Actually, the only woman I loved before was my mother Ann
An on the fifteenth of May, Chrissie, you became my wife and we were so happy

Then five children did we two have, and now we were complete.
With our little bundles of joy, growing up till an accident
Did shatter our lives, My darling Ruvani the youngest
Was crushed but not down we had more happy years together but she
Left us twenty years later, now she is with Chrissie in the stars
My Chrissie did you not promise me, one day we would die together
I had made all my plans to be with you, but now I in the dark, and lonely too.
Then GOD made a miracle when my three children did step in
With all their love the darkness got better, I'm sure you made sure

Now I sit in the dark sometimes and I close my eyes
And there you are now by my side again laughing and talking
Like the time we first met, it's like though you never left me
I will be joining you Chrissie soon and this time
My darling we will never part.

Answers for puzzles on page 8

Word ladder - ROSE, rise, wise, wide, bide, bids, BUDS

Puzzle - 6. In each row $A+B+C=D$

Whatever
the reason.
Whatever
the season.



AvamysTM
fluticasone furoate

Allergic rhinitis relief

The Most prescribed
Asthma and COPD
treatment of
all time!*

SERETIDE
salmeterol/fluticasone propionate

Breathe easy. Stay that way.



* Thorax 2012;67:266e267. doi:10.1136/thoraxjnl-2011-201522
* Top 100 Selling Drugs of 2013. Medscape. Jan 30, 2014.



For the use of medical professionals only.

Glaxo Wellcome Ceylon Ltd.
121, Galle Road, Kaldemulla, Moratuwa, Sri Lanka.
Tel: +94 11 2636341-2 Fax: +94 11 2622574

SRI LANKA'S PREMIER SOLAR PROVIDER



JLanka Technologies

partnered by the world's leading solar power distributor **solar**edge



Trouble with heat?
Install an AC at your home &
Zero your bill with Solar Panels

+94 112 786 786
support@jlankatech.com
www.jlanka.com

LEADING TECHNOLOGICAL ADVANCES

JLANKA®, committed to complement the environment through the enhancement of communities. JLANKA® provides the most cost effective, state-of-the-art and maintenance savvy solar energy system. Enjoy every moment in your home. Improve your home with solar. Contact the JLanka office in your area.

Up to 15% discount till end of April



M- 88
Inland Postage Paid



SLMA NEWS

THE OFFICIAL NEWSLETTER OF THE SRI LANKA MEDICAL ASSOCIATION

To

.....

.....

.....

.....

If undelivered return to:
Sri Lanka Medical Association. No 6, Wijerama Mawatha, Colombo 7