New initiatives in evidence-based learning in obstetric fistula surgery in the developing world

SOHIER ELNEIL AND MULU MULETA

Obstetric fistula is a problem commonly encountered in the developing world that results in debilitating urinary and/or faecal incontinence. Sohier Elneil, a UK urogynaecologist, and Mulu Muleta, a fistula surgeon from Ethiopia, chart a history of fistula care and outline progress made.

Historically, many women suffered fistulas in Europe and the USA, until the middle of the last century. However, with social, economic and health developments, this condition all but disappeared in the developed world. It still poses a major problem in Africa and Asia, where access to modern obstetric care, including caesarean section, can be limited.\(^1\),\(^2\) Over the course of a lifetime, one in 12 women in Africa will die in pregnancy or labour, particularly in the rural areas.\(^3\) This is a phenomenal figure, akin to three jumbo jets full of passengers crashing fatally every 24 hours. More startlingly, for every woman that dies in labour, at least 20 lives are destroyed by terrible injuries sustained during obstructed labour. Long distances combined with high cost of care and poor nutrition make women more vulnerable to obstetric fistulas, particularly in West Africa,\(^4\) the horn of Africa\(^5\) and the Indian sub-continent.\(^6\)–\(^8\)

Conservatively, it is estimated that there are two to three million women with obstetric fistula still awaiting surgery. The success of the repair depends on meticulous surgery, excellent nursing care and prevention of ...
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complications.9–11 However, the number of capable and dedicated surgeons remains a major stumbling block in the management of this condition.

In Africa and Asia, initiatives were undertaken by doctors from differing surgical backgrounds, nurses and philanthropists, to combat this debilitating problem. Their philosophy was to provide a dedicated centre of excellence to treat these women from their native country and surrounding states.12 They also provided training and education but several problems persisted. These included a lack of consensus on fistula classification, working in isolation and little or no evidence-based medicine in decision making. Consequently, training in fistula surgery was often thought to be patchy, inadequate and unfocussed. Most importantly, though, there was no way to assess trainees or to determine their suitability. As a consequence, patient outcomes were very poor in some arenas. In addition, fistula surgery was highly politicised in the developing world, which often hampered progressive thoughts and ideas. Fortunately, with increasing awareness of these situations, many agencies poured money into initiatives of fistula care, with the focal point being the need of the local healthcare providers. This was an impressive start but global consensus remained the key.

To achieve global agreement, several impediments needed to be overcome. These included coordination of clinical efforts to prevent duplication of care, open communication channels to enable better coordination of efforts to ensure well-managed and targeted service provision, a universally accepted fistula classification to enable accurate communication between units and surgeons about the conditions that they are treating and the input of fistula surgeons working in the field, such as the International Society of Obstetric Fistula Surgeons (ISOFS), which was formed in September 2008.

The global effort started to take shape at the start of this century, with the formation of the International Working Group on Obstetric Fistula (IWGOF) established by the UNFPA (United Nations Family Planning Association), the World Health Organization (WHO), the International Federation of Gynecology and Obstetrics (FIGO), Engender Health, multiple international non-governmental organisations and, more recently, ISOFS. Their first priority was to try reaching an agreement on a globally accepted fistula classification. Once adopted, a classification system would be an invaluable tool for training, communication and multicentre research. Their second priority, in tandem with the Royal College of Obstetricians and Gynaecologists (RCOG), was to strengthen and support evidence-based learning in obstetric fistula surgery.

Until the IWGOF came together, only a handful of units were appropriately equipped to provide training to a satisfactory level with experienced trainers, adequate number of cases and satisfactory training facilities. Although they did an excellent job in equipping young surgeons with the necessary skills to return to their own countries to further extend this work, some were hampered by independent bodies, who have taken on the

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task of producing a 'training manual' in an attempt to formalise the training process. Some of these manuals were disparate and imprecise, maybe because of a lack of expertise or direction, and so they were not readily usable in all situations. Understandably, a unified approach was desperately needed.

FIGO took on the mantle of a unified training programme for the group and started a process, which is now in the piloting phase. The remit of the FIGO fistula committee was to reach a consensus on what a training manual should include, to contribute to the classification debate and to develop an evidence-based course for a selected surgical or gynaecological trainee, who has attained at least three years of surgical training in their home country. The training structure is modular, with each module or subject area being further subcategorised into specific objectives. Each module can be achieved within a stipulated period of time, as determined by the trainer and the trainee. But, rather than this being a didactic process, the trainees were encouraged to follow a path of evidence-based training. The main support for the latter was provided by the RCOG. Using the agreed information, provided by the fistula surgeons and other members of the IWGOF, they were able to formulate and develop learning tools, logbooks and objective structured assessments of technical skill (OSATS) for each module. This is the first time that such an initiative has been developed for a specific internationally recognised health problem. Using the manual will not only provide a guide to surgical training but will also initiate audit of surgical outcomes, thus facilitating research in the field and promoting publication in the medical and nursing literature. For the manual to be fully accepted, a consensus on fistula classification must be reached. It is on this last awkward point that the success of the manual will rest but perhaps with the help of ISOFS and the IWGOF a consensus may be reached within the next few years. This situation is not unusual, as similar problems were encountered when attempts were made to reach consensus on classifying gynaecological tumours 20 years ago.

The manual is currently undergoing its initial trials in pilot studies in parts of Anglophone and Francophone Africa and Asia. The initial results should be available within the next year. Thereafter, the training manual should become available to all fistula units and institutions for wider use.

Although the objectives of this whole process were to unify the fistula community, to develop standardised training programmes and to improve outcomes, it must not be forgotten that this condition is completely preventable. Therefore, the issues which are the basis for it, social and economic development of girls and women who are ‘at risk’, need to be tackled. This includes universal access to emergency obstetric and medical care and instituting appropriate integrated social and economic development programmes. This would effectively prevent the problem in the long term but, more importantly, it would be highly sustainable. In the interim period, the holistic approach to medical and surgical treatment, rehabilitation and community follow-up instituted by many well-known fistula surgeons, including the tremendous efforts of the Hamlins and their team in Ethiopia, Waaldijk and Lawson in Nigeria, Ouatarra and Gueye in Senegal, Abboo and Kelly in Sudan, Rassen in East Africa, and Akhter in Bangladesh, have brought obstetric fistula to the forefront of the world’s medical media. Their exacting work has meant that more women’s lives are being rebuilt. By embracing WHO’s
mantra of ‘health security for women throughout the life-span’, in tandem with the new initiatives, we can improve the quality of all women’s lives. No more so is this needed than in a woman suffering from a fistula.

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References

As obstetricians and gynaecologists, we form a small but important part of the worldwide effort to prevent mothers dying from childbirth. Why a small part? There are so many facets to maternal mortality that all cannot be addressed under one organisation and there are failings in providing care from the community level to the hospital. The three delays is the classic model: delay one – knowing when there is a healthcare problem at the community level; delay two – travel to health care; and delay 3 – getting quality health care. Tackling all these delays is crucial and ‘strengthening health systems’ is the buzz phrase that becomes important when tackling a dysfunctional health system to which all stakeholders should work. The third delay is our remit and the RCOG International News aims to bring you articles relating to this topic from College activity.

In this edition, Olivia Roberts discusses ways of working internationally for short-term placements and Kate Alldred, who is the current Eleanor Bradley Fellow in Uganda, give us an update on what is evolving into a long-term sustainable project.

For most of us in the UK, international travel might not be possible. However, there is much that we can do. Advocacy has become increasingly important for women’s health in low resource countries, particularly on a governmental level when political priority and input can influence healthcare investment. In a recent survey of the international members of the RCOG, 89% of respondents felt that advocacy was a responsible part of being a gynaecologist. This is an important finding of the survey, as most of us do not have advocacy experience and spend most of our time in direct clinical care. For those of us in well-resourced countries, we can all be advocates for our specialty in the wider world. Lobbying Members of Parliament, attending meetings related to global maternal health, organising local meetings and even joining a liaison group are ways of getting involved. Can you be an advocate? A new Advocacy Subgroup of the International Office has been set up and is developing its agenda and there will be more information on this exciting development in months to come. Please put 1 July 2010 in your diary for the RCOG event Reducing Maternal and Newborn Deaths – a follow-up meeting to the 58th RCOG study group. This is an important meeting looking at ways of addressing the complex social, economic and clinical causes of maternal and neonatal mortality. We hope to see you there and that you have a good spring and summer.

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A family planning clinic was established in Madagascar in 2007, after an unmet need was identified by an expedition doctor working with a conservation group based there. In this article, Kosnatu Abdulai discusses the work done by the project, its benefits and the continuing challenges it faces.

Andavadoaka is a small fishing village on the southwest coast of Madagascar, not unlike the many other coastal communities that surround it. With the population doubling-time of Madagascar being approximately 20 years and a fertility rate of over five births per woman, there is increasing pressure on limited coastal resources and the situation in which couples cannot provide for their large families is common.

The newly established family planning clinic is especially important in an area with such dwindling resources. Before the establishment of this local family planning service, a woman in the village of Andavadoaka who wanted to access contraceptive services faced a 50-km journey on foot through spiny forest to Morombe, the nearest town.

The work done by the clinic empowers couples to produce sustainably sized families. The problem is fairly evident shortly after one arrives in Andavadoaka. Most families have more than five children, many more than ten and half of the village’s population is under 15 years of age. In one clinic, I counselled a woman who had given birth to 14 children. These numbers are clearly unsustainable and most couples do not intend to have such large families. Not only are such large families extremely difficult to support, they also pose a risk to women’s health, with high maternal mortality figures (one in 200 births). Abortion is illegal in Madagascar, so deaths from unsafe abortions from unwanted and unplanned pregnancies push these figures higher still. For this reason, family planning is about more than just promoting the use of contraception; it is also about empowering women to make fundamental decisions about their health and their lives.

Since the opening of the clinic in August 2007, the project has uncovered a huge unmet need in the area and has been welcomed by the people of Andavadoaka. In its first year, 246 women attended the clinics with 100 months’ worth of combined oral contraceptive, 66 months’ worth of progestogen-only pills and 125 depot medroxyprogesterone acetate (DMPA) injections being administered.

Owing to the success of the family planning clinic in Andavadoaka, the team is expanding its services by running satellite clinics. Surrounding coastal villages in the same region of Madagascar face many of the same challenges as Andavadoaka, including the
same need for access to family planning services and advice on how to protect themselves against sexually transmitted infections. The establishment and delivery of these satellite clinics formed the bulk of my work. With many of the villages up to a day’s travel away, they proved too far for the team medic to travel to on a regular basis. It was therefore our job as medical students to travel from village to village, armed with an interpreter, a guide and a great deal of energy and enthusiasm. Here, we raised awareness about contraception and sexually transmitted infections, seeking the opinions of the people we met and establishing where the most appropriate place to hold satellite and outreach clinics would be, in addition to addressing any concerns about the clinics.

As well as speaking to the local people, we also arranged meetings with the village elders to gain approval for the running of the clinics in the village. To allow the clinic to be integrated fully into village life, it was important that local customs and traditions such as these were respected. The response was usually a positive one with the local people welcoming the services and the elders agreeing to their provision in the villages. With the help of our guide and interpreter, we also walked around each village, trying to identify potential sites for running the satellite clinics, taking pictures of possible venues and making valuable contacts in the villages. After each visit to a village, we went back and reported our findings to the medical officer. We hope that the work we did in laying the foundations will allow the team to set up these satellite clinics and spread the great work they are doing into surrounding villages.

In addition to contraceptive work, the clinic is also addressing issues of sexual health in the village. I was actively involved in this aspect of the project and we used a wide range of fun and interesting ways of trying to get this message across. In addition to providing contraceptives to women, we also taught men and women how to use condoms appropriately and provided free condoms to them. We held meetings in the village with different groups: men, women, boys and girls, to encourage open discussion about sexual health, decorated T-shirts with condom logos and organised a football match for the local men against the project’s team with a presentation about sexual health beforehand.

Raising awareness about all of the issues around sexual and reproductive health has become one of the most important objectives of the project. Until recently, the prevalence of HIV has been relatively low in Madagascar, at less than 2%. This is a welcome exception to the trend that has swept across most of sub-Saharan Africa, with high prevalence of the disease plaguing much of this part of the world. Alarmingly, there has been a rapid increase in HIV, as well as epidemics of other sexually transmitted infections such as gonorrhoea and syphilis. The current increase in mining and oil drilling in Madagascar is drawing labour from Southern Africa where HIV is rife. The worry is that this influx will lead to the initiation of a HIV outbreak in a country where sex education is limited. Raising awareness of sexually transmitted infections is therefore vital in preventing the HIV pandemic that is already rippling through much of sub-Saharan Africa from spreading to this island.
Family Planning in Madagascar

While the project is doing great work and making real progress in the area, it does also face challenges with regard to use of the services. There have been situations where oral contraceptive pills have been sold by patients and the team recently received reports that fishermen have been using condoms as a waterproof seal around torches, which they have been using to catch lobster at night. These examples serve as a reminder about the importance of continued education on the appropriate use of the service offered, to both individual women and the wider community.

The work done in the family planning clinics enabled women to take control of their fertility and plan their families. While it is important that women take control of their own health and are given the tools to do so, the education and collaboration of others in the community is equally important to maintain this. Likewise, by facilitating the planning of sustainable sized families, we are not only improving the health of women but also of the surrounding community by ensuring that the children that are born can be provided for and the ecosystem upon which these communities depend upon can sustain the population size. Family planning has extensive and far-reaching implications, not only for the women themselves but for the community and environment around them.

I would like to thank Wellbeing of Women and the RCOG for their generous award that allowed me to contribute to this important and worthwhile project, which is making great steps to allow the women of Southwest Madagascar to manage their reproductive and sexual health.

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2009 John M Eisenberg Patient Safety and Quality Award:
Dr Noreen Zafar FRCOG

The RCOG would like to congratulate Dr Noreen Zafar on being awarded the John M Eisenberg Patient Safety and Quality Award in the International category. The awards recognise the achievements of individuals and organisations who have made significant and lasting contributions to improving patient safety and healthcare quality.

Dr Zafar’s vision is to offer high-quality gynaecological care and to empower women to become good decision makers about their own and their family’s health. Dr. Zafar has worked independently to promote wellness among girls and women, without government or any other support. She has overcome many social taboos in her quest and has established health awareness programmes related to precancer screening, teenage gynaecological health and reproductive health. Dr Zafar has initiated nearly a dozen campaigns under the umbrella of the Women’s Health Initiative.

If you would like to support Noreen in her quest to improve women’s health services in Pakistan, please contact her at noreen_zf@hotmail.com or visit her website for further information – Girls and Women’s Health Initiative – www.gwhi.org.
Reducing maternal mortality in Sri Lanka

PRASANTHA WIJESINGHE

Sri Lanka has a low maternal mortality rate, a remarkable achievement for a developing country in the Indian subcontinent. Various factors have contributed to this low rate, including positive and sustainable social welfare policies, the control of communicable diseases like malaria, expansion of quality maternity services with improved accessibility leading to their greater use and the introduction of antibiotics have all contributed. Professor Prasanth Wijesinghe, who is Chairman of the RCOG Representative Committee in Sri Lanka, explains.

Sri Lanka takes pride in a low maternal mortality rate (MMR) when compared with neighbouring countries in the Asian region. This was achieved through years of dedication and sound policies, eventually leading to improved awareness and use of services by the community. A little over 100 years ago, Lionel Lee, a British civil servant in Sri Lanka (then Ceylon), in his report on the 1881 population census of Ceylon, stated as follows. ‘The reason for the higher female mortality in the adult age period may probably be found in early marriages and consequent diminished vitality. There is also no doubt that mortality in child bearing is excessive. It is said that the ascertainment rate of mortality in Ceylon is one death to 40 from accouchement against one in 185 in England. The fact that in the vast majority of cases, the women are without skilled assistance at the time of delivery and that their troubles come upon their unmentionable hovels absolutely devoid of sanitary management strengthens the opinion that in this is to be found a very active cause of female mortality’.

Sri Lanka has a population of over 19 million and there are over 3 million estimated eligible families. Sri Lanka has achieved a dramatic reduction in MMR from 2000 per 100,000 live births in 1930 to 38 per 100,000 live births in 2005. At present, post-partum haemorrhage, pregnancy-induced hypertension, heart disease complicating pregnancy and septic abortions are the leading causes for maternal mortality. During the 20th century, commitment towards the control of malaria and subsequently the introduction of emergency obstetric care services, have helped reduce the MMR.

Possible causes for low MMR

Over the years, successive governments implemented policies which resulted in a high literacy rate through free education, empowerment of women and a free health service easily accessible to any citizen anywhere in the country; factors which led to women enthusiastically seeking quality antenatal care and more than 98% of births taking place in hospitals. Throughout the last century, various factors at various time periods have led to the reduction in MMR in Sri Lanka. For example, in the 1930s, the control of malaria and development of maternal care services have helped reduce the MMR. Subsequently, the extension of trained maternal care services, improved accessibility and greater use of these services...
Reducing maternal mortality in Sri Lanka

and the introduction of antibiotics have all contributed to the reduction of MMR. At present, the supervising and monitoring system, improved communication facilities and the establishment of an active maternal death surveillance system, together with the improved health education of mothers, are responsible for the low MMR.

The preventive healthcare system in the country, comprising medical officers of health, public health nursing sisters and public health midwives, provides antenatal care for almost all pregnant women. These carers provide supplementation and screen women for anaemia, hypertensive disorders, diabetes mellitus and other medical disorders, including cardiac disease. An important aspect addressed by the preventive healthcare staff on the ground level is the health education of the women about antenatal care, maternal and fetal wellbeing and post-natal contraception.

The fact that the majority of women deliver in hospital with hardly any home deliveries has led to a reduction in MMR. All the hospital deliveries are attended by trained healthcare personnel and a consultant obstetrician will always be responsible for the management of the inward obstetric patients. The Postgraduate Institute of Medicine (PGIM) and the Sri Lanka College of Obstetricians and Gynaecologists (SLCOG) conduct training programmes for doctors which lead to a postgraduate degree or a diploma.

Following the death of an obstetric patient (all deaths including late deaths up to one year after delivery) an institutional and a field inquiry will be conducted to find out the cause of the death. Discussions are held at institutional, district and at national levels. Reports developed at national levels indicating the shortcomings or concerns and highlighting areas for improvement are made available to all stakeholders to be used in changing policy and practice where appropriate.

What can be improved to reduce the MMR even more?

Sri Lanka was involved in a civil war during the last 30 years, which affected all aspects of civil life. In 2009, the war ended, shedding the lights of hope into possible infrastructure and healthcare development in the war-driven north and east of the country where the MMR was the highest.

Even though the hospitals are equipped with emergency obstetric care, the infrastructure may not be in the optimum condition. The government should focus their attention more on this aspect.

Unsafe abortions contributed to 13.9% of all maternal deaths in 2005. Even though it is illegal, over 1000 terminations of pregnancy take place every day in the country. SLCOG and the family health bureau of the Ministry of Health are involved in the process of educating the general public of the hazards involved in illegal terminations and are conducting pilot projects to train healthcare staff to identify and effectively treat women presenting in life-threatening septic shock following septic abortion. A possible success in this region will help reduce the MMR even further.

Although the community has access to family planning services through the family planning association, preventive healthcare family planning clinics and hospital family planning clinics, we see an unmet need of modern contraception among Sri Lankan women. This is a possible contributor to maternal mortality in women with medical illnesses which needs focussed attention in the future.

At present, the supervising and monitoring system, improved communication facilities, the establishment of an active maternal death surveillance system and the improved health education of mothers are responsible for the low MMR. The country can achieve an even lower MMR with further infrastructure.
Reducing maternal mortality in Sri Lanka

development, provision of family planning services, especially to those suffering from serious medical illnesses where pregnancy poses a serious risk, reduction of illegal termination of pregnancies and continued efforts to educate the Sri Lankan public on health-related issues.

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References

Joint Meeting on Women’s Health

Royal College of Obstetricians and Gynaecologists and Kosovo Obstetrics and Gynaecology Association

13–15 May 2010 Pristina, Kosovo

Day 1 Scientific Programme on:
Safety and audit for maternal and perinatal health
Structure and standards of cancer care, screening for gynaecological cancers

Day 2 Workshops on:
Colposcopy
In collaboration with the European Federation of Colposcopy (EFC) and the International Federation for Cervical Pathology and Colposcopy (IFCPC)
Maximising outcomes of infertility treatment modalities

Day 3 Workshops on:
Contraception and reproductive health
In collaboration with the Faculty of Sexual and Reproductive Health and the European Society of Contraception
Development of guidelines and protocols that conform to local needs

Further information and registration details are available on the RCOG website: www.rcog.org.uk/events/2nd-rcog-eurovision-conference-kosovo
A Doctorate in sociology turns to obstetrics

LINDSAY BARNES

Lindsay Barnes graduated from Brunel University in 1980 and studied for her Doctorate in Jawaharlal University, New Delhi. Lindsay has no medical or nursing background. She and her husband have set up an obstetric and neonatal service from a very poor backward area in the State of Jharkhand (formerly part of Bihar). Here, she recounts her experiences and appeals for help from the obstetric community.

I came to India from England in 1982, planning to spend two years in Delhi to complete a post-graduation course in sociology. Instead, I ended up staying on, trying to provide obstetric services in a backward area of Jharkhand – one of the poorest states in eastern India. It is an ongoing story that I would like to share. The village where I live and work is in the state of Jharkhand, one of the poorest in India, and is 25 km from the nearest town of Bokaro. The area we live in has over 100 villages and a population of nearly 200,000 but with no resident doctors. There is a primary health centre with doctors available only during the day for outpatient services. There is no government hospital in the whole district – with a population of nearly 2 million – which provides free or low-cost emergency obstetric care for the poor.

My involvement with childbirth in the villages started in 1994. Before this, I had marginal involvement in villagers’ health problems. I had two children of my own by then and, given the absence of doctors, I had to learn how to deal with most illnesses that we encountered. Villagers started to come to me with their minor health problems. But when a group of villagers came in the middle of the night to help a woman in childbirth I was out of my depth. Despite my protestations that I knew nothing of childbirth, they pleaded and insisted. So off I went with David Werner’s book, Where There is No Doctor. Fortunately, as for most births, nothing untoward happened but the fact that villagers had called me was shocking enough – they must have been really desperate.

I decided to call a meeting of all the women in the village the next night – and around 70 women squashed into our verandah where I put the question to them: “Where do you go when you have problems in childbirth?” No one answered. I had lived in the village five years by then and realised that I had to get my head out of the sand. I had no ‘big plan’ as to what to do but I tried to deal with issues one by one in the best way I could. I understood that we had to rely, as far as possible, on local resources: traditional midwives, knowledge and people. This has proved to one of the strong points of our programme, ensuring its sustainability.

We started with yearly health fairs, then monthly camps, which grew to weekly clinics. Now we have clinics three days a week, providing services to around 600 women a month. Most of the women come for antenatal care. Fifteen years ago, antenatal care was unknown of in our area, as it is in most of rural India. The government’s antenatal care provides only for tetanus toxoid injections and iron tablets – if at all. Village women rarely demand antenatal care and only access health care for specific problems.

In the early days of our programme, most women came in the last month of pregnancy with serious problems: severe anaemia, oedema and hypertension, and so on. Nowadays, with women accessing care from the early stages of pregnancy, we rarely see cases of pre-eclampsia or severe anaemia at the
time of delivery. We have provided antenatal care to over 5000 women in the last five years and there has been only one case of eclampsia (where the mother was promptly referred and both mother and baby survived) and no maternal death from haemorrhage or anaemia. None of these women suffered a ruptured uterus or fistula. In an area of India where the maternal mortality rate is probably around 500 per 100,000 live births, this no small achievement.

Now antenatal care has been well established in the community, there is much peer pressure to go for a ‘check up’ as soon as pregnancy is confirmed. For the young women of the family, this is a much-valued outing and an excuse from doing housework. They come from villages up to 30 km away, wearing their best, brightest saris. Together with investigations, counselling and the check-up, they are encouraged to eat roasted gram flour on a daily basis: this protein-enriched food supplement is a boon to women from families where meat, fish and milk are rarely seen and even pulses are a luxury.

With antenatal care being so quickly accepted, it was obvious that childbirth would be the next issue to address. None of the families wanted to go to a private nursing home in the city (where a ‘normal’ delivery costs 3000 rupees – more than a whole month’s income for a poor manual worker) or to the government hospital in the next state. Families refused to even think about where they would go in case of need, believing this would be a self-fulfilling prophesy. ‘When the time comes, then we will think’, was the usual response to the idea of ‘planning for birth’ and, effectively, there was not much of a choice anyway.

So we have tried, over the years, to make a real choice available to poor women. We now provide 24/7 care for women in childbirth. We have ‘qualified’ nurses as well as trained village women available round the clock, with an ambulance on hand. Many women now come for unproblematic, normal deliveries. In nearby villages a home birth is unusual, rather than the norm that it was ten years ago.

As demand for services has increased, new hurdles remain to be negotiated. Each time we need to send women for caesarean section, we have to make uncomfortable decisions: costly private clinics or the dirty crowded government hospital. Or the most uncomfortable one to make: ‘Save the tree, we will have more fruit next year’, as villagers tell us, when we feel that surgery is needed to save the baby.

So we embark on our last, biggest challenge of all: to provide obstetric surgery. We have exhausted our ‘local resources’ to some extent here. Outsiders, qualified doctors with experience, are needed. I am increasingly aware that I will have to extend my hand beyond our village in the hope that there are medical professionals out there willing to extend their hand too.

We have achieved much over the years, for which I am thankful and satisfied – still I am hopeful of achieving more. It is much, much more than I could have hoped for and I have no regrets for the path I have chosen.

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Sexual violence in Zimbabwe

STEPHEN P MUNJANJA

Sexual violence against women is a major public health problem and a violation of human rights. It is an international issue and is related to a lack of access to education and opportunity and to a low social status in communities. All workers in women’s health should be aware of the problem in their communities, as a wide range of physical, mental, sexual, reproductive and maternal health problems can result from violence. Early recognition and reporting is important. Obstetricians and gynaecologists will not infrequently encounter rape associated problems including injuries. In this article, Stephen P Munjanja writes on the problems in Zimbabwe.

Sexual violence is prevalent in Zimbabwe. In more than 98% of cases, it involves the rape of females and this will be the subject of this short article. At health facilities and police stations across the country, rape is a common complaint but such reports are the tip of the iceberg. Various studies have attempted to estimate the true prevalence in other countries of Southern Africa but this has not yet been done in Zimbabwe. The most reliable estimates are that the lifetime exposure to sexual violence among females is 23%. In South Africa one in four adult men have committed rape and it is likely to be the same in Zimbabwe.

The patriarchal nature of the culture puts women at risk from rape. Women are expected to be unquestioning and submissive and sexual conquests are prized among men. Bride ‘price’ has to be paid before marriage; once married, a woman cannot report rape. A man can get away from a rape accusation by paying bride ‘price’ and marrying the woman, since polygamy is accepted. This happens quite often with adolescent rape. Rape myths are prevalent among men. One of them is that a woman who is dressed seductively or who accepts a date is inviting sex. Another is that women shout ‘rape!’ when they are caught having consensual sex.

There are two recent developments which have further increased the risk to women of rape. Firstly, the HIV/AIDS pandemic has made women more vulnerable. The morbidity and mortality from the disease causes family disruption which leaves women disempowered. Orphanhood is now a well-known risk factor for rape. There is also a common myth that a man who is HIV-positive can be cured of his status by raping a virgin.

Secondly, food insufficiency, unemployment, displacement and political instability, which have happened during the current socioeconomic deterioration, have contributed to a reported increase in rape complaints at health facilities. A worrying development is the rise of politically inspired sexual violence. A month before this article was written, the non-governmental organisation AIDS-Free World released a report entitled ‘Electing to rape: sexual terror in Mugabe’s Zimbabwe’, which documented 341 rapes committed by 241 perpetrators during the violence of the June 2008 election. Rape was used as a tool to target political opponents. Victims ranged from five to 70 years of age. The suspects have not been apprehended and some have been heard to boast of their immunity when they meet their victims.

Zimbabwe has adequate laws to deal with sexual violence. The Sexual Offences Act of 2001 is comprehensive and even allows for complaints of marital rape to be made,
something which is culturally unpalatable. If HIV is transmitted during the rape, there is an added penalty if the suspect is convicted. Women who fall pregnant can seek termination of pregnancy. The problem is ignorance about the laws, fear of making reports and the cultural atmosphere of blaming the victim. The justice system has traditionally been unsympathetic towards victims and the health system does not have the resources to provide the quality of care required.

Recently, however, there have been some positive developments. With funds from donors, among them the Open Society Initiative for Southern Africa (OSISA), the United Nations Development Fund for Women (UNIFEM) and United Nations Population Fund (UNFPA), adult rape clinics have been opened in the major cities of Zimbabwe. Family support clinics for victims of child sexual abuse have been opened in Harare and Bulawayo. These clinics offer care and support away from the emergency and casualty departments of busy hospitals, which are quite unsuitable for this purpose. These clinics are staffed by nurses and doctors who have been specially trained to provide ‘victim-friendly’ care. The test kits needed for pregnancy, HIV, hepatitis and other sexually transmitted diseases are available and so are the antibiotics and antiretroviral drugs for post-exposure prophylaxis. A policewoman is part of the clinic team, to provide guidance on the legal processes.

As part of these developments, the courts and police departments have established ‘victim-friendly’ centres in their stations, although this has not yet extended widely to rural areas. The training of the prosecutors and policemen have been held together with that of the health providers and have been funded by UNFPA and the Sexual Violence Research Initiative (SVRI) of South Africa. The initial training of such teams started in Johannesburg in 2008. National training in Zimbabwe has started at provincial level and several courses have been held.

There are still many challenges ahead. Harmful cultural attitudes and practices should be changed but this will take a long time, particularly if leaders do not provide good examples. The information about Zimbabwe’s laws should be disseminated widely to increase demand on the services. In rural areas, access needs to be expanded to match the services in urban areas. The quality of forensic analysis of the tissues needs to be improved by the inclusion of DNA testing.

Finally, the health and justice systems should make preparations to take over the funding from donors, to ensure sustainability. Expansion of the services to reach every woman cannot be done by the nongovernmental organisations. It is a basic right for survivors to access good quality care and justice.

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Mozambique, has responded to this by training up Clinical Officers to be Licentiates. Clinical Officers are the backbone of medical services in countries like Zambia, Kenya and Tanzania. They undergo four years of training in basic medicine and surgery and are often the first health contact for millions of people. They are able to manage and treat many illnesses, such as respiratory diseases, urinary tract infections and malaria, and can carry out simple surgical and orthopaedic procedures. They are especially good at providing health care under difficult circumstances, such as in remote locations with limited drug supply and minimal backup. In Zambia, about 90 Clinical Officers have trained as Licentiates since the programme commenced in 2002. The training is a two-year programme, including six months of theory, modules in medicine, surgery, obstetrics and gynaecology and paediatrics and two months of revision.

Monze Mission Hospital has been chosen for the obstetrics and gynaecology module. Monze is a tertiary referral unit with an annual delivery rate of about 2700. The consultant there is Michael Breen MRCOG. Michael has worked in Africa for about 20 years and is especially involved in fistula surgery. I did a year’s training in the specialty but for most of my professional life I was a general practitioner. We had a GP maternity unit in our town with about 250 deliveries a year. Most of these were straightforward but we did some assisted vaginal deliveries and the occasional breech and multiple pregnancy. I was (and still am) ‘loosely’ attached to the obstetrics and gynaecology department in our local district hospital and am a UK and international instructor with the Advanced Life Support in Obstetrics group (ALSO).

Michael likes me to come to Monze at the beginning of each obstetrics and gynaecology module and devote myself fulltime...
to the students. This has the advantage that
my only ‘job’ is to teach the students, thus
freeing Michael to run the department and
do his own work, which also includes out-
reach. Admittedly, Michael describes my
work as ‘the blind being led by the partially
sighted’. My programme with the students
involves daily ward rounds with Michael at
7.30am followed by the usual departmental
work in the labour ward, operating theatre,
clinics, scanning and so on. We cover prac-
tical procedures such as induction and aug-
mentation of labour, breech delivery, twins,
operative deliveries, retained placentas, and
more. The caesarean section rate in Monze is
about 8–10% so teaching this procedure is an
important part of my work. Michael is usu-
ally at hand to cope with serious complica-
tions such as placenta praevia, abruption and
tears. We lack many instruments and tech-
nologies used in the UK but nevertheless we
manage effectively. Although we have a
cardiocograph, there is no paper for it.
The vacuum extractor is of the bicycle pump
variety and we use a Foley catheter and
child’s balloon for uterine tamponade for
postpartum haemorrhage. The Mirena®
intratuaterine system (ideal in an African sit-
uation) is too expensive.

On the gynaecology side, I teach the stu-
dents outpatient assessment, dilatation and
curettage, laparotomies for ectopics, biopsies,
cervical cerclage, and so on. Later in their
programme Michael also teaches them to
perform hysterectomies. By the end of their
attachment, each student will have per-
formed at least one classical caesarean sec-
tion and one caesarean hysterectomy. So far,
about 90 licentiates have been trained in
Monze and the feedback (limited for logis-
tic reasons) is that not only are the students
still performing the procedures in their
own hospitals but also that the referral rate in
obstetrics and gynaecology to tertiary or sec-
ondary hospitals has fallen considerably.

I feel very privileged to be involved in this
programme and to work with Michael
Breen, who is such an inspiring, enthusiastic
and entertaining colleague, as well as being
so committed to improving the health of
women in Africa.

Peter Blackwell-Smyth
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The RCOG 8th International Scientific Meeting of Obstetrics and Gynaecology was held 6–9 December 2009 at the prestigious Emirates Palace in the coastal capital of the United Arab Emirates, Abu Dhabi. The meeting was attended by 1200 participants, with the majority from the Middle East, Africa and South East Asia. The meeting was held in collaboration with Abu Dhabi Health Services (SEHA) and under the Patronage of Her Highness Sheikha Fatima Bint Mubarak, wife of the late Ruler Sheikh Zayed. Her Highness was awarded the Honorary Fellowship in appreciation of her role in empowering women in the area and for her great contribution to the development of health services for women and children of Abu Dhabi.

Scientific sessions were run in four streams:
- Fetomaternal
- Gynaecology
- Gynae Cancer/Sexual and Reproductive Health
- Standards and Professional Development

State-of-the-art lectures were delivered by 50 Speakers; 62 free communications and more than 350 posters were presented by young doctors, with the greatest input from the Middle East. Local research work, case reports and practices in the area were all presented. Ten plenary sessions included topics such as obstetric medicine, urogynaecology, fertility problems and fetal surveillance. Some highlights included Professor Chervenak discussing the sensitive issue of the ethical dimension of the fetus as a patient. Professor Gamal Serour presented the Singapore Lecture and tackled the
science and ethics of new technologies in improving women’s health. Tahir Mahmood, Vice President of the RCOG, captivated us with his update on the pandemic H1N1 virus. Professor Gordon Smith discussed causes and consequences of the rising caesarean section rate, which is currently 23% in the UAE. Finally, a talk on the heritage and culture of Emirati women, delivered by Professor Rafiaa Ghabash, was a highlight of the conference. The meeting was an overall success judging by the huge participation of delegates.

**El Sheikh Mohammed**  
Chair, RCOG International Representative Committee, UAE  
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1. Attending a lecture  
2. Professor Abdel Latif Ashmaig Khalifa, Sudan, receiving his Fellowship Honoris causa from the President  
3. A refreshment break  
4. Delegates attending one of the lectures  
5. Professor Gamal Serour, Egypt, receiving his Singapore Lecture Commemorative medal from Dr Charles Ng, Singapore  
6. New Fellows and Members awaiting their admission  
7. The RCOG stand  
8. The platform party  
9. His Excellency Dr Ahmed Mubarak Al Mazrouei with members of the local organising committee  
10. Delegates attending the Welcome Reception
Despatches from Uganda: the Eleanor Bradley Postgraduate Fellow in Obstetrics and Gynaecology

KATE ALLDRED

Kate Alldred recently completed her ST3 year in Merseyside. She has taken a year off-programme to spend time at Mulago National Referral and Teaching Hospital, Kampala, as the Eleanor Bradley Fellow in Obstetrics and Gynaecology. The Fellowship was developed by the RCOG International Office and is funded by the Alan and Cyril Body Trust. Here, Kate gives an update, following the report from her predecessor, Kate Lightly, last year.

Many of the doctors and midwives who I consider to have had a significant impact on my career so far have spent time working in developing countries. Their tales of unusual pathology, flying-squad style obstetrics and human resilience left indelible marks in my mind from very early on in my medical student career. I felt a strong draw towards a similar path but there was always something – job applications and MMC, research, mortgage and so on, that prevented me from upping sticks and taking the plunge. Then I heard about the Eleanor Bradley Fellowship, read a little bit about Uganda as a country and felt very strongly that it was now or never.

Mulago is one of the largest maternity units in the world, delivering upwards of 30,000 babies a year, with a high maternal mortality ratio: 566 in every 100,000 in 2008. There are approximately two to seven perinatal deaths a day. The central labour ward delivers 22,000 babies a year and the midwifery-led unit delivers 8000–10,000.

The Fellowship was set up with the aim of improving working relationships between junior doctors and midwives at Mulago and to exchange knowledge and skills. As only the second Fellow to come out to Mulago, the role is still relatively new and, while the department had some expectation of what the fellow can offer, it is still a malleable role.

I spend around 65% of my time doing clinical work and the remainder of the time is spent teaching midwifery staff and working on projects in conjunction with specialists and midwives to improve outcomes for women and their babies. I have spent the majority of my clinical time on the labour ward.

The clinical work is extremely challenging, with difficulties encountered in all aspects of the work – access to theatre, availability of staff, sutures, blood, drugs and so forth. This is not rural medicine but the sheer volume of patients crammed into a space designed for far fewer women and a staff that has not expanded significantly since the hospital was first opened mean that it is very difficult to do as much as possible for as many as possible. The department does operate like a large family and therefore you are rarely left to deal with unfamiliar cases alone.

The teaching aspect is one of the most enjoyable parts of my work and I run a weekly training session for midwives, which was started by the original Fellow, Kate Lightly. We have recently run an emergency skills drills training session for midwives, with the help of consultant and midwifery staff from Liverpool Women’s Hospital. The midwives thoroughly enjoyed the ‘mega drill’ type set-
having made some sort of a difference, both of which we badly need.

I have also been involved in the production of good practice guidelines, adapting commonly used treatment regimens for a resource-poor environment has certainly been a challenge. We are trying to introduce the concept of obstetric triage, initially in the admission room, which is proving to be a monumental task. It is difficult to change practice radically and this can at times be very frustrating. Things take time and perseverance. Other projects I hope to see come to fruition during my time here as a Fellow are the implementation of a fully functioning postoperative recovery area – something that my predecessor started – and the creation of a postnatal high-dependency area which we badly need.

I still have over seven months left here and I have a lot more work to do. I hope to leave having made some sort of a difference, both directly through the treatment of women and their babies and indirectly through passing on skills and knowledge. I hope to return to my specialty training programme more skilled and a better person and obstetrician, owing to the clinical and life experience I have gained.

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How to adopt and adapt guidelines

Guidelines are admired everywhere. Currently, only the Green-top Guideline on the treatment and prevention of malaria (No. 54A & B) is of particular interest to the international community. Producing specific guidelines for individual communities is an elaborate and complex process. The RCOG Guidelines Committee has recently produced Consensus Methods for Adaptation of Guidelines, a paper illustrating the methodology for altering guidelines for different communities with different resources. A link to this guidance will be included in a future RCOG Update when it becomes available. This will enable professional communities to alter any guideline to a form deliverable within their own area of responsibility. We commend its use to you all. This paper can be found at www.rcog.org.uk/development-of-rcog-green-top-guidelines-consensus-methods
ELINOR CARLISLE

Elinor Carlisle spent four weeks of her elective placement working at Kiunga Hospital, in the Western Province of Papua New Guinea (PNG). Kiunga Hospital is a 38-bed general hospital serving the Kiunga area and surrounding villages. Elinor’s aim while she was there was to record the weights of the babies delivered, to see if babies born in PNG really are the smallest in the world and to research why this might be.

I attended weekly antenatal clinics to assess care and advice given. Some women had to walk for almost half a day in the baking heat and humidity to attend the clinics, as there were no outreach programmes. It made me realise why attendance rates in PNG might be so low.

The clinics started with a health talk, delivered to the 100 or so women in the queue outside. I was interested to hear the nurse tell the expectant mothers that the most important health message for them to remember during pregnancy was that they should make sure they washed themselves properly before clinic, so they didn’t smell. Other advice was that women should ensure they had enough sanitary pads with them when they came into hospital to deliver. Their final (presumably, least important) point was that the women should always take their malaria (chloroquine) and blood tablets (folic acid and iron). I was relieved to hear this mentioned, although there was no mention of other aspects of antenatal health issues, such as smoking, drugs, diet and the use of mosquito nets.

The first visit was difficult, because most mothers didn’t know how old they were, let alone if they had a family history of diabetes. And on top of these problems were the mothers from bush villages, who spoke a variety of different languages other than Pidgin English: 12% of the world’s total languages are spoken in PNG.

During my stay, 41 babies were delivered in total, with a mean weight of 2.73 kg. From the data I recorded, some interesting trends were identified. As expected, the smallest babies were generally born to the smallest mothers, although this appears to link more to the mother’s weight than height. The smallest babies also had a lower average gestational age, although most of these were estimated after delivery using the Dubowitz scoring system, as the mothers didn’t usually know.

It was interesting to see that the number of antenatal clinics attended also increased with increasing size of the babies and that 11 mothers had not attended any clinics. The smoking and alcohol rates were higher in mothers with smaller babies. The mothers who modified their diets tended to have bigger babies but most mothers said they did not think these factors were important during pregnancy. Almost all of the mothers owned and used mosquito nets and were aware of the malaria risk, which was reassuring to hear.

One thing which became apparent when I was assisting on deliveries was that there was nothing ready in the event of a clinical prob-
An Elective in Papua New Guinea

My elective in PNG alerted me to the challenges of medicine in developing countries and gave me a huge amount of respect for the health workers there who have left the comfort of health systems in developed countries. It also made me appreciate the UK health system and the importance of the multidisciplinary team in delivering optimal patient care.

Undertaking this project was an extremely interesting and eye-opening experience, which taught me first-hand about different beliefs and practices involved in obstetrics around the world; I would like to thank the Royal College of Obstetricians and Gynaecologists for giving me this opportunity. Having this extra insight into the specialty made me feel more strongly that obstetrics is the career path I would like to follow. I also hope that within this specialty, I will be able to return to PNG and other developing countries as a qualified doctor, and contribute more to the continuing improvement of obstetric care.

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We in the International Office of RCOG have been working to improve women’s health worldwide for five years now. We have developed courses and are teaching skills to local healthcare workers to save lives, hoping to alter the staggering statistics of death in childbirth that exist in the developing countries of our world today.

Over 80% of these deaths are preventable. Too many women do not have access to basic health care and skilled birth attendants when they need them and give birth without help and in appalling conditions. Many women also suffer complications during childbirth that can have a long-lasting impact on them and their children.

Our courses are run by an energetic and dedicated team at LSTM, led by Nynke van den Broek, supported by an enthusiastic teaching faculty of volunteer obstetricians and gynaecologists, anaesthetists, midwives and others. We aim to make 2010 the best and most successful year ever.

For more information on our work and how you can support us, please go to www.rcog.org.uk/international. Details of who to contact if you are interested in becoming part of the faculty that delivers the training on the Life Saving Skills courses can also be found here.

How a donation could help

£50 could pay for the cost of local transport and accommodation for one local participant to attend a Life Saving Skills – Essential Obstetric Care and Newborn Care course

£100 could pay for a newborn silicone resuscitator for use in training courses

£125 could pay for the cost of a cardiocompression torso to help train medical staff in developing countries

£200 could pay for facilitator guides for UK faculty and locally trained trainers to use in the delivery of Life Saving Skills courses

£500 could help pay for an obstetric phantom with fetal doll for use in training

£1,000 could pay for the costs of training a healthcare worker in an under-resourced country in maternal and newborn care
RUTH BIRD

Ruth Bird’s medical elective period gave her the opportunity to undertake placements in Ethiopia, working in the main referral hospital in Awassa as well as in a small rural health centre in Wondo Genet which provides emergency care for the community.

My first day in Awassa was a harsh reminder that I had chosen to do my elective in the developing world. The morning meeting where obstetric cases were presented showed a picture of high infant and maternal mortality. Sadly, my first ward patient was a woman complaining that she could no longer feel her baby moving who was found to have a prolapsed cord. She later gave birth to a stillborn child in a room with three other women all with new babies. I was heartbroken to hear that her two previous children had also died in their first year of life.

There are no curtains around the beds so women go through labour and are examined in the same room as others. With no hospital gowns, they give birth in the clothes they arrive in. I was amused yet disturbed to find birds flying around the delivery room (not storks!).

Only 27% of women receive any antenatal care and only one in ten women have a trained attendant present at delivery. Many women have to walk for up to two days in labour to get to the referral hospital and they often try to deliver at home, presenting only when there are complications.

During my time here, I attended a presentation on screening for cervical cancer in the developing world in a resource-limited environment. Currently, Ethiopia does not have a screening programme so most people present with advanced disease. Awassa Hospital is keen to write a protocol but the logistics of how to recall patients and follow up positive results is a nightmare, with many patients coming from up to 200 km away and limited communications. There are also the challenges of funding, equipment and staff training.

Globally, 75% of obstetric maternal deaths are caused by conditions which are all treatable: haemorrhage, infection, eclampsia, unsafe abortion and obstructed labour. Most of these deaths are preventable through improved access to adequate healthcare services, including safe and effective family planning methods and emergency obstetric care.

I saw a disproportionate number of ruptured uteruses, common here because of the long labours, small under-developed pelvises and...
the absence of antenatal care. The theatres were 28 degrees. I must have sweated half my body weight by the end of a single operation. Retained placentas were removed without any anaesthesia and, in fact, none of the women in labour received any sort of pain relief.

I've met some of the bravest women in Ethiopia. Pregnancy is a normal physiological state for women but without appropriate levels of care, resources or a good underlying level of health within a population, preventable complications can have devastating effects.

After Awassa, I travelled to Wondo Genet Health Centre staffed by one health worker (manager) and ten clinical nurses. I was the only doctor, essentially a GP/A&E service for a population of 71,000 in southern Ethiopia, two hours away from the nearest hospital.

We saw about 50 malaria patients a day, although I’m told this can be up to 250 a day in the high season. Other common conditions included intestinal parasites and typhoid fever. We were frequently without light, meaning that basic laboratory tests could not be done. Everyone left with anti-biotics/antimalarials based on a guessed diagnosis when the light was out.

One of the women I encountered highlighted the need for cervical cancer screening. A 68-year-old cachexic lady was carried in with a month-long history of being unable to stand, anorexia and vaginal bleeding. She was clinically very anaemic with low abdominal pain and bone pain. The clinical nurse, recognising that he was out of his depth, said “I think she is very sick, you must help me”. He asked what I thought was wrong with her and asked me to examine her. I found it very difficult to give my opinion without the comfort and security of blood tests, scans and a biopsy but I was forced to admit that her most likely diagnosis was one of a gynaecological malignancy. He asked us what we could do for her and the honest answer was nothing, even in Awassa. Instead, we were forced to cobble together an inadequate palliative prescription consisting of regular painkillers and ferrous sulphate.

The vaccination programme in Southern Ethiopia is very good: every child receives quinvaxen; a pentad of diphtheria, tetanus, pertussis, hepatitis B and HIB plus additional polio and BCG vaccinations. Once a month, they run expeditions into the remote mountain villages to vaccinate. Free HIV and tuberculosis treatment is available: a massive public health initiative encouraging people to seek treatment and so reduce the spread of disease. However, HIV-positive mothers have no choice but to breastfeed, as formula milk is not readily available, affordable or sustainable.

On my final day we were called to see a woman with an incomplete miscarriage. She refused to have the retained products

Ethiopia: obstetrics and emergency health care in a resource-limited environment
removal because she didn’t want to expose between her legs owing to her modest cultural beliefs. In the end, she left an hour later without the procedure. I can only hope her bleeding stops and that she did not die of sepsis. I found her modesty in the face of death quite difficult to deal with, feeling like society had somehow failed her. This case taught me that, despite my health beliefs, I have to respect individual patient’s ideas and that providing information so that patients can make an informed decision is sometimes all you can do.

A recent addition to the health centre is the motorbike ambulance: able to carry one patient, a medical worker, plus emergency supplies for on-site treatment, it greatly reduces the time taken to get essential medical assistance to remote communities when complications occur during labour. The staff receive training on difficult deliveries and monitoring in labour, allowing them to handle extreme circumstances.

Working with the healthcare staff in Ethiopia was a steep learning curve, as many of the resources, procedures and protocols differed. It was strange in the village being in a position where I was the most experienced person and having to make decisions based on history and examination alone. These placements allowed me to reflect on the value of receiving a high standard of ‘specialist’ medical care and a constant reminder of benefits of a national health service. I think the placement will benefit my future career, as I had the opportunity to see a wide range of conditions that are influenced by all aspects of patient’s lifestyle, socioeconomic status and cultural beliefs, something that gave me a greater understanding of how a patient’s background and beliefs have an effect upon their health. Aside from this, I was able to improve my clinical, communication and surgical skills in a challenging working environment. I believe that I was able to not only learn a great deal from this placement but also be a beneficial resource in a country short of trained professionals.

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VICTOR CHILAKA

Victor Chilaka describes his experience of attending a lively night at the College to launch the Nigerian Liaison Group.

If you are member of the RCOG with roots in Nigeria, you would have missed a wonderful outing if you were not at the RCOG grounds on the night of 26 September 2009. It was a spectacular gathering involving the cream of Nigerian Fellows, Members and trainees of the RCOG. The organisation and presentation of the event was spectacular and a number of attendees described it as a tender mix of a typical Nigerian outing and the gentility of a British dinner dance. It did start on time though!

As the guests started to appear at the College, mostly dressed in black evening wear, the pressure was mounting on the organising caucus on how the day was going to turn out. Mr Atiomo (Associate Professor at the Queens Medical Centre, Nottingham), who is the chairman of the organising committee, mentioned that it would be unfortunate if the outing was a disappointment after many months of planning involving a number of members who have crisscrossed the country many times and invested enormous amounts of man-hours in the planning. He needed not to have worried because right from the beginning of pre-dinner drinks, the crowd had started to gather with friendly and excited chats and loud laughter that characterises the extroverted nature of many Nigerians. Among the guests of honour was Her Excellency The First Lady of Kwara State of Nigeria – Barrister (Mrs) Oluwatoyin Saraki. Her Excellency has been a frontrunner in the bid to reduce maternal mortality in Nigeria and she was keen to work with the Nigerian Liaison Group (NLG).

When the voice of the Master of Ceremonies Mr Niyi Agboola (Consultant, Milton Keynes) politely, yet authoritatively urged people to move into the hall for the ceremony, little did they know what they were in for that night. The order of the introductory talks was carefully arranged. Mr Tony Falconer (Senior Vice President of the RCOG) who was doubling up also as the one of the chief hosts (remember we were on RCOG grounds) welcomed the guests and gave a scintillating talk about the RCOG activities in the international scene and how the College was willing to cooperate with allies internationally to drive down the suffering of women and to reduce maternal mortality in under-resourced countries. His speech was an eye-opener and a reminder that the party was not just for merrymaking. There was real seriousness about the gathering. His speech was followed by Mr Fred Achem, who is the chairman of the RCOG Representative Committee in Nigeria and also a commissioner for health in one of the Nigerian states. He had travelled all the way from Nigeria to attend the event. He spoke fluently on what he perceived as areas of possible cooperation between the RCOG and Nigeria as a nation. It was after his speech that Mr Atiomo gave a rundown of the activities of the NLG so far and how the group can insert itself between the RCOG and the infrastructures that exist in Nigeria. A good number of members of the NLG have all seen and been part of both sides of the divide.

By this time, it was becoming clearer why the event had been organised and why so many Nigerian specialists and trainees had taken out time to grace the occasion. Nigerians are very passionate about their origins. When two or more Nigerians are together, the discussion is always about the situation of
Nigerian obstetricians and gynaecologists
dine with a tall ambition

the country, ranging from politics to international image and health. Most believe that Nigeria has excellent potential and wish to build on the ongoing excellent work back home. Most are willing to contribute their quota to help and this is often done on individual basis with no significant impact slowly. The NLG had become a reality and the plan for the official launching event was set in motion. Few of the attendees at the ceremony will fully appreciate the amount of work that had been undertaken to make the event a success.

The introductory speeches were quickly followed by a presentation on cervical screening in Nigeria. This was a realistic reminder of the situation in Nigeria, where cervical cancer screening is nonexistent and available to only those who not only understand its importance but can also pay for it.

The comedian Eddie Kadi took the floor and entertained the floor warmly with his barrage of Briticised Nigerian jokes. This was then followed with an address by the College President, Professor Sir Sabaratnam Arulkumaran, who has been an inspiration to the group with words of encouragement and a book donation.

The real party took off in earnest after dinner and as the members danced, chatted and socialised, they understood that they had a challenge on their hands if they were going to make any positive impact on the health and wellbeing of women living in Nigeria. They also understood the importance of closely collaborating with the various governmental, nongovernmental and charitable organisations already working hard to achieve these goals.

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Working internationally for short-term placements

OLIVIA ROBERTS

Working internationally has its rewards but it remains difficult when in full-time employment in the UK. Recently, however, it has become easier to arrange short-term placements in low-resource countries, as Olivia Roberts, a Senior Research and Committee Officer with the British Medical Association International Department, explains.

As a senior researcher at the British Medical Association (BMA)’s International Department, part of my work is to help doctors at all stages of their careers take time to work in other countries to share their knowledge and expertise with international colleagues. More importantly, however, is the opportunity to gain knowledge and skills about health in other countries. Although not a doctor myself, I spent two years working in Vietnam on sexual and reproductive health in young people. Working for the Population Council, I researched young people’s access to abortion services in a country that has the highest rate of abortion in the world but low access to pre- and post-counselling and follow-up care, including contraceptive services. Working with international donors and specialists, as well as local researchers and health professionals, we helped to identify problems and worked to reduce stigma and discrimination and to increase quality of care. This was a challenging but hugely rewarding experience and it helped to inform my work today, advising health professionals on how to make working internationally a part of their NHS careers.

For obstetrics and gynaecology in particular, a period of international work can include encountering conditions that are not commonplace in the UK and which are not part of routine training. Routine health problems can take on an entirely new complexion in a different health service, where access to health care is poor or patients present late. The involvement of obstetricians and gynaecologists in international development is of critical importance, linking to the United Nations Millennium Development Goals. But it is not only working in developing countries: many doctors choose to experience health systems around the world – the USA, Australia and New Zealand are popular for language reasons and mobility of health professionals is increasingly common in the European Union.

Working on the BMA guidance, Broadening Your Horizons, opened my eyes to the myriad of ways doctors combine their careers in the NHS with a period of time a different health system. UK doctors, of all ages, experience and specialty decide to take time to train and work in countries all over the world. It can be for short periods or a couple of years, a one-off as a young doctor to a long-term ongoing relationship with a country or hospital. The RCOG/Voluntary Service Overseas is an excellent example of a structured fellowship but it is certainly not the only way. Some doctors prefer a certain level of support, others more flexibility. Similarly, employers can be happier to accommodate a short period of absence (six weeks) whereas others prefer longer so that they can structure service delivery accordingly. The important thing is to find out what the local policies and practices are, look for advice from your employer and medical Royal College and ask for advice from experienced colleagues. With planning, a bit of research and perseverance, it can be done.

While this may seem a leap into the unknown, there are national policies to support time outside the UK for both trainees and senior doctors and a number of core principles apply. These are outlined in the BMA guidance but here are a few key tips:

- **Start talking**: notify your employer or educational supervisor that you are thinking about taking time out. Your human resources department should
also be able to help with relevant information.

- **Know your rights:** familiarise yourself with national and local policies.
- **Make friends:** talk to others about their experiences and how they made it a success (and what they would avoid).
- **Early-warning:** once you’ve decided this is for you, give as much notice as possible to your employer or trainer. National guidance says three months but in reality you are likely to get a much more positive response and be better-prepared if you can give at least six months notice.

**For doctors in employment:**

- **Resignation:** you do not have to resign from employment to take time out and you may be eligible for a career break. Ask your employer for local policies.
- **Pensions:** the implications from a break in service for your pension can be significant, so it is important to get advice as early as possible. There is a small amount of government funding for doctors who volunteer with a small number of partner organisations.
- **Keeping in touch:** if you are planning on returning to the same employer, letting them know your plans can help you keep up to date with service developments. This is important for re-entering NHS service and can reduce the need for refresher training, though this may still be required to some degree.

**For trainees:**

- **Seek advice:** talking to experienced senior colleagues can help you prepare on a practical level and they may also be able to help you maximise your educational experience by advising on what to be aware of.
- **Application:** think about what it is you want to achieve from this placement and make your aims, both personal and professional, clear in any application or covering letter.
- **Recording your experiences:** talking to your educational supervisor or professional mentor about how to record your experiences can be valuable, even if the period out of training is not to count towards training, as these experiences can be useful additional information for future employment.

The BMA helps with advice for doctors wanting to take time out to work or train around the world. Guidance is available on our website or by contacting the BMA International Department or AskBMA, which is a service to offer advice on members’ work-related problems and help with local representation if required.

It is strongly recommended that members contact the BMA or the RCOG International Office for advice before a period of absence as, often, steps can be taken to both maximise your experience and ensure a smooth return to NHS service.

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Contact details
RCOG International Office:
+44 (0) 20 7772 6367
BMA International Department:
internationalinfo@bma.org.uk
AskBMA: 0300 123 1233

Further information:
www.bma.org.uk/careers/working_abroad/broadeningyourhorizons.jsp

Olivia Roberts
Senior Research and Committee Officer
BMA International Department
ORoberts@bma.org.uk
Dear RCOG Members and Fellows,

3-month VSO teaching roles in Cambodia throughout 2010

International development charity VSO works in partnership with hospitals and health centres in rural Cambodia, to improve maternal health and strengthen the knowledge and skills of healthcare staff.

In March, July, and September 2010 we urgently need a consultant or senior registrar Obstetrician and Gynaecologist for 3-6 month roles providing on-the-job training to Cambodian doctors.

Based at a regional referral hospital, you’ll provide targeted teaching to improve the competence of local doctors in emergency obstetric procedures. Mentoring the doctor in charge of obstetrics, you’ll coach him in management skills, helping strengthen essential services. You’ll work alongside other VSO health professionals, who will help ensure your work has a lasting impact.

VSO covers all costs and provides accommodation, volunteering allowance, insurance and training. NHS pensions are protected by a government fund.

For more information, visit vso.org.uk/volunteer/volunteer-placements/health/obstetricians-and-gynaecologists.asp or contact ruth.grearson@vso.org.uk.

Interested and available in 2010?
Apply online at http://www.vso.org.uk/volunteer/apply-now/

Best wishes

Ruth Grearson
ROBERT PATTINSON

Robert Pattinson from Pretoria writes on the importance of audit in low-resource countries and gives practical advice on how this can be started.

A pencil and paper is all the equipment it takes to audit maternal, perinatal and child health. A recent meta-analysis of audit and feedback in low- and middle-income countries showed a thirty percent reduction in perinatal mortality.¹ As such, audit (defined as a methodological examination and review of a situation or condition concluding with a detailed report of findings) must be the most cost-effective intervention in maternal and child health, yet it is not an intervention that is widespread in low- and middle-income countries. If audit has this potential to reduce mortality then surely it should be performed in every health institution?

Perhaps its effect is over-rated. The meta-analysis of perinatal audits in low- and middle-income countries was based on published articles. Maybe only audits that successfully reduced perinatal mortality were thought to be worth reporting and thus submitted for publication. Further, it is known that articles reporting success are more likely to be published than those reporting failure or no change. Supporting the publication bias suggestion is the Cochrane Library systematic review on audit and feedback, which reports only a small but significant change. This might, however, be greater in low- and middle- than in high-income countries.²

In an ideal world, audit identifies areas where care can be improved and, once the people involved know of these problems, they change their behaviour so that the problems do not recur. In other words, it is the Hawthorne Effect: someone is watching so I had better do my work properly. This simple intervention will improve care and, ultimately, mortality rates should be reduced.

For perinatal audit to function, we need people who will count all the perinatal deaths, compare their management with set criteria and produce a report, whether locally or for a larger area. These people will need perseverance to collect all the cases, patience to analyse them against set criteria and persistence to produce a report. In other words, we need people with an ‘accountant’s personality’.

Once the report is produced, the report should be fed back to those concerned. Who are those concerned? Healthcare providers directly involved in the cases are the obvious first step. For example, those working in labour wards should know about all the perinatal deaths from asphyxia. Ward et al.³ reported a reduction in deaths from intrapartum asphyxia when all deaths in their labour ward were audited.³ However, the reduction in deaths from birth asphyxia was all that changed. There was no reduction in the other causes of death, such as perinatal deaths associated with complications of hypertension in pregnancy.

In-house audit meetings are the easiest to organise and hence the easiest situations to influence. The next group requiring feedback would be representatives from those areas that refer to the institution. This means that there must be some mechanism for these people to attend or to receive the feedback
In South Africa, a committee was appointed by the Minister of Health to perform confidential enquiries into maternal deaths in 1997. This committee has diligently collected, analysed and reported on the causes of maternal deaths, the missed opportunities, substandard care and avoidable factors within the health system and made recommendations on how the deaths could be prevented. The committee has produced four comprehensive reports, in 1999, 2002, 2006 and 2009.4–7 Since the first report,4 the recommendations to reduce maternal deaths have remained more or less the same. A survey in the third comprehensive report indicated that very few of the recommendations had been implemented.6 South Africa has also national perinatal care survey reports since 20008 and a survey on the quality of care of children in hospitals since 2003 which report biannually or annually.9 Each report makes recommendations; these recommendations have likewise remained constant. The South African committees have been excellent accountants but terrible advocates. The effect of audit has been minimal, although audit and feedback has occurred, completion of the audit cycle (that is, implementation of solutions and re-evaluation) has not.

In 2008, a group driven by health advocates brought the situation of maternal, neonatal and child care to the attention of the policy makers. They published a glossy document called Every Death Counts which synthesised and simplified the problems identified and recommendations made in the reports on maternal, neonatal and child care.10 The document reached every Member of Parliament and the national press. Maternal, neonatal and child care has now been put in a prominent position on the national agenda and currently the recommendations made in the reports are being energetically pursued by health care managers.

**Its costs in equipment are minimal, its rewards in terms of lives saved or improved quality of care can be immense.**

improved if healthcare providers, managers and policy makers are persuaded to act by the data revealed in the audit. The ‘accountant’ who collected, analysed and reported on the data seldom has the personality to become an ‘advocate’ to persuade the various groups to change. Different skills are involved.

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Audit and feedback requires accountants, completion of the audit cycle requires advocates. Audit is simple but very hard work. Its costs in equipment are minimal, its rewards in terms of lives saved or improved quality of care can be immense. To be successful, however, there must be an enormous commitment by those involved and those involved must be a combination of accountants and advocates. They must have patience, persistence and passion. Perhaps the authors of the seven articles reviewed in the meta-analysis were successful as they had a team fulfilling these requirements.

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References:
8. Six reports have been published under the title *Saving Babies: A Perinatal Care Survey of South Africa*. Executive summaries and reports can be viewed on the Perinatal Problem Identification Program v2 website [www.ppip.co.za/saving_babies.html].
9. Four annual reports have been published under the title *Saving Children*. Reports can be viewed on the Child Healthcare Problem Identification Programme website [www.childpip.org.za/index.php?option=com_content&task=view&id=16&Itemid=30].
Sims Black Travelling Professorship

Applications are invited from centres outside the British Isles to receive a visitor during 2010.

In keeping with the original intentions of the fund, the purpose of the visit would be for the visitor:

- to contribute to postgraduate education by presenting lectures, participating in seminars, group discussions and clinical demonstrations (if appropriate)
- to gather information about systems of postgraduate education and training and assist in developing programmes.

Applications should clearly indicate the area of particular interest and expertise required and, if appropriate, which new techniques or methods of clinical management you would like to hear about. Please also outline ways in which your country might benefit from such a visit.

It would be useful if applicants could submit a proposed programme indicating the expected date of travel and length of stay (maximum of three weeks) but allowing a six-month lead time. We will also require confirmation that a detailed report will be submitted within three months of the visit, indicating the benefits of such a visit.

A limited number of awards are available in any one year; they will be allocated to the centres, which, in the opinion of the assessors, submit the best application. Council reserves the right to withhold the award if, in its opinion, no project of sufficient merit is submitted.

Closing date for applications is 30 June 2010

Submissions may be sent by email or post. Please submit your applications to Beryl Stevens, Director of International and Corporate Affairs, RCOG, 27 Sussex Place, Regent’s Park, London NW1 4RG, UK; tel: +44 (0) 20 7772 6222; Fax: +44 (0) 20 7772 6359; email: bstevens@rcog.org.uk