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## **RISING TREND OF CEASAREAN SECTION IN SRI LANKA**

### ***Introduction***

Caesarean section (CS), a major surgical procedure which was a feared operation until the 20<sup>th</sup> century and has shown a significant rise in Sri Lanka as well as the world, evoking concerns about its associated long term and short term risks as well the economic burden on the health care system [1,2]. Although majority of births take place via vaginal delivery, Sri Lanka shows an increase in CS rate from 34,53 % in 2015 to 43,1 % in 2021 with a decrease in maternal mortality rate by 7 % and no significant change in neonatal mortality rate [3].

Vaginal delivery is a safer option for the fetus and mother at full term, when spontaneous labor occurs or if amniotic and chorionic membranes rupture. It yields a shorter a hospital stay, less chance of rehospitalization, high recovery rate from labor and birth, low requirement for strong pain relief .CS which involves surgical delivery through incisions in the mothers' abdominal wall and uterus is only medically indicated when vaginal delivery poses a potential risk to mother and fetus. Elective CS are scheduled surgery indicated in multiple gestation, fetal malpresentation, shoulder dystocia, abnormal or indetermined fetal heart rate tracing, placenta previa, previous surgery on uterus or previous CS, maternal medical conditions and infections like HIV, genital herpes, high blood pressure, diabetes. Emergency CS is an unexpected emergency delivery done in case of a potential risk to mother and/or baby during pregnancy or labor and is indicated in placental abruption, cord prolapse, fetal distress, macrosomia failure of progression of labor [4]. Unlike vaginal delivery, CS is associated with a high maternal, neonatal morbidity and mortality rate [5]. Fatality is 5 times higher in all c-sections, even elective CS carries fold higher chance of mothers death compared to planned vaginal delivery [2]. Complications include lacerations, hemorrhage requiring hysterectomy, sepsis, venous thromboembolism, amniotic fluid embolism, adhesion formation, bladder injury, intestinal obstruction, compromised health of infant in both long term and short term, neonatal respiratory distress and in subsequent pregnancies high risk of placenta previa, accreta, stillbirth and uterine rupture [4].

An unbiased assessment of risks and benefits would assist in discussing a controversial issue in modern obstetrics and selecting the suitable method of delivery, however is should be taken into consideration that a planned vaginal delivery may result in an emergency CS which carries a higher risk than a planned CS [5].

### ***Goal***

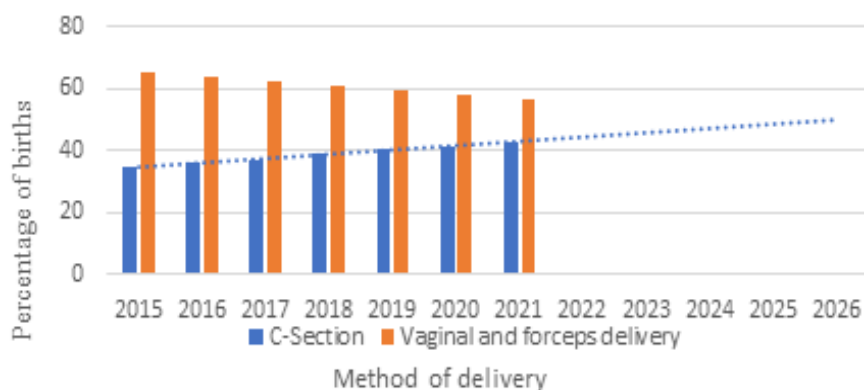
To evaluate and identify the reasons for the increasing rate of CS in Sri Lanka, and to assess the public awareness of the associated short term and long term complications. To study the possibility of reducing unnecessary c-section procedures, thereby reducing government expenditure.

### ***Material and research methods***

Conducting an online survey on 100 women living in urban areas of in Sri Lanka regarding their choice of method of delivery, reason of choice and awareness. Analysis of medical, scientific literature on this topic and annual reports of family health bureau, annual health statistics of Sri Lanka.

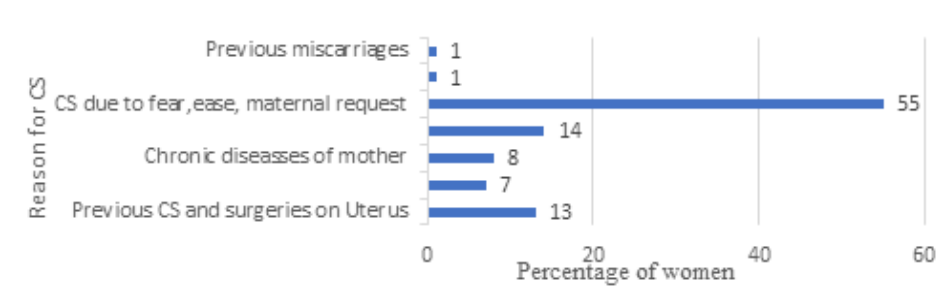
### ***The results of the research and their discussion***

An increasing number of mothers request delivery by elective c-section without any accepted medical condition, due to the general perception that CS is much safer now than the past and popularization of CS by the private health sector. According to the national statistics of family health bureau of Sri Lanka there is an increase rate of CS by 1,12 % each year for the past 7 years as shown in figure 1. In 2021 43,1 % of all deliveries were done through CS [1].



**Figure 1 – Forecast of CS in Sri Lanka**

In accordance to the current trend, by 2026 more than 50 % of all births will occur through CS in Sri Lanka which will impose a major economic burden on government health sector due to the high cost of CS. Although the rate of maternal mortality rate has decreased by 7 % from 2015 to 2021, with insignificant changes in neonatal mortality, no adequate study has been done on the changes of postpartum maternal and neonatal morbidity rates with CS in Sri Lanka [1]. According to a study made on 100 women living in urban areas of Sri Lanka, 53 % have undergone planned CS, 19 % vaginal delivery, 16 % emergency CS, 12 % both vaginal and CS for different pregnancies and the reason for selecting CS is indicated in figure 2.



**Figure 2 – Reasons for undergoing CS**

According to WHO Robson Ten Group Classification of different categories of pregnancy, 21% of women belong to group 5 of multiparous, singleton, cephalic, full term, with a previous caesarean scar and 13% of women belong to group 2b of nulliparous, singleton, cephalic, full term, pre labor CS. [6]. Even though 53% of women have undergone CS, only 31% of women are aware of the associated complications of CS and 67% believes that there is not enough public awareness about the long term and short term risks of CS. Despite 68% of women being aware that vaginal delivery has less post complications on the mother 55% of women have undergone CS due to the fear of CS and belief that CS is easier than vaginal delivery.

### ***Conclusion***

The dramatic increase in the rate of CS in Sri Lanka is mainly due to maternal request without any medical indication and by the lack of knowledge about the complications of CS in relation to vaginal delivery, policies promoting subsequent CS and discouragement of vaginal

delivery. Further research is required to better identify the factors and indications for executing CS and to compare the maternal, neonatal morbidity and mortality rate for vaginal delivery and CS individually. Government awareness programs should be carried out in maternity hospitals highlighting the benefits of vaginal delivery over CS. Appropriate measures should be taken to minimize the risks of surgery and anesthesia related to CS. Obstetrician should not merely carry out patients wishes, all risks should be informed to the patient before a selection is made. Furthermore, layman should not be led to the conclusion that CS is the best option for delivery and vaginal delivery is a poor approach. Thereby, an attempt can be made to reduce the unnecessary CS carried out in the country without compromising the care given to the mother and baby.

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## **AWARENESS AND KNOWLEDGE ABOUT HEALTHY SEXUAL RELATIONSHIP AND GYNECOLOGICAL CARE AMONG LATE ADOLESCENTS AND YOUNG ADULTS IN SRI LANKA**

### ***Introduction***

Gynecological care and sexual health of late adolescents and younger adults is an important health concern and a focus of global attention. Population ages between 10–19 years are categorized as adolescents. Adolescence is the phase of transformation from puberty to adulthood, hallmarked by physical, physiological psychological development among adolescents. Late adolescents and young adults ages between 18–21 and beyond approximately until age 36 generally have completed physical development [4].

Education about the female reproductive system and gynecological care is important to prevent future gynecological problems. It must know at least the basics about menstrual cycle and why they happen. Not only that but also should be aware of menstrual bleeding volume to prevent developing anemic conditions. Education about gynecological hygiene is important to prevent extragenital infections [1, 2, 4].

Awareness about Sexual health is far more complex than simply working to reduce disease risk. It encompasses physical health and emotional, mental and social aspects of sexuality. Knowledge about birth control methods, sexually transmitted disease prevention, screening