DIALOG

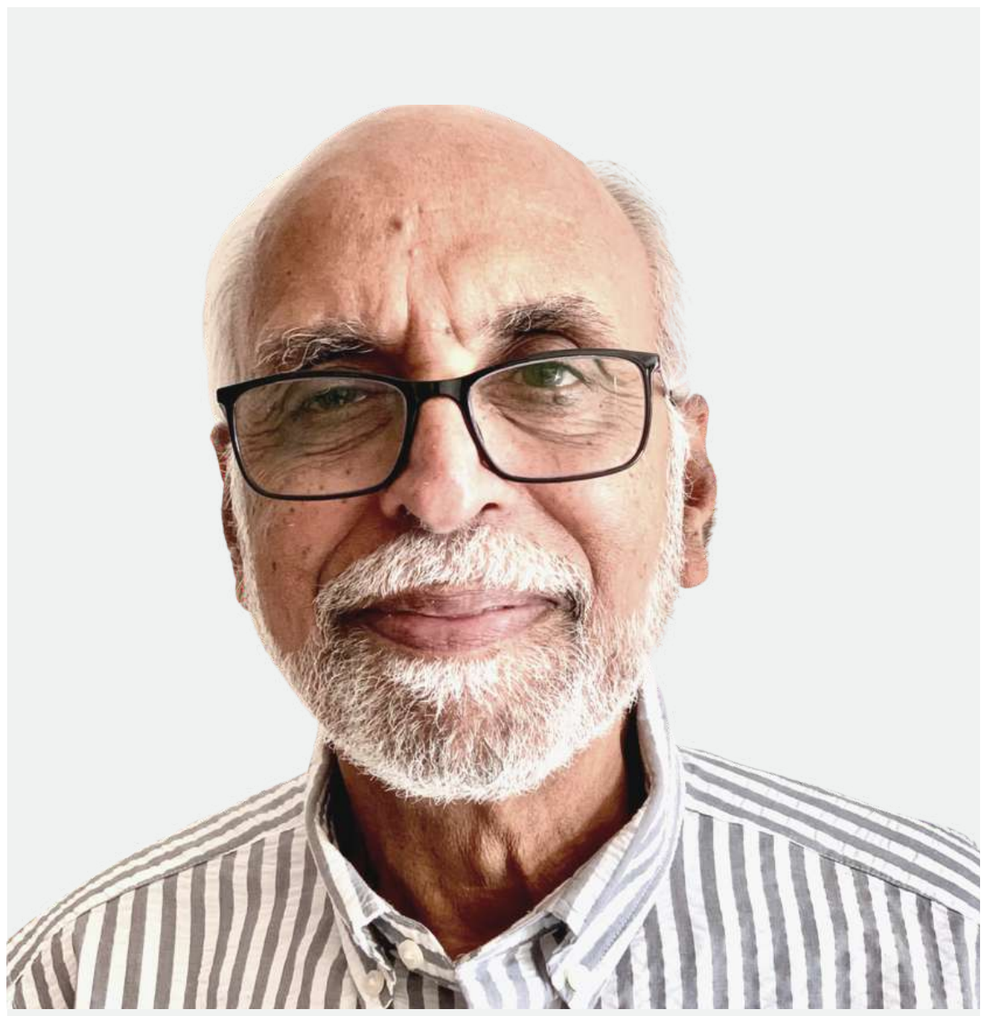
VOL 2 | NOV 21

Safe Maternal Care - Every Woman's Right.

SOLUTIONS THROUGH DIALOG

A platform for exchange of ideas between healthcare providers to share experiences and lessons on providing a safe and respectful childbirth to all women.

CURATORS



PRIORITIZING PATIENT SAFETY FOR PATIENTS IS PERTINENT TO THE FUTURE OF HEALTHCARE.

DR. VIJAY AGARWAL
President, CAHO

BY ENSURING PATIENT SAFETY IN ALL FACETS OF HEALTCARE, INCLUDING CHILDBIRTH, WE CAN CREATE AN ENIVRONMENT OF TRUST FOR THE PATIENT.

DR. LALLU JOSEPH
Secretary General, CAHO

CONTINUAL UPSKILLING OF HEALTHCARE WORKERS ON INDUSTRY STANDARDS, CONSCIOUS IMPLEMENTATION AT ALL LEVELS OF THE CARE CONTINUUM AND CONSISTENT MONITORING VIA AUDITS AND CHECKLISTS ARE CRUCIAL TO SUSTAIN BEST PRACTICES TOWARDS PATIENT SAFETY AND QUALITY OF CARE.

DR. ANURADHA PICHUMANI
Executive Director, Sree Renga Hospital, Chengalpattu, TN;
Chairman, Quality Professionals Division, CAHO

SOLUTIONS THROUGH DIALOG

Ensuring the safety and comfort of pregnant women and subsequently respectful childbirths is only the stepping stone in making it a reality across the country. The different facets of decision makers must work together to ultimately reduce mortality rates of new mothers and neonates.

"IF YOU WANT TO KNOW HOW STRONG A COUNTRY'S HEALTH SYSTEM IS, LOOK AT THE WELL-BEING OF ITS MOTHERS."

- HILLARY CLINTON

DIALOG stands apart as a medium dedicated to being the arbiter of exchange of information and ideas, between stakeholders, industry leaders, and national leaders. On the occassion of World Patient Safety Day 2021, where maternal and child safety was the theme, this issue is dedicated to exchanging ideas and experiences that can pave way to making safe and respectful childbirth a reality for every woman in every institution.

COMMUNICATE WITH YOUR PATIENT THROUGH PERSONALIZED INFORMATION & TIMELY CARE REMINDERS.

SEND PERSONALIZED CARE COMMUNICATION FROM YOUR TEAM AND LET YOUR PATIENT KNOW SHE IS CARED FOR.

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CAHO-AICC RCOG collaboration

TO IMPLEMENT WHO SAFE CHILDBIRTH CHECKLIST

CAHO conducted a LIVE World Patient Safety Day virtual event, on 17-Sep-2020 between 4:30 and 7:00 pm India Standard Time. Keynote addresses were presented by Dr.S.Shanthakumari, President, Federation of Obstetric & Gynaecological Societies of India (FOGSI), India on *Quest for safe motherhood in India: Where are we?* and by Dr.Ranjan Kumar Pejaver, President, National Neonatology Forum (NNF), India on *Trained Birth attendant cover in labour room and impact on safe childbirth,* which highlighted the importance of safe maternal and newborn care – the theme of the programme.

A collaboration between CAHO and the All India Coordination Committee of Royal College of Obstetricians and Gynaecologists (AICC RCOG) was launched to implement the WHO Safe Childbirth Checklist in India. Dr Bhaskar Pal, Chairperson, AICC RCOG; Dr Piyush Gupta, President, Indian Academy of Pediatrics (IAP) spoke on the significance of this collaboration.

Thematic competitions were also held by the Zonal Chairpersons of CAHO in their respective geographies and winners were recognised with prizes during the programme.

Guest of honour Dr V.P.Paily, HOD (O&G), Rajagiri Hospital, Kochi, India, in his address, elaborated on his work on Confidential Enquiry into Maternal Deaths in India and the improvements it brought about to Patient Safety.

The programme was well attended by over 1000 participants from across continents.

For your reference, the checklist can be downloaded here.

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MR. SURESH LULLA
Quality Champion of India
QIMPRO

QUALITY CAPSULE +

Failures can be contained in the research & development stage

Product Life Cycle

Products have life cycles. The four stages are: Introduction; Growth; Maturity; Decline. In an ideal world, the four stages have equal time.
The responsibility for each stage is unique:

- **Introduction:** Research & Development Department
- **Growth:** Sales & Distribution Department
- **Maturity:** Marketing Department
- **Decline:** Cost Accounting Department.

THINK: Tata Nano; HM Ambassador; HMT Watch; Bata Ambassador, Polson Butter.

Organization Life Cycle

Organizations too have life cycles: Introduction; Growth; Maturity; Decline. Organizations aim to have an infinite Growth stage. We call it organization life extension.
Organizations extend their lives by launching a series of new products. With planned obsolescence. They are strong on Research & Development.
Survival is compulsory. Success is not guaranteed.
THINK: ISRO; Hindustan Unilever; Marico; Mahindra; Asian Paints; Amul; HDFC Bank.

Start-Up Life Cycle

In start-up organizations, the Introduction stage is critical. Innovative products and services are developed, at speed. Better, Faster, Cheaper, and Different.
The Growth stage in successful start-ups is exponential. And the Maturity stage is a distant dream.
Very few start-ups succeed.
THINK: Ola; Flipkart; Paytm; Make My Trip.

How can more start-ups be successful?
For a start, I recommend that each start-up use a unique Quality / Reliability Tool, FMEA (Failure Mode and Effect Analysis), during the Introduction stage. This is not rocket-science.

Recommendation

In fact, every organization should embrace FMEA.
Failures can and must be contained in the Research & Development stage.

Random Thoughts:

1. Should Reliability Engineering be a specialization at IITs?
2. Suggestion: A start-up for digital training on Quality Engineering and Reliability Engineering.
3. Suggestion: A start-up for effective repair of potholes.
4. Should investors in start-ups be taught FMEA?

Patient Safety - Maternal and Child Health

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World Patient Safety Day 2021

For World Patient Safety Day, 17 September 2021, WHO urges all stakeholders to “Act now for safe and respectful childbirth!” with the theme “Safe maternal and newborn care”. Approximately 810 women die every day from preventable causes related to pregnancy and childbirth. In addition, around 6700 newborns die every day, amounting to 47% of all under-5 deaths. Moreover, about 2 million babies are stillborn every year, with over 40% occurring during labour. Considering the significant burden of risks and harm women and newborns are exposed to due to unsafe care, compounded by the disruption of essential health services caused by the COVID-19 pandemic, the campaign is even more important this year.

Pediatric Cover in Labour Room and Impact on safe Child Birth

With an annual birth rate of 27 million in India, the neonatal mortality rate is 21/1000 live births. The significant causes of newborn deaths are preterm births, low birth weight, perinatal asphyxia, early onset sepsis, and congenital anomalies. More than 70% neonatal deaths occur in the first week of life, and institutional deliveries have crossed 80% of the total deaths. The four prescribed antenatal visits rate is 52%. Therefore, the onus is on us to provide safe and respectful delivery as well as mother and newborn healthcare. In this context, the presence of Paediatricians should and would ensure: communication and counselling, preparation, resuscitation if needed, cost effective intervention, cost effective mandatory practices, shifting of the baby as appropriate responsibility of peadiatrician, and finally documentation.

Communication and Counselling – The responsibility lies with obstetricians, labour room staff, paediatric team and ancillary staff.

Antenatal history – Risk factors of the mother, details of the baby in-utero to check for multiple pregnancies and to check everything else right from the weight of the baby to the gestation age, and conducting counselling of parents/caregivers in a respectful manner while also keeping in mind the sensitivity of the situation, if any.

Regarding need for resuscitation, its possible and probable complications, prognosis should be done as applicable. Cost effective interventions are needed to improve quality of newborn immediately and in the long run.

DR RANJAN KUMAR PEJAVAR
Professor of Neonatology, President NNF India

Single course antenatal steroids – have been well tried out and has become standard of care for women at risk of preterm birth before 32 -34 weeks gestational age. This intervention which is actually performed by the obstetrics, is the responsibility of the paediatrician. Compliance rate is 80-90% in urban areas, but is only 60% nationally.

Second intervention – Magnesium sulphate for women at risk of preterm birth for neuroprotection of foetus. This simple intervention reduces the risk of cerebral palsy by 33% if given to the mothers who qualify for it.

Delayed/deferred cord clamping – waiting for a minimum of 1-3 mins is known to decrease neonatal and infant anaemia. This is significant as india has the highest rate of anemia in children between 1-9 years. The benefits of this intervention last upto a year.

The question is do we have a peadiatrician attending each and every delivery? NO. We need to remember that 90% of babies need only initial steps that can be handled by trained staff.

Delivery on abdomen of mother – In rural or semi-urban areas, this is commonly practiced, but there is some hesitation in mothers and doctors of urban areas regarding delivery onto stomach and lower chest. A lot of benefit of skin to skin contact at this early stage exists including encouraging breastfeeding and it may reduce crying. It regulates body temperature, stabilizes baby's breathing and heartbeat and helps the baby feel safe.

Use less O2 for resuscitation – As hyperoxia is as dangerous as hypoxia, use of oxygen should be thoughtfully monitored. 3 meta analysis studies found first breath and cry of newborn resuscitated with 100% oxygen was significantly delayed as compared to those resuscitated with room air.

Prolonged period of oxidative stress exists in infants resuscitated with 100% oxygen.

The current recommendations suggest that newborns <35 weeks of gestation be resuscitated with room air. And >35 weeks be started off at 21-30% and titrated with saturations. Resuscitations with oxygen higher than 65% is not recommended.

Hypothermia is a silent killer. On its own, hypothermia may not cause mortality, but it adds on to the issues babies may have, like prenatal asphyxia or sepsis. This is an avoidable complication by using simple things like having multiple towels – one to wipe the baby and one to wrap the baby. Preheating warmer in resuscitation corner before the baby is born, reducing temperature of room where baby is delivered. As time goes on ambu bag will be replaced with t-piece resuscitator. Since the compression switch on the ambu bag is not controlled, and early damage of barotrauma in early babies can be very detrimental, T-piece should become standard operation procedure. Non-invasive ventilation using CPAP are being taught and its use is being encouraged. CPAP given in delivery room can reduce the need of conventional ventilation, reduce the number of days in ventilation and lead to early discharge from hospital.

One of the responsibilities of paediatrician is to ensure baby gets post-resuscitation care depending on the type of help baby is given. If it is simple resuscitation, then ensure skin to skin contact with mother is maintained and breastfeeding is ensued as soon as possible. If baby needs positive pressure ventilation, observe for an hour or so in the postnatal ward or the step down nursery. If baby has had advanced resuscitation, then observe for short duration in NICU and do whatever is required before transferring back to the mother. Maintaining stable temperatures in the wards and ICU and while transporting is responsibility of paediatrician and prevents morbidity later on.

EARLY BREASTFEEDING

Breastfeeding should be started within an hour of delivery. Exclusive breastfeeding should continue for 6 months. Introduction of complimentary feeding should be done after that along with continued feeding until 1-2 years.

Current Situation – only 42% newborns are breastfed within the hour, and 55% are breastfed exclusively for 6 months. Percentage of breastfed infants supplemented with formula feeds within 48 hours is 19.2%.

RESUSCITATION

India has a very structured Neonatal Resuscitation program – IAP and NNF together do the neonatal resuscitations. From 2009 – 2020, 1,21,136 professionals have been trained.

DR. S. SHANTHA KUMARI
President FOGSI

Safe Motherhood In India

Safe Motherhood is a journey from before pregnancy to beyond the journey of life. One cannot have a safe motherhood without having first a safe childhood and safe adulthood. It is imperitive to take care of our girls at all stages of life.

Safe motherhood can be achieved by controlling pre-existing medical disorders and optimizing women's health for safe reproductive outcome; managing medical disorders unmasked in pregnancy; ensuring healthy mother and baby; providing optimal postnatal care of mother and baby including contraception; ensuring continuum of care for woman's and child's health.

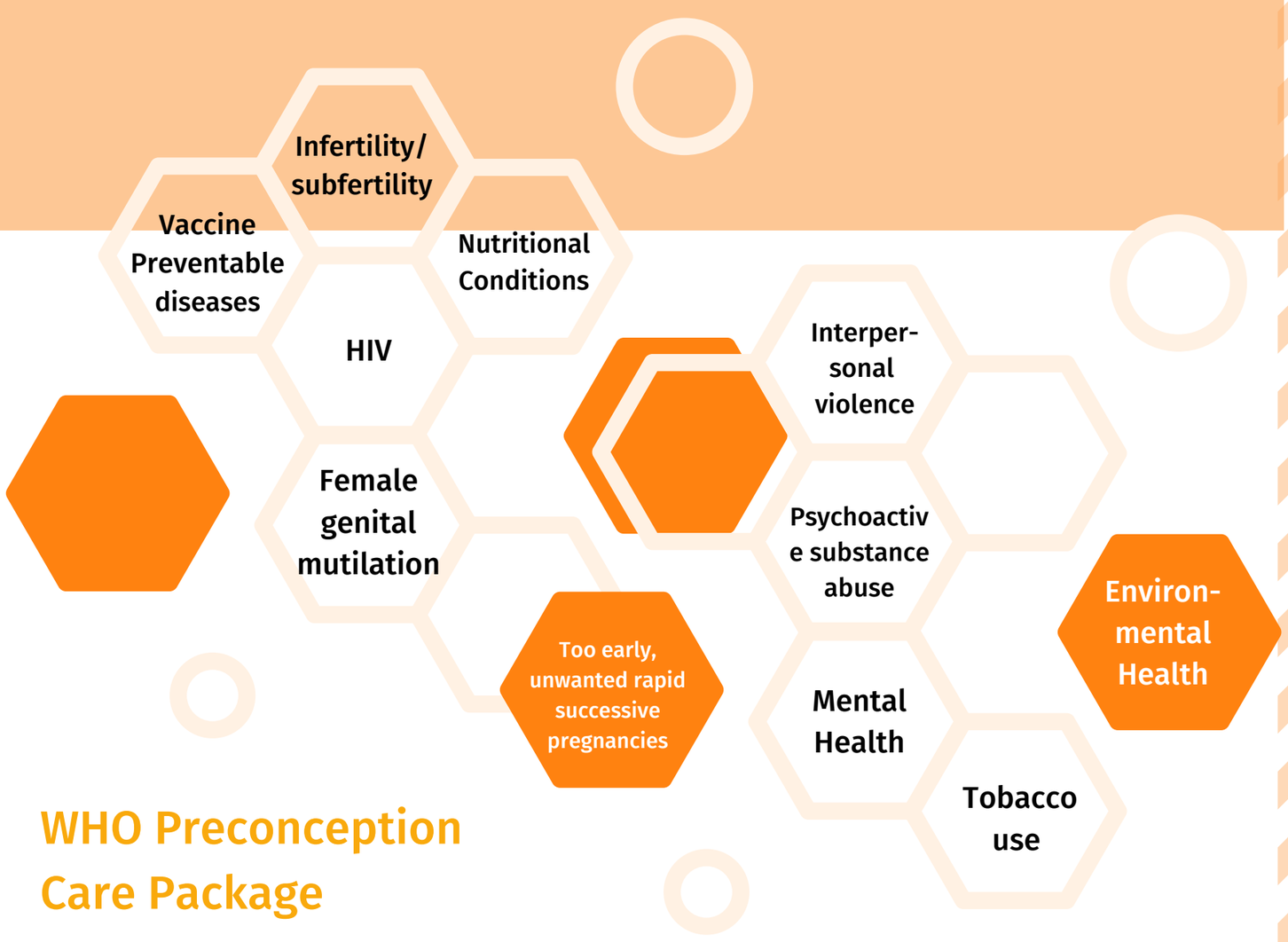
Adolescent health whether it is physical, mental, social, reproductive or sexual, all need to be taken of for the girls to grow up to have safe pregnancies and childbirths. A lot of adolescent girls present with PCOS and anaemia, which affects reproductive health, pregnancy, newborn's health, causes metabolic syndrome, or even malignancy. This needs to be looked at holistically to provide intervention and treatment.

PREGNANCY AND NON COMMUNICABLE DISEASES

Safe pregnancies are not complete without discussing NCDs (Non Communicable diseases). India is the capital of diabetes and with the large number of births happening in India, we cannot talk about achieving safe motherhood without resolving NCDs.

There is a window of opportunity for predicting occurrence of NCDs in later age. This starts right from the beginning as part of pre-pregnancy counselling to address diet, exercises, psychosocial and other abuses etc. Preconception care needs to be given as organogenesis has already happened by the time a pregnant woman comes into the clinic.

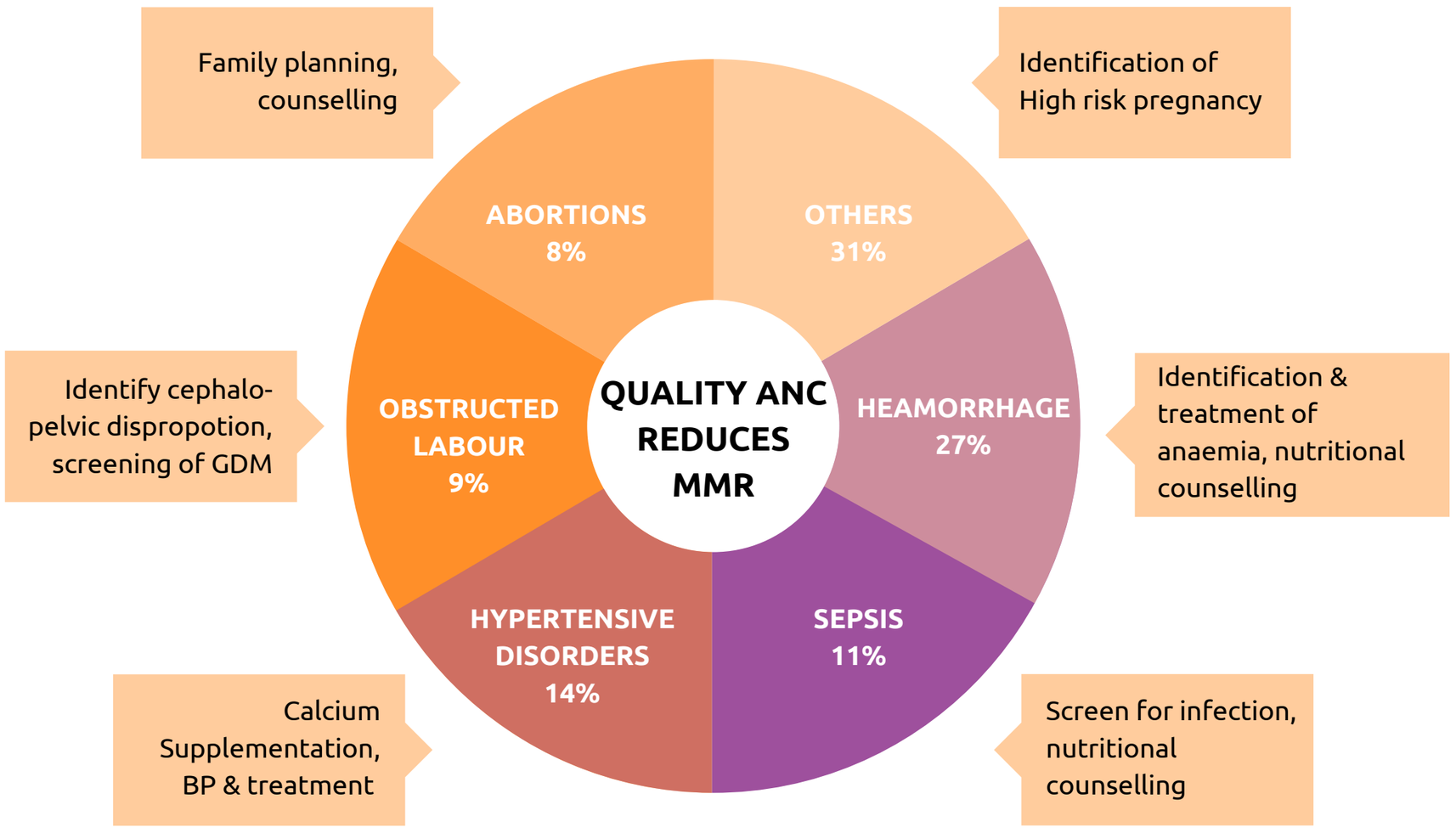
The Health and Family Welfare Department of the Govt. of India has been really focused on Reproductive and Child health within the country.



WHO Preconception Care Package

ANTENATAL, INTRA-NATAL AND POST NATAL CARE

High quality Antenatal care has a potential to directly affect antepartum deaths and reduce complications during intrapartum and postpartum periods. Quality Antenatal care reduces Maternal Mortality Rate.



"Violence Against Women also has a significant effect on poor antenatal and neonatal health."

Patient Safety Kerala – CRMD experience

In Kerela, we have achieved an MMR of <30/100,000 as of last year. We believe that it is partially due to the way we have been auditing maternal deaths and acting on it.

KFOG strategy on safe maternal and newborn care was to audit and then act on the findings of the audits.

Types of Audit – Morning Report; Confidential Review of Maternal deaths, near miss audit, facility based audit, and verbal autopsy. We have been practicing morning report since 2000. All staff in the labour room and in the department attend a meeting for a short time every morning to recall what had happened in the previous day and what the plan of the current day will be. Good points are appreciated while the shortcomings are addressed. Reprimand should never be the order. We found this to be the most effective way to audit as the event is fresh in the mind, and if conducted in a way that avoids fault finding, people are likely to join in.

KFOG initiated the Confidential Review of Maternal Deaths in 2004 with full support from the Govt. of Kerala. WHO initiated this audit and assisted in starting the audit. From its inception, it has pledged to decreased MMR within the state. We plan to achieve a target MMR of 20 by 2030.

What can KFOG do to achieve this goal of reducing MMR? Support is needed from politicians, administrators, patient and family, society at large, nurses and midwives, and other branches of medicine. KFOG got together non ob/gyn colleagues who were supportive of reducing MMR.

To avoid maternal deaths, we should know why mothers die, how many of them die, and what steps will help to avoid those deaths. The truth however, comes out only when the audit is anonymous. The British started this in 1952, where the principle was "no name, no blame". Our findings on why mothers die was published. The real strength of CRMD is the large number of voluntary assessors of obstetricians and non OBs in the system. Later on it was found, we should expand it from death to near misses. The review of this can also be done confidentially.

DR. V.P. PAILY
HOD, Obstetrics & Gynaecology,
Rajgiri Hospital, Kochi

DECENTRALIZATION OF AUDIT

Maternal Death and Near Miss Surveillance and Response (MDNMDR). Once you identify by surveillance, it should be followed by action.

MDNMSR – Done at district level. Meetings are organized by the RCH (Reproductive and Child Health) officer, and chaired by the collector or DMO. Here we find out about the deaths that happened in each district anonymously, and near miss cases are discussed in detail so that we can learn lessons from it. The idea is to find out why they died, and if there are avoidable causes, what can be done to avoid it and find strategies.

MATERNAL DEATHS - COMMON CAUSES

Postpartum Heamorrhage (PPH) - was still found to be the number 1 killer. Methods were then figured out to avoid PPH: Active management of the third stage of labour (AMTSL) and 4th stage management have to be as per the KFOG guidelines. Any bleeding has to be arrested immediately.

Hypertension - is another killer. Guidelines were outlined as to what can be done to address it. Identify hypertension by regular BP check during antenatal period. Control it before it reaches dangerous levels. Use Magnesium sulphate as per KFOG protocol.

AFE (Amniotic Embolism)- Avoid hyperstimulation, use prostaglandins for induction judiciously. Avoid drugs like epidosin in late labour, be prepared to handle acute collapse. Consider perimortem C-section.

Sepsis – reinforce aseptic practices, proper waste disposal, proper use of antibiotics.

Pulmonary embolism – Avoid enforced bed restriction, encouraged early ambulation and fluid intake.

There should be a proper way to manage obstetric emergencies that may occur. Emergency obstetric care and life support is encouraged and training is given to the staff.

In 2013, we started Quality Standards. We crystallized active management of issues and concerns, and found that during an emergency in the hospital, only nurses may be present and others arrive when its too late. Therefore we established the Obstetric Rapid Response Team that would be present wherever delivery occurs in the hospital. These need to be trained in getting vascular access and put forward basic life support. A pool of trained personnel must be available in the hospital round the clock in every shift.

The training includes ability to have vascular access, intra-osseous fluid administration, CPR, steps to arrest bleeding, etc.
This is not a substitute for Emergency obstetrics and life support training, but in emergency obstetrics time is very critical.

Minimum standards of delivery points must also be maintained durig accreditation of hospitals.

We should declare a strategy of zero tolerance to avoidable maternal deaths using a comprehensive approach with obstetricians, paramedical staff, administration and the Government.

Country experiences of Implementing WHO childbirth Checklist

In the context of WPSD's theme for 2021, a Panel Discussion was held on **Country experiences of Implementing the WHO Safe Childbirth Checklist** (WHO SCC). It was moderated by Dr Katherine Semrau, Director, BetterBirth Programme, Ariadne Labs, Boston, USA. The panelists included Dr Rose Molina, Core Faculty, Ariadne Labs, Boston, USA, Dr Hema Divakar, Medical Director, Divakar Speciality Hospital, Bangalore, India, Dr Anuradha Pichumani, Executive Director, Sree Renga Hospital, Chengalpattu, India, Dr Vikram Datta, Director-Professor, Lady Hardinge Medical College, New Delhi, India, Ms Farah Diba, Lecturer, University of Syiah Kuala, Banda Aceh, Indonesia, Dr Azza Farouk Noredinn, Director of Patient Safety, FMOH, Sudan and Dr Malitha Patabendige, Acting Consultant (O&G), Base Hospital, Pottuvil, Sri Lanka. The panelists exchanged and shared their experiences in implementing the WHO SCC, leading to rich knowledge sharing.

The key points of the Panel Discussion have been featured in our magazine

"It (the WHO checklist) can work in a variety of settings and environments. It doesn't have to be a city or a hospital and doesn't have to be a small maternity home. It can work anywhere because adaptability is key."

DR KATHERINE SEMRAU
Director, BetterBirth Programme, Ariadne Labs, Boston, USA

Elaborating on the Know-Do Gap framework, Dr. Rose Molina explained that globally, poor quality of healthcare causes more deaths than insufficient access to care.

Introducing Ariadne Labs and the work they do in supporting the widespread use of the WHO SCC, Dr. Rose Molina also presented an overview of the Checklist used at four different pause points during the care continuum. Key take home messages were:
- Key principles around adaptation to local context, leadership buy-in, stakeholder engagement, and field testing resonated across implementation settings.
- Persistent discrepancy between optimal enabling environment and resource constraints.
- WHO Safe Childbirth Checklist Implementation Guide could be improved with greater specificity for addressing challenges and implementing in a variety of contexts.

DR ROSE MOLINA
Core Faculty, Ariadne Labs, Boston, USA

We have found that the WHO safe childbirth checklist, is easy to adopt, easy to modify and easy to implement among low resource settings too.

DR. ANURADHA PICHUMANI

Executive Director, Sree Renga Hospital, Chengalpattu, TN;
Chairman, Quality Professionals Division, CAHO

Briefly explaining how the WHO SCC (Safe Childbirth Checklist) fit into the growth trajectory of her 30-year-old multi-speciality hospital catering to the semi-urban and rural population of her region, Dr. Anuradha Pichumani highlighted how the familiarity with the WHO Surgical Safety Checklist helped in the faster adoption and implementation of the WHO SCC at her institution.

Speaking on the role of CAHO in strengthening patient safety through skilling of staff of clinical and non-clinical functions throughout the healthcare industry, Dr. Anuradha Pichumani underlined CAHO's plans to collaborate with various clinical societies. In association with the Royal College of Obstetricians and Gynaecologists (India Committee), a baseline survey is planned to be conducted for the WHO SCC usage across India including an evaluation of the interest of hospitals in adopting the checklist and developing a timeframe for implementation of the same.

Discussions have been initiated with OGSSI, to promote the adoption of the WHO SCC checklist in southern states of India. CAHO has been promoting the WHO SCC with various Government and private teaching institutions across India.

Quality Improvement comes from a passionate heart, and requires a receptive environment, a supportive healthcare system, and lots of skill related to psychology of change being inbuilt.

DR. VIKRAM DATTA

Director-Prof, Lady Hardinge Medical College, New Delhi

In 2017, the LaQshya initiative was launched by Govt of India, which was the labour room quality improvement initiative. One of the short term aims of this programme was implementation of 60% of Safe Childbirth Checklist. We had a core group of volunteers who were dedicated, motivated and trained into QI, to get it implemented across country starting from district, sub district hospitals and medical colleges. When we embarked on mission it was more complex than thought. We used something like translating research into practice platform.

We mainly relied on point of care quality improvement methodology to bring about a 2 way feedback mechanism between the care workers and the healthcare system, which was practically non existent before. We identified and nurtured change champions, because we believed that if even if the system withdrew support, these change champions would still remain connected to us.

Most of the setups where Checklist and LaQshya was implemented had no quality management system. So we tried to upskill them in quality improvement methodology and at the same time giving them a taste of quality control to simplify data management. If we want health system to adapt to using the checklists, we must start in medical and nursing schools first.

DR. MALITHA PATABENDIGE

Acting Consultant (O&G)
Base hospital Pottuvil,
Sri Lanka

In Sri Lanka, we have improved maternal statistics but we were stagnating in terms of bringing down maternal mortality rate for about 8-10 years.

The WHO SCC was adopted in one of the largest maternity hospitals in Sri Lanka. Though there are many formal checklists in maternity hospitals that already include some of the points from the WHO SCC, these lists are different across different hospitals. The WHO SCC was implemented after making context-based changes suitable to the Sri Lankan guidelines and the healthcare personnel within the country.

At the moment two hospitals use the WHO checklist. One of the large drawbacks is the lack of support from statutory bodies.

MS. FARAH DIBA

Lecturer Univ of Syiah Kuala, Banda Aceh, Indonesia

Mother and baby data on top of the form was made part of the patient file so it wouldn't get lost. The questions regarding medications also had a timestamp added. On Page 1, we added call for help symptoms like breathing difficulty, fever or chills and epigastric pain. On Page 2, we made the complete delivery section be filled at bedside of the patient.

For baby preparation, we changed the use of sterile blade into scissors to cut the cord. On Pages 3 and 4, for giving antibiotics to the baby, as most primary healthcare in the country do not have paediatrician, the baby needs to be referred immediately to one for special care and monitoring. Three additional answers were added to the questions pertaining to family planning. On the danger sign list, we added an option to seek help in case cord infections occur. And finally, we provide every mother a list of danger signs on the day they are discharged with a list of contacts of the midwives and primary care giver.

DR. AZZA FAROUK NOREDINN
Director of Patient Safety, FMOH, Sudan

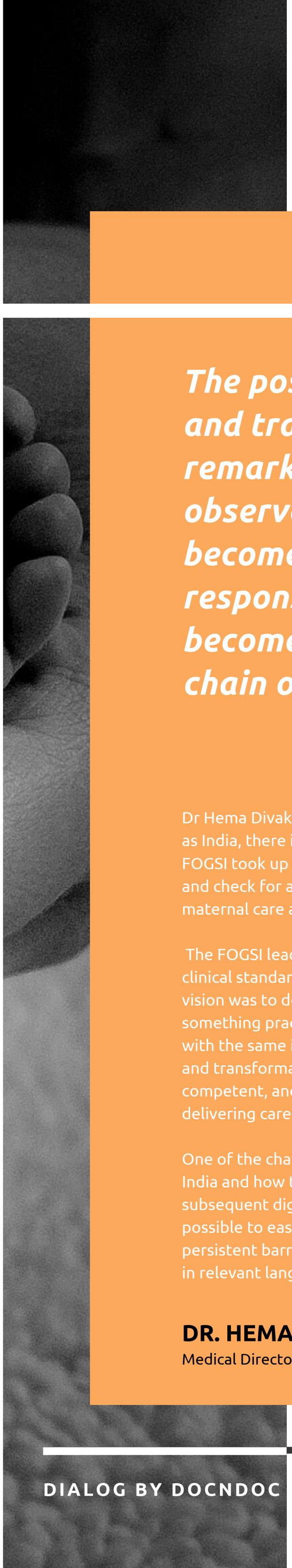
Maternal and neonatal health is a national priority in Sudan. The pilot was in the form of pre- and post-intervention study to determine the adaptability of the checklist in healthcare provider practices in the largest maternity hospital in Khartoum, Sudan, where 35,000 deliveries occur per year.

The intervention included introduction of the WHO SCC and training of the staff in the use of the WHO SCC after being adapted to use in local setting, like translation of the form particularly of the section referring to the midwifery practices. It was observed that overall practice of delivering C-section deliveries improved.

Areas of weaknesses were identified. The post intervention conducted 2 months later observed no reduction in the number of C-section deliveries. Midwives reported using the checklist 98% of times.

It showed a significant improvement of more than 6% in nursing practices related to childbirth. Compliance of doctors was much lower than nurses. They were using the checklist for 15% of the vaginal deliveries. Yet there was a significant improvement in 80% of doctor-related procedures. Introduction and implementation of the WHO SCC was done despite the challenges in our setting like availability of supplies, high turnover of staff. The checklist significantly improved the best practice of healthcare delivery provided by physicians particularly for maternal and neonatal care.

We seek to bring more support for implementation by adaption and adoption of checklist by senior level leaders, particularly of maternal and neonatal health society, obstetrics and gynaecology society in Sudan.



The post training skill and transformation was remarkable to observe. They had become competent, and responsible and had become important in the chain of delivering care.

Dr Hema Divakar mentioned that in a vast, complex and as diverse a country as India, there is a need for many champions to be able to do their bit. FOGSI took up the opportunity to look into the private sector and check for adherence to clinical standards especially in regard to safe maternal care and found a large gap between the knowing and the doing.

The FOGSI leadership embarked on the design and implementation of 16 clinical standards in alignment to the WHO safe childbirth checklist. The vision was to do something simple, something doable, something feasible, something practical and pragmatic. This was practiced in various settings with the same infrastructure and the existing staff. The post training skill and transformation was remarkable to observe. They had become competent, and responsible and had become important in the chain of delivering care.

One of the challenges was in reaching the interiors and remote locations of India and how to access the on-site trainers. With COVID and the subsequent digital transformation, this issue was resolved and it was possible to easily reach 14 locations pan India. Language was still a persistent barrier. Different teams of staff were made to deliver the topics in relevant languages.

DR. HEMA DIVAKAR
Medical Director, Divakar Specialty Hospital, Bangalore

Lessons from every Maternal Death

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This year's theme for World Patient Safety Day was Safe Maternal and Newborn Care. This reminded me of a case of maternal death I had evaluated a few years ago.

A primigravida had a vacuum assisted delivery after induction of labour for postdates. After the delivery, the obstetrician was concentrating on the harvesting of blood from the umbilical cord for stem cells and failed to realise that the patient was bleeding heavily. Once alerted, resuscitation started. She did not respond to the usual measures for uterine atony and the obstetrician then decided to perform a hysterectomy. She collapsed before she could be taken to the OT. Postmortem examination revealed an extensive cervical tear. This unfortunate lady illustrates many learning points. A primigravida is a patient at risk as she has not proven her obstetric performance. Quality antenatal care is vital. To compound her risks, she went post-dated.

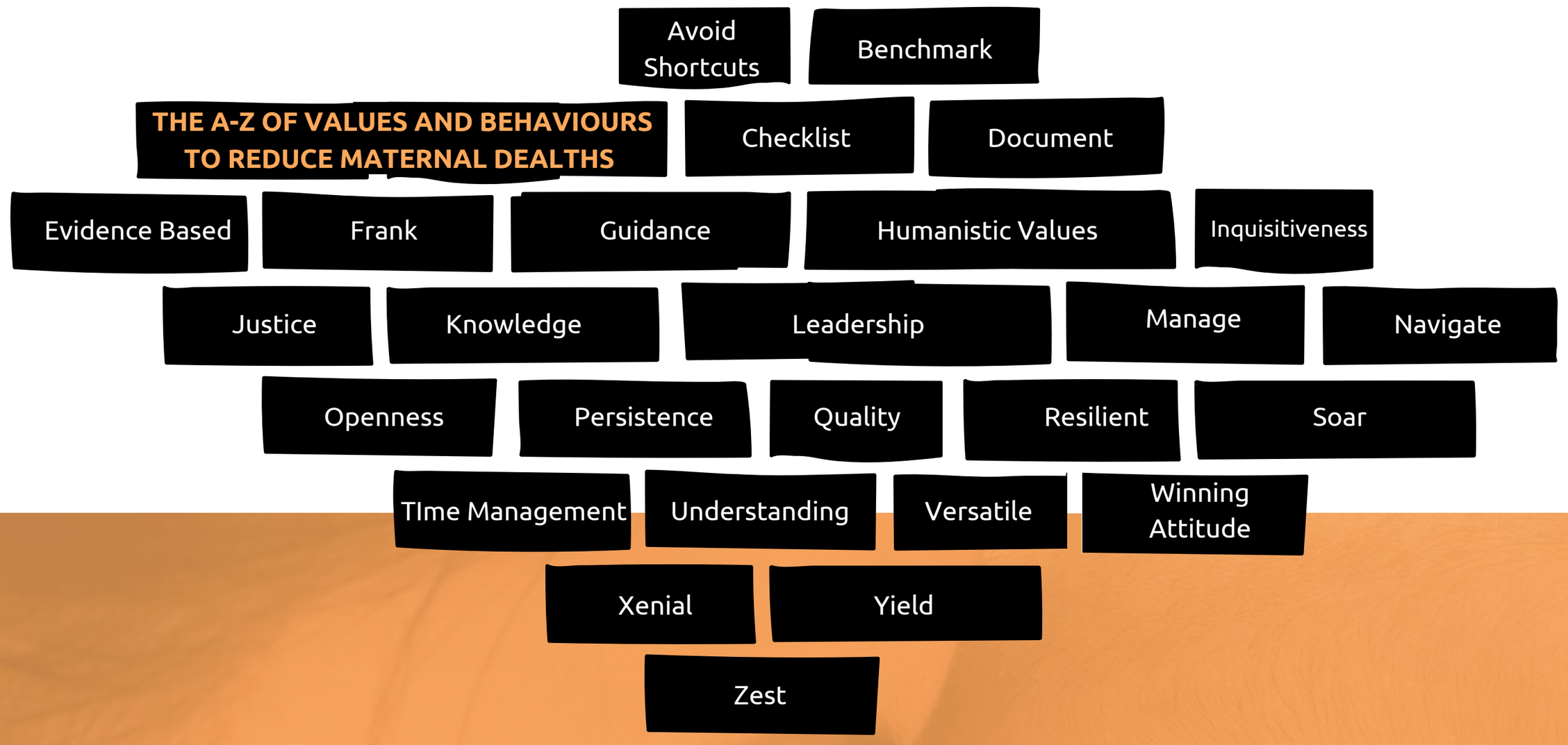
Prolonged pregnancy has been associated with risks of intrauterine growth restriction, intrauterine death, macrosomia and an increased risk of operative deliveries. Obstetric evidence has concluded that routine induction of labour after 41 weeks reduces perinatal mortality without any increase in the caesarean section rate.

A maternal death is a tragedy that ranges far beyond the death of a mother, leaving irreparable scars on her family and the wider community. It must be averted at all costs and lessons must be learnt from every death by all maternity care givers.

It is important that the woman makes an informed choice of waiting for spontaneous labour beyond 41 weeks or undergoing induction. The risks and benefits of labour induction versus expectant management must be discussed and documented in the obstetric notes by the care giver. The obstetrician was distracted with taking a sample from the cord while postpartum haemorrhage was ongoing. This loses vital time for the team to commence resuscitation of a patient with PPH. Cord blood extraction for the purposes of procuring stem cells should only be undertaken when the patient does not suffer from any complications. One must always ensure that maternal considerations come first and always override fetal concerns. This basic obstetric principle has never changed in obstetric practice.

When there is obstetric collapse, the red alert system should have been activated. This system ensures the coming together of other personnel such as the anaesthetist, other obstetricians, nursing and allied health personnel and notification of the blood bank for speedy access to blood in emergency situations. One must never work alone when the patient is collapsed. Additional pairs of hands are always welcomed.

The principles of ABCD are followed in the management of collapsed patients: A:Airway, B:Breathing, C:Circulation and D:Disability. In obstetric conditions, D may also indicate delivery. If cardiopulmonary resuscitation does not succeed in restoring circulation by 5 minutes after the diagnosis of cardiac arrest, then a perimortem caesarean section should be performed.



A curriculum for an Advanced Diploma in midwifery was developed taking all lessons learnt from maternal deaths. There was increased emphasis on practical skills in the management of the major causes of deaths, emergency care and the referral system.

In gestations of 20-24 weeks, a hysterotomy should be performed to aid maternal resuscitation. A paediatrician should be called if the fetus is of a viable gestational age.

Resuscitation in a patient with collapse needs good teamwork and rapid decision making. Someone in the team must take the leadership role. Prevention is always wise and may be achieved by potentially avoiding the collapse by antenatal risk assessment and appropriate management.

The above case was one of many case illustrations written from actual cases in the Confidential Enquiry of Maternal Deaths and these were widely distributed. The CEMD allowed for improvement in work processes based on the remedial factors in care identified in the audit.

Examples of these included the use of the partogram in the hospital setting and at home, protocol development (such as for anaemia), conduct of combined inter-disciplinary clinics for medical disorders in pregnancy and the creation of the red alert system in hospitals which allowed for rapid mobilisation of specialists in O&G as well as anaesthesia and support staff for obstetric emergencies such as postpartum haemorrhage, eclampsia and collapse.

We are now witnessing a changing trend in maternal deaths from direct obstetric causes to indirect maternal deaths and fortuitous deaths. This change emphasises the fact that that efforts in training as well as improvements in the quality of obstetric care have had an impact. Empowerment of midwives was a key component of the CEMD activities. This included the colour coding system used in Malaysian antenatal care which was designed to streamline referrals by midwifes to the hospitals. A woman given a red code by a midwife could be admitted to a specialist hospital immediately without any hindrance. Midwives now are allowed to continue heparin for thromboprophylaxis, give antenatal steroids to mothers with preterm labour and provide intramuscular magnesium sulphate under guidance from protocols from the Ministry of Health.

Some labour wards in the public hospitals allow midwifery-led care for appropriately selected patients in specialist hospitals. Safety is paramount in maternity and neonatal care and the theme for World Patient Safety Day 2021 could not be more apt.

A Quality Improvement Initiative to Improve the duration of Kangaroo Mother Care in Tertiary Care Neonatal Unit of South India

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BACKGROUND

India has the highest number of preterm births and maximum number of neonatal deaths due to prematurity.

Chengalpattu Government Medical College had 11,593 deliveries annually, in the year 2020, of which 2252 of neonates were low birth weight.
A Cochrane Review of 2016 concluded that Kangaroo Mother Care reduces the morbidity and mortality in low birth weight infants. The average duration of KMC in our unit was around 4.2 hrs/ baby/ day.

OBJECTIVE

To improve the duration of Kangaroo Mother Care in stable low birth weight babies from short duration (<4 hrs) to continuous duration (>12 hrs) over 8 weeks.

METHOD

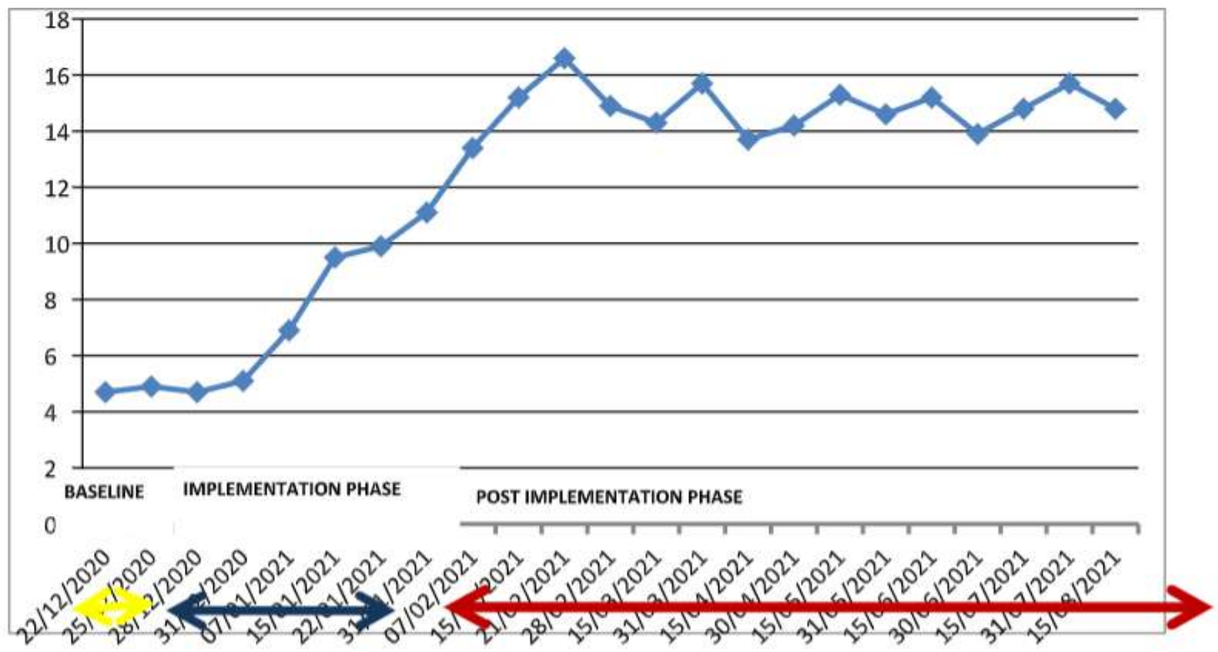
The implementation phase was conducted during January and February, 2021. All babies with birth weight < 2 kgs and who were haemodynamically stable were enrolled in this study.

A QI team comprising of staff nurses, nursing-in-charge, resident doctors and senior consultants was formed.

Potential barriers were listed using Fishbone analysis.

Various possible interventions were identified and a priority matrix was constructed to decide the sequence of introduction of changes. The following measures were introduced sequentially and subsequently tested by multiple PDSA cycles.

- Ensuring the availability of KMC charts with all mother
- Combining KMC chart with individualized weight chart
- Documentation of KMC duration in case sheets
- Increasing number of KMC chairs
- Opening of Family Centred Care Unit and Mother- NICU
- KMC slings for mothers
- Videos in local language for education of mothers
- Rewards for mothers and staff nurses.



Outcome indicator: Duration of KMC was recorded by bedside nurses on daily basis.

RESULTS

- A total of 86 newborns were enrolled.
- At the end of 8 weeks, average duration of KMC increased to 16.6 hrs/ baby/ day from baseline of 4.6 hrs/ baby/ day.
- The intervention which was most useful in increasing the duration of KMC, was opening of M-NICU.
- We were able to sustain the improvement at the end of 6 months.

Sequential Quality improvement measures helped to increase the average duration of KMC in unit from 4.6 hr/ day to >12hrs/day without any financial expenses.

DR. GIGI SELVAN

Annai Velankanni Multi Speciality Hospital
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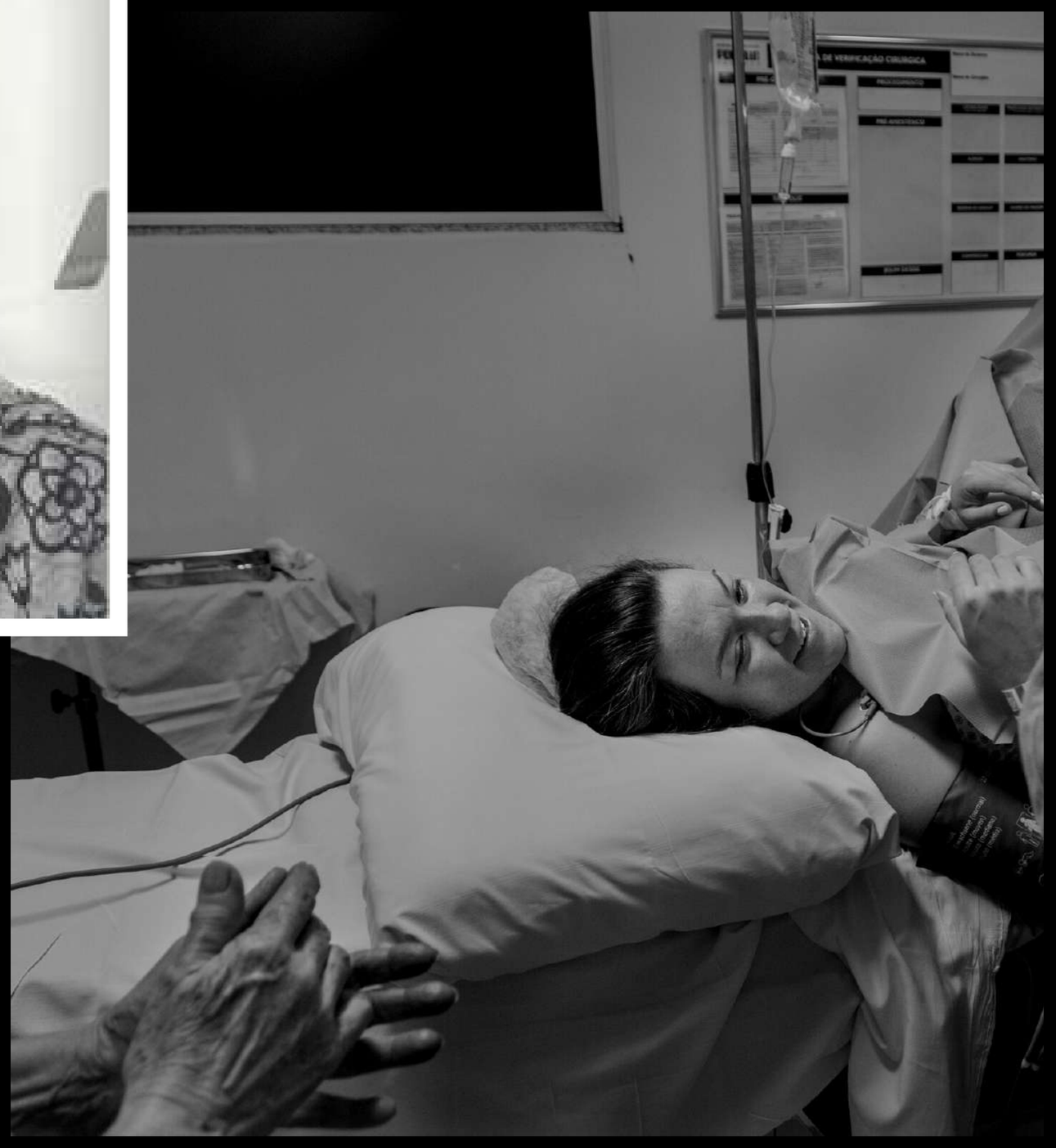
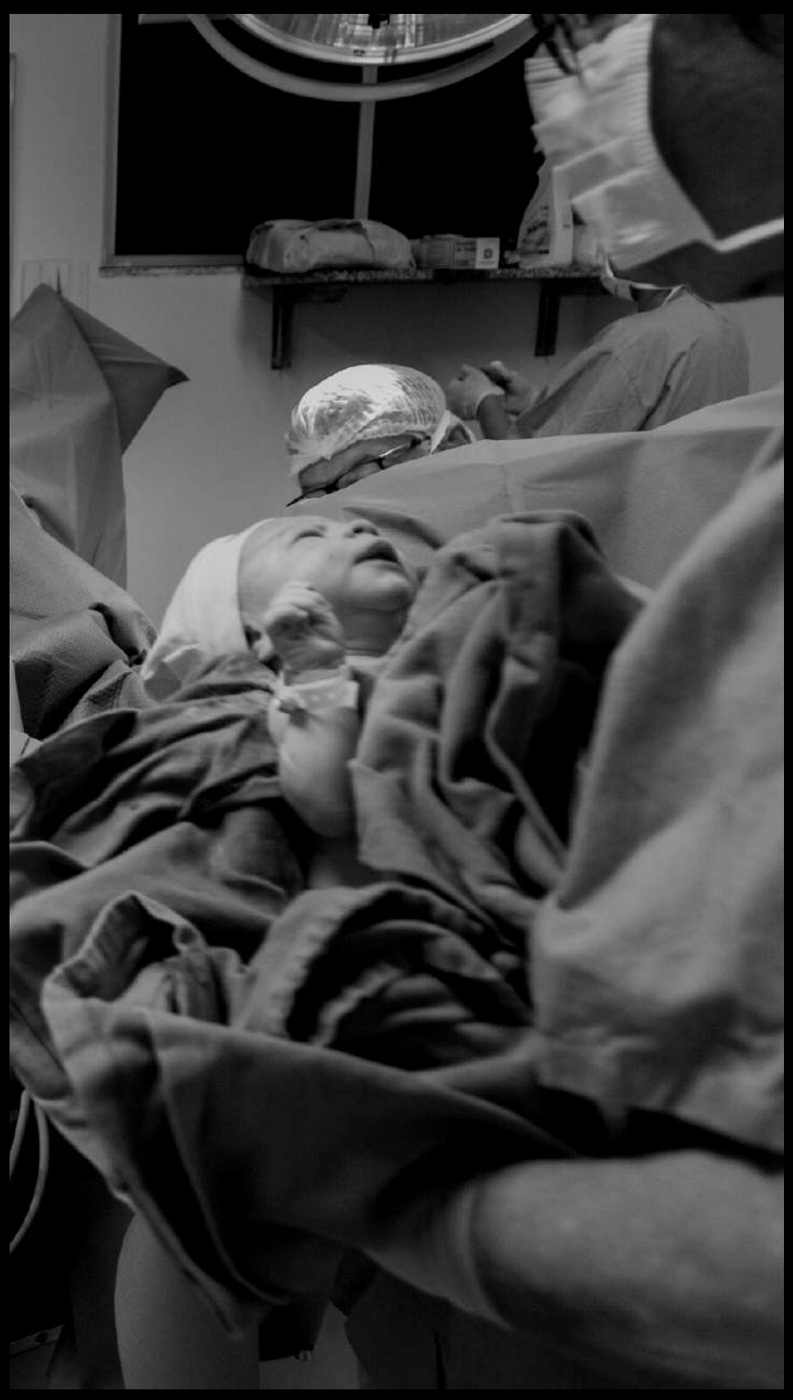


Once In A Life Time Experience

FOR A PERFECT RESULT IN DIFFICULT SITUATIONS TEAM WORK IS ESSENTIAL HELPING EACH OTHER WITH A SAME GOAL.

It was a Saturday afternoon, 9th January 2021, at about 4pm, when a 108 Ambulance with great speed entered into our Hospital campus. A young pregnant mother who was unconscious was whisked into our casualty. She had no palpable pulse and no recordable BP, except that her body was warm. Our casualty team assessed and found that mother had no heart beat as she was in cardiac arrest. Immediate resuscitation was started. Our OG team arrived immediately and decision of LSCS was made. Our ICU team immediately started CPR and I had to rush to the casualty.



By the time I reached, our OG team was all set and the patient was draped for LSCS in the casualty. The CPR was going on, and with the Pfannenstiel incision and dark colored blood oozing I immediately got scrubbed & draped. In seconds, I opened the uterus & delivered a baby which was limp with no cord pulsation.

The neonatal team took over the baby. Placenta was removed & slowly the blood color changed to normal. With a big sigh of relief, I started suturing the patient. Meanwhile the ICU team intubated the patient and shifted her to the ICU.

Due to the raging COVID-19 pandemic, unknown status of mother and witnessed arrest, a decision was taken for the emergency LSCS to save baby and the mother. Baby was delivered under aseptic precautions, and immediately after delivery, there was spontaneous onset of cardiac activity which was supported with vasopressols and mechanical ventilation, papillary reaction to light was also present. Emergency bedside cardiac scan showed severe heart failure with peripartum cardiomyopathy. Mother was given post operative care, cardiac supportive care with slowly weaned off ventilation support over a month. The post operative day zero was stormy though and the ICU team worked hard to keep the mother alive.

Coming to the history of the patient, she was 34 weeks pregnant ANC mother with history of acute breathlessness for 6 hrs with severe hypertension and 1 or 2 episodes of seizure and fever for one day.

Patient suddenly went into cardiac arrest while being shifted to the Medical college hospital from the primary health center. It was the ambulance driver who on the way seeing the patient collapsing brought her to our hospital.

BABY'S PROGRESS

Baby was limp at birth. No improvement with suction and stimulation. Baby was intubated with 3 size ET tube. Bag and tube ventilation given with coordinated chest compression. Umbilical Vein catheter inserted and fluid resuscitation done. Baby's heart rate improved, No spontaneous breathing. Blood gas done at birth showed severe respiratory acidosis. Baby required mechanical ventilation for 48 hours. Later intubated to room air. At discharge baby was on oral feeds and gaining weight.

The mother went home with the baby after a month. She had a bit of loss of orientation and difficulty in walking. Needed support to walk and to take care of the baby. But after 3 months she was able to come for review carrying the baby herself. It was a joyful movement to see them both. I would conclude, I almost did a postmortem LSCS as a once in a life time experience. Thank God Almighty and our Annai Velankanni team, ICU specialists, Neonatologists and Ogicians.

This miracle of saving both the mother and baby was only possible because of the team sprit with a focused goal to save both. Not only that but the team was available at the exact time giving this mission priority.

Respectful Maternal Care

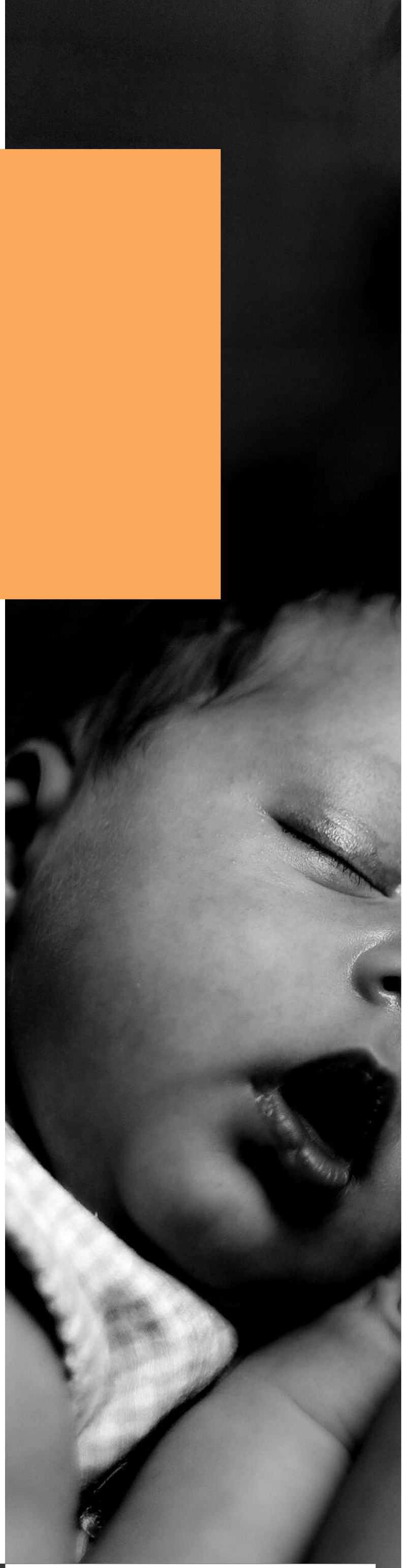
DR KAMINI RAO
Medical Director, Milann – The Fertility Centre

A woman is a precious being and needs all the more love and care when she is expecting a baby. It is very important to know how you should treat her during pregnancy and that is where the topic “Respectful Maternity care” arises. As delicate as she gets and as strong as she may seem it is a given to take care of her. You, as a partner/husband can begin with accompanying her to regular visits to the doctor. Just the thought of you being with her by her side will ease a lot of stress.

When you’re expecting a baby its very important to make sure there is teamwork. It's important to support the mother to be, both physically and emotionally. When I say physical it means that touch and feel are important, give her a hug, hold her hand let her feel that special nurturing touch from you, that small gesture will create a sense of warmth and comfort for her for sure

"To be pregnant is to be vitally alive, thoroughly woman, and distressingly inhabited."

- Anne Christian Buchanan



The mother may have to go through certain dietary changes and it might be difficult for her to do so, and that's when you can jump in and reassure her that you will stand by her through this and that she is not alone.

Emotional support is just as important. Make sure you try and understand her. At times she may have mood swings or even some blues; in such cases let know her that its normal to go through this phase, show her affection and ask her if she needs anything.

A mother also goes through bodily changes and may have severe nausea and vomiting accompanied by body ache and back pain. It is important not to demean her but give her that extra touch or reassurance by trying to talk her through the pain by being next to her and making an attempt to understand the ordeal she is going through.

You can also try some exercises with her or play calming music and mediation. Keep in mind that every woman is different and the pain experienced during labour also differs from woman to woman. Pain during labour is caused by contractions of the muscles of the uterus and by pressure on the cervix when she is in labour. It is very important for you to make sure you are present to help her through the birthing process. Making sure that that the mother is covered properly while birthing is something you need to pay heed to, as she won't be aware of covering herself due to the pain and anxiety that she is enduring and giving her a hand is necessary.

With this, I end my words on “Respectful Maternal Care” and wish all the mothers a very happy and joyous journey of birthing.

Managing Maternal Health in Public Health Systems

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LAQSHYA and NABH Assessor

Public health facilities in India, have witnessed a substantial increase in the number of women accessing the institutions for antenatal, intranatal and newborn care. Govt of India has made long strides in providing quality and safe maternal and newborn care to the increasing number of beneficiaries attending the various levels of L1,L2 and L3 health facilities ranging from PHC,CHC,SDH GH AND MCH.

Managing maternal health in public systems involves meeting the needs of the child bearing woman with available resources at point of care, timeliness of services, geographic location, age, socioeconomic status, overuse of care and availability of appropriate transportation. Keeping all these factors in mind, regulation of access to resources have been planned by GOI, by designating their facilities as BEMONC (basic emergency obstetric newborn care), and CEMONC (comprehensive emergency obstetric and neonatal care). This has resulted in optimal alignment of NEEDS and RESOURCES with specialist care reserved as far as possible for the high risk cases.

The MOHFW in collaboration with NHSRC (Nationa health systems resource centre) has also taken up several interventions and programme aids such as MNH toolkit, standard guidelines for labor room, DAKSHATHA (capacity building trainings) NQAS (national quality assurance standards) establishment of skill labs, PMSMA (camp for detection of high risk pregnancies on 9th of every month). These interventions have been formulated to mitigate the risks identified for a pregnant mother during her antenatal, intranatal and postnatal period. The latest guidelines are the LAQSHYA standards which when followed and implemented, transform the labour room and maternity OT in terms of both quality and safety.

Pregnancy and child birth are physiological processes, but they are prone to complications which can be managed by prompt identification of the risks and their mitigation.

We will now look into the various strategies the NHM and MOHFW have implemented to manage maternal health in an efficient and effective manner with equity.

Following the LAQSHYA checklist there has been a doubling of institutional deliveries since 2007 and a reduction of IMR by 50%, a reduction of maternal mortality by 80%, which speaks volumes about the public health teams' dedication.

Challenges do remain in various areas which have to be addressed as and when necessary. This has resulted in introduction of SUMAN programme, which is yet to be fully implemented. SUMAN (surakshit matriva ashwasan) incorporates the LAQSHYA standards with additional guidelines for the sustainability of the achieved quality and achieving of zero preventable deaths of mother and newborn. Incentives, awards and branding of LAQSHYA certified facilities has motivated the staff working in the facilities who have now realized the advantages of team work. The adherence of the PHF to the standards is assessed periodically by district, state and national level assessors who are qualified for conducting assessment.

RISK	MITIGATION	STANDARDS
Adolescent pregnancy	RMNCH-A programme	NQAS
High Risk Pregnancy	PMSMA	NQAS
Anaemia	Availability of supplements: oral & parenteral	NQAS
Inadequate knowledge of staff	Skill labs, dakshatha trainings	NQAS, LAQSHYA
Vacant staff positions	Human resource planning as per iphs	IPHS, LAQSHYA
Space constrictions	Standardized labour rooms with triage area, sterile labour rooms, septic labour room, eclampsia room etc	LAQSHYA
Drug, equipment need	Support services strengthening, calibration of equipments	LAQSHYA
Sepsis	Infection control programme	NQAS, LAQSHYA
Difference in standard of care	Quality method and tools	LAQSHYA
Emergency management, life saving measures, birth-preparedness robust referral system	OSCE tests for staff of all levels as part of capacity building, Safe birth, safe anesthesia and safe surgery checklist implementation. Newborn resuscitation training.	LAQSHYA

This system of continual planning and implementing of health care quality standards will go in a long way to achieve our aim of assured, dignified and respectful maternal care all our women.

The table represents only part of the various risk mitigation strategies implemented now in public health facilities in India.

Improve Quality of Care in your Labour room

DR. USHA KUMARI VISHWANATH
HOD, Obstetrics & Gynaecology, Sri Ramachandra Medical College

Intra Partum Labour Monitoring App
Simple, Safe, Secure

The past year and a half has presented us with new challenges. It has impacted our practice severely and changed how we manage the care of our patients. The changed circumstances have made us rethink much of what was considered routine and taken for granted before. At Sri Ramachandra Medical College, a tertiary care hospital dealing with a multitude of complex cases, this has forced us to innovate and adapt and equip ourselves to better serve the patients under our care.

Over the course of the past 18 months, we have brought technology into the Labour Room practice. Let me introduce you to Suraksh, a simple, safe and secure mobile app to help improve the monitoring of patients in labor. We have benefited immensely from using this product and I am positive that Suraksh will make a huge difference in the intrapartum management of pregnant women.

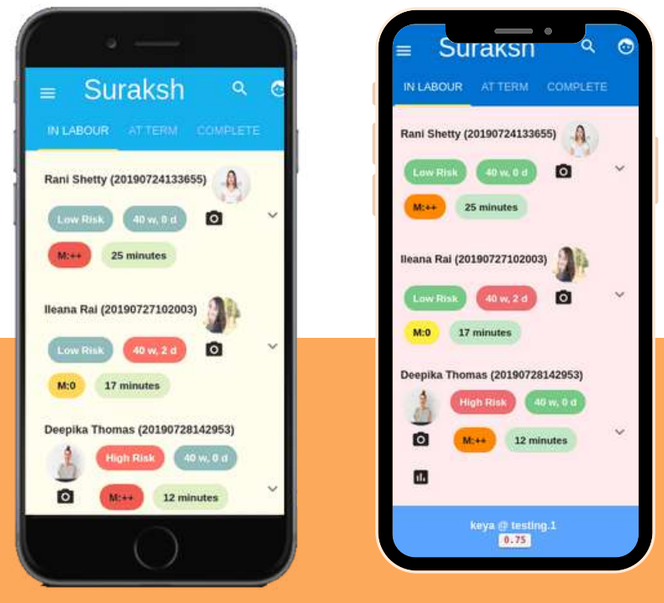
BENEFITS OF SURAKSH

The Suraksh App was recognized at the recently concluded CAHOTECH International Conference for the several benefits it offers over our traditional practices.

- Paperless capture of Labor Records / user friendly entry options with help guide which acts as a training tool for the young doctors & nurses.
- Auto Capturing of Partogram / alerts for deviations in the progress of labour
- Scheduled Reminders for reassessment & Escalations for better monitoring
- Comprehensive Intrapartum PDF Report is generated at the end of the delivery
- Complete Risk Assessment and availability of all patient data which serves as a good registry
- Drug Chart with allergies highlighted
- Digital CTG images that can be uploaded
- Consultants can monitor their patients closely and interact with the labour room team at all times from any part of the world
- Abnormal Investigations get highlighted in red Indications for LSCS are captured as per Robson's score and LSCS rate and induction rate are auto captured dynamically. The data can be used for conducting LSCS audits and there is provision of entering morbidity or complications with root cause analysis and recommendations to avoid such events in future.

There is provision for close monitoring during the first one hour after delivery with recording of pulse, blood pressure, contractility of uterus & amount of vaginal bleeding. There is also the capture of mop/instrument count with all relevant patient safety details making it a sound record that can defy possible litigation.

These are only some of the many benefits of using Suraksh. The younger generation of doctors and nurses are more comfortable using a smartphone or tablet than filling in reports by hand.



Please visit our website at https://vplan.in and register for a free webinar on how to use Suraksh in your practice. Avail of this opportunity to learn the impact of new technologies on obstetric practice in the 21st century. We look forward to also addressing any questions that you may have.

DR. EVITA FERNANDEZ
Chairperson, Fernandez Foundation

Preserving Human Rights in Childbirth

A broad perspective on world history highlights many significant milestones brought about by women who led change revolutions. Elizabeth Cady Stanton and Lucy Stone ensured the US Constitution granted women voting rights. Rosa Parks, an African-American woman, refused to give up her seat to a white person and ignited a nationwide boycott leading to radical change in racial segregation laws. Kadambini Ganguly, the first Indian female doctor, made Calcutta Medical College open its doors to aspiring female students, ushering women to become doctors in India.

The White Ribbon Alliance (WRA) – a global advocacy movement for reproductive, maternal and newborn health, launched the campaign “What Women Want”. This campaign brought together organisations worldwide to ask one million women and girls in 114 countries about the one thing they want most for their own reproductive and maternal health care.

These were the responses from women in India:
-Respect and dignity in birthing
-Privacy
-Kindness
-A birth companion
-Clean bed and toilet at the place of birth
-The freedom to walk and birth in a position of choice

The request for more midwives and nurses was one of the highest requests from the global WHAT WOMEN WANT campaign. Women once again led a revolution to help protect the fundamental human rights of childbirth.

It is important to note that no woman asked for five-star quality interiors. Women asked for basic human values. I believe these answers will resonate with every pregnant woman across our country irrespective of her social, educational, and financial status.

Let me enumerate some common examples of disrespectful care women face during labour:
- Birthing in an environment that has no sense of privacy
- Forcing a woman to birth in a passive state and not allowing her to choose her preferred position
- Using medical interventions that alter the natural process of birthing
- Not acquiring the consent of the woman throughout the birthing process
- Performing a caesarean when natural birth is possible
- The absence of skin-to-skin contact after birth and not allowing immediate breastfeeding.

With its annual birth rate of 26 million and institutional births being made mandatory, India faces enormous challenges. Women birthing in public facilities are offered financial incentives. Patient volumes, therefore, increased by 30- 40 per cent with no parallel increase in the infrastructure. As a result, we have a workforce that is exhausted and stretched beyond human capacity. In such an environment, mothers are subjected to more abuse and rude behaviour by weary and overburdened healthcare staff. However, India's Ministry of Health and Family Welfare introduced two significant initiatives that have helped endorse respectful maternity care as a national program and an indicator of quality.

1. Midwifery-led care clinics in public hospitals across the country. Midwives offer high-quality, compassionate, respectful care - this is the heart of midwifery.
2. Laqshya – a labour room Quality Improvement Initiative: Respectful care is one of the quality indicators on the LAQSHYA accreditation checklist.

The obstetric community must recognise the government's efforts to make respectful maternity care a vital component of childbirth practice.

We must remember that respectful, compassionate, high-quality care is not a privilege but the fundamental human right of every pregnant woman.

Safety in NICU

DR. SUNEEL C MUNDKUR
Professor, Department of Paediatrics
KMC Manipal

Safety in NICU is important because of many reasons like ow birth weight and prematurity of neonates who are physiologically immunocompromised, frequent invasive procedures through all orifices including total parenteral nutrition, sudden exposure from internal sterile mileu to the external environment, challenged enteral feeding, inadequate and incompetent staff, complacency in infection control techniques and many more. The fluctuations in temperature, oxygen or glucose level may prove fatal. Hence, stringent safety and quality checks need to be implemented.

INFRASTRUCTURAL SAFETY

The NICU must have adequate space for various activities to avoid over-crowding and infection. Adequate space should be available around the warmers for the equipment and for free movements. NICU should have separate areas for high risk, septic and premature babies with facilities for isolation/barrier nursing. There should be a separate room for procedures (exchange transfusion, umbilical vein /artery catheterization), for formula preparation and breastfeeding with adequate hand washing facilities.

INSTITUTIONAL AND INSTRUMENTAL SAFETY

Availability of stable uninterrupted power supply, potable water supply, an efficient system of temperature/ventilation/humidity control with AC filters that are regularly cleaned/replaced and hand washing facilities. Equipment and supplies should not be shared between infants. A system of planned preventive (and break down) maintenance and recalibration to ensure optimal operational reliability and fault free functioning of all equipment like infusion pumps.

IMPLEMENTATION SAFETY

Quality manual with documented procedures complying with national and international guidelines is the must. Infection prevention and control manual with strict hand hygiene compliance, aseptic techniques, minimal handling of the neonates shall be available and implemented.

INTELLECTUAL SAFETY

NICU shall be managed by trained, competent and privileged staff. They must be aware of infection control practices, and be immune to rubella, measles, polio and chicken pox and HBV and preferably yearly influenza vaccination.

INSECURITY SAFETY

Visitor management is important. Visitors should be treated on an individual basis, View babies through the viewing box, If mandatory to enter in the unit, allow only parents after rounds with hand hygiene protocol and use protective clothing. The 24x7 experienced security personnel to check entry is preferable.

INFECTION SAFETY

Minimization of catheter days, strict hand hygiene compliance. Monitoring /surveillance of nosocomial infection, safe use and disposal of sharps, prevention of CLABSI and VAP, reduce duration of Total Parenteral Nutrition. Infection safety & sharp disposal policies and Proper PPE should be available and used when appropriate to emphasize infection prevention.

INTERCOMMUNICATION SAFETY

There should be a procedure laid down for recording and communicating the sex of the babies to the parents at birth. It can be ensured by taking a photograph of the baby's entire body along with the face of the mother and her particulars or at least a footprint & the date and time of birth.

INJECTION AND INFUSION SAFETY

Safety for identification of the neonates to avoid medication, sampling, other errors or mixing/swapping of babies. Identity bands with all the details should be tied soon after birth. Sterile preparation of all fluids to be administered, promotion of early enteral feeding, judicious antibiotic usage & prevention of misuse, awareness on allergies, contraindications, and drug–drug Interactions. Accurate anthropometry and dosing are important strategies in medication safety. Liberal use of drug references, dosing charts, appropriate formulary, clinical pharmacy services, complete prescriptions, and avoiding vague ambiguous instructions, error prone abbreviations and verbal orders (strict read back, if used) minimize errors.

INSTRUCTIONAL SAFETY

Ensuring standard practice of educating the parents about nutrition, breastfeeding, immunization and safe parenting and documenting the same in the medical records and involving the parents in decision making.

Quality and safety in NICU is of paramount importance as patients are not only critically sick, but are physiologically immunocompromised.

Preimplantation Genetic testing – For better Maternal Outcomes

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The progress of modern society has greatly affected the fertility of women. In recent years, there has been an increase in the number of women with childbearing age greater than 35 years in both developed and developing countries. To some extent, the decrease of fertility is due to advanced maternal age which decreases ovarian reserve and leads to the decrease of embryo quality and causes increased risk of miscarriages and chromosomally abnormal babies.

As the use of assisted reproductive technology has increased over time, Pre implantation genetic testing along with IVF has improved maternal outcomes by reducing the burden of multiple gestation and miscarriages due to aneuploidy. Many countries have thus implemented voluntary recommendations for elective single embryo transfer (eSET) with preimplantation genetic testing of embryos.

There are three types of preimplantation genetic testing (PGT): preimplantation genetic testing for monogenic (single-gene) disorders (PGT-M), preimplantation genetic testing for structural rearrangements (PGT-SR), and preimplantation genetic testing for aneuploidy (PGT-A). DNA for genetic analysis is usually obtained from biopsy of trophectoderm cells from a blastocyst on day 5 or day 6 after fertilization. Genetic analysis involves DNA amplification using a variety of strategies (eg, whole-genome amplification, polymerase chain reaction [PCR] amplification), followed by use of one of several available platforms for analysis of the amplified DNA.

The main reasons that patients choose PGT-M is to avoid having a pregnancy with a fetus affected by, or at risk for, a severe debilitating disease and to increase the parents' chances of having a human leukocyte antigen complex-compatible offspring. Couples with balanced translocations choose PGT-SR to reduce the risk of recurrent pregnancy loss (RPL) from unbalanced translocations. Pre implantation genetic testing for Aneuploidy (PGT-A) is used for detection of aneuploidies, or chromosomal abnormalities, across all 24 chromosomes (22 autosomes and the X and Y chromosomes) Examples include trisomy 21 (Down syndrome) and monosomy X (Turner syndrome). PGT increases delivery rate from 11.5% to 81%. Clinical pregnancy rates following PGT embryo transfer range from 23% to 51% worldwide with a delivery rate ranging from 18% to 43%.

Preimplantation genetic testing for aneuploidy remains a good tool of embryo selection, for a selected category of patients with normal ovarian reserve and should be only practiced by select IVF clinics that have adequate experience with embryo biopsy and preimplantation testing.

Improving Childbirth Experience

DR. VIJAYALAKSHMI SESHADRI
Senior Consultant Obstetrician & Gynaecologist,
Sundaram Medical College Foundation, Chennai

Childbirth is a once in a life time experience for every woman, and is an event that she awaits with anxiety while she goes through her pregnancy. With the reducing number of deliveries that happen nowadays for every woman, it is a precious experience that remains stored as an indelible memory. And, if it is a cherished one, she feels a completeness in her life. We, as care givers, can make that happen. As efficient obstetricians, we have a great responsibility to make every pregnancy culminate into a successful outcome. Meticulous medical care, strict observation of checklists, procedural precisions, and supreme commitment help in safe and good conduct of deliveries. Labour and delivery are the challenges that the woman face with a
bold persistence and when she hears her baby cry and sees her newborn smiling at her, she forgets all her stress and strain that brought her baby into this world. But, as moments pass, she looks back at the sequence of events and re-lives those moments. The scenes of her reactions and her efforts, aiding the magical system of the nature, cross her vision and she recollects all the responses of the medical team. Any exchange of irritable conversations, any expression of anguish and any outpouring of angry tones dilutes the thrill and excitement that she so proudly enjoys as a new mother. Some guilt or some feeling lingers on to know if it could have been better.

The medical and the paramedical team take on great efforts, put up with a lot of stress and tight schedules, but a little lack of patience, a little less tolerance to her expressions of pain and anxiety, seemingly lesser sympathy, perceptively lower comforting attitudes are the features that take away the mutual respect for having done their best.

Soft touches, smiling attitude, comforting words give lot of quality to their equation.

Analgesia as indicated, supporting postures, allowed diet, permitted ambulation, clean environment are de-stressing factors. Allowing her to meet her relatives and her attendants keeps her experience elated. Counselling with required knowledge transfer and avoidance of scary information are the hallmark of her good birthing experience. Her husband or partner sharing the moment of the arrival of their creation gives them boundless happiness and helps deepen their bond. The first instance of skin to skin contact with her baby and the first breast feed that she so selflessly does, aggravate the joys of her birthing experience. Hence, in all possible circumstances, that should be encouraged.

Let us all be more focused to give a richer, merrier, sweeter experience of birthing to every woman that we deliver under our care.

INTERESTING READS

Alternate Birthing Techniques

Sourced from Journals

While most pregnancies are dealt with at hospitals under supervision by a team of specialists, alternative birthing techniques provide an opportunity for no risk healthy pregnant women to have their babies comfortably in a safe way of their choosing. Most communities around the world and in India have practiced some form of traditional birthing techniques for women that ensures adequate healing time, and rest for the mother postpartum. It also allows bonding time between mother and baby that is beneficial to them both.

Some of the commonly practiced and popular birthing methods are: The Lamaze Method, Water Births, and the Bradley method, among others.

LAMAZE

The Lamaze Birthing technique emphasizes breathing, changing positions and walking around at certain points during labour. All of this can help alleviate some of the anxiety associated with childbirth. In case of restricted birthing environments, breathing can be a nonpharmacological comfort strategy available to women. Conscious breathing and relaxation, especially in combination with a wide variety of comfort strategies, can help save the need for intervention and have a safe, healthy birth.

Click here for extra reading.

WATER BIRTH

After the first water birth reported in a medical journal in 1805, its popularity increases in the 1980s and 1990s with women still opting for water deliveries or water births even today.

Here women give birth in a tub filled with warm water, undergo labour while remaining in the water, and the baby is brought to the surface after being born. There has been a lot of research done in this area, and while the American Pregnancy Association recommends for preparations to be made for delivery to occur out of water in case of complications, there are some benefits of water birth like - reduced 3rd and 4th degree tears, reduced pain as compared to land births (vaginal births out of water), potentially lesser postpartum blood loss, and better overall satisfaction for the mother.

Click here for extra reading.

Investigations comparing newborns found no difference in foetal or neonatal deaths, Apgar scores or needs for NICUs. The risk for adverse neonatal outcomes however, remained high.

Pre-Screening to evaluate risks, counselling to understand the possible implications, before considering any birthing methods is of utmost necessity. It is critical to note that none of the alternative birthing techniques are free from its complications, yet one of the most startling benefit is the comfort and satisfaction that a mother may feel in choosing her own birthing method. Support from Ob/Gyns, pediatricians, and presence of trained birth attendants, midwives, or nurses is still significant to ensure the birth goes smoothly, and is a joyous occasion for the mother, and the caregivers.

Providing choice to a pregnant woman, free of risks, and under supervision from her doctors can prove to provide a fresh approach as we strive towards achieving safe and respectful childbirth for all.

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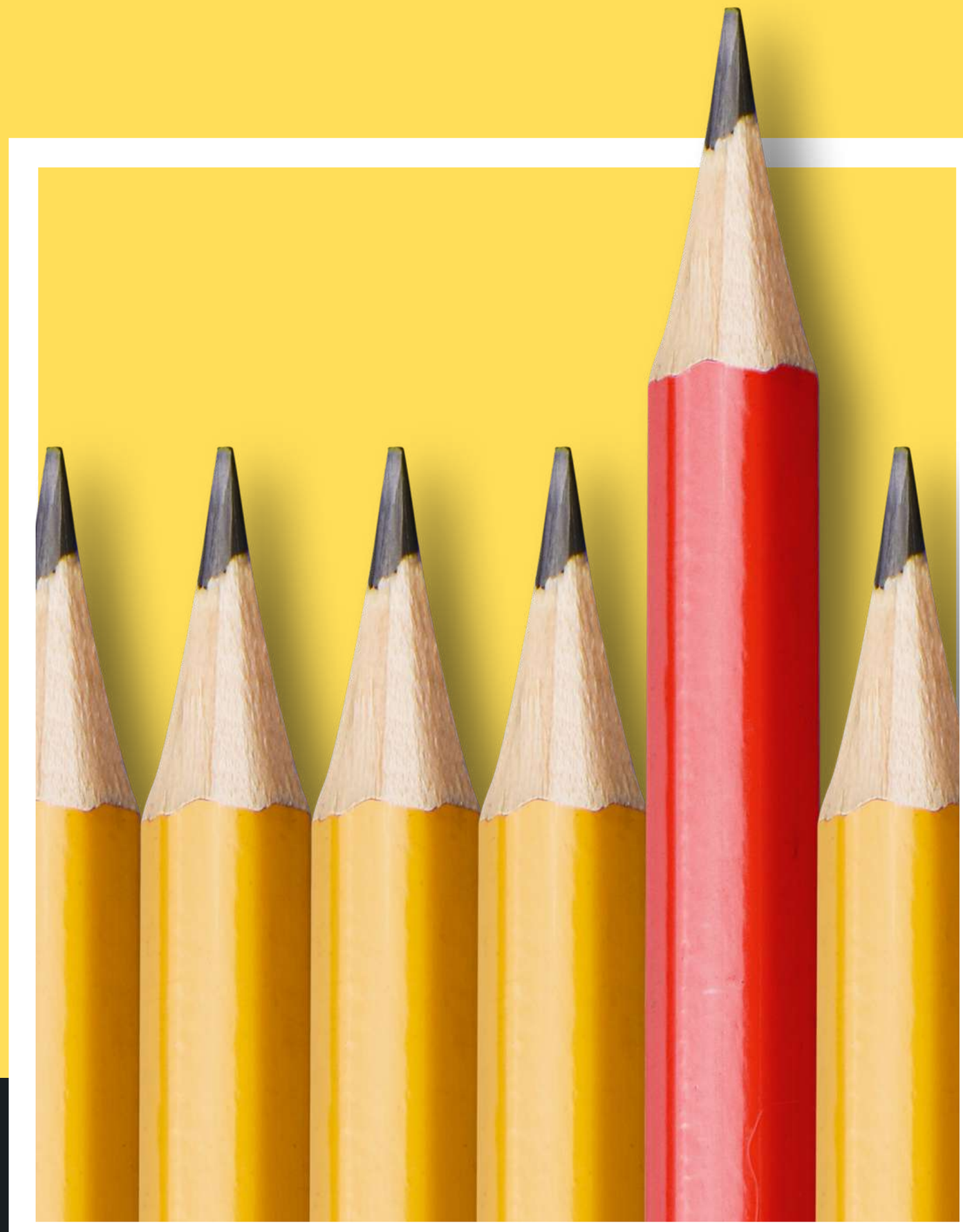

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