


Data availability statement

This manuscript does not contain any data because of the article type (Letter to the editor). ■

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Re: Implications for the future of Obstetrics and Gynaecology following the COVID-19 pandemic: a commentary

Sir,

With immense interest we read the article entitled, 'Implications for the future of Obstetrics and Gynaecology following the COVID-19 pandemic: a commentary' by Kasaven et al.¹ The article briefs on the challenges faced

and assesses the impact of COVID-19 on the healthcare workforce, service providers and public perception. Pregnant women constitute a vulnerable group because of their increased risk of developing complications from viral respiratory infections. To tackle the unmet demands of obstetric care amidst the social distancing protocols and the halting of outpatient services, many obstetric patients have been using telehealth.¹

We would like to thank the authors for an insightful brief. However, although the commentary sheds light on the inaccessibility of telehealth, it fails to provide solutions to the obstacles imposed on rural communities in adopting and implementing telehealth, both technologically and physically. The global challenges and unique solutions faced by developing countries must also be addressed.

Telehealth clinics exist for rural communities in some inaccessible areas; nonetheless, the current challenges of these clinics include the patient's physical absence, dissatisfaction through scheduling delays and the lack of technological infrastructure for these systems. Studies note that the use of a dedicated virtual health practitioner eliminates these concerns. A case study examined three models of care to conduct a return of investment (ROI) analysis. The three models investigated included- setting up a telehealth clinic, in-person hospital visits and having a virtual health practitioner. They concluded that the third model was the only service model to have a positive ROI over 3 years.² It eliminates patient dissatisfaction as they do not need to worry about transportation and is economically beneficial.

Additionally, one study assessed the feasibility of a paediatric telehealth network in Honduras with consultation support from the USA. They found that 100% of the respondents were satisfied and would continue receiving support from a virtual health practitioner. However, one of the setbacks from the study was poor internet connectivity.³

In developing countries, particularly in the worst-hit South Asian countries like India, poor internet penetration and connectivity issues presented several restrictions, and thus the obstetric care had to be revamped through mobile apps, telephone triage, offline/online local help groups and community health workers. Teleconsultation played a pivotal role in delineating high-risk patients so that their care could be individualised. India benefitted from a collaborative healthcare model that combined both health workers in the community and regional levels of healthcare centres.⁴

Thus, dedicated virtual health practitioners and connectivity support serve as cheaper and effective methods for patients in rural and tribal communities across the world. International consultations can also be used to help those from impoverished countries where fears of attending crowded clinics exist along with a severe shortage of healthcare workers. As such, the recognition of the practicality of virtual health practitioners and the implementation of a collaborative healthcare model needs to be established to aid in the delivery of virtual prenatal visits for those in rural and remote communities.

Disclosure of interests

None declared. Completed disclosure of interests form available to view online as supporting information.

Contribution to authorship

The conception and planning were jointly performed done by RA and SC. The original write-up was planned by RA. The write-up was further analysed, evaluated and revised by SC.

Details of ethics approval

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Data availability

Data openly available in a public repository that issues data sets with DOIs. ■

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RE: Modification of oxytocin use through a coaching-based intervention based on the WHO Safe Childbirth Checklist in Uttar Pradesh, India: a secondary analysis of a cluster randomised controlled trial

Sir,

We read with great interest the study entitled *Modification of oxytocin use*

through a coaching-based intervention based on the WHO Safe Childbirth Checklist in Uttar Pradesh, India: a secondary analysis of a cluster randomised controlled trial by Delaney et al.¹ We appreciate the authors conducting the trial on addressing oxytocin as a double-edged sword in intrapartum and postpartum period. However, we wish to make certain observations that will further help in comprehending the results of the study.

Taking into consideration that the study was conducted in India, which is a developing nation, certain aspects of the study need more clarity. First, it would be more transparent to share the 'current standard of care' in the facilities selected under the study, as they form the control arm of the investigation. Second, the study mentions the involvement of basic healthcare facilities like the primary health centre, the community health centre and the first referral unit. It would be of much help if the authors could kindly provide the criteria for selection of the 'convenience sample' of 30 out of the initial 60 facilities. We believe that a specific protocol for choosing the sample facility can eliminate the possibility of selection bias.² Also, maintenance of the cold chain is integral for the potency of oxytocin, it would be of importance to mention if this facet was adhered to strictly because Uttar Pradesh is known for its frequent episodes of power cuts. Furthermore, it would be helpful if the authors could share the '28 essential birth practices' checklist, to allow better understanding of the coaching involved in training the birth attendants.

The study has certainly elaborated on the impact of judicious use of oxytocin in the intrapartum and postpartum periods. However, a few aspects need further scrutiny. We are aware that obstetric complications, like pre-eclampsia, gestational diabetes, severe anaemia and premature rupture of membranes, and fetal complications, like congenital anomaly, prematurity and fetal growth restriction, can independently be a mainspring for maternal

and perinatal outcomes. There was no mention of restriction of these confounding factors. Furthermore, information on whether the onset of labour was spontaneous or induced and whether the mode of delivery was vaginal or caesarean would help our understanding.

The importance of postpartum use of oxytocin in the active management of labour has been highlighted effectively, but the study excluded the analysis of participants who were given misoprostol and methergin. We would like to know if this was a significant number of patients. Also, this raises the thought of whether these were patients in whom oxytocin alone did not suffice to manage the postpartum haemorrhage. Considering this aspect, the exclusion of such patients from the analysis would lead to spurious results.

Disclosure of interests



None declared. Completed disclosure of interests form available to view online as supporting information.

Data availability

All data provided are original and not a duplication from any other source. ■

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