

A person wearing blue medical scrubs is shown from the chest down. They are holding a small, glowing blue and white globe of the Earth with both hands. A stethoscope is visible around their neck, resting on their chest. The background is a soft, out-of-focus blue.

# O&G

**Magazine**

Vol 15 No 2 Winter 2013

## Global challenges

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists



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# From the President



Prof Michael Permezel  
President

This issue of *O&G Magazine*, focusing on global women's health, highlights the efforts of many of our colleagues in the specialty, almost always at the cost of considerable personal sacrifice and sometimes confronting significant dangers to not only themselves, but to their families as well. Of course, there is often an element of a desire to fulfil personal goals combined with opportunities to explore and experience new things. Common to all though is the enormous sense of public duty and we should applaud them. For every instance cited here, there are dozens more that will go unpublicised. Perhaps it is time the

College gave more recognition to these achievements. Although such recognition is neither likely to be sought after nor even

particularly welcomed, as the late Dame Elizabeth Murdoch was wont to explain, anonymous contributions produce great personal fulfilment but do little to encourage others to follow the same path. Global health most certainly needs others to follow the path of those already involved.

Altruistic contribution to the cause of women's health is not, of course, confined to resource-poor settings. Indeed, it could be argued that every Trainee and Fellow makes such a contribution in their day-to-day practice, whether in private or public, by doing that much more than the minimum demanded by the task in question. Readers will know of some whose altruistic contribution would appropriately be measured in femtograms, but the great majority thrive on the personal satisfaction of providing not just an adequate clinical service but exemplary care.

Part of this extended service is contributions made in a professional capacity. A wide range of activities are not immediate clinical care, but nevertheless enhance the professional qualities aspect of the attributes of a Fellow – in the same way that the

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# Annual Scientific Meeting





development of professional qualities is an important thread of the FRANZCOG curriculum. The College is very pleased that activities in this area will now be recognised in the new Online CPD program, which will apply to new Fellows from 2013 and all Fellows renewing a CPD cycle from 2014. One early comment from the Australian Medical Council team accrediting the College was an interest to see that the College was moving to electronic and online communication with both Fellows and Trainees. Online CPD is here. Training documentation will change from paper to electronic as soon as feasible.

Online CPD is, therefore, more than submitting CPD electronically over the internet. Implicit in this updated version of CPD is also the ability to accrue points in the category of Professional Qualities as well as the more traditional areas of Clinical Expertise and Academic Abilities. As described in more detail in this issue of *O&G Magazine* (see p71), Fellows will still need 150 points in a three-year CPD cycle, 25 of which must be Practice Audit and Review (PAR). A new stipulation will be that each Fellow must also have 25 points in each of the three areas (Clinical, Academic and Professional). While this is new, the majority of Fellows will find their current CPD activities slot nicely into these three categories. For some, it will lead to a broader range of CPD and particularly encourage (and reward) participation in events of a professional nature. Some might even wish to include some College activities in their CPD profile. Few activities provide as profound a learning

experience as teaching and training junior colleagues. Contributing to guideline development, coordinating a local PROMPT course or hospital clinical audit are all important activities for which CPD points may be gained. So too are activities associated with selection of Trainees into a College training program.

At the time of going to press, selection of the Year 1 Integrated Training Program (ITP) Trainees for 2014 is already near completion in New Zealand and applications have closed in Australia. Few issues raise more passion among the Fellowship than those around selection to the specialty. I am no less passionate. The first task is to have strategies in place that encourage the most suitable doctors into the profession. This must begin with positive experiences as an undergraduate medical student. Any decrease in time given to undergraduate obstetrics or reducing the quality of that experience will negatively impact on the future of our profession. Increased birthing targets for student midwives during training have been announced recently. This can only further reduce opportunities for medical students who often struggle to achieve the necessary priority. Those clinicians (and I am one) who continue to believe in obstetrics as a core component of undergraduate medical education must be prepared to advocate even harder for the medical students in their hospitals. Communicating initiatives in global women's health (as per this issue of *O&G Magazine*) is a strategy that is highly likely to encourage the best and most suitable of undergraduates into this profession.

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Having established the best pool of applicants currently possible, what then are the criteria whereby they should be selected? The current College selection process is under review with a working party chaired by Dr Sarah Tout (College Vice-President and Chair of the Training Accreditation Committee). While not wishing to pre-empt the findings of that working party, it is fair to say that the College is not selecting just one sort of clinician. Women's health in Australia and New Zealand needs general O and Gs, it needs O and Gs with special interests and it needs subspecialists. It particularly needs researchers and teachers, as many universities struggle to attract Fellows into the academic workforce. Above all, the profession needs provincial O and G specialists.

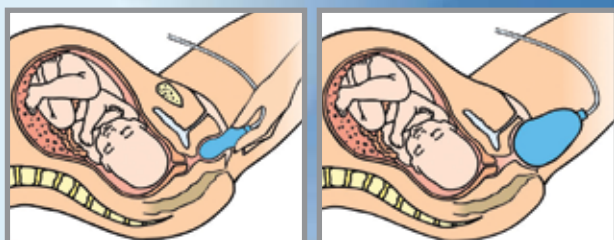
At the recent (and excellent) Provincial Fellows ASM in Mildura, I was again concerned, but not surprised, to hear of the workforce shortages in some key provincial centres. This is not news, but it has to be remedied. What is new is doing something rather than talking about the shortages: 'Don't think, Do!', said J Kennedy (of Hawthorn, not the USA). Much is known of the attributes of an applicant more likely to choose a provincial career and the Selection Working Party is aware that the 'likelihood of choosing provincial practice' is one of the key selection objectives.

Having chosen a cohort of Trainees more likely to pursue a rural career, it is important the training pathways facilitate that objective. A Provincial Training Working Party, chaired by Dr Tony Geraghty,

has been formed to ensure the College has training pathways that maximise the numbers choosing to establish practice in provincial centres. Much of the best gynaecological surgical training comes from the provincial centres with procedure numbers, on average, more than twice the number obtained from an equivalent time in a tertiary hospital. In many ITPs, the tertiary hospitals depend on the rural rotation to ensure adequate gynaecological surgical training. In return, the tertiary hospitals will need to provide 'tertiary training' for any future rural ITP Trainee.

I conclude my third report, by updating you on the Eligible Midwife issue in Australia. The College position remains that RANZCOG joins with the AMA and NASOG in mandating the imperative of Consensus Consultation and Referral Guidelines as part of the planned new 'determination' in which an Eligible Midwife will no longer need a collaborative agreement with an obstetrician. As of today, the Federal Health Minister, the Chief Medical Officer and Chief Nurse have listened to our concerns, although the College of Midwives continues to shun the previously agreed consensus. The women of Australia need firm linkage of the new determination on Eligible Midwives to the Consensus Consultation and Referral Guidelines and the College will continue its efforts in order to see this occur.

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# From the CEO



Dr Peter White  
CEO

Once again, the approach of the Winter issue of *O&G Magazine* and the need to pen this column brings home the cyclical nature of not only the seasons, but also the activities of the College. The Annual Scientific Meetings (ASMs) of the New Zealand Committee and the Provincial Fellows have been held in Hawkes Bay (Napier) and Mildura, respectively. My thanks and congratulations go to Dr Craig Skidmore and A/Prof Ian Pettigrew and their respective teams, along with the College staff involved, for once again holding quality meetings that have served the professional needs of

a range of College members, as well as those who may not yet be College members, such as medical students. By the time this column is being read, the combined South Australian/Northern Territory and Western Australian Committees' scientific meeting will have occurred in Darwin from 31 May to 2 June, and preparations are well underway for the College's ASM in Sydney from 8 to 11 September. As always, much commitment has been shown by those involved in the organising to cater for the needs of attendees at these events.

For some time now I have written in regard to two initiatives that have been under development at the College: a new College CPD program and a revised FRANZCOG Training Program. It is satisfying to be able, through this column, to inform readers that both initiatives have been developed to the point where they are now poised to be active for relevant groups within the College. Again, both represent the culmination of much activity by all involved and information in relation to both is contained in separate articles in this issue of *O&G Magazine* (see p71 and p78).

I strongly encourage all College Fellows to familiarise themselves with the new CPD program, including its structure, requirements and associated online facility; and all involved with the FRANZCOG Training Program to familiarise themselves with the changes to the program being introduced for Trainees commencing the program from 1 December this year. Also, in regard to the latter, there will be associated changes that will apply to Trainees currently undertaking FRANZCOG training and it is important that all involved are aware of the changes. The College is extremely aware of the need for wide-ranging communication in relation to both these initiatives and I would urge all who need to familiarise themselves with the details of either initiative to take advantage of the information offered through communication from the College through this year.

Both the President and I have written in the previous issues of *O&G Magazine* about the reaccreditation of the College that is occurring during 2013. The College reaccreditation submission was submitted to the Australian Medical Council in late March and the document is available on the College website at: [www.ranzcog.edu.au/the-ranzcog/ranzcog-submissions-reports/submissions.html](http://www.ranzcog.edu.au/the-ranzcog/ranzcog-submissions-reports/submissions.html). The submission serves as an informative overview of the activities of the College in relation to what is considered by the relevant accrediting bodies as its core functions and is commended to anyone wishing to apprise themselves of the College's core activities at this time.

As is standard practice for the reaccreditation process, representatives of the College have held an initial meeting to discuss and clarify aspects of the submission with members of the accreditation team. Further activity associated with the process will see a range of external stakeholders invited to comment on the College's reaccreditation submission, the distribution of surveys to College Trainees and training supervisors, as well as international medical graduates who have applied to the College for assessment of their specialist qualifications obtained overseas,



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and visits to a sample of hospitals involved in the training of FRANZCOG Trainees. The process culminates with a series of meetings of the accreditation team with members of key College bodies in the first week of September, with an outcome of the process expected by the end of the year.

Another activity that involves considerable time at this stage of the year is the formulation of the College's budget for the forthcoming financial year. As always, the intention is to keep increases in College subscriptions and other fees to a minimum and it is pleasing that College subscription renewals for all membership categories for the 2013–14 financial year will increase by an amount slightly less than the corresponding Consumer Price Index increase for the appropriate period.

I wrote in the column this time last year of the need to ensure the College is able to cover the costs associated with the increasing expectations of members, including Trainees, and the desire to ensure all groups contribute appropriately to meeting the necessary costs inherent in delivering the services relevant to each group. In particular, the extent to which the College underwrites activities relating to the training of Trainees in the MRANZCOG/FranzCOG Training Program, as well as the subspecialties, as determined through an analysis of College income and expenditure by activity and associated cost centres, was highlighted. The result was the decision of the Board to move away from the somewhat 'light touch' approach that had until then been applied to increases in training fees, to a series of larger increases over a period of three financial years that would ultimately see the cost of providing services associated with training covered. The increases associated with the 2013 calendar year and to be applied for the 2014 calendar year will go a significant way to achieving that aim and I thank all involved for their understanding of the need to increase training fees in this way in order to ensure that services, including initiatives associated with the College's ICT Strategic Plan, can be delivered to all College member groups, not just Trainees, at the level that is reasonably expected. At this stage, it is anticipated that a further, smaller increase in the 2015 calendar year will achieve the desired aim and see the cost of providing services associated with training undertaken on a sustainable basis.

Recently made available on the College website is the College's Strategic Plan for the period of the current Board and Council. The plan is wide-ranging in nature, perhaps even tending towards the ambitious, yet reflects the diversity of activities that the College is currently undertaking. That said, however, it is felt to represent a realistic work schedule for the period and it will be exciting to see the objectives marked off over the next 18 months. As with the College's reaccreditation submission, I would encourage all College members to familiarise themselves with the Strategic Plan, which can be accessed via the College website at: [www.ranzcog.edu.au/the-ranzcog/governance/ranzcog-strategic-plan.html](http://www.ranzcog.edu.au/the-ranzcog/governance/ranzcog-strategic-plan.html).

Another aspect of activity signalled by the preparation of the Winter issue of *O&G Magazine* is the advertising of application details for awards (Fellowships/Scholarships) that are awarded by the RANZCOG Research Foundation, either from funds held by the Foundation or dispersed on behalf of other entities using the selection process and infrastructure of the Foundation. Again, I remind all RANZCOG Fellows resident in Australia that they are entitled to become members of the Foundation on an annual basis

at no extra cost as a result of arrangements introduced to reflect the annual donation that the College makes to the Foundation. Fellows who wish to become a member for the 2013–14 financial year may do so online via the my.ranzcog member portal or by contacting Ms Frances Gilleard at the College ([fgilleard@ranzcog.edu.au](mailto:fgilleard@ranzcog.edu.au)). The College continues to support research funding in New Zealand through the Mercia Barnes Trust. The most recent awards from the Trust have been made to Drs Katie Groom and Emily Liu and I offer my congratulations to them both.

Of interest to all readers would be the recent forum organised by the Medical Board of Australia (MBA) as a preliminary step towards developing a discussion paper in relation to revalidation in the medical profession in Australia. As all associated with RANZCOG are aware, participation in CPD has long been a requirement for the ongoing certification of Fellows and Diplomates of this College, as well as other categories of membership; a requirement that has become accepted as the norm across the profession. Indeed, the discussion that could be heard less than a decade ago in relation to one group being asked by another to justify the need for participation in CPD on the basis of a perceived lack of evidence for effectiveness in improving practice has now given way to one that asks whether or not CPD in its current form is sufficient for maintenance of both ongoing competence and public trust in the profession.

There is a range of mechanisms by which this matter has been addressed in countries outside of Australia and New Zealand; perhaps the most well known being that which is beginning operation in the UK, which involves a five-yearly cycle of revalidation based on annual appraisals. The merits of a system such as that, compared to those used in jurisdictions that attempt to identify 'at risk' practitioners, compared to the current CPD-based system is a discussion that the MBA is beginning in Australia. It is of significance, for example, that the Medical Council of New Zealand (MCNZ) now requires annual participation in both audit and peer-review activities as part of its recertification requirements and the College has recently written to all Fellows resident in New Zealand to clarify the requirements of the MCNZ in this regard. This is an area that will receive much attention in the coming years as regulatory bodies attempt to balance all the relevant interests and distil the pertinent issues. It is an area that the College will actively follow with interest and attempt to contribute to when the opportunity arises, while continuing to ensure that its CPD programs continue to evolve to meet the standards set by the relevant regulatory authorities in a manner that is meaningful and achievable for those participating.

Once again, I close by noting the volume and range of activity being conducted by the College and reminding all of the need for College members to become involved in order to enable this activity to continue to occur. This is a healthy, vibrant organisation that can provide both professional and personal satisfaction to those who are involved in its activities. It is heartening to see new Fellows and Diplomates becoming involved in College activities and the rewards are clearly there for those who are able to and who do make the choice to contribute. It can be easy to underestimate the number of people who do contribute to the work of pro-bono-based organisations such as the specialist colleges; however, the College is a membership organisation that requires ongoing input and I thank those who do make the effort to give of their time and expertise in whatever capacity.



# Editorial: healthy women, healthy world



A/Prof Stephen Robson  
FRANZCOG

Many of my private obstetric patients, and indeed their partners, share their concerns with me during the course of antenatal care. Particularly during a first pregnancy, women have understandable worries about the safety of their babies and their own well-being during delivery. In reality, though, the women I care for are in a better position than 95 per cent of other women on the planet. There is no safer place to have a baby, or to be born. Most of my patients have a loving family, carry no burden of chronic disease

and have access to some of the best health facilities available. Perhaps this can allay their fears a little.

How different the situation is only a short flight from Australia or New Zealand. Many midwives and doctors in our countries will never see a

woman die in labour; for our colleagues in the region, such tragedies occur all too commonly. If you look around the typical primary school classroom in Papua New Guinea, for example, it is likely you will see the face of a girl who will die in pregnancy. This thought continues to horrify me.

Last year, the Public Health Association of Australia (PHAA) published its policy on maternal health in Asia.<sup>1</sup> The document summary states:

Maternal mortality continues to be a major challenge to global health systems. The vast majority of maternal deaths are preventable. Maternal mortality is impacted by the social determinants of health: poverty, education, employment, access to health care, health status and gender inequality. Australia is well-positioned to take a leadership role in tackling these issues. These few sentences encapsulate the appalling situation facing millions of women who live in our region. It is likely that for every woman who dies, perhaps 20 women suffer a long-term adverse outcome of birth – prolapse, infertility, obstetric fistula and/or incontinence. At the heart of this tragedy is the terrible fact that most of the long-term health problems and deaths related to pregnancy are preventable.

In this issue of *O&G Magazine* we focus on the challenges faced by women who live in the Asia-Pacific region, and the challenges encountered by those trying to help. You will find articles offering an overview of the problems, information about organisations working towards change and some stories from the frontlines from people trying their best to change the lives of women and families in our region.

It is not lost on us that our College is ideally placed to lead efforts in dealing with health injustice for women in the Asia-Pacific region. Former RANZCOG President Dr Kenneth Clark elaborates on this point in these pages. The PHAA document<sup>1</sup> lists the key steps in helping improve conditions for women, and I summarise them here. Strengthen links with like-minded associations in the region, and with grass-roots organisations based in those countries. Lobby the governments of our countries, and provide leadership in eradicating violence against women. Advocate for the provision of family planning, skilled birth attendants at all deliveries and emergency obstetric care whenever it is required. Assist in strengthening and retaining the women's health workforce in the region. Aim for accurate and useful data collections, and hold the Government to account for effective development assistance that reaches its targets.

The team behind *O&G Magazine* believes that no other organisation across our region is better placed to help. Our College motto translates to: out of the darkness and into the light of life. There is no greater need for an escape than from the darkness that binds so many of the women in our neighbouring countries. We hope the stories in these pages inspire everyone who reads them.

## Reference

- 1 Public Health Association of Australia. Policy-at-a-glance: Maternal mortality, social determinants of health, millennium development goals in Asia policy, 2012. ([www.phaa.net.au](http://www.phaa.net.au)).



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# Where do we stand now?

The Partnership for Maternal, Newborn & Child Health

The Millennium Development Goals 4 and 5 provide a direction to achieve women's and children's well-being. The Global Strategy for Women's and Children's Health provides vital support to this, and catalyses worldwide action to accelerate progress towards achieving the MDGs. Many countries have recorded good progress, but much remains to be done.

Globally, under-five mortality has reduced by 35 per cent (1990–2010).<sup>1</sup> More children survive today than they did a decade ago. In 1990, there were more than 12 million under-five deaths globally, but in 2010 this had reduced to 7.6 million. The child mortality rate dropped from 88 deaths per 1000 live births, in 1990, to 57 in 2010. Although the rate of decline at 2.5 per cent per year between 2000 and 2010, was an improvement from the 1.9 per cent year between 1990 and 2000, it is still insufficient to meet the MDG.<sup>4</sup>

Newborn deaths (41 per cent) form the single largest category of deaths among under-fives.<sup>1,2</sup> Preterm complications and birth asphyxia are the major causes for newborn deaths (see Figure 1). Pneumonia, diarrhoea, malaria and other infections such as tuberculosis, measles and so forth cause more than half the deaths in under-fives. Although not included in this category, as they are not counted as child deaths, there were 2.6 million stillbirths in 2008.<sup>3</sup>

Under-five deaths have declined by at least 50 per cent in some countries, but continue to be particularly high in sub-Saharan Africa.<sup>1,4</sup> About one in eight under-five children continue to die in sub-Saharan Africa, and one in 15 under-fives die in Southern Asia. Sub-Saharan Africa, with 121 deaths per 1000 live births, has nearly twice the average rate seen in low- and middle-income countries. But some large reductions have also been seen here between 1990 and 2010, as four sub-Saharan countries recorded the largest absolute reductions. India, Nigeria, Democratic Republic of Congo, Pakistan and China account for half the under-five deaths.<sup>1</sup>



In many countries, significant progress has been made to ensure child and maternal health is supported by the healthcare infrastructure.

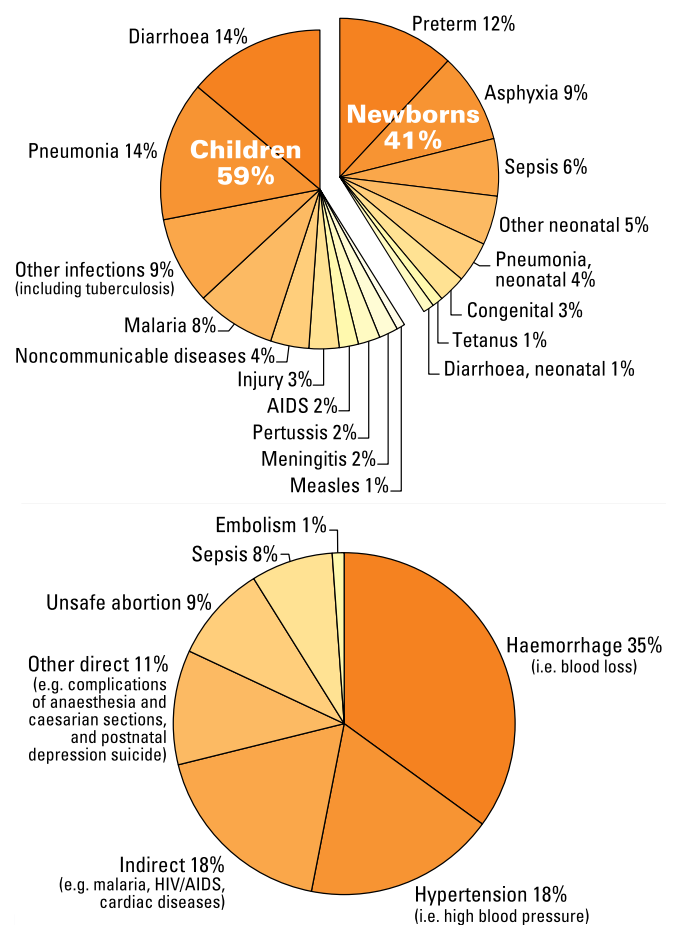


Figure 1. Main causes of death. Top: Causes of deaths in children under five years (7.6 million deaths every year/ around 21 000 preventable deaths every day). Bottom: Causes of maternal deaths (350 000 deaths every year/ around 1000 preventable deaths every day). Adapted from: Countdown to 2015 (2010) and UN Inter-agency Group for Child Mortality Estimation (2011).

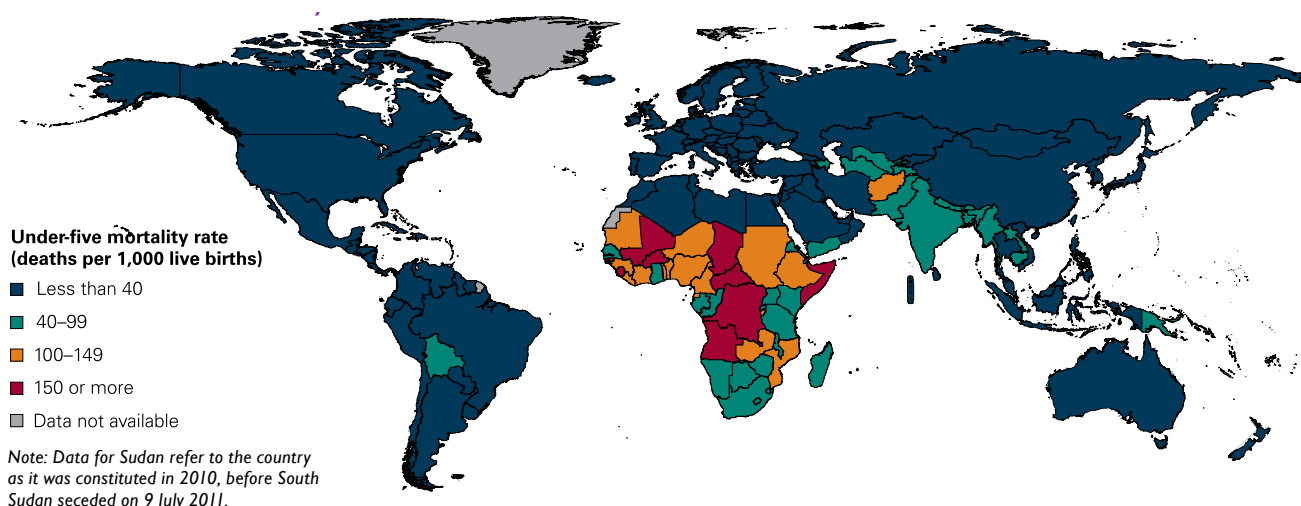


Figure 2. MDG 4: Child mortality rates.

Source: UNICEF (2011). *Levels & Trends in Child Mortality, 2011*; Estimates developed by the UN Inter-agency Group for Child Mortality Estimation (PDF). [www.unicef.org/media/files/Child\\_Mortality\\_Report\\_2011\\_Final.pdf](http://www.unicef.org/media/files/Child_Mortality_Report_2011_Final.pdf).

Children in rural areas and from the poorest households are vulnerable. Even in areas where child mortality rates could be generally low, poor children under-five years in rural areas are 1.7 times more likely to die than those in urban areas.<sup>1</sup> Children from the poorest 20 per cent of households face more than twice the risk of dying as children in the richest 20 per cent of households.

Children of mothers with secondary or higher education face less risk of dying.<sup>1,4</sup> Basic primary education among mothers brings down child mortality rates, but with secondary or higher education the reductions are much more significant.

The chances of survival are almost two-fold higher if a child's mother has secondary education. For example, in Latin America and the Caribbean, the ratio of under-five mortality among children who had mothers with no education to that of those with primary education is 1.6.<sup>4</sup>

This ratio increases to 3.1 between mothers with no education and those with secondary education, implying that higher educational levels bring larger benefits.

Maternal mortality rates in low- and middle-income countries dropped by 34 per cent (1990–2008).<sup>4,5</sup> Despite a significant drop from 440 maternal deaths per 100 000 live births in 1990, to 290 deaths in 2008, the progress in low- and middle-income countries is not at a rate that can achieve the MDG. The progress has been uneven across regions with some regions such as Eastern Asia, Northern Africa, South-Eastern Asia and Southern Asia reporting reductions of 40 per cent or more, while others such as sub-Saharan Africa showing only a 26 per cent reduction.

About 87 per cent of maternal deaths happen in South Asia and sub-Saharan Africa (2008).<sup>5</sup> South Asia has shown a 53 per cent reduction (1990 to 2008), but is still host to a large number of maternal deaths. With maternal mortality rates of 280 deaths per 100 000 live births and 640 deaths per 100 000 live births, South Asia and sub-Saharan Africa, respectively, bear the largest burden of maternal deaths in the world (see Figure 3).

More than 50 per cent of maternal deaths are due to haemorrhage and hypertension.<sup>6</sup> This high proportion of deaths due to haemorrhage and hypertension reflects the poor access to basic as well as emergency obstetric care. Unsafe abortions, which are also preventable, account for nine per cent of maternal deaths. About a fifth of the maternal deaths are due to indirect causes such as cardiac diseases, malaria, HIV/AIDS, etc. (see Figure 1).

Skilled birth attendance in low- and middle-income countries increased from 55–65 per cent (1990–2009).<sup>4</sup> There has been significant progress in many regions, but that is not enough yet. For example, in South Asia, skilled birth attendance improved from 32–50 per cent (1990 to 2009), but coverage is still low here as well as in sub-Saharan Africa (46 per cent).

The proportion of women who received care from a skilled health worker at least once during pregnancy increased from 64 to 81 per cent (1990 to 2009), but the proportion of those who had the recommended four contacts is only 51 per cent.<sup>4</sup>

South Asia and sub-Saharan Africa have the lowest antenatal coverage. In South Asia the coverage for at least one contact is 70 per cent, while that for four contacts is 44 per cent. If India is excluded, the proportion of women having four contacts goes down to 26 per cent in this region.

Childbearing among teenagers in low- and middle-income countries continues to be high at 54 per cent (2008).<sup>4</sup> Overall, teenage childbearing decreased between 1990 and 2000. But the rate of decline slowed down between 2000 and 2008, and in some places childbearing in this age group has actually increased. In sub-Saharan Africa, however, there has been little change in the past two decades and it still records the highest rate (122 births per 1000 women aged 15 to 19 years).

Although 61 per cent of all married women or those with a partner (15 to 49 years) use contraception (2008), unmet need is high in some areas.<sup>4</sup> In sub-Saharan Africa in 2008, only 22 per cent of women in the above category used any contraception. And the

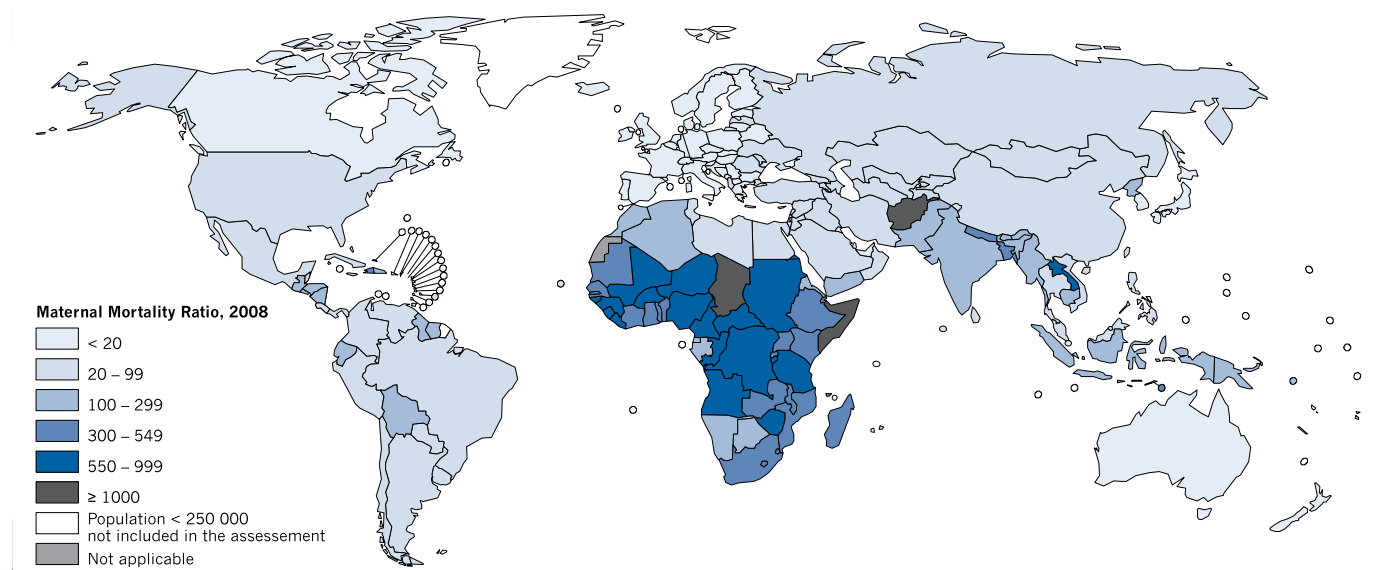


Figure 3. MDG 5 – Maternal mortality rates. Source: WHO (2010) Trends in maternal mortality 1990 – 2008 (PDF) [whqlibdoc.who.int/publications/2010/9789241500265\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf).

proportion of women in sub-Saharan Africa who wished to delay or avoid pregnancy, but did not use any contraception, was 25 per cent. These facts point to the low contraceptive prevalence in this region. Donor aid for family planning services as a proportion of total healthcare aid decreased from 8.2 to 2.6 per cent between 2000 and 2009.

The sub-Saharan region is home to the highest maternal mortality rates and teenage pregnancy rates, lowest rates of skilled birth attendance and contraception prevalence, making it the most unsafe place for a woman to become pregnant. With a growing population in the childbearing age group in low- and middle-income countries, the pressure on reproductive and maternal health services is set to increase. If the current trend of dwindling funds to reproductive health and family services continues, it could exacerbate the high rates of teenage pregnancies and low contraceptive use/prevalence – potentially leading to unsafe abortions and maternal deaths.

Poverty and lack of education are key determinants of under-five mortality rates, high rate of teenage pregnancies, low contraceptive use, lack of access to skilled birth attendance, undernourishment among children, lack of access to clean drinking water and proper sanitation. Improvements in these two key determinants can help accelerate progress in other areas.

This is an edited version of the PMNCH Knowledge Summary 1: Women's & Children's Health: Progress Towards MDGs 4 and 5, which is available to download from: [portal.pmnch.org/knowledge-summaries](http://portal.pmnch.org/knowledge-summaries). Reproduced with permission.

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The Partnership (PMNCH) joins the reproductive, maternal, newborn and child health (RMNCH) communities into an alliance of more than 500 members to ensure that all women, infants and children not only remain healthy, but thrive.

RANZCOG is a member of the PMNCH.



# Shifting goalposts



A/Prof Stephen Robson  
FRANZCOG



Tara Taubenschlag  
Send Hope Not Flowers

How the Millennium Development Goals herald another failure for global women's health.

Maine and Rosenfield, writing in 1999, said:

'A deep, dark continuous stream of mortality...[for] how long is this sacrifice to go on?' William Farr, the first registrar general of England and Wales, asked this question about maternal mortality in England in 1838; a century and a half later, we still have not answered it.<sup>1</sup>

Over three cool and clear September days in 2000, exactly one year before the World Trade Center attacks, the United Nations complex in New York hosted the 'Millennium Summit.' The meeting played host to the largest gathering of world leaders to date, and the

specific agenda was to define the role of the United Nations in the new century. The General Assembly resolution leading to the summit had attempted to grasp 'a unique and symbolically compelling moment to articulate and affirm an animating vision for the United Nations.' Over the three days, the 189 member states ratified the United Nations Millennium Declaration, agreeing to assist people in the developing world to attain a better life by the year 2015. To provide a framework for mapping progress, the leaders focused on clearly-defined issues that were summarised as the Millennium Development Goals (MDGs).

In the wake of the summit, all of the 193 member states of the United Nations, as well as two dozen large international organisations agreed to achieve the goals in the stated timeframe, now only two years away. The goals are listed in Table 1. Of special interest to us is MDG number five (see Table 2). The goal is very specific and two-fold: reduce the maternal mortality ratio by three

quarters, and achieve universal access to reproductive health. Unfortunately, things are not looking good for the achievement of the maternal health MDG. Lack of progress towards achievement of MDG 5 became apparent in September 2010, a decade after the goals were agreed to, when the United Nations Secretary-General launched the Global Strategy for Women's and Children's Health. This renewed strategy called for an additional US\$40 billion from developed countries and NGOs 'in response to slow progress and the moral urgency of reinvigorating efforts to tackle child and maternal mortality.'<sup>2</sup>

## The scope of the problem

The World Health Organisation (WHO) estimates published in 2007 suggested that more than 500 000 women died each year from complications of pregnancy and childbirth.<sup>3</sup> The report also emphasised that many more women survived such complications, but were permanently affected, suffering lifelong ill health and disability. However, the effects were highly disparate between different countries, and even within countries. Indeed, it was noted that, 'the difference in maternal mortality rates between developing and developed countries show[ed] the greatest disparity of all health indicators.'<sup>3</sup> The vast majority, about 90 per cent, of all global maternal deaths were found to occur in South Asia and the sub-Saharan region of Africa.

There had been previous attempts to deal with the appalling rates of maternal death in these regions. The Safe Motherhood Initiative was initiated at a major international conference in Nairobi back in 1987. The conference led to a subsequent series of national and regional 'Safe Motherhood' meetings, designed to raise awareness among those responsible for public health policy.<sup>1</sup> The FIGO meeting the following year devoted plenary sessions on maternal mortality in developing countries, and a 'program of collaboration between obstetrics societies in developed and developing countries was begun.'<sup>1</sup> One of the stated aims of the Safe Motherhood Initiative was to reduce maternal mortality

Table 1. The Millennium Development Goals

1.	Eradicate extreme poverty and hunger.
2.	Achieve universal primary education.
3.	Promote gender equality and empowerment of women.
4.	Reduce child mortality rates.
5.	Improve maternal health.
6.	Combat HIV/AIDS, malaria, and other diseases.
7.	Ensure environmental sustainability.
8.	Develop a global partnership for development.

Table 2. Indicators for progress with MDG 5

Target 5a	Reduce maternal mortality by three-quarters between 1990 and 2015:
5.1	Reduce the MMR*
5.2	Increase the number of births attended by skilled health personnel
Target 5b	Achieve universal access to reproductive health by 2015:
5.3	Increase the contraceptive prevalence rate
5.4	Reduce the adolescent birth rate
5.5	Increase antenatal care coverage
5.6	Reduce unmet need for family planning

\*MMR – Maternal Mortality Ratio.

by half by the year 2000. Yet at the start of the new millennium, when the MDGs were developed, maternal mortality remained unchanged from 1985.

How can this happen? Maine and Rosenfield<sup>1</sup> drew the following conclusion:

In our view, an important reason for the lack of progress in reducing maternal mortality is the absence of a clear strategic focus in the Safe Motherhood Initiative. One of the keys to the success of the Child Survival Initiative was that it gave governments and international agencies a short list of actions required to prevent deaths among young children from the most common causes.

In contrast, the Safe Motherhood Initiative [was] much broader. According to WHO, the initiative encompasses family planning, antenatal care, clean/safe delivery, essential obstetric care, basic maternity care, primary health care, and equity for women. While all of these are clearly worthy and important goals, in fact only one, essential obstetric care, includes actions that can substantially reduce maternal deaths.

### Show us the numbers

To determine whether strategies to reduce maternal death actually work, it is important to obtain data. This may sound simple, but it is not. In developed countries such as Australia and New Zealand, civil registration of maternal death is in place. Civil registration systems mean that there is scrupulous ascertainment of the numbers of maternal deaths, and usually a national confidential inquiry system, to determine the causal factors for such deaths. These systems were discussed in detail in the previous issue of *O&G Magazine*. Such civil registration data is almost always non-existent in resource-poor countries.<sup>3</sup>

For this reason, information about rates of maternal death in developing countries are invariably presented as estimates based on a number of methodologies – household surveys, ‘sister-hood’ methods, reproductive age mortality studies (RAMOS) and population censuses.<sup>3</sup> In countries where many women deliver away from health facilities or where births are not officially registered, mortality data can be extremely difficult to estimate. This leads to extremely wide confidence intervals around such estimates. For example, the estimated rate of maternal mortality for South East Asia is 240 per 100 000 with a possible range between 160 and 350.<sup>3</sup> With such discrepant estimates, it can be almost impossible to tell whether risk-reduction strategies are having any effect at all.

Unsurprisingly, different bodies publish different estimates of the MMR and rates of improvement. As van den Broen and Falconer<sup>3</sup> point out:

Individual countries do not always accept these estimates especially if these are dissimilar to those the country itself reports for example as a result of the most recent DHS. Analysis of trend shows that at the global level the decrease in maternal mortality between 1990 and 2005 was less than one per cent per year. In 2010 this is calculated to be 1.3 per cent or 2.3 per cent [depending on the source]. Overall it can be argued this is indeed an improvement but these estimates are still well below the estimated 5.5 per cent decrease need annually to achieve the MDG 5 indicator by 2015.

### What is going wrong?

MDG 5 is the worst performing of all the goals. Despite all efforts, a number of countries are not only showing no improvement, but their MMR is actually getting worse.<sup>2</sup> Estimates published in the *Lancet* in 2011<sup>2</sup> reveal that, ‘although there is acceleration in many countries, only nine of 137 developing countries are likely to achieve both the MDG 4 and MDG 5 targets by 2015.’ Why should this be, with an additional US\$40 billion allocated to the problem as recently as 2010? Lozano and colleagues<sup>2</sup> see the reason as follows:

Many proven intervention strategies are available for both children and mothers. The major hindrance to the use of resources effectively to scale up coverage of key interventions is health system bottlenecks such as in the health workforce, health system infrastructure, health information systems, supply chain logistics, and managerial capacity.

In reality, part of the problem is that nobody actually knows what works. When a systematic review was conducted to summarise the evidence of the impact and effectiveness on MDG 5 outcomes of official development aid, the authors concluded that they could



*A healthy mother and a healthy baby: the best outcome for the family and the community.*



*Empowering women is a driver of long-term change.*

find few meaningful data and that there were 'major gaps in the evidence base that should be used to inform new approaches and methodologies aimed at measuring the impact of official development aid.'<sup>4</sup> In other words, the evidence of effectiveness for the aid strategies being funded was scanty. This leaves the world in the situation of not knowing the size of the problem, not knowing how accurately to measure whether the help is actually working and not knowing what works anyway.

Despite the bad news, the Australian Government seems upbeat about achieving the MDGs. The AusAID website ([www.ausaid.gov.au](http://www.ausaid.gov.au)) contains the following statement:

Fulfilling the MDGs is both important and achievable. Reducing by half the proportion of people who suffer from hunger would be a remarkable achievement, but millions of people would continue to live in poverty. The Australian Government is both intensifying efforts to support achievement of the MDGs, and planning for the post-2015 challenges.

Australia's Parliamentary Secretary for Climate Change, Mark Dreyfus, made the following remarks at a UN Symposium for Development in May of 2012:

I like the example of empowering women as a driver of long-term change – as a good way to make development socially and economically sustainable. Take a girl, provide her with nutritious food and access to basic healthcare, give her opportunities to receive an education, and later, employment opportunities. We know that this girl is less likely to marry young. She is more likely to have her children later and indeed have fewer children and these children are more likely to be vaccinated, fed well and educated

themselves. Her family as a whole may be lifted out of poverty due to this investment. Educating millions of girls in places where this has never been the case can have huge benefits for whole communities and countries. The money we spend in Afghanistan to educate girls may be the single most transformative and sustainable aid we can provide.

The Director General of AusAID, Peter Baxter, was more realistic when addressing the Lowy Institute in back in 2010:

[Our] region [...] contains about two thirds of the world's poor, many of whom live in China and India. In contrast with China and India with their huge populations and substantial growth potential, the Asia Pacific region is also home to many small island developing states such as Tuvalu and Kiribati. These small island states face enormous challenges in making faster progress towards the MDGs due to their lack of human and physical resources and their remote geographic locations. But of course relying on statistics based on China and India would hide the unevenness of progress between countries in the Asia Pacific and within many countries themselves. Even national statistics hide the reality that while some groups have made good progress others have not.

Questions we need to look at are why some countries such as Vietnam have made relatively strong progress while others such as the Philippines have not. Why are Vanuatu and Samoa making stronger progress towards the MDGs than their Pacific neighbours?

### **Is MDG 5 a failure?**

Australians Tim Sullivan and Jane Hirst reviewed the progress towards achievement of MDG 5 in 2011, four years from the





*A supervised birth is a safer birth – for mother and baby.*

deadline of 2015.<sup>5</sup> They concluded that the targets were very unlikely to be achieved, but were optimistic: 'The achievements of isolated countries suggest that success is not unattainable.'

Similarly, in the editorial of a special supplement in *BJOG* dealing with progress towards MDG 5, the comment was made that results are: 'difficult to achieve despite the continued efforts of some incredibly committed healthcare professionals to improve outcomes for mothers and children.'<sup>6</sup> The editors went on to write that:

High level advocacy for better maternal and child health services is much needed, as well as continuing 'grass root level' efforts. We must celebrate what has been achieved, but encourage even greater efforts in the future.<sup>6</sup>

Others are not so impressed. Prof David Grimes, who spoke so passionately at the RANZCOG Annual Scientific Meeting in Auckland, is convinced that misogyny is at the heart of disadvantage for women in many parts of the world. Speaking at the ACOG Annual Clinical Meeting in 2011, he said:

Every day, misogyny kills women around the globe in two ways: directly through violence and indirectly through apathy.

Women are dying needlessly because societies just don't value them. Examples [...] range from lack of equal treatment, to emotional and physical abuse, to murder. Maltreatment of women has been institutionalized by governments and religions for millennia.

Approximately 343 000 women worldwide die each year from complications of pregnancy and childbirth, an average of one death every other minute... Nearly all of these deaths are preventable. [Certain] societies have yet to make the decision that these women's lives are worth saving.

It is obvious that many and varied reasons account for the extraordinary difficulties encountered in trying to save the lives of women. Vast amounts of money do not seem to be helping. In the end, it seems that little has changed since Maine and Rosenfeld analysed the reasons for failure of the Safe Motherhood Initiative back in 1999:

Although few women in developing countries have yet benefited from the Safe Motherhood Initiative, we believe that the organizational capacity and the international and national resources exist to significantly reduce maternal mortality. Widespread availability of and access to emergency obstetric services would be a dramatic breakthrough for women in developing countries. Solutions to a major public health problem that do not require technological breakthroughs are rare. In this case, we know what is needed; the challenge is to put our knowledge to work.

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# Making it count

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Sciences, UPNG**

there is a need for an increased focus on training needs of MNCH health workers.<sup>3,4</sup>

There are ongoing challenges in training, retaining and providing adequate professional development opportunities for skilled MNCH workers in PICs.<sup>1,5</sup> Many factors contribute to the health workforce constraints in PICs, including outward migration, poor retention incentives and a lack of opportunities for in-country training.

**What is needed to support the skilled health workforce in maternal, reproductive and child health in the Pacific?**

Progress towards achievement of the Millennium Development Goals (MDGs) across the Pacific island countries (PICs), particularly for MDG 5, that targets maternal morbidity and mortality, has been patchy.<sup>1</sup> Countdown to 2015 reports suggest that more can and should be done to address maternal, newborn and child health (MNCH), coverage of evidence-based interventions that require skilled health workers is critical.<sup>2</sup> It is clear that in the high-mortality-burden countries of PICs, to meet the clinical and public-health gaps,

Chronic staff shortages often occur in areas with the highest levels of need and the fewest available skilled healthcare workers.<sup>5</sup>

Australia and New Zealand (ANZ), as high-income countries in the Asia-Pacific region, have a long history of involvement in providing training and support for health workers from PICs.<sup>6,7</sup> Substantial input from committed individuals and supporting organisations have built up a sustainable surgical program in PICs for example.<sup>8</sup> We know from international evidence that availability of appropriately trained doctors, nurses and midwives is positively correlated with coverage of skilled birth attendance and therefore positive outcomes in MNCH.<sup>9</sup> Yet, the critical issue of a local workforce in MNCH in PICs has not got the attention it deserves. We aimed to address this lacuna, through exploring the initiatives currently undertaken by ANZ peak bodies, in the area of training, support and collaboration for MNCH health workers in PICs.

## Methods

We conducted semi-structured interviews by telephone with key informants (n=9) affiliated to the major medical and nursing educational institutions in Australia and New Zealand in MNCH and the two educational institutions in PICs that train MNCH workers, namely Fiji National University (FNU) and the University of Papua New Guinea (UPNG). The interview transcripts were thematically analysed then triangulated with the findings of the scoping literature review.

*Table 1. Support provided by ANZ bodies for a skilled maternal newborn and child health workforce in the Pacific region.*

Organisation	Pacific Committee	Key activities	Training	Budget
RANZCOG	Asia Pacific Committee active for over 20 years. Reports to RANZCOG Board.	Academic support for Pacific Medical Schools. CPD Program, Associate membership for Pacific O&G specialists. Incentives for achievement for Pacific O&G trainees and Fellows. Scholarships for Pacific doctors and midwives.	Core activity. Largely clinical skills. Systematised through liaison with Pacific medical schools.	Yes
RACP, Paediatrics and Child Health Division	Pacific Committee just being formed, terms of reference being finalised.	Informal relationships and professional support. Drivers for activity are Pacific background physicians living in NZ.	Ad hoc. Paediatric Society of NZ funds Pacific doctors to attend meetings in NZ.	No
RACGP	No	Tailored GP training program for rural PNG doctors through National Rural Faculty over last two years, offer honorary overseas membership for registrars enrolled in PNG training program.	National Rural Health Faculty in collaboration with UPNG developed training program.	No
NZ College of Midwives	No	Informal links with Pacific born midwives. PNG project driven by an individual.	Pacific midwives being trained in Auckland University of Technology.	No
Australian College of Midwives	No	Informal relationships and professional support: focus on PNG, Fiji. Scholarships for Pacific midwives to attend conferences.	E-learning packages available, not targeted at international midwives.	No
NZ College of Nurses	No	Focus on Maori/PI nurses working in NZ. Informal support to Pacific-born nurses.	Not targeted.	No

## Findings

A recurring theme from all respondents, from ANZ peak bodies as well as UPNG and FNU, was the abundance of goodwill from individuals and agencies flowing towards PICs and health workers. Much of the support was informal and based on personal relationships and cultural ties. Table 1 lists the key activities undertaken by ANZ bodies in supporting health workers in MNCH.

### Training as most visible form of support

RANZCOG offers a number of training and support programs and initiatives administered and monitored by the RANZCOG Asia Pacific Committee (see Table 1). Significant support for MNCH training at undergraduate level came from AusAID and New Zealand Aid through the support of Pacific medical and nursing schools.<sup>3,10</sup> Respondents suggested, however, that many training initiatives were ad hoc and poorly planned.

### Limited human resources base

There is only a small pool of people who have the requisite qualifications to enter the healthcare workforce in PICs, attributed to the shortage of training facilities at a country level. A recent World Health Organisation (WHO) country report on Papua New Guinea (PNG)<sup>11</sup> noted, despite significant bilateral aid, there remain enduring gaps in healthcare resourcing, characterised by an 'inappropriate distribution of healthcare staff' and compounded by 'education and training, which do not always meet the healthcare system needs'.<sup>12</sup>

### A complex migration dynamic

There was agreement that migration from PICs of skilled health workers generally benefits ANZ. In the New Zealand context at least, losses of domestic nursing and medicine graduates to the overseas 'market', including Australia, render the human resource dynamic in the region much more complex to address. There are also concerns about the active 'poaching' of health professionals from PICs.

### Lack of specific skills

Specific clinical skills shortages were acknowledged, such as in ultrasonography, laparoscopic surgery, gynaecology and vacuum- and forceps-aided delivery. Primary care, mental health input and public-health expertise were all felt to be lacking in PICs. Research skills in reproductive health were likewise a major lacuna, in spite of suggestions from regional WHO that ANZ research councils should provide support for research training opportunities in the Pacific.<sup>13</sup>

### Lack of engagement with Pacific health needs

The issue of geographical inequity in relation to MNCH service delivery in PICs is most pronounced in PNG. The generally weak health infrastructure and support systems in PICs were often not factored in while planning or delivering health and support initiatives by ANZ teams.

### Funding for MNCH initiatives

ANZ, through their respective aid agencies, have made significant financial contributions to the delivery of healthcare services and the

construction of healthcare facilities in PNG and Fiji. A breakdown of MNCH-specific funding is difficult to derive however, in spite of both aid programs listing MNCH as priority.<sup>14-17</sup>

## Discussion: a call to action

Today there is a significant shortfall of skilled health workers required to meet the health MDGs by 2015, in our own region.<sup>19</sup> We found that while a rhetorical commitment to providing support, training and collaboration opportunities to PICs exists within ANZ peak bodies, material plans and resourcing to advance these stated objectives are largely lacking, on the part of both major medical training bodies and government agencies in ANZ. As two of the most significant 'receiving' countries of regional health worker migration<sup>20</sup>, ANZ have an ethical responsibility to respond to the challenges of delivering equitable and quality MNCH services in the region.

Although training initiatives loomed large in the scope of what ANZ bodies deliver and training is an important need for MNCH workers in PICs<sup>21</sup>, training is not always evidence-based or delivered in a planned, coordinated fashion. RANZCOG, as the regional training organisation for reproductive health, takes its role in PICs seriously. Indeed, RANZCOG's sustained commitment not just to training, but also collegial support to MNCH health workers and initiatives in PICs, provides leadership and a way forward for other professional organisations. Respectful partnerships on an equal footing with PICs health workers and regional organisations are one way of achieving this. The Pacific Society for Reproductive Health (PSRH) as a regional organisation with a big mandate can be more effective if appropriately supported by ANZ governments, by tackling training and research needs in MNCH for the whole region.

Political will has been identified as a major factor, in either enabling or impeding the achievement of both the MDGs and reducing inequities in health and well-being.<sup>22</sup> The challenge, as it stands, is therefore to optimally align the workforce needs of PICs and the political willingness that leaders in the public health field espouse, with available resources, to engage in capacity building initiatives that are mutually beneficial. We propose the following recommendations to address this ongoing dilemma; a call to action for ANZ peak bodies.

## Recommendations

1. That there is closer alignment between the activities of regional professional training colleges involved in reproductive and child health and NZAid/AusAID bilateral programs.
2. That the national governments in Australia and New Zealand prioritise training within their own countries when domestic shortages of health professionals become intractable issues.
3. That aid and development agencies develop mechanisms to fund placements in high-need countries, in a sustainable manner, within a mid-term timeframe (five- to ten-year cycles).
4. That a regional body well supported by global health and development agencies and ANZ governments, take on the role of training in clinical skills and public health research in MNCH.

## Case study: what is working well?

The Pacific Society for Reproductive Health (PSRH) is an example of an enduring and successful partnership between the reproductive health workforce of Pacific Island Countries and colleagues and institutional bodies in ANZ. Founded in 1993, with funding from AusAID and the Fiji School of Medicine, the PSRH held its inaugural meeting in 1995, in Vanuatu.<sup>18</sup> Membership of the PSRH is currently 'open to all those involved in reproductive or neonatal health care in the Pacific' and the activities of the organisation are supported by an active Secretariat. The formal programs initiated by the PSRH have been: a newsletter that maintains communication with members and stakeholders; active efforts to recruit engaged members in all member countries; a biennial conference providing a platform for PIC researchers and clinicians to exchange ideas and network; skills workshops training; and action plans adopted at PSRH conferences, which aim to address local MNCH needs.

This role can be taken on by PSRH, if appropriately funded.

5. That the following specific strategies to improve training, support and collaboration be implemented:
  - Sustained efforts in MNCH training, including more training opportunities and an increase in undergraduate training in medicine, nursing and allied health, supported by regional planning.
  - Increased professional recognition and opportunities for collegial engagement: modelled on the RANZCOG Associate Membership category and increasing reciprocal training arrangements.
  - Investment in midwifery: more direct investment in midwifery and training for midwives, based on a situational-learning model.
  - Targeted resourcing of MNCH: transparent investment in MNCH specific initiatives regionally planned and coordinated, particularly in frontline services.

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# Good neighbours?



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comparable contributions of larger 'sister' Colleges such as RCOG (UK), ACOG (USA), and SOGC (Canada).

Improving women's health in Asia Pacific – how can RANZCOG best contribute?

I would like to begin this article with a premise – some of you may consider this a judgmental statement – and ask you to consider its veracity as objectively as you can: that the contribution of RANZCOG, and of the RACOG and RNZCOG before it, to the advancement of women's health outside of Australia and New Zealand has been modest. What is more, RANZCOG's level of contribution in such spheres potentially could be expanded, if we take

– populations vary from little more than a thousand people, for instance in Niue, to over seven million in Papua New Guinea (PNG). The island nations are scattered over a truly huge part of the world's surface. Southeast Asia, on the other hand, has many low-income nations although there are several undoubted exceptions. Populations in the low-income countries are, in the most, extremely large – Indonesia being a prime example with a population of well over 200 million people.

Low income, for any country anywhere in the world, brings the inevitable challenges to health of poverty and lack of adequate infrastructure – sanitation, water, health facilities, and information technology. In the Pacific and Southeast Asia the key tyrannies are broader still and include:

- poverty;
- inadequate and unreliable infrastructure;
- burgeoning populations and often high fecundity rates;
- political instability (and, in some instances, corruption); and
- shortfalls in health facilities, equipment and supplies and trained health workers.

Clearly, such pervasive factors all negatively impact on the provision of even vaguely adequate health services but, in addition, several factors dramatically compound the problems facing women: low education levels – both absolute and in comparison to men – and low social/societal status, with all the extremely destructive corollaries of oppression, exploitation and violence against women.

As doctors, understandably, we tend to focus on the medical means of addressing inequities in health – this is the approach with which we tend to be most familiar. Yet progress on the fundamental issues of education and status of women could potentially make a much greater impact on the health of women and children in our region.

Difficulties for women and their families don't stop there, we need to add several relatively modern-day phenomena:

- The loss of skilled health workers and administrators (brain drain) to high-income, developed nations. Poignantly, this of course includes migration to Australia and New Zealand.
- The rise of chronic, non-infectious diseases; diseases of the West, if you will.
- The complexities of reliance on international aid and the negative consequences of short-term, unsustainable aid projects.

If we are to distil this into medical issues for women and children in the Pacific and Southeast Asia, we see:

- high perinatal morbidity and mortality rates;
- high maternal morbidity and mortality rates – currently many of the data available on such matters are estimates at best as data-collection systems are rudimentary or non-existent in some nations – PNG has maternal mortality rates of in the order of 733 per 100 000 live births<sup>1</sup>, placing it in the group of countries with the highest rates in the world;

'...in 2013, in many nations of the Pacific and Southeast Asia, life for women and their children is still extraordinarily arduous and hazardous.'

It is certainly true that over the last 30–40 years many individual Fellows, Associates and Trainees have contributed hugely to improving women's health beyond Australia and New Zealand, especially in the South Pacific and in Southeast Asia. Over the same time period, our College's contribution has tended to be relatively unstructured, at times inconsistent, and in some cases limited in substance. In part, the relative youth of our College is certainly a consideration. On another level, I have sometimes wondered whether our national psyches contain a touch of smugness and introspection at times – something of the 'lucky country' syndrome on both sides of the Tasman – might be a contributory factor.

Despite these personal observations, it is clear that RANZCOG is maturing in an organisational sense and I commonly hear of, and see, many Fellows and Trainees wanting to contribute to a College that seeks to help the women of our region. In my current roles, I also see more planning, strategy and intent emerging from within the College. In this vein, I would like to look at where the challenges lie and then comment on how RANZCOG and how we as Fellows, Associates and Trainees can contribute best over the coming decades.

## The biggest challenges

Our 'backyard' consists of the island nations of the South Pacific and the numerous countries of Southeast Asia. The South Pacific countries can all be considered as low-income nations





*Sustainable, scalable improvements in low-resource countries' healthcare systems are the key to happy outcomes for women and babies.*

- high fecundity rates, low contraception rates, high rates of unsafe abortion;
- endemic violence against women and children, family and partner violence included;
- high rates of infertility;
- increasing prevalence of HIV;
- high rates of certain malignancies – as an unenviable example, Fiji has an extremely high incidence of carcinoma of the cervix (51 per 100 000 women, compared to eight per 100 000 in New Zealand<sup>2</sup>), but lacks a comprehensive screening program and has no radiation facilities for treatment of women; and
- escalating rates of chronic, non-infectious diseases, including diabetes, hypertension, chronic airways disease and joint disease.

Putting matters simply and somewhat brutally, in 2013, in many nations of the Pacific and Southeast Asia, life for women and their children is still extraordinarily arduous and hazardous. The burden of disease – in every sense of the word – is extremely heavy.

### **RANZCOG's role**

Where do we as a College, and as individuals, even begin to start if we are to make a difference? What are we doing now, and what can and should we be doing? RANZCOG, both in its own right and in association with charitable Trusts and Societies, is doing many things, including:

- training and education programs for doctors, midwives and nurses in the South Pacific;
- administrative support for the Pacific Society of Reproductive Health and for the Brian Spurrett Foundation; and



*RANZCOG-supported ultrasound training in Honiara.*

- coordination and administration of a CPD program for RANZCOG Associates working in the Pacific.

Some Fellows, Associates and Trainees contribute huge amounts of time and energy on a voluntary basis to a range of projects and initiatives in the region. As a substantial and worthy medical College, there is, I believe, opportunity for us to collectively increase our levels of activity in furthering women's health in our wider region. If we are to meaningfully contribute we need to:

- Develop a clear and strategic approach.
- Work with the people and governments of the countries we are endeavouring to support, and with all relevant agencies. Working with other medical Colleges will also make sense in many instances.
- Focus on capacity building and sustainability of whatever we help to build.
- Build on our strengths, for example:
  - in education, training and support of health professionals working in the Pacific and Southeast Asia;
  - in coordination and facilitation of volunteers, locums and donations; and
  - in advocacy on Women's Health and women's rights in the Pacific and Asia, in Australia and New Zealand, and at international forums, including FIGO.

In everything we do, we must work with our neighbours to build culturally sound, sustainable improvements in health systems to benefit women's health. I believe there is great potential for our College further advance its level of endeavour in this arena. We can take this opportunity to advocate for improvements in the social status, education and health of women in the Pacific and in Southeast Asia. We may be pleasantly surprised at how much notice is taken of what we have to say, by the public and by agencies and governments.

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# The Chennai model: not just practising on the Indians



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The proverb says 'give a man a fish and you feed him for a day, but teach a man to fish and you feed him for a lifetime' – can the same principle be applied to medicine?

When asked to write about my experiences in Chennai, I turned to Dr Jay Iyer who has visited Chennai with me. The first desire was to write about how great the experience was and is. However, I wanted to reflect on a more serious and sombre concern of mine, which is the questionable

concept of doing good by practising surgery on people who may not otherwise have access to it.

As our Trainees get less and less gynaecological surgery, their ageing supervisors may have mentioned 'practising on the Poms' – the difference between that and what may be happening in India and Nepal and elsewhere is that in the UK there was an in-house expert resident who was supervising and held the ultimate responsibility: the British consultant. That may not be the case when Trainees work in the developing world.

In 1999, I had the pleasure of visiting a budding pelvic surgery unit in Chennai at the Kasturba Gandhi (Gosha) Hospital. Situated in the deprived area of Triplicaine, it catered to millions of women who were looked after by female doctors.

The situation was heart breaking: young women trudge hundreds of miles to the grounds of the hospital, with fistulas mainly. These fistula patients had been completely ostracised from their villages. Life has no hope; the only reason for this visit was a rumour that something could be done in this place for them.

Enter Dr Rajamaheshwari – the 'in house, resident matriarch' – a trained urologist (the first female urologist in India) and a gynaecologist. She has sacrificed her life to get services to the poorest of the poor suffering from pelvic dysfunction. I saw her struggle and her determination when she asked me to see a 'few' patients the first time – we saw 63 patients in four hours.

My next task was to confer with my wife Paula and tell her what I saw and felt. It was the same old story of any public Indian facility: dirt, poverty, overwhelming numbers and no money. The operating room was very basic, there were insufficient instruments, gloves were recycled and so forth – but the people smiled and appeared happy in their determination to make a difference.

My wife and I decided to adopt Gosha as a project. Initially, we carried between 200 and 400kg of sheets, curtains, equipment, instruments and so on, three times a year. On these visits we would do surgical teaching and workshops for a week and get exhausted, but feel good that we did some good to women.

Within two years we realised we needed to do this differently. Just going there like a knight in shining armour and saving the day felt good personally, but was not changing the ethos. Enter a whole army of generous friends and colleagues – Malcolm Frazer, Bob Shull, George Kaladelfos, Paul Riss, Peter Nelmes, Chris Barry, Yik Lim, Audrey Corstiaans and many others. These people generously gave their time for free, gave money and gave their expertise to train the local faculty. This was the most important turning point. Two doctors from Gosha travelled to Texas, Vienna and Townsville and so the cycle of self-sufficiency began.

Meanwhile, being Indian, I was aware that maybe throwing money at the problem would rid of my guilt, but not solve the problem. Hence, with the help of Raji and others, we set up a seeding fund and built the fistula ward. This facility allowed women to be segregated from the general patients so they could have their privacy and improved hygiene by being staffed by dedicated nursing staff. The fistula ward was mainly stone masonry so that it could be hosed off daily.

Next were the operating rooms and the patient waiting area. In 2007, I was astounded to see what had been achieved: a brand new surgical suite with three tables, air conditioning, state-of-the-art lighting, instruments and most importantly a dedicated waiting area for the pre-operative patients. This was the most dignifying aspect of care that I felt every woman deserved from the beginning.

What has happened since? In 2007, the Government of Tamil Nadu named the ward after my wife 'the Dr Paula Rane Fistula Ward'. The Urogynaecology and Reconstructive Pelvic Surgical Society of India (URPSSI) was set up, with Bob Shull and me as the Patrons. The first official urogynaecological training unit was set up at Gosha and Dr Yik Lim was the first exchange Trainee from Australia.

The unit has gone from strength to strength and its educational endeavours have shown a reduction in obstetric fistula numbers in south India. Most of my colleagues have stopped visiting the unit, happy that it has become self-sufficient. My current ITP registrar visited the unit and took some photos for me. They show it is



*When the Ranes first visited the hospital there were no chairs in the waiting room and no appointments system.*



*The Dr Paula Rane Fistula Ward (above left) and the associated improvements have made a big difference to how the women are treated.*

possible to make a sustainable change by empowering the local faculty and being persistent.

I am not against people offering their skills abroad for free and donating their time generously, I am concerned the woman at the receiving end may not be ideal to receive that care especially in non-fistula prolapse surgery. Do these women know what is being done? Do they know who is doing it? Do they know what not to do after surgery and can they afford/manage that? Do they know who will follow up with them? Do they know who to contact if they have a problem?

I worry because the next woman could be my aunt or my cousin and unless the questions above have answers, I would not want them to be 'practised' on.

My experience in Chennai has set me up to another place: Kathmandu in Nepal. The goal is the same – empower the local faculty by giving time, expertise and equipment. Identify the dedicated bright faculty members – bring them to Australia (with

all its inherent challenges) and use my colleagues and friends to help me help more and more women around the world.

I could not finish this article without mentioning women from the Zonta clubs in North Queensland, who wept at the photographs shown to them and gave 'till it hurts'. Recently, a group of septa- and octogenarian women from a nursing home donated 100kg of baby hats, booties and shawls since it is cold in Nepal. I don't know who benefits most here. This kind of generosity humbles me, but also stimulates me to encourage more and more of us to step out of our bubble from time to time.

#### **Acknowledgements**

Many thanks to Dr Jay Iyer, MBBS, MD, DNB, FRCOG, FRANZCOG, who helped with the preparation of this article.

A big thank you to Paula, and Ben and Tara, my children – they are Dad's best army!

# Treating prolapse and building capacity



Dr Ray Hodgson  
FRANZCOG, MRCOG

How a project to treat pelvic organ prolapse in Nepal grew into an endeavour to build workforce capacity.

Australians for Women's Health (A4WH) began its life as an organisation whose sole function was to provide surgical camps to treat pelvic organ prolapse (POP) in remote areas of Nepal. Its original name was 'Prolapse Down Under'.

Following the first prolapse

camp in Solokhumbu, it was decided that the organisation could also assist in combating the other major female medical problem in Nepal: high levels of maternal mortality.

Nepal has a staggeringly high prevalence of POP. The World Health Organisation (WHO) estimates more than 600 000 Nepalese women suffer with some form of 'uterine prolapse'<sup>1</sup>, with almost 200 000 in urgent need of surgery.<sup>2</sup> This translates to ten per cent of the reproductive-age population, however in some districts the prevalence is as high as 44.5 per cent.<sup>3</sup> Furthermore, unlike

Western countries, the majority of POP in Nepal occurs in relatively young women. Forty-five per cent of symptomatic POP occurs in women less than 24 years of age (see Figure 1).<sup>4,5</sup> There are very few local doctors trained in pelvic floor surgery.

Nepal remains one of the poorest countries in the world, with 82 per cent of the population living in rural areas. Access to medical facilities is limited in these areas and the majority of the population depend on subsistence farming for their livelihood.

Severe forms of POP significantly limit the working capacities and sexual function of these women. As a result, many are deserted by their husbands or families.<sup>4,6</sup> As with the problem of genital fistula, the severe prolapse problem results in significant humiliation and social stigma.

A4WH regularly takes teams of gynaecology surgeons, anaesthetists, nursing and ancillary staff to remote areas of Nepal to provide prolapse camps. Other semi-urgent gynaecological surgery

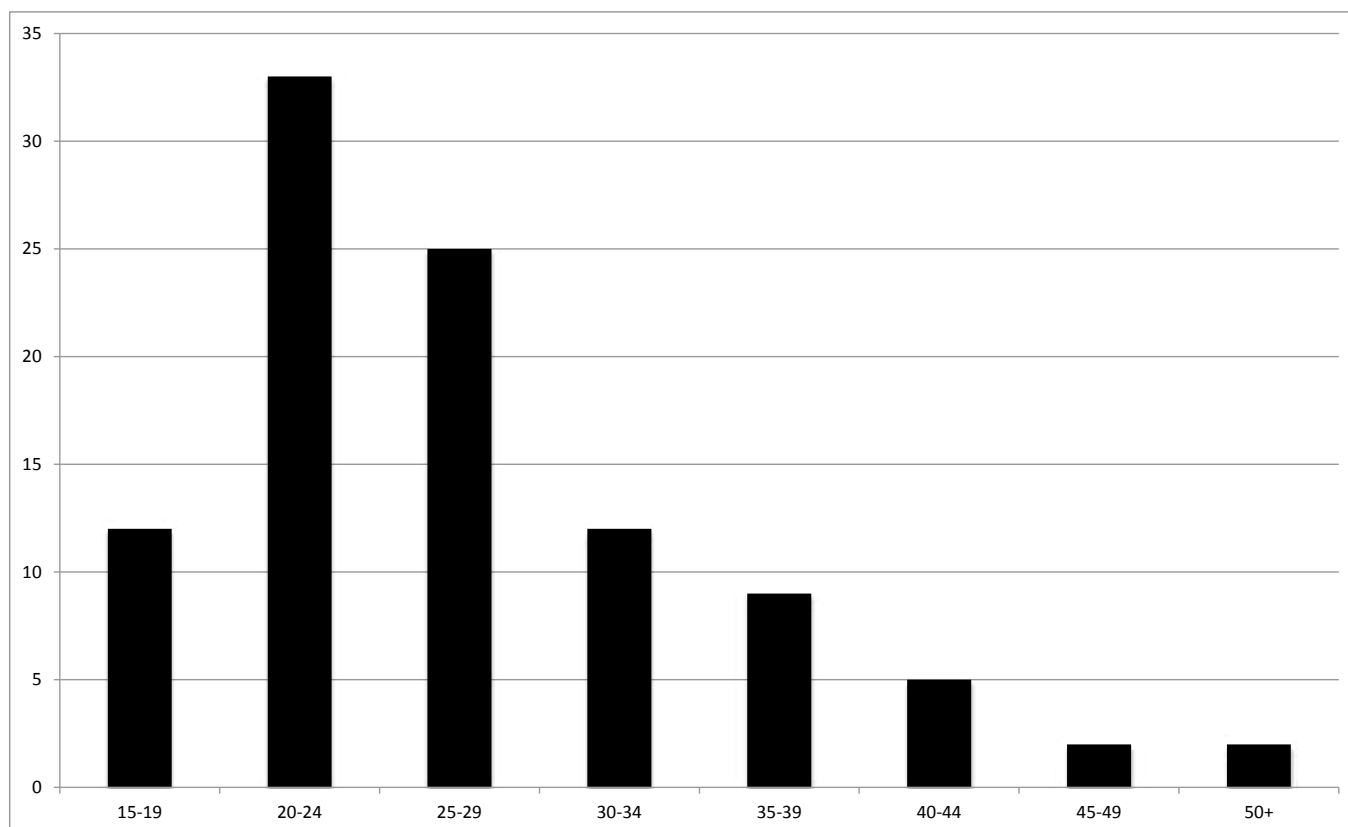


Figure 1. Percentage age distribution of uterine prolapse onset in Nepal. Adapted from Pradhan, 2007.<sup>5</sup>



is performed when necessary. A4WH is one of a number of local and international organisations providing surgical prolapse camps.

Conditions in prolapse camps are often quite challenging. The environment is often harsh, surgical facilities and equipment are limited. Electricity load shedding in Nepal means that power is unavailable for several hours each day at unpredictable times. Local electricity generators are either unreliable or absent and it is not unusual to operate under torchlight.

Pathology laboratories provide basic haematology and biochemistry, but many camps do not have readily available blood banks. Pre-operative pathology includes blood typing and, in the rare event of the need for blood transfusion, whole blood from a local relative or team member is used.

A4WH camps last two to three weeks to allow volunteers to coordinate their annual leave. Despite the considerable challenges of each prolapse camp, the mood of each team is remarkably upbeat. There is a wonderful camaraderie among the team.

### **Prolapse: why so many, and why so young?**

Several qualitative studies have shown POP in Nepal is associated with a number of conditions. The most common associations are heavy workload during pregnancy and the immediate postpartum period, absence of skilled birth attendants (SBAs) at birth and poor diet.<sup>7,8,9</sup>

Measures designed to reduce the incidence of POP must include public health strategies to prevent the condition. However, public education alone is not enough to overcome firmly entrenched behaviour in rural areas of Nepal. Patriarchal and gender discrimination are major social determinants of POP in this

country.<sup>10</sup> Women are often expected to return to heavy working duties, often within one week of childbirth.<sup>11</sup>

Two of the guiding principles of volunteer work that are instilled into volunteers at A4WH are:

- do not interfere with the local traditions and customs; and
- do not tolerate the abuse of human rights.

Clearly there are times when these two principles are in direct conflict with each other. How to resolve this dilemma?

The more important of the two principles is to stand against the human rights abuse inherent in gender inequity. However, external intervention in social and cultural institutions is particularly challenging, because these are highly sensitive areas and involvement could easily be viewed as 'cultural imperialism'. Proposing this form of social change is not an erosion of cultural liberty; rather it allows women freedom of choice. Promoting gender equality and the empowerment of women is not a 'Western' view imposed on developing countries; all 191 member states of the United Nations unanimously adopted this undertaking in the United Nations Development Declaration (MDG 3).<sup>12</sup>

As far as possible, attempts to promote healthy behaviour requiring cultural change are achieved through the use of local Nepalese intermediaries – people who share our own beliefs in gender equality and women's health. During A4WH camps, selected respected locals are instructed to instruct households in health education, including the necessity of appropriate rest during and following childbirth or surgery; and the importance of antenatal care and SBAs at birth and during the puerperium.

In 2012, only 19 per cent of births in rural Nepal were attended



*Daily blackouts add to the challenge of performing any surgical procedure.*



*Severe uterovaginal prolapse in a 28-year-old woman.*

by an SBA. A4WH is involved in a number of projects aimed at increasing the proportion of deliveries attended by SBAs.

### **Criticism of prolapse camps**

Studies following government and non-government prolapse camps have been limited. Criticism has been applied in a number of areas. Qualitative studies from some of these camps have shown that preoperative counselling is often poor, with up to 20 per cent of women having no understanding of the surgery provided.<sup>4</sup> Intermediate and longer-term postoperative follow-up is often lacking. There is concern that in a number of prolapse camps, the surgical treatment of severe forms of POP has been by vaginal hysterectomy alone, with minimal attention to the vaginal walls and vault – the so called ‘trophy hysterectomy’ camps.<sup>13,14</sup> There is understandable apprehension that in the near future many women from these camps will present with prolapse of the vaginal wall and/or vault.

### **The A4WH prolapse camp**

All patients undergo screening for significant POP and co-morbidities. In every A4WH prolapse camp it is a prerequisite that thorough, translated pre-operative counselling and information, education and communication (IEC) materials are provided to all women contemplating surgery. All patients undergo a pre-operative Quality of Life (QoL) questionnaire, and as many patients as possible undergo a post-operative QoL assessment six- to 12-months after surgery. Locating patients in remote areas several months post-operatively is often a difficult exercise and, to date, only 43 per cent of patients have undergone formal post-operative QoL assessment. Results show that 92 per cent of patients who have

undergone prolapse surgery with A4WH are either satisfied or very satisfied. Data are continuing to be collected.

### **Maternal mortality in Nepal**

Nepal shares many of the problems of other developing countries, including the absence of a vital register of births and deaths. As a result, the maternal mortality ratio (MMR) is an estimate only, based on extrapolations using the ‘sisterhood’ method. In 2009, the Nepalese Government reported the MMR to be 247 per 100 000 live births; however, the true figure may be significantly higher than this. Adjusting for the well-documented problems of underreporting and misclassification, in 2010, the United Nations Children’s Fund (UNICEF) and WHO estimated the Nepal MMR to be 380 per 100 000 live births.<sup>15</sup> As in all developing countries, the vast majority of causes of maternal deaths are preventable. A4WH is involved in a number of projects in an effort to reduce maternal mortality.

### **Antenatal clinics**

While in developed countries antenatal care (ANC) has not been shown to reduce maternal mortality, it is generally agreed that in developing countries, where there is a higher prevalence of a number of potentially life-threatening conditions, ANC is highly likely to improve the MMR.<sup>16</sup> In a country where education and the basic health of women and girls is poor, ANC provides the opportunity to teach hygiene, sanitation and nutrition, and to recognise specific pregnancy risk factors. Furthermore, in India, ANC has been shown to lead to a fourfold increase the SBA attendance at birth.<sup>17</sup> Numerous international agencies have adopted SBA attendance as a leading indicator of maternal health.<sup>18,19</sup>



*The original team in Phaplu, Nepal.*



*Hands-on antenatal ultrasound training.*

In Nepal, there are many cultural and gender-based barriers preventing women from accessing ANC. Currently, only 28 per cent of women attend at least one antenatal visit<sup>18</sup> (WHO currently recommends a minimum of four visits<sup>20</sup>). We have found that the provision of free antenatal ultrasound during ANC greatly increases attendance of both the woman and her husband.

A4WH is training Nepalese midwives in the provision of modern ANC. We also provide regular antenatal ultrasound training sessions to Nepalese midwives working in areas where formal ultrasound is unavailable. After three weeks of training, the majority of midwives are competent in the ultrasound diagnosis of many high-risk pregnancies including placenta praevia, multiple pregnancy, malpresentation and more severe forms of intrauterine growth restriction. A4WH ultrasound training camps will shortly be commencing in other countries.

### **Training local doctors**

The long-term success of aid programs will only be achieved through sustainability. Training of local doctors (and other medical staff) is essential. During every camp A4WH teams train selected local surgeons in POP diagnosis, treatment and postoperative care. The challenge is to retain suitably trained doctors in rural and remote areas, as the large majority eventually choose to work in major cities in Nepal or other countries. We are currently undertaking discussions with the Nepal Ministry of Health regarding potential solutions to this problem, including three-year rural bonds for trainee local gynaecology surgeons.

### **The future**

A4WH will continue to provide prolapse and maternal care camps, three to four times a year. Post-operative follow-up at 12 months of QoL and objective assessment be pursued with vigour.

A RANZCOG registrar exchange program is proposed for a teaching hospital in the mountainous district of Kavrepalanchok.

A key to improving women's health is to increase the level of education of both males and females. A4WH will shortly commence regular laptop computer training programs for local teachers in Nepal. Australian teacher volunteers will join surgical and maternal camps to instruct local primary school teachers in basic computer techniques. The Nepal Government has acquired a limited number of laptop computers for students in several schools in remote districts.

We are very fortunate and privileged to be living in a country where women's health is of a very high quality. I believe that every one of us – practitioners experienced in women's health – has a duty to contribute in some way to improving the health of women in countries like Nepal, where the quality of women's health is appalling.

I founded the international aid organisation A4WH in 2010. The principles of A4WH are to provide pelvic floor surgery and to reduce maternal mortality in developing countries. Currently, the majority of the work is being performed in Nepal.

A4WH is continually seeking volunteers for its regular overseas activities. Volunteers include: gynaecologists experienced in POP surgery, anaesthetists, theatre nursing staff, midwives, ultrasonographers, school teachers and general hands. Potential volunteers should visit: [www.A4WH.org](http://www.A4WH.org).

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# The power of thinking small



Dr Peter Scott  
FRANZCOG

**'Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed it is the only thing that ever has.'**

Margaret Mead, cultural anthropologist

My initial reaction on first seeing the 'five-star' luxury of the new birthing centre at Canberra Hospital was to wonder what women and midwives in Indonesia would make of such facilities. In eastern Indonesia women give birth, two to a room, on vinyl-

covered benches in a stark, whitewashed delivery ward.

Labour and birth are a challenge in any circumstance, but, fortunately, very few Australian women need fear dying in labour. Yet in some of our closest neighbouring countries death really is lurking at many births: bleeding; eclampsia; prolonged labour; and infection being common occurrences. To make matters worse, the facilities and skills for dealing with them are poor or non-existent. The loss of a woman's life is no less a tragedy in these places, albeit more common. Moreover, neonatal and infant deaths are commoner when the mother has died and for each woman who dies 20 more will suffer serious morbidity.

I think perhaps the greatest challenge in women's health in the world today is addressing the travesty of maternal mortality in the developing world, where every minute a woman dies as a result of pregnancy and childbirth. This has been recognised not only as a medical problem, but also by the UN as an issue of human rights. Of the UN's Millennium Development Goals, MDG 5, relating to women's health, is the one least likely to be achieved in many countries. In parts of eastern Indonesia, the official maternal mortality ratio (MMR) is 450 per 100 000, although the real figure is probably higher and certainly the MDG aim of a 75 per cent

reduction by 2015 appears destined to fail. MMR is seen as 'the most sensitive indicator of the quality and total functionality of the healthcare system of a country' and of gender inequality. The reasons that women continue to die in childbirth in places like eastern Indonesia are varied and include a daunting mixture of political, economic, societal and cultural factors. The further-flung islands of Indonesia are a long way from the seat of power and a cycle of poverty, political indifference and resignation contributes to the problem.

It is a small world, and I think many of us feel a desire to do something about the obvious imbalance and inequity between the well-resourced system that we benefit from and the poverty of some of our nearest neighbours.

I have had the good fortune to be involved in two small projects organised by the Flinders Overseas Health Group, aimed at improving emergency obstetric skills in frontline midwives in a poor region of eastern Indonesia. I wrote about my Indonesian experience in this magazine three years ago.<sup>1</sup> For our 2009 program we obtained AusAID funding specifically aimed at reducing maternal mortality in line with MDG 5. We were able, over five individual one-week visits, to deliver a program of 'teach the teacher' and practical hands-on training in the town of Ende on the island of Flores. The objective assessments and anecdotal feedback from that course were very gratifying and we were asked to return, in 2012, to provide a similar course in the adjoining district of Nagakeo: this program is ongoing at present.

Nagakeo is a newly chartered administrative district, located at the end of four picturesque hours' drive, over mountainous and poorly maintained roads, from the nearest hospital at Ende. The



*The health centre in Boawae, where the training sessions were held.*



*Local children in Boawae.*

births occur in health centres, some that lack even basic resources such as sphygmomanometers and sometimes a reliable 24-hour electricity supply. Almost always the midwives are the frontline deliverers of care to the women, many of whom are iron deficient. For some women, transport to the health centres is difficult. Others choose not to seek treatment from conventional midwives and instead are looked after by traditional village birth attendants.

All of the midwives have only trained to level one of the three-level training structure and facilities are very basic. As was the case in Ende, this situation lends itself very well to the type of practical hands-on training we have offered. In this resource-poor setting, the timely application of simple skills can literally be the difference between life and death. Management of postpartum haemorrhage and basic neonatal resuscitation are two obvious examples. I sometimes liken this training to riding a bicycle: reading a thousand books about it won't give you the skill, but once you have the skill it's basically impossible to lose it, and it can be passed on to others readily.

A simple example is an exercise in estimation of blood loss, using measured amounts of artificial blood in pads, kidney dishes and so on, and having participants make estimates of the amounts and tabulating the results. We were able to show the midwives how estimation is inaccurate. Indeed, the principle that the larger the loss, the poorer the estimate applies from Queen Charlotte's to Canberra. Everybody makes the same mistakes. Again, in their resource-poor environment, early recognition of the problem can be lifesaving and our students reported that they had simply never thought of measuring the estimation of blood loss. The expenses for this exercise are a few pads and some chocolate sauce, raspberry syrup and flour to make the blood. Similarly, a dimensional improvement in the application of bimanual compression of the uterus – a potentially lifesaving technique – requires only a simple pelvic model and a cushion. Other topics we taught include adult resuscitation and airway management (eclamptic seizures are a common event), vaginal breech delivery, dealing with shoulder dystocia and management of obstructed labour.

As a further endorsement of our 2009 course, one of the local participants, the head midwife of the Ende delivery suite, Ibu Sincé, volunteered to give up her time to come and assist with our teaching in Nagakeo. Ibu Sincé told how after the teaching

we had done in Ende, in which one or two of our PowerPoint™ slides had discussed the superiority of magnesium sulphate over diazepam for the treatment of eclampsia, the midwives had insisted that the doctors change the pre-eclampsia protocols to mandate the use of magnesium sulphate. This was a major success for us, occurring in a place where the hierarchy is such that at our initial meeting it was all we could do to get midwives to sit at the same table as the doctors.

I believe that in general there is a kind of hierarchy of beneficial activities. The least beneficial thing – though still important – being the Santa Claus effect of donating things such as (often expensive) equipment. In reality, the more beneficial activity is teaching simple, sustainable and transferable skills. The icing on the cake is undoubtedly the empowerment of individuals to be agents of beneficial change, especially within a system characterised by poor infrastructure and entrenched bureaucracy. I really cannot imagine a greater reward for any effort that has gone into this program. I also believe that simply our willingness to turn up in this remote part of Flores is itself an incentive for positive change.

One of the great lessons for me has been the value of teamwork, with individuals contributing unique talents and skills to a greater whole. As well as Ibu Sincé, we have an interpreter, Yohanes Sebastianus, a local Florensiian who has done a Masters of Education in Adelaide. This local input has allowed us to fine tune the program to ensure that it caters to the actual needs of the participants and that we remain culturally sensitive and appropriate. The contribution of these people to the program has been invaluable.

The personal rewards for this type of work are considerable: I often tell people that these trips are better than a holiday. Being openly welcomed, as a non-tourist, to such a different culture, in such a physically beautiful environment, is in a sense reward enough. In addition, the enthusiasm and application of the participants, and the positive outcomes that they have reported, lift our spirits. These are wonderful open-hearted people and there is always plenty of laughter across the language barrier.

We were unable to obtain AusAID funding for this second course, so at this stage the Australian participants are volunteers who pay their own expenses. Fortunately, the charity Send Hope Not



*Midwives learn basic resuscitation skills.*



*Teaching uterine compression techniques.*





*Estimating blood loss is as difficult in a low-resource setting as it is anywhere else, the difference being that here it has not previously been recognised.*

Flowers ([www.sendhope.org](http://www.sendhope.org)), in its first year of operation, has already been able to contribute funds to the program. I think the symbolism of the celebration of a birth here in Australia contributing to improved maternal outcomes in a poorer place is powerful and we hope that this association will continue.

The skills that are taught are simple and readily transferable and we hope that eventually we will become redundant, as our local clinical leaders take on the task of providing this teaching to surrounding areas. Clearly, the need for simple aids to the training will continue and we are also looking into the possibility of establishing a scholarship to enable midwives to travel to larger centres, to obtain level-two and -three qualifications. This would be very likely to generate a trickle-down effect on skills and confidence within the district.

In the face of the huge obstacles of poverty, poor infrastructure and bureaucratic inertia, I think that the small-scale and practical nature of this training makes it an effective and efficient use of resources. It has already led to improvements in the care of the women and the self-belief of the midwives in these districts. I believe we are developing here a model for a program that could be extended to other parts of Indonesia.

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# HPV in the developing world



Dr Louise Farrell  
FRANZCOG

Attempts are being made to lift the burden of a disease that falls disproportionately on the world's poorest countries.

On World Cancer Day 2013, the Global Alliance for Vaccines and Immunisation (GAVI) announced support for the Human Papilloma Virus (HPV) vaccine in eight countries: Ghana, Kenya, Madagascar, Malawi, Niger, Sierra Leone, Tanzania and Lao

PDR. This is welcome news indeed for these low-resource countries that carry a high burden from HPV infection.

It has been well established that persistent infection with certain strains of HPV is required for the development of cervical cancer. In the 1970s, study of the epidemiology of cervical cancer recognised a sexually transmitted agent played a role in the causation of cervical cancer. The infectious agent most favoured at the time was herpes.

In 1976, Harald zur Hausen proposed that it was human papilloma virus (HPV) not herpes that was implicated in the causation of cervical cancer. In 1983, zur Hausen identified HPV DNA in cervical cancer tumours. In 2008, he was awarded the Nobel Prize for his research that, having uncovered the cause of cervical cancer, ultimately led to the development of vaccines to prevent disease caused by HPV infection.<sup>1</sup>

Zur Hausen was the first scientist to develop molecular probes for viruses. In 1974, he used DNA hybridisation and restriction enzyme polymorphisms to initiate the numerical system of HPV typing and to classify strains in plantar and flat warts – HPV 1 to 4. Identification of other HPV types followed. In 1984, the zur Hausen group observed that HPV 18 frequently becomes integrated into host DNA in tumours. They noted that in each case the open reading frames for the oncogenes E6 and E7 are preserved and expressed. This pinpointed the importance of these genes in carcinogenesis. HPV 16 and 18 together were shown to account for approximately 70 per cent of the world's cervical cancers.<sup>1</sup>

Since that time, over 130 different types of HPV have been identified, with approximately 40 infecting the anogenital tract. Of those 40 types, approximately 14 have been identified as potentially oncogenic, with HPV 16 and 18 the most frequently found. The natural history of the HPV virus has been extensively examined, though there are still unanswered questions about viral latency and natural immunity. It is, however, clear that in the female genital tract cervical cancer is a rare outcome of a very common infection. The figure widely quoted by the American Social Health Association is that by age 50 years 80 per cent of American women will have acquired at least one type of genital HPV infection.

At the time that HPV was proposed to be the cause of cervical cancers, it was suggested by Syrjanen that a subset of cancers of

the oral cavity and larynx may be caused by HPV.<sup>2</sup> In 2007, the International Agency for Research on Cancer (IARC) concluded that there was sufficient evidence to support the carcinogenicity of HPV in the penis, anus, oral cavity, oropharynx and tonsils and limited evidence to support carcinogenicity of HPV in the larynx.<sup>3</sup>

The worldwide prevalence of infection of HPV in women is estimated at 11–12 per cent, with higher rates in sub-Saharan Africa (24 per cent), Eastern Europe (21 per cent) and Latin America (16 per cent).<sup>4</sup> Cervical cancer is the only cancer in which HPV infection is the undisputed necessary precondition for its development. Of the 610 000 cancers attributable to HPV worldwide, the vast majority – 530 000 (86.9 per cent) – are cancers of the cervix or uterus.<sup>5</sup>

Cervical cancer rates show a strong association with level of development. The rate of cervical cancer is many-fold higher in poorly resourced countries than in developed countries; with 86 per cent of cervical cancers occurring in the low-resource countries.<sup>6</sup> There is a seven-fold variation in the incidence of cervical cancer between the different regions of the world, with rates ranging from five per 100 000 in Western Asia to 35 per 100 000 in Eastern Africa in 2008. The countries with the highest incidence rates in 2008 were Guinea and Zambia (56 and 53 per 100 000, respectively). Australia has the second-lowest rate in the world at seven per 100 000.<sup>6</sup>

There were an estimated 275 000 deaths from cervical cancer worldwide in 2008, accounting for eight per cent of all female cancer deaths; 88 per cent of these deaths occurred in developing countries. Worldwide, cervical cancer is the third-most common female malignancy after breast and large bowel cancers and ranked number four in causes of female death after breast, lung and large bowel cancers. Not only is the incidence rate of cervical cancer in developing countries higher, but the five-year survival rate is lower – less than 20 per cent in low-resource countries as opposed to more than 65 per cent in high-resource countries. Australia has the lowest death rate from cervical cancer in the world at less than 2/100 000 while in East Africa it is 25/100 000.<sup>4</sup>

The five most prevalent types worldwide are HPV 16 (3.27 per cent), HPV 18 (1.4 per cent), HPV 52 (0.9 per cent), HPV 31 (0.8 per cent) and HPV 58 (0.7 per cent).<sup>4</sup> As previously mentioned, HPV 16 and 18 account for approximately 70 per cent of all cervical cancers.

Though the evidence for HPV involvement in other cancers, such as oesophageal cancers, was raised at the same time as its role in cervical carcinogenesis, the causal role is not as firmly established except in anal cancer. Unlike cervical cancer, the other cancers are not entirely attributable to HPV. Thus incidence calculations are derived from the proportion of these cancers that are attributable to HPV and the total numbers of those cancers. It is assumed that the incidence is similar in men and women and indeed male



genital HPV prevalence has been shown to be generally well correlated with the prevalence of genital HPV in women in the same population.

It is calculated there are approximately 12 000 vulvar cancers, 24 000 anal cancers, 11 000 penile cancers, 9000 vaginal cancers and 22 000 cancers of the oropharynx attributable to HPV worldwide.<sup>4</sup>

As well as malignant disease, HPV infection imparts a substantial burden in the form of genital warts, which are largely caused by HPV 6 and 11. The incidence is not always easy to estimate as collection of the disease statistics are complex and are not uniformly collected by most countries. An exception is the UK, which has a national reporting system. There was a reported approximate eight-fold increase in the total number of genital warts between 1971 and 2001. This was thought to be due to marked changes in sexual behaviour. The rates of genital warts rose by 15 per cent from 2001–07 in the UK, but appears to have stabilised in the last five years.<sup>8</sup> One study in England based on data from general practice and genito-urinary medicine clinics reported 80 531 new and 68 259 recurrent cases in the year 2008. The annual cost of treating genital warts in England was estimated at £16.8 million.<sup>9</sup> In Germany in 2005, the cost of treating genital warts was estimated at €54.1 million.<sup>10</sup> A widely quoted figure from the USA is approximately US\$200 million per year.

Following large trials, a quadrivalent vaccine, Gardasil®, covering HPV 6, 11, 16 and 18 was first licensed for sale in mid 2006, followed in 2007 by bivalent vaccine Cervarix®, covering HPV 16 and 18. In April 2007, Australia became the first country to introduce a government-funded national HPV vaccination program for young women. This has been replicated by other well-resourced countries – including New Zealand, the UK, most of Western Europe and many provinces in Canada. In the USA, vaccination is both privately and publicly funded.

However, these countries have well-established screening programs and already low rates of mortality from cervical cancer. The vaccine is going to be most effective in countries that are not so privileged. Fortunately, through a variety of charitable mechanisms, including the Gardasil Access Program funded by Merck in partnership with organisations such as GAVI and the Australian Cancer Foundation, the vaccine is being delivered to the poorly resourced areas of the world such as Rwanda and Uganda, where cervical cancer is the most common cancer diagnosed in women and the incidence more than three times the global average.

The burden of HPV infection is significant globally, being responsible for two and seven per cent of the total cancer burden in more-developed and less-developed countries, respectively.<sup>11</sup> Until now, better resourced countries have been able to reduce the burden by screening and early treatment. With the advent of vaccines an opportunity exists to reduce this burden worldwide.

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## VOLUNTEER OBSTETRICIANS NEEDED IN ETHIOPIA

Up to one in 16 women are dying from pregnancy and related conditions during their lifetimes in sub-Saharan Africa. Almost all of these deaths can be prevented. Ethiopia accounts for more maternal deaths than any other country in the region.

Dr Andrew Browning, currently resident in Tanzania, is seeking volunteer qualified obstetricians and midwives to work in regional hospitals in Ethiopia.

One such hospital is in a town called Barhir Dar in Northern Ethiopia. It seeks to serve the millions of women who cannot afford basic maternity care in the government hospitals.

The volunteers will have the chance to impact on the lives of women and their families in a very real way and also to train the local health staff in emergency obstetric care.

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# Contraception in remote PNG



**Dr Gregory Jenkins**  
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**Hospital**

Overcoming the logistical barriers to the provision of contraception is having many beneficial knock-on effects, including preventing maternal mortality.

Papua New Guinea (PNG) is one of Australia's nearest neighbours and yet has one of the highest reported rates of maternal mortality in the world. It is sobering to realise that within a couple of hours' flying time from Australia there is a country with a maternal mortality rate of over 700:100 000<sup>1</sup> (Australia is about 8:100 000).

There is an enormous unmet need for contraception in the developing

world. The provision of reliable contraception is one of the most cost-effective means of reducing maternal mortality. It also provides a range of other community and social benefits (for example, improved educational opportunities for adolescent girls and women as well as reduced reliance on unsafe abortion practices). It is estimated that maternal mortality in the developing world could be reduced by about 30 per cent by widespread availability of reliable contraception.<sup>2,3</sup>

## The Trobriand Islands

In 2012, I became involved in establishing a project to initiate the provision of contraception in a remote group of islands in the Milne Bay Province of PNG. The Trobriand Islands are located off the eastern tip of PNG in the Solomon Sea. The population was extensively studied by the anthropologist Molinowski and was the subject of his book *Sex and Repression in Savage Society*.<sup>4</sup> The Trobriands have since often been referred to as the 'islands of love', based on their sexual customs and free love traditions. Interestingly, they were the basis of the sexual morality in the Aldous Huxley novel *Brave New World*. It is perhaps little wonder that contraception has eventually become an issue of major importance.

The vast majority of the population inhabit Kiriwina Island, which is the largest isle of the Trobriand Island group. Data from a recent PNG census indicates that the population of Kiriwina Island is in excess of 50 000 people. To put some context on this, the population was said to be stable at around 10–12 000 since the early part of last century. It is not clear why this increase has occurred. Nevertheless, this population explosion is having a dramatic effect on life on the island, with issues such as food supply and disputes over land becoming serious problems.

Kiriwina Island has one hospital and one doctor (externally funded). He commenced work there in 2011 (for the previous 20 years there was no doctor). The hospital's electricity supply is by diesel generator for a few hours a day and is unreliable; there is usually running water in parts of the hospital. There is, however, excellent mobile phone coverage across the vast majority of the island.

There is no reliable supply of contraception. Depo-Provera, the oral contraceptive pill (OCP) and condoms are on offer through the outpatient clinic at the hospital, but are frequently out of supply. Access to the hospital is also an issue as many villages on the island

are quite remote from the hospital and, of course, as far as the surrounding islands are concerned it is even more problematic.

Marie Stopes had recently established a family planning clinic in the Highlands in PNG and were reporting good success with contraceptive implants, although the overall numbers were quite small. After some consideration we decided that implants would be the best option for our mission. We used the Sino-implant (II). This is the option being promoted by the Bill and Melinda Gates Foundation-funded global contraception initiative, and these Chinese-manufactured implants have been used safely and effectively in many developing countries around the world.<sup>5</sup> The Sino-implant (II) is a two-rod subdermal implant system that releases 150mg of levonorgestrel. It is effective for between four and five years and is currently about half the cost of Implanon.

## Operation contraception

In preparation for our project, the doctor from Kiriwina and a local midwife visited the Marie Stopes clinic in the PNG Highlands for implant training. An extensive community contraception education campaign was mounted across Kiriwina Island. Our plan was to conduct a one-week contraception blitz (and at the same time perhaps scope other health-improvement opportunities) to create momentum and then have the local staff provide ongoing service. Our project manager, Wendy Stein OAM, was a key factor in the success of this mission. She had visited Kiriwina Island many times, was instrumental in the appointment of a doctor to the island and was the initiator, organiser and driving force behind the mission.

This was my first occasion working in a remote, resource-poor setting and both individually and as a team we faced many challenges. We worked in close collaboration with our colleagues from Kiriwina Island. Marie Stopes had kindly provided us with 500 implants. Women arrived in droves, on foot, by boat and quite literally by the truck load. We ordered an urgent air freight consignment of more implants that unfortunately did not arrive – they were off loaded at the preceding airport to make way for a coffin, but that's another story. We ran out of implants with one day of our mission remaining. However, the local doctor and midwife were now experts in implant insertion and we had set the contraceptive ball rolling.

By the time we returned, six months later, the implant tally was well over 1000 (by rough calculation that's about ten maternal deaths prevented). Again, we established very clear goals prior to the mission: follow-up and evaluation of the implant users; train and accredit more local staff; and conduct some outreach implant insertion clinics for the hard-to-access areas.

By the end of our second one-week stay we had educated, trained and formally accredited 14 additional local staff for implant counselling and insertion (there are two staff with excellent expertise in implant removal); inserted a further 500 implants and conducted evaluations on over 200 women whose implants had been in situ for four to six months; and conducted some valuable outreach clinics.

### Outcomes

Evaluations were completed for 225 women. Their average age was 28.7 years with an average duration of implant use of 4.4 months (range 3–7 months). Mean parity was 3.4, including 18 nulliparous women and 72 women with five or more children. The satisfaction rate was 92.4 per cent (208/225). Nine women had an undiagnosed early pregnancy at the time of implant insertion and these implants were removed. Only two women requested implant removal because of side effects. Excluding the pre-existing pregnancies, that is a continuation rate of 99 per cent.

These data provide very strong support for the ongoing roll out of implantable contraception in PNG. The report from our mission, including the evaluation summary, was circulated to local and national health authorities in PNG. Within weeks there was enthusiastic interest in running similar programs at other sites in PNG. Based on the model we employed on Kiriwina Island, our project manager Wendy has now established numerous other clinics across the Milne Bay Province, with the staff we trained becoming the trainers for the new clinics. It is just over 12 months since our first mission and so far more than 3500 implants have been inserted. A further 16 health workers have been trained/accredited and 11 health centres now have trained staff and are stocked with implants, including Alotau Hospital (the major hospital in the province). The program continues to expand and, to date, there have been a number of other firm enquiries from health centres outside the Milne Bay Province in PNG wishing to establish similar programs.

More than 700 people attended a recent community education session on contraception in a remote area. Women and their partners want safe reliable contraception. It saves lives and has the capacity to change communities.

### Acknowledgements

This project would not have been possible without the support of Rotary (RAWCS), Marie Stopes, DAK Foundation and of course the two fantastic teams of volunteers who gave freely of their time and expertise. Prof Glen Mola and Dr Miriam O'Connor also provided invaluable advice and support. I would like to dedicate this article to Lucy who passed away from HIV-related illness shortly after our second mission. She was a tireless helper. Her dedication, sharp intellect and dry wit was an inspiration to us all. She is survived by her four-year-old daughter Bernadette.

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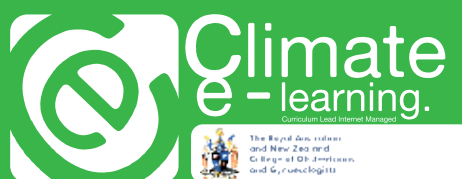
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# Increasing supervised births



Dr Barry Kirby  
DRANZCOG

A new trial program is improving maternal outcomes for women giving birth on the remote islands in the Milne Bay province of Papua New Guinea by encouraging them to seek a supervised birth.

Improving on Papua New Guinea's (PNG's) dismal maternal mortality ratio (MMR) in time for the Millennium Development Goal (MDG) 2015 deadline continues to be a challenge for health authorities in a nation where village births are the most

convenient option and culturally the normal practice for the majority of rural women. In 2012 only 40 per cent of women were able to achieve a facility supervised birth: the other 60 per cent gave birth at home with only a female relative to assist them. A Demographic Health Survey in 2006 calculated the PNG MMR to be 755/100 000<sup>1</sup>: this figure is second only to Afghanistan in the Asia-Pacific region.

PNG has 20 very diverse provinces at very different stages of development. Even within one province there can be diverse cultures, many different languages and a variety of landscapes from coral atolls to impenetrable jungle and mountain ranges. Although the causes of maternal deaths are basically the same in all provinces, measures taken to reduce the MMR in one province may not necessarily have the same effect in another.

## Poor supervised delivery rate

Maternal mortality has been investigated by a number of studies and most recently in the islands region of Milne Bay.<sup>2</sup> The study showed that Milne Bay women most commonly die during childbirth or shortly thereafter from haemorrhagic shock and in more than 50 per cent of cases the cause of death is postpartum haemorrhage (PPH), secondary to a poorly contracted uterus. Retained placenta is also a common association of PPH-related deaths. It was found that most cases would have been preventable, if there had been timely and appropriate midwifery and obstetric management.<sup>2</sup> However,

because most women deliver in their village home, delay in deciding to transport the woman to a health facility when something goes wrong often proves to be fatal.

Of the 6630 births that occurred in the islands around Milne Bay in 2011, only one in four mothers were able to get a supervised delivery in a health facility.<sup>3</sup> In the study many women were interviewed about their views on birthing: the following statements from village women from Milne Bay outer island communities exemplifies the attitude of many women living in remote locations where it is logistically difficult to get to a health facility to have a supervised birth:

- Mothers see having a baby as normal and feel it's safe for mothers to deliver in the village.
- Husbands look after the children while mothers deliver.
- There is a problem with providing food for mother and guardian when we go to the health centre for delivery.
- We just deliver in the village with help from our native herbs.

In our survey, a large number of rural women were asked why they did not make an effort to go to the health centre for supervised birth. Typical answers were:

- I came into labour and then it was too difficult to walk to the health centre.
- I didn't want to go too early to the health centre and then have to wait around for several days. There is no food in the health centre, and besides I do not want to be away from my family and children for too long.
- I don't know my actual expected date of delivery; it's very far to walk to the health centre.
- We do not have transport when we come into labour and the distance is very far to walk.
- We feel ashamed to go to the health centre for delivery when we do not have all the clothes and other things for the baby.
- It costs money to deliver at the health centre (usually about



Delivering the baby bundle gifts.



Nimosa Health Centre staff with the 'grab and run' emergency obstetric kit.





*Women from the outlying islands are dependent on boats (and fuel) being available to get them to the health centre for a supervised delivery.*

K10) and we are poor people.

- I feel shy to expose myself to a male nurse.
- Some of us find it difficult to communicate with health staff who do not speak our local language.
- We fear being scolded by nurses because we have not used family planning or because our clothes are not in good condition.

For multiparas when the first pregnancy outcome was a successful village delivery, it is often doubly difficult to convince women to undertake a three- or four-hour walk to the health centre for a supervised birth, particularly when there are fees to be paid and the health staff are not welcoming.

In response to findings in the study and the mothers' concerns as outlined above, the Hands Of Rescue Foundation in Milne Bay initiated a baby bundle gift program at three selected health centres in June 2012. The centres selected were in those areas where significant numbers of maternal deaths occur each year.

The aim of the trial was to increase the number of supervised deliveries at the selected centres by giving a baby bundle gift to all mothers who chose a supervised delivery there. At the same time, a Hands of Rescue team visited the health centre to provide essential and obstetric and newborn care training for the staff.

The Milne Bay Province is an island province with 160 named islands, scattered over 250 000km<sup>2</sup> of ocean. The population of 209 054 is distributed between the PNG mainland and surrounding islands.<sup>4</sup> The vast majority of the people travel on foot or by traditional sailing canoe, dinghy or locally built wooden boats. People are subsistence farmers and fishermen/fisherwomen and are extremely cash poor. The three health centres where the trial is currently running are Sehulea, Bolu Bolu and Nimoa.

The Baby Bundle Gift Program has several components and consists of a mother and baby gift, staff incentive, obstetric emergency training for staff and the supply of an obstetric emergency kit for the health centre. Participating health centres also benefit from the installation of a water supply and solar lighting to the labour ward where required and construction of a bush material waiting house for expectant mothers to come and stay to await the onset of labour. We have also provided an emergency food fund for mothers as part

of the support package. The trial is being carried out by the Hands of Rescue Foundation, based in Alotau under a Memorandum of Understanding with the Milne Bay Provincial Health Authority.

### **The baby bundle gift**

The baby bundle gift component of the program consists of 18 items, catering for both mother and baby's needs at the time of delivery. The bundles were supplied to Sehulea, Bolu Bolu and Nimoa health centres in June 2012 and will continue until June 2014, when the program will be evaluated. Each bundle is valued at K60 (AU\$25) and contains:

- a plastic baby bath;
- a full-size bath towel;
- six cotton nappies;
- a cotton sarong for the mother;
- baby oil (100ml);
- a full-size cotton bed sheet;
- baby powder;
- underwear for the mother;
- underwear for the baby;
- six washable sanitary pads;
- a towel for wrapping baby;
- female and male condoms;
- a singlet for the baby;
- a treated mosquito net;
- five safety pins;
- laundry soap;
- hand soap; and
- a roll of toilet paper.

Items are packed into the plastic baby bath in Alotau and I deliver them in person to the health centres. Records are kept of the names and addresses of mothers receiving the bundle and balanced against the number of deliveries recorded in the health centre delivery registers.

Finance for this program comes from Send Hope Not Flowers, based in Canberra, Australia, and Hands of Rescue in Alotau, PNG.

Every six months, each participating health centre receives K250 in cash to be used as emergency food money for mothers awaiting delivery. Moreover, to encourage health staff to improve their bedside manner and accept the expected increased workload that



*Mothers and fathers receive baby bundles in Sehulea.*



*The first group of mothers from Nimoa to receive baby bundles.*

this program will generate, a K20 (AU\$8) bonus is paid for every delivery over and above the case load of the previous year. This bonus is shared equally among all staff of the health facility.

To up-skill staff in the management of obstetric and newborn complications, emergency obstetric care (EmONC) training is carried out in the health centre at the start of the trial and at subsequent follow-up visits during the trial. The training focuses on recognition and management of shock, PPH and manual removal of retained placenta, the use of misoprostol to reduce haemorrhage from miscarriage and PPH, vacuum extraction to assist delivery, the use of magnesium sulphate in severe pre-eclampsia and eclampsia, and the management of postpartum sepsis. It is expected that each health centre will receive five sessions in EmONC training in the two-year period of the program.

Sehulea Health Centre has had a new bush material waiting house constructed and a well to collect water suitable for washing and bathing. Water was also connected to the labour ward hand basin. Waiting houses have also been constructed at the Nimoa and Bolu Bolu health centres.

## Results

Sehulea Health Centre services a population of 6310. The furthest antenatal clinic point is a four- or five-hour walk inland into the mountainous region where the majority of the population live. Sehulea health centre had 58 supervised deliveries in the ten-month period prior to the beginning of the support program. In the ten months since introducing the baby bundles, in June 2012, the health centre had supervised 141 deliveries. This represents a 143 per cent increase in supervised deliveries. Mothers are coming from a wide area to deliver in the health centre and as far as two-days' walk from Sehulea. Since the program commenced, the staff have been paid a K1420 bonus for the extra 41 deliveries.

There have been 15 recorded complications, including five retained placentas and four PPHs since the trial commenced. In the previous year, there were eight retained placentas and three PPHs. There has been one recorded maternal death in Sehulea since the program commenced. This was a woman with an ectopic pregnancy who exsanguinated while waiting for a medivac to the provincial hospital at Alotau. In previous years, Sehulea has typically had three or four maternal deaths per year. The number of new babies who presented for vaccinations at the well-baby clinic during the same period was 176, indicating that at least 35 mothers delivered in the village since the trial commenced.

Bolu Bolu Health Centre services a population of 7671. In the nine-month period before the trial commenced, the health centre supervised 87 deliveries. In the nine-month period since entering the program there have been 123 deliveries: this represents a 71 per cent increase in supervised births. In this area there have been 203 attendances for newborn vaccinations, this seems to indicate that at least 80 women delivered in the village. Bolu Bolu recorded 21 cases of PPH and two cases of retained placenta in the first nine months of the trial.

Nimoa Health Centre provides for a population of 2372. It had 99 supervised deliveries in the nine-month period before the commencement of the trial. Since introducing the baby bundles, the health centre has had 186 deliveries in just over nine months. This represents a 55 per cent increase in supervised deliveries. The staff was paid a total of K1320 since the program commenced for the extra 66 deliveries so far in the trial. It is estimated that 40 women have delivered in the village. There have been no maternal deaths in the health centre and one maternal death has been recorded in the village, which has yet to be investigated. A summary of results since introducing the baby bundle gift component is shown in Table 1.

*Table 1. Results of the trial to date.*

Health centre	Interval in months	Supervised deliveries 2011–12	Supervised deliveries 2012–13	Increase	PPH, retained placenta	Estimated village births	Maternal mortality
Sehulea	10	58	141	83 (143%)	4, 5	35	1
Bolu Bolu	9	87	123	36 (41%)	21, 2	80	0
Nimoa	10	120	186	66 (55%)	11, 3	40	1

## Discussion

The trial is in its early days, but it already shows mothers approve of the new incentives offered by their health centre. The baby bundle program addresses the concerns previously voiced by rural women throughout Milne Bay. Despite long distances to travel, women are showing they will make the effort and choose a supervised delivery in their local health centre when there is client-focused care and they are offered a small incentive to do so. Raising awareness about the program was initially carried out by health staff during regular antenatal clinics. This soon became unnecessary as new mothers arriving back in their village with the baby bath and gifts quickly spread the news to other mothers in their area.

Sehulea stands out as having had the greatest increase in supervised births since the beginning of the trial. This may be because the health centre is accessible on foot for most mothers in the surrounding villages. For other health centres it is necessary for mothers to use sea transport (usually a canoe) piloted by their husband. Bolu Bolu is accessible on foot to 70 per cent of the population while the rest must travel by sailing canoe to reach the health centre. Nimoa Health Centre is situated on a small island in the middle of the Louisiade Archipelago and the majority of mothers must travel considerable distances by sailing canoe to reach it. Husbands are relied on for this task and wives often complain that the men are too lazy to take their wives to the health centre. Consequently, we have added an incentive for men in the second generation baby bundles planned for the next phase of the study. Family planning will also be included in the next round of incentive baby bundles.

However, Sister Sera at Nimoa recently reported: 'husbands are very happy because it assists them with the little money they can earn to support the mother and baby.' She also asked those women who delivered in the village did so despite the incentive offered by the Nimoa Health Centre. All the women said they wanted to come to the centre, but they had no way of getting there, because their husbands do not have a sailing canoe.

It is normal practice for the Nimoa antenatal clinic team to bring mothers back for confinement on their return from their clinic points. Nimoa has not been able to conduct clinics every month because of insufficient fuel for their outboard motor. This same problem resulted in the death of one mother in her village in 2010.<sup>2</sup> Shortage of fuel equals no antenatal clinics and, therefore, maternal deaths, to put it simply.

Women were encouraged to treat the baby bundle gift as a gift from the health centre itself. There is no self-promotion by the program's sponsors on the baby bundles. Staff had the added satisfaction of giving the gift and mothers were happy to receive thus improving the staff-patient relationship.

There has been no increase in the number of complications arising as a result of the increase in supervised births. Staff members have been encouraged to adopt a new policy of placing an intravenous cannula in every mother admitted to the labour ward. An attitude of 'every mother may suffer a PPH until proven otherwise' is taught at EmONC training. Supplies of essential drugs, such as oxytocin, ergometrine and misoprostol, are available in the health centres.

The baby bundle program could easily be criticised as being unsustainable and because it may encourage more pregnancies. On the other hand, it is the responsibility of a caring government to assist

women and families to have safe reproductive health and the Milne Bay provincial health authority has shown every effort to support the program. It is hoped the program will become part of the healthcare system in the long run. As mentioned above, family planning input will be added to the program in the near future.

How long does it take to change the culture of village births to one where a supervised delivery is considered the normal practice? The answer to that question still remains to be seen. The baby bundle program should continue for at least two years then it could be downsized but continue to include incentives for mothers and husbands to accept family planning for a further two years. The cost of a baby bundle gift for every mother of a baby born in a health centre in the remote islands of Milne Bay province in a year is less than the cost of a new vehicle.

With 2015 fast approaching, the MDG 5 target of reducing maternal mortality by two-thirds in PNG is unachievable at present. Encouraging mothers to have a supervised delivery and convincing men and women to accept family planning are two strategies that will contribute towards achieving the MDG 5 target.

Encouraging mothers to have a supervised delivery at the same time as up-skilling staff and encouraging staff to adopt mother-friendly attitudes are the objectives behind this trial.

Early results are encouraging and show that mothers will respond and change traditional birthing practices when conditions and attitudes at their local health centre are equal to or better than those in their village.

## Acknowledgements

I would like to sincerely thank Send Hope Not Flowers for its generous contribution towards the purchase of baby bundles for this trial and to Profs Steve Robson (Canberra) and Glen Mola (School of Medicine Port Moresby) for their material support and advice in making this program possible. I would also like to acknowledge the generous support of the Volaris, Neville and Silcox families of Alotau and the Milne Bay Province Provincial Health Authority's involvement in the trial.

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# Caesarean in Indonesia

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Indonesia faces the development question of how to ensure that obstetric interventions, such as caesarean section, are appropriately available and not overused.

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Most Australians don't realise it, but Indonesia is a wealthier country than Australia. Examining gross domestic product (GDP) by purchasing power parity (PPP),

what money actually buys in each country, shows that Indonesia ranks as number 16 in the world, with an annual GDP (PPP) of over US\$1.2 trillion. By contrast, Australia ranks as number 19, with a GDP (PPP) of just under US\$1 trillion. At the official exchange rates, however, Australia is richer (US\$1.5 trillion compared to Indonesia's just under US\$800 billion)<sup>1</sup>, but PPP is a more realistic comparison of wealth because it reflects what money can actually buy in that country (goods, services and labour are usually significantly less expensive in Indonesia than Australia). However, even the difference in GDP by official exchange rates will soon disappear between the two countries, as Indonesia's faster growth rate than Australia (six per cent compared to three per cent) will increase Indonesia's wealth disproportionately to that of Australia.

## Why should Australia give aid to Indonesia?

Indonesia is still a developing country. When the pie of national wealth is cut up among each population, Australia's 23 million inhabitants receive unimaginably bigger slices of wealth than do Indonesia's 250 million inhabitants. A developing country such as Indonesia has different priorities in expenditure<sup>2</sup>, spending more on infrastructure and poverty eradication. Australia's healthcare spending is just under nine per cent of GDP compared to Indonesia's three per cent. With ten-times the population and one-third the proportional healthcare expenditure, Indonesia spends less than 1/30th on the healthcare of each of its citizens than Australia does. Tellingly, the maternal mortality rate in Indonesia (220:100 000) is 30-times Australia's maternal mortality rate (7:100 000).

## How is caesarean section important?

About 30 million of the 200 million women who become pregnant every year will develop life-threatening complications requiring emergency treatment.<sup>2</sup> Caesarean section (CS) is the most significant of these medical interventions and the most commonly performed major obstetric intervention.<sup>3</sup> While it can be lifesaving, it has the most significant physical impact with the greatest potential for short, medium- and long-term complications for the mother and baby. Most importantly to a developing country such as Indonesia, where resources are relatively scarce, it is the commonest major obstetric procedure with the highest cost to the health system.

The 2007 Indonesian Demographic and Health Survey (IDHS) data<sup>4</sup> indicate that the goal of making such emergency obstetric intervention available to all pregnant women is slowly being achieved and this has been associated with remarkable improvements in health outcomes. Births with trained medical or midwifery assistance have increased from 46 per cent in 1995 to 77 per cent in 2009, accompanied by significant reductions in neonatal and maternal mortality.<sup>5</sup> In the 2007 survey, 93 per cent of women had at least one antenatal visit from a health professional, (79 per cent of this care by

a midwife), and 74 per cent were delivered by a health professional, although the majority of Indonesian women still have their baby at home, (54 per cent total, 30 per cent urban, 71 per cent rural). This medicalisation of childbirth has been facilitated by initiatives such as the health insurance scheme for the poor, introduced in 2005, financed by a reduction in the fuel subsidy.<sup>5</sup>

## What is the Indonesian CS rate?

IDHS data suggest that the Indonesian CS rate in 2007 was 7.3 per cent. This figure was derived from 1020 CSs reported out of 14 043 births covered by the survey. Since there were more than five million births in Indonesia in 2007, even though the sampling of the survey is as best as can be designed, the validity of such a large extrapolation has been questioned.

This is particularly so in the light of reported referral hospital CS rates of 30–50 per cent.<sup>6</sup> This high figure may reflect successful triage and referral, or it may be that CS is being performed for non-standard indications. Although these rates may at first appear to be excessive, they may also be appropriate in a country where the majority of births (54 per cent) occur at home. If only very ill women are being referred to the hospitals to have CSs<sup>7</sup>, then this may actually be appropriate practice. However, according to IDHS data, CS is more common in urban women (11.3 per cent versus 3.9 per cent in rural women). It is also commoner in the highest wealth quintile (16.8 per cent versus 1.8 per cent in the poorest). These statistics suggest CS practice is being done inappropriately, in that it may be too high in one group or, conversely, too low in another. By linking indications for CS with clinical outcomes for both mothers and babies, as possible in our study, the appropriateness of CS practice can be evaluated.

## Is this CS rate appropriate?

The often quoted WHO 15 per cent 'ideal CS rate'<sup>8</sup> is based on poor evidence (level V, from expert opinion). The optimum CS rate is very controversial. In low-income countries where rates of CS are typically low, the caesarean rate can be negatively correlated with neonatal and maternal mortality.<sup>9</sup> There is some evidence to suggest rates less than ten per cent are suboptimal, and an increase in CSs from that rate would prevent both maternal and perinatal deaths.<sup>10</sup> However, although increased access to CS may improve maternal and neonatal outcomes, CS rates of over 15–20 per cent may not result in better outcomes.<sup>11,12</sup> Little association has been found between CS rate and mortality outcomes in high-income countries.<sup>9</sup> Moreover, CSs require many resources and can divert such resources from more basic and cost-effective healthcare.

## What progress has Indonesia made?

Indonesia has made significant advances in education and health. Improvement in adult literacy has increased from 61 per cent in 1971 to 93 per cent in 2003, especially among women. Infant mortality has fallen from 142 per 1000 live births in 1971 to 34 per 1000 in 2007. Per capita income has improved significantly. Despite this, there remain considerable obstacles to improving



health efficiency, especially with regards to obstetric intervention. Whereas developed nations typically have national databases in order to monitor perinatal outcomes and the benefits or harm caused by interventions, such systematic routine data collection does not currently exist in Indonesia.<sup>11</sup> Monitoring outcomes of interventions, such as CS, and linking them to outcomes is not possible.

The most quoted maternity statistics are from the IDHS conducted every four to five years and last completed in 2007.<sup>4</sup> It is a cluster survey, stratified for urban and rural, using random sampling. Sampling approximately 35 000 households, results are extrapolated to over 205 million people. The validity of this survey can be questioned, not only from the exponential extrapolation of its data, but its reliance on unreliable memory recall<sup>11</sup> from participants in an unwieldy 736-question-field questionnaire.

### What can we do?

We are developing a study to facilitate perinatal epidemiologic data collection in three tertiary maternity hospitals in Indonesia (Denpasar, Malang and Surabaya), each with CS rates of about 40 per cent and will aim to use an audit cycle in each centre, to establish consensus guidelines. The three Indonesian hospitals are all centres of excellence where opinion leaders practice and teach. A network of these sites, linked to an Australian clinical and academic team, has been formed over the past four years, with annual clinical and scientific meetings aimed at improving the practice of high-risk obstetrics and promoting formal maternal fetal medicine training. At the most recent Australian/Indonesian combined clinical meeting in Denpasar, participating clinicians identified CS audit and perinatal epidemiology practice as an area where we could learn from each other and where research was most needed. Transferring skills in perinatal epidemiology to the Indonesian medical team and expanding the role of Indonesian midwives into epidemiologic research will encourage sustainability.

CS is costly, diverting resources and personnel that could be used more effectively elsewhere. Indonesia has policies to improve pregnancy care by increasing hospital births and replacing traditional birth attendants with professionally trained midwives and obstetricians. CS, the most significant obstetric intervention, reduces maternal and perinatal morbidity and mortality when it is available to pregnant women. As we have discovered in Australia, however, if CS is widely available, it may be used inappropriately. Helping Indonesia to learn from the Australian experience may avoid such mistakes being unnecessarily repeated.

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# On the Thai-Myanmar border

Dr Rose McGready  
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**SMRU Thailand**  
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life studying malaria, the most common parasitic infection of pregnant women. In 1994, I volunteered for a six-month job in a refugee camp called Shoklo, in the jungle on the Thai-Myanmar border. Antenatal clinics were mobile: we would carry medicine, a microscope and a blood-pressure cuff, and walk across log bridges or muddy trails, or take long tail boat rides or four-wheel drives, to meet the pregnant woman. Our clinics were bamboo and leaf: enough to keep off the hot sun or tropical downpours. Malaria was a common and sometimes devastating problem. Before the end of the first rainy season, I witnessed a maternal death from malaria in an eight-month pregnant mother of two, who initially regained consciousness with intravenous quinine and

In terms of global health, refugee and migrant pregnant women remain a highly vulnerable and often difficult-to-reach population. Early detection and treatment reduces maternal morbidity and mortality from malaria.

In 1990, at Sydney University, medical students learned about malaria during a one-hour lecture. There was no way at that time to know that I would spend most of my working

later succumbed to acute respiratory distress syndrome, a common complication of *P.falciparum* malaria in pregnancy.

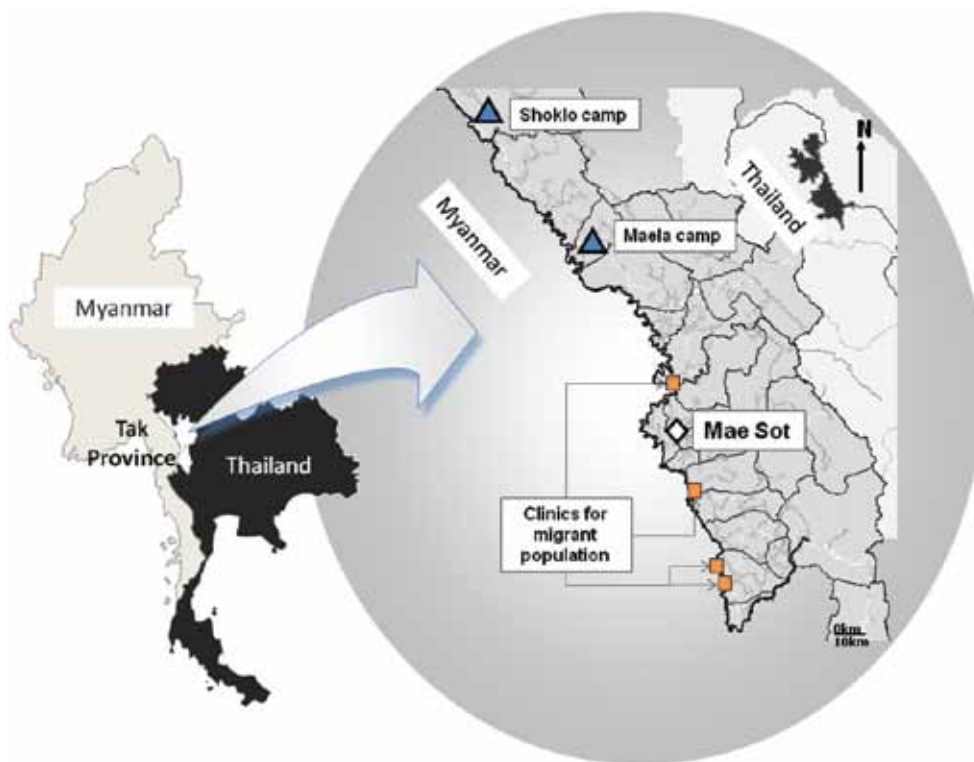
The lifecycle of the parasite dictated that we screened women weekly. The region is notorious for a high level of multidrug resistant strains of *P.falciparum* malaria that left us without any drug for prevention. Women who were positive for malaria would be treated directly to prevent progression to the severe form of the disease. Birth with skilled birth attendants was provided in Shoklo camp although access issues meant many women still birthed at home. The camps for refugees still exist despite apparent political change in Myanmar and the antenatal clinics remain very popular.

Shoklo Malaria Research Unit ([www.shoklo-unit.com](http://www.shoklo-unit.com)) falls under the scientific and logistical umbrella of the Mahidol Oxford Tropical Medicine Research Unit (MORU) based in Bangkok, and is supported by the Wellcome Trust of the UK. Malaria principally causes low birthweight and anaemia, although maternal death,



Practising breech drill during 2013 ALSO course in Maela Refugee camp. (Photo by Gabie Hoogenboom.)





The location of Shoklo Malaria Research Unit Clinics in the refugee camp and at migrant sites on the Thai-Myanmar border. © Verena Carrara.



Taking a finger-prick sample of blood to detect malaria in a pregnant woman in Maela Refugee Camp. (Photo by François Nosten.)



Ultrasound gestational age assessment in Maela Refugee camp introduced in 2001. (Photo by Adrienne White.)



*Early detection of malaria in pregnancy allows for treatment before the disease becomes severe. (Photo by François Nosten.)*

miscarriage, preterm labour, stillbirth and neonatal mortality are also associated with malaria in pregnancy in this area. Maternal mortality (MMR) has fallen dramatically with the provision of early detection and treatment of malaria for all pregnant women: *Pfalciparum* malaria related MMR in the refugee camps fell from an estimated 1000 per 100 000 (430–2320)<sup>1</sup> in the year before the introduction of antenatal screening to zero, in 2005, and has remained at that level since.<sup>2</sup> The decline in migrant women MMR has been less marked: 588 (100–3260) to 252 (150–430) from

1996–2000 to 2006–10. Infant mortality has likewise fallen from 250 per 1000 to <40 per 1000.<sup>3</sup>

Reducing the MMR remains one of the ongoing challenges for SMRU and much of the global community working in resource-poor settings. Many of the WHO recommendations for treatment of malaria in pregnancy have been derived from the malaria pregnancy studies conducted at SMRU.<sup>4,5</sup> In the largest first trimester malaria study reported to date, we recently quantified pregnancy loss from *Pfalciparum* and *Pvivax* infection and the effect of antimalarial drugs (chlorquine, quinine and artesunate) at this vulnerable time.<sup>6</sup> SMRU currently provides delivery by skilled birth attendants for approximately 2500 women per year and they handle all major obstetric emergencies except caesarean section, with support from a doctor with training in obstetrics, who cannot be present 24 hours per day.<sup>7,8</sup> The caesarean section rate is five per cent and these women are referred to the local Thai District Hospital. Life and clinical practice are different to Australia – the use of epidural in labour was rejected by the skilled birth attendants and local women are highly motivated to have vaginal delivery. We have no pain relief to offer women in labour.

Teaching and learning of skilled birth attendants in this environment has been challenging. It took 18 months for staff to be confident in the use of partogram because they were not used to reading a graph. Since 2006, some refugees have had the opportunity to resettle in the UK, USA, Canada, Norway, the Netherlands and Australia. The entire staff of skilled birth attendants needed to be replaced and training efforts intensified. SMRU has had



*Learning how to auscultate the pregnant abdomen during 2013 BLSO course in Wang Pha migrant clinic. (Photo by Gabie Hoogenboom.)*





Routine antenatal care visit at Maela Refugee camp. (Photo by Adrienne White.)

overwhelming support and encouragement from the friendly Australia-Pacific Branch of Advanced Life Support in Obstetrics (ALSO®) since 2008. In our first year we held three ALSO participant and one instructor course in the space of two weeks. One-third of the local staff passed to Australian standards, although many have not finished school and none hold higher degrees. Most local staff struggle with the theory, as schooling in the eastern part of Myanmar has been piecemeal during 50 years of military rule. Language is a major hurdle – when English is spoken it is usually as the third or fourth language after S’kaw Karen, Poe Karen or Burmese. In 2013, Basic Life Support in Obstetrics (BLSO®) began with four courses and 74 participants. Translation of materials is frustrating, but made significantly more bearable by moments of comic relief: translation of ‘move the woman into the all-fours position’ for shoulder dystocia management came out as ‘move the woman into all four positions.’

SMRU welcomes visiting medical students or trained midwives and doctors who can come for at least eight weeks, space permitting. Staff, language and time constraints limit the number we can take at a single time. For me, somehow a planned six-month stint quickly became 19 years. I miss Australia and most things Australian and, you may think it goes without saying but it must be said, my family and friends. This is balanced by a rare opportunity to work in an amazing place alongside remarkable people, both local and foreign, who have enriched my life in more ways than I can ever hope to repay, as Confucius says: ‘Find a job you love and you’ll never work a day in your life.’

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# Saving mothers' lives



**Dr Tane Luna Ramirez**  
Obstetrician and Gynaecologist  
Women's Health Advisor  
**Médecins Sans Frontières**

Working in some of the most deprived regions of the world, Médecins Sans Frontières continues to witness the large scale of maternal mortality and strives to improve its delivery of care to reduce it.

This magazine's last issue (*O&G Magazine* Vol 15 No 1) focused on maternal death, detailing the key causes of mortality for mothers – postpartum haemorrhage (PPH), sepsis and hypertensive disorders – and how, even in the developed world, their risk cannot be overstated.

Every year around 287 000 women globally die from complications during pregnancy and childbirth – 99 per cent in developing countries – and most of these deaths are avoidable. Nearly a third of developing-world mothers still receive no skilled care during birth or immediately after delivery.<sup>1</sup> Annually, three million babies lose their lives in their first four weeks, again 99 per cent of them in developing countries.<sup>2</sup> Mothers, and babies, often die at home, having never reached

a health facility – deaths that may never be recorded. Thus the maternal mortality ratio (MMR; maternal deaths/100 000 live births) may be highly underestimated.

International humanitarian medical aid organisation Médecins Sans Frontières works in some of the most deprived contexts for women worldwide. It provides emergency obstetric and neonatal care in the highest mortality countries, as well as during natural disasters and conflict situations.

This article shares some of the numerous challenges to delivering that care. I am an obstetrician who has spent four years working in the field to improve the odds of survival for women in countries such as Democratic Republic of Congo, Liberia and Pakistan. Today, I am based in Sydney, and work as a medical advisor within Médecins Sans Frontières' medical department.

The disparity in terms of health indicators between developed and developing countries is greater for maternal mortality than for any



Mothers wash their newborns in one of three post-natal wards in the emergency centre for gynecological and obstetric care managed by Médecins Sans Frontières' since 2006 in Kabezi district, Burundi. The organisation has worked in Burundi since 1992. © Sarah Elliott 2012.



other.<sup>3</sup> According to the World Bank, the MMR is highest in Chad (1100), followed by Somalia, Sierra Leone and Central African Republic.<sup>1</sup> Nigeria has an MMR of 630. However, a retrospective (1990–1999) population-based study of 171 621 deliveries in Kano state in northern Nigeria estimates an MMR of 2420<sup>4</sup> – more than three times the official country average – and thus highlights the problem of underreporting and regional variation.

Australia has an MMR of 8.4 and New Zealand, 17.8.<sup>1</sup> A big hospital in Sydney, averaging 5000 births a year, may experience no maternal deaths in a year. Médecins Sans Frontières' project in Jigawa State, Nigeria, neighbour to the aforementioned Kano, similarly handled just over 5000 deliveries in 2012 – and recorded 80 maternal deaths. Yet the MMR of 2420 in Kano indicates this may be only 20 per cent of the likely maternal deaths in the catchment population. We may be seeing just the tip of the iceberg.

So why is mortality so high and what are the challenges to combating it?

Apart from a small percentage of women with established high-risk pregnancies (previous caesarean section or previous pre-eclampsia for example), most life-threatening obstetric complications are unpredictable and arise during labour or 24-hours postpartum. In many places where we work, where women are usually not referred early or where travel can mean significant delays, these complications present at the severest end of their spectrum. Eclampsia complicated by pulmonary oedema or stroke; severe anaemia (Hb <2 gr/dl) after placental abruption or postpartum

haemorrhage (PPH); disseminated intravascular coagulation; and ruptured bladder and uterus after obstructed labour are some of the complications that an obstetrician may have rarely faced in a developed country hospital. Such complications increase the complexity of diagnosis and appropriate treatment.

Most maternal deaths in Médecins Sans Frontières' facilities occur within 24 hours of arrival. The biggest challenge for an obstetrician is to provide prompt, skilled obstetric care knowing that death will often be unavoidable. Yet nothing is more rewarding than to find that all the obstetric knowledge acquired over long years was useful to save a woman's life and benefit her whole family's future. The effect of a mother's death can have a highly fatal impact on all her young children: in the neonatal period mortality risk increases nine-fold without a mother; in children aged two to five months, this can increase up to 25 times.<sup>5</sup>

Women present late for many reasons, particularly isolation. Transport can be expensive, or non-existent. Roads may be cut or unsafe for travel. Lack of health facilities within reach compounds this. No woman should have to travel more than two to three hours to reach emergency obstetric care; in the case of PPH if she had to travel that far, she would be lucky to survive.<sup>6</sup>

Maternity waiting homes are one way of overcoming the isolation. In Médecins Sans Frontières' projects in countries such as Sierra Leone, Democratic Republic of Congo, and the Autonomous Region of Bougainville in Papua New Guinea, women are encouraged to admit to a waiting home at the end of the third



*The author and team conducting a caesarean section for a woman with post-term pregnancy. Médecins Sans Frontières opened a private, secondary hospital in May 2011 in Peshawar, Khyber Pakhtunkhwa (KPK) province, Pakistan, providing free-of-charge, specialised emergency O and G care. © P.K. Lee 2011.*



trimester. Here they are monitored with regular health checks and midwife visits, and nourished until delivery. Uptake is limited, however, by a woman's circumstances at home. She may be the main caregiver to multiple children, if not also a breadwinner, and unable to be absent.

Multiple factors also weigh in at the time of delivery. The World Health Organisation (WHO) considers caesarean section rates of five to 15 per cent the optimal range for targeted provision of this life-saving intervention for mother and infant.<sup>7</sup> However, caesarean section in a resource-limited setting has to be carefully considered due to the implication for future pregnancies. In places characterised by very high fertility rates, performing a caesarean section for fetal life-saving purposes might expose the woman to a higher risk of major obstetrical complications in subsequent pregnancies, owing to scarred uterus (including ruptured uterus, placenta praevia and accretism). Also, political or economic developments may make surgery unavailable the next time, whether from the national health service or an international organisation. So, although the decision whether to have a caesarean section ultimately resides with the mother, our medical guidance must reflect a range of factors that may not exist in a higher-resource context.

Médecins Sans Frontières' strategy is based on WHO recommendations: to establish an effective referral network between basic emergency obstetric and neonatal centres (BEmONCs), where normal deliveries take place under midwives' supervision, and comprehensive centres (CEmONCs) where surgical procedures and safe blood transfusion are available around the clock for obstetric complications. Through this strategy, mortality has been shown to decrease. In Bo district, in southern Sierra Leone in West Africa, where Médecins Sans Frontières has been present since 2008, maternal mortality today is 351, which is 61 per cent lower than the official country-wide rate of 890 per 100 000 live births. In a similar project in Burundi, in Kabezi district, the district MMR is 74 per cent lower than Burundi's national average.<sup>8</sup>

Emergency obstetric care, access to safe abortion and family planning are identified as the most achievable, cost-effective strategies to reduce MMR in resource-poor settings.<sup>9</sup> Médecins Sans Frontières offers all these services, but there are still major challenges to making the latter two routinely available in all projects.

Another ongoing obstacle is the lack of specialised human resources to deliver our required level of obstetric care. This lack is even more pronounced for contexts such as Pakistan and Yemen, which necessitate female obstetricians. This cultural constraint is understood and accepted, but puts a greater pressure on Médecins Sans Frontières' recruitment needs.

The provision of emergency obstetric care is at the forefront of Médecins Sans Frontières' work in sexual and reproductive health. The organisation will continue to expand its emergency obstetric and neonatal care programs to contribute to the survival of women, and their babies, at the most vulnerable time of their lives. The lives of women must stay high on the agenda for all health providers and political players to significantly reduce the number of avoidable deaths in the future.

To find out more about working with Médecins Sans Frontières as an obstetrician/gynaecologist, please go to [www.msf.org.au/join-our-team](http://www.msf.org.au/join-our-team).

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## Expanding the Horizons in Female Care

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# What women want: making global challenges personal



**Emma Macdonald**  
Co-founder, Send Hope Not Flowers

'In the 19th century, the paramount moral challenge was slavery. In the 20th century, it was totalitarianism. In this century, it is the brutality inflicted on so many women and girls around the globe.'

Pulitzer Prize-winning journalists Nicholas D Kristoff and Sheryl WuDunn

Women face challenges from the moment of conception. Writing in 1990, Indian economist and Nobel laureate Amartya Sen drew attention to the fact that millions of women appear to be 'missing' from countries in Asia. Sen lamented that, 'these numbers tell us, quietly, a terrible

story of inequality and neglect leading to the excess mortality of women.' Subsequent research has lent weight to suggestions that the use of ultrasound in some countries has fed a culture of pregnancy termination when a fetus is thought to be female. Others have proposed that infanticide of female babies or neglect and withdrawal of medical care for female children may play an important role in this incredible gender imbalance.

What do we make of a world where pregnancy is terminated or newborns are killed or die as a result of neglect just because they are not boys? How can we possibly tolerate this in the new millennium?

## Healthy women, healthy world

In Australia and New Zealand, women now make up the majority of health service providers and the majority of carers in the community. Data from the Australian Bureau of Statistics reveals that women outnumber men as carers by as many as four to one. Similarly, the average number of hours women spend caring for children outnumbers men by two to one, and appears to be increasing. For these reasons alone, the health of women seems fundamental to the wider health and well-being of our communities.

Despite such a pivotal role in community and family health, there are marked and well-described disparities between different groups of women in Australia alone. As a prime example, Indigenous women have a life expectancy more than 15 years less than that of non-Indigenous women – a difference driven by higher rates of violence, cancer and other medical conditions. This incredible health disadvantage is further exacerbated by remoteness. Non-urban women have higher rates of health problems such as diabetes and hypertension, are less likely to participate in cancer-screening programs and are more likely to have a poor diet and to smoke. All of these compelling forces



*What do these women want? Investment in healthcare, postponement of marriage and provision of education and training would be a good start.*

conspire to increase the chance of early death with increasing distance from a city.

Even in urban centres, migrant women are disadvantaged by unfamiliarity with English. This language difficulty means that women find access to health information difficult and are at an educational and employment disadvantage. These women subsequently face extraordinary health challenges, often with minimal family support. In such communities, rates of mental health pathology – depression and post-traumatic stress disorders – are high, coupled with health problems uncommon in our communities since the 19th century: untreated dental disease, nutritional deficiencies and infectious diseases.

### Know your neighbours

As bad as things can be for some women in our countries, things are considerably worse only a short flight from the capitals of Australia and New Zealand. Indeed, in some of these countries the problems seem completely overwhelming. Across the globe, well over half a million women die from pregnancy-related causes every year. Although data collection is often limited, it is clear that about 99 per cent of maternal deaths occur in developing nations. Among these deaths, it is estimated that unsafe abortion alone accounts for almost 70 000 deaths annually.

The highest rates of maternal death are found in African countries, where the lifetime risks approach one in 16. To put this in some perspective, lifetime risks in Western nations are rarely above about one in 3000, and the risk in any individual pregnancy is often around one in 10 000. Death, however, is a blunt statistical instrument. It is likely that another 20 million women will suffer serious birth complications, including fistula formation and infertility, each year.

Analyses of the causes of death and debility from pregnancy in developing nations make depressing reading. At the head of the list are difficulties in accessing safe and reliable contraception; and limited or absent access to skilled assistance during birth. Killers that have been tamed in the developed world – haemorrhage, eclampsia, obstructed labour and infection – are still rampant in large areas of our world. The majority of women across the globe still have no access to the most basic elements of maternity care: antibiotics, anticonvulsants, oxytocics, manual removal of the placenta and instrumental vaginal delivery.

In their book *Half the Sky – Turning Oppression Into Opportunity For Women*, Pulitzer Prize-winning *New York Times* journalists Nicholas Kristoff and Sheryl WuDunn make the following observation:

The equivalent of five jumbo jets worth of women die in labor each day... life time risk of maternal death is 1000 times higher in a poor country than in the West. That should be an international scandal.

Adding to this list of miseries is the needless and pointless practice of female genital mutilation. Girls will commonly undergo such procedures between the ages of six and 12, and face the removal of part or, in some cases, all of their external genitalia. The remaining tissues are often crudely sewn together. Much of this brutality is meted out by other women. Using unsanitary equipment and practices, young girls face the immediate risks of bleeding and infection, sometimes leading to death. In the aftermath, women who subsequently become pregnant face obvious problems during childbirth.

Another aspect of this disrespect for girls and women is the institution of 'child marriage'. Child marriage can have multiple adverse impacts on the health and life of the young girls involved. Their formal education, so often the key to health and well-being, is often limited. They face increased risk of sexual infections, in particular HIV and papillomavirus, the initiator of most cervical cancers. The likelihood of early pregnancy and the risk of death or disability from birth complications is subsequently high.

### Not only birth...

Few people in the developed world realise that cancer of the cervix is the most common malignancy in developing nations. Striking women during their reproductive years, cervical cancer kills almost as many women as pregnancy does. The WHO estimates that there are more than half-a-million new cases every year, and the majority of women affected will die a terrible death from their disease. The screening programs that we take for granted – regular Pap smears and colposcopy when required – are virtually non-existent in many countries and regions. Even when detected, treatment options for many women are extremely limited.

As cervical cancer is associated with the papilloma virus, so the other now-endemic virus, HIV, continues to spread. In developing nations, the majority of women do not know their HIV status. Few are ever tested and the small proportion who are tested and found to carry the virus rarely receive treatment. Transmission of HIV from mother to offspring occurs with high frequency and estimates suggest that more than two million pre-teenage children are living with HIV across the world. The infection is almost always acquired from the child's mother.

### What do women want?

Any review of the health and status of women and girls, on a worldwide basis, makes for depressing reading. Are these problems so overwhelming that nothing can be done?

The question is often asked, 'What do women want?' From the perspective of the developing world, some important principles are well recognised:

- Investment in women's and girls' health has benefits not only for the individuals, but for society as a whole. Healthy women, healthy world.
- Postponement of marriage and pregnancy until girls actually reach womanhood can dramatically improve the health of women and, in turn, community health.
- Provision of education and training, whether formal education or vocational training, coupled with reliable methods of family planning, have enormous potential to interrupt the otherwise inevitable cycle of disempowerment of women and ensuing poverty.

With such goals in mind, programs that inform and educate girls about reproductive health, prevention of sexual infections, contraception and family planning, HIV transmission and how to seek healthcare are critical. Governments must make preventive care and treatment for reproductive health issues intrinsic to any initiatives.

When speaking at the RANZCOG Annual Scientific Meeting, last year, I was asked by the attendees what do Australian women want. My reply? That women want us to care about women in neighbouring countries, and across the world. They want us to



care about disadvantaged women in our own country. And, most importantly, they want society as a whole to be a healthy place for women and their families.

In preparation for the conference I spoke with friends and colleagues about what they wanted specifically from their own healthcare professionals and systems. The responses were consistent. Women rate the following as the most important qualities in healthcare: competence, time, patience, compassion and honesty. While those nouns come from a very middle-class, first-world perspective, they seem apt words to aspire to when considering the health of women across the world:

- Competence: having the skills to help effectively – surmounting distance and poverty.
- Time: taking the time to find out what the problems are and placing them firmly on the global agenda.
- Patience: understanding the magnitude of disadvantage and the entrenchment of barriers for so many women – knowing these problems cannot be solved quickly.
- Compassion: caring enough to actually do something. Not giving up.

- Honesty. Acknowledging the myriad cultural, religious, historical, political, social and economic problems that, even in the 21st century, continue to disadvantage women.

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#### About the author

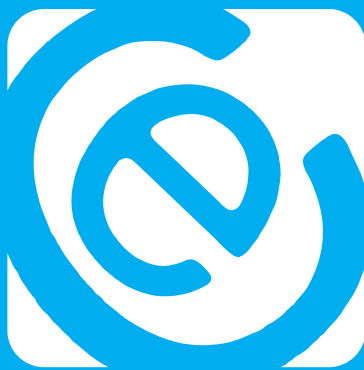
Emma Macdonald is a senior journalist with the *Canberra Times*. She has won numerous awards for her reportage, including two Walkley Awards, the John Douglas Pringle Award for Journalism and a Vincent Fairfax Ethics in Leadership Fellowship. She writes on social, education and political issues.

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# Compare and contrast



**Dr Jennifer Weishaupt**  
O and G Registrar  
Nepean Hospital, NSW

The day in the life of a maternity ward: factors influencing perinatal mortality in rural South Africa and Western Australia.

The perinatal mortality rate (PNMR) is the most sensitive indicator of obstetric care. For developed countries such as Australia, in particular, Western Australia, the rate for babies over 1000g is usually less than six per 1000 births. For developing countries, as is the case for South Africa, the

PNMR ranges from 30–200 per 1000, a much higher rate which paints a very different picture.

I have been very fortunate in my medical career to have been given the opportunity to work in both a developing country, South Africa, where I grew up and studied medicine, and a first-world country, Australia, where I currently work as a registrar in O and G. In my practice I can appreciate that a maternity ward is not simply a machine where the outcomes can be predicted from the input. Obstetric care is, rather, a complex adaptive system where outcomes or the 'output' can be unpredictable and in different hospitals, especially in rural areas, the same inputs might have completely different outcomes. Hence, changing the health system so the quality of care can be improved is a complex intervention, particularly in obstetrics where the obvious differences in perinatal mortality rates are so unmistakably contrasted in the environments where I have worked.

This article aims to share my unique experiences in comparing the two rural hospitals' maternity profiles from 2008: Bethal Hospital, Mpumalanga, a district hospital in South Africa; and Bunbury Hospital, a similarly sized regional hospital in Western Australia. The comparable directorates are those components that highlight areas addressed in the everyday happenings a maternity ward, such as equipment and staffing. The second component is to compare and extrapolate already published perinatal mortality rates and literature of South Africa and Western Australia. Stillbirths and neonatal death rates were also analysed as well as causes of weight-specific mortality rates comparing these differences in a first- and third-world setting.

The World Health Organisation (WHO) definition differs significantly from the Australian definition of the perinatal period. Therefore Australian data include babies of at least 400g (or at least 20 weeks if birthweight is unavailable) while the WHO definition commences at 500g (22 weeks if birthweight is unavailable). In addition, the WHO defines perinatal deaths as less than seven days (defined as 'early neonatal period' in Australia) while Australia includes deaths up to 28 days. Perinatal mortality rates of Aboriginal and Torres Strait Islander babies of Australia are therefore not comparable to rates for Indigenous populations in the other countries, such as South Africa. Owing to the well-documented discrepancies of PNMR, international comparisons are difficult to analyse, as demonstrated by this article.

The PNMR is nonetheless an important and unique health status indicator, since it addresses the two related issues of late fetal deaths and early infant deaths, many of which are considered preventable. In South Africa, in 2008, there were 1 836 439 births (DHIS data 2010) and 64 883 perinatal deaths (PPIP database), giving South Africa a perinatal mortality rate of 35.3. Among the babies born in 2008 in Western Australia, there were 30 234 births, 224 stillbirths and 57 neonatal deaths, providing a perinatal mortality rate of 9.2 (20 weeks and more) per 1000 total births.

The perinatal mortality rate above is calculated by birthweight of >500g, which gives a figure of 6.0 for Western Australia by WHO, whereas it is 9.2 when calculated by Australian definition of >20 weeks. The perinatal mortality rate in 2008 for babies with Indigenous mothers in Western Australia was 19.0 per 1000 total births compared with the rate of 8.6 per 1000 total births for babies with non-Indigenous mothers.

In Western Australia a neonatal death (the death of a live-born baby during the first 28 days of life) is more likely to occur before the end of the first day of life. In 2008, 43.9 per cent of neonatal deaths occurred in babies aged less than one day. Among the neonatal deaths whose final neonatal cause of death was related to immaturity, the most common diagnoses were extreme immaturity and hyaline membrane disease and among those with hypoxia the

Table 1. Comparing PNMR in South Africa and Western Australia in 2008.

Perinatal Mortality rate/1000	South Africa	WA
All: >500g (WHO)	35.3	6.0 (9.2 > 20 weeks)
<500g	No data	3.3
500 – 999g	714.4	1.98
1000 – 1499g	327.9	0.628
1500 – 1999g	138.42	0.562
2000 – 2499g	49.6	0.562
2500g+	12.0	2.27

Table 2. Neonatal mortality rates per weight category in 2008.

Neonatal mortality rate/1000	South Africa <7 days	WA <28 days
Total > 500g	126.62	1.6 (1.9 > 20 weeks)
< 500g	No data	1.23
500 – 999g	438.1	2.63
1000 – 1499g	132.4	1.05
1500 – 1999g	48.0	0.88
2000 – 2499g	10.6	0.88
2500g+	4.0	3.3

common diagnosis was hypoxic ischaemic encephalopathy and meconium aspiration.

South African neonatal death statistics detail the probable avoidable factors related to early neonatal deaths. In early neonatal deaths due to immaturity, administrative factors were the most common, with lack of facilities, transport and staff featuring prominently. In early neonatal deaths due to hypoxia, the skill of the healthcare provider recorded the highest numbers of probably avoidable factors, almost three times those of healthcare provider-related deaths due to immaturity. Lack of skills seems to be the major problem associated with these deaths.

The prevalence of stillbirth is on average three times greater in the less developed areas of the world than in the more developed areas.<sup>3</sup> In Western Australia in 2008, the two major primary causes principal of fetal deaths were extremely low birth weight (<1000g) 33.9 per cent and lethal birth defect, 28 per cent. In Australia, the stillbirth rate in 2008 was 7.3 per 1000 live births and in South Africa, just over three times this at 22.3 per cent. There are three principal obstetric causes of stillbirths identified in South Africa. Most perinatal deaths in South Africa fall into the category unexplained stillbirths (22 per cent). The second most common primary obstetric cause of death is spontaneous preterm birth (53 per cent being less than 1000g). The third most common cause is intrapartum asphyxia (labour related asphyxia, meconium aspiration and cord around neck) and birth trauma.

Extrapolating the data, the highest fetal death/stillbirth rate in Western Australia in 2008 was in the teaching hospital (22.7 per 1000 live births). The referral of mothers in Western Australia with a high-risk pregnancy and/or known stillbirths is illustrated by the fact that nearly two-thirds of fetal deaths (63.4 per cent) were delivered in the metropolitan teaching hospitals. In South Africa in 2008, the PNMRs are low in the Community Health Centres 10.41 per 1000 births (1500 perinatal deaths), which suggests the referral system is working reasonably well. The high rates at the tertiary level in South Africa may also be because the sickest patients end up there, as in Western Australia. However, in South Africa some of these hospitals also function as regional hospitals when there are no regional hospitals in the area.

Complications of hypertension and antepartum haemorrhage are the next two categories that still feature as mortality factors in South Africa. With regards to antepartum haemorrhages, 80 per cent were classified as abruptio, the rest being due to placenta praevia, seven per cent, antepartum haemorrhage of unknown origin, nine per cent and the remained as unspecified antepartum haemorrhage

Table 3. Stillbirth rate per weight category in 2008.

Stillbirth rate/1000	South Africa	Western Australia
Total >500g	22.3	4.3 (7.3 > 20 weeks)
<500g	No data	4.11
500 – 999g	685	2.01
1000 – 1499g	226	0.58
1500 – 1999g	96	0.54
2000 – 2499g	39.53	0.54
2500g+	8	2.23

at four per cent. If both pre-eclampsia/eclampsia and abruptio placenta are combined the proportion of perinatal deaths is 22.8 per cent, becoming the most prominent cause of perinatal deaths in South Africa.

### Recommendations

Implementation of national standard perinatal mortality audit programs aimed at improving the quality of care could substantially reduce perinatal mortality in all settings. Some hospitals in South Africa only complete the first section of PPIP, i.e. the number of births and deaths per birth weight category and do not complete the causes of death or avoidable factors sections. Tools have now been developed and produced for the audit of the quality of care, protocols of management and accreditation of services in Southern Africa. The care of the mother – antenatally, intrapartum, postnatally – and of the newborn infant have been shown to be mutually complementary and should be dealt with together as a continuum in any intervention. Better data on numbers and causes of perinatal mortality are needed, and international consensus on definition and classification related to stillbirth and perinatal mortality rates is a priority. All parents should be offered a thorough investigation, including high-quality autopsy and placental histopathology. The proportion of unexplained stillbirths associated with under investigation continues to impede the efforts in stillbirth prevention.

Culturally appropriate preconception care and quality antenatal care that is accessible to all women has the potential to reduce stillbirth rates for both countries. Obesity and smoking are important modifiable risk factors for stillbirths in Australia, and advanced maternal age is also an increasingly prevalent risk factor in both countries.

Problems of the quality of care during childbirth in South Africa and for the immature or hypoxic neonates are the areas where most preventable deaths occur. In South Africa, problems for which there are interventions that can improve the outcome for perinatal mortality are: the recognition and management of preterm labour, hypertension and intrapartum hypoxia. For newborn babies, the major interventions that can improve the outcomes are: the care of the small and sick baby, and resuscitation of the newborn. Avoidable factors show there is a problem in the care given by medical personnel in all aspects of care from the antenatal clinic to postnatal and newborn care. In some instances it has been identified that there are insufficient staff

Table 4. Perinatal mortality causes in 2008.

Perinatal mortality cause	South Africa	Western Australia
Unexplained stillbirth	22%	21%
Spontaneous preterm birth, low and extremely low birth weight, IUGR	23%	36.25%
Intrapartum asphyxia and birth trauma	16%	3.5%
Hypertension	14%	0%
Antepartum haemorrhage	11%	0%
Fetal abnormalities	4%	35%
Infections	5%	1.35%
Pre existing medical condition	2%	0%
No obstetric cause found	3%	1.8%



Table 5. Comparing maternity and hospital facilities in a district/regional hospital in South Africa and Australia in 2011.

Maternity and hospital facilities	Bethal Hospital, Mpumalanga, South Africa	Bunbury Hospital, WA
Background	Public Hospital 175km from Johannesburg, Gauteng	Public Hospital 175km from Perth, WA
Total deliveries	1329	830
Total beds	288: 80% occupancy	134: 91% occupancy
Maternity ward	17 maternity beds, 3 delivery beds	10 Maternity beds, 3 delivery suites
Medical staff	1 consultant O and G, 1 senior house officer (O and G), 1 senior house officer (paediatrics), no anaethetists (senior house officer)	6 consultant O and Gs, 8 GP obstetricians, 3 O and G registrars, 1 O and G resident, 1 paediatric resident, 4 paediatricians, 8 anaethetists
Laboratory	Offsite – 70km away	Onsite – weekdays (0700-0030), weekends (0700-2230)
Blood bank	Offsite – 20km away (2 units emergency blood onsite)	Onsite – emergency blood available
CTG machine	1 (currently broken)	4
Antenatal clinic and theatre	1 high-risk clinic per week, 2 antenatal (doctor) clinics per week – walk in, 2 theatre days/week	2 high risk clinics per week, 1 (midwife clinic/shared care) per week – appointment only, 5 theatre days/week

on duty, and that they are not adequately trained to manage the patients delaying timely interventions.

Placental pathology and infection is recognised for the first time as being the most important contributor to perinatal death in South Africa. Placenta/placenta bed diseases are also associated with preterm birth and are a recognisable link to a substantial proportion of stillbirths in Western Australia. Large disparities (linked to disadvantages such as poverty) in stillbirth rates need to be addressed by providing more educational opportunities and improving living conditions for disadvantaged women in both South Africa and Australia.

### Conclusion

Changing the health system, and more so maternity care, so that the quality of care can be improved is a complex process. One can presume that once avoidable and modifiable factors have been

identified and made well known there will be a self-correction with a consequent reduction in perinatal mortality. Recommendations alone do not bring about change, they need to be implemented. An audit or literature review is not necessarily going to change practice, it is clinical care that needs to improve and once we change people we can implement change in practice.

### Acknowledgements

I wish to thank Bunbury Hospital in Western Australia and Bethal Hospital in South Africa for their support and contribution to this article.

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- 3 www.who.int .

Table 6. Comparing neonatal facilities in a district/regional Hospital in South Africa and Australia in 2011.

Neonatal facilities and equipment	Bethal Hospital, Mpumalanga South Africa	Bunbury Hospital, WA
Level of nursery	1	2
Incubators	3	4
Resuscitation beds (open care neonatal systems)	1 (limited – kept in delivery room)	2 (extra 3 in delivery suites)
Neonatal ventilator	0	1
Controlled heated respiratory humidifier	0	1
Warmer	1	2 (plus 1 infant control warmer)
Monitors	0	3
Pulse oximeter	0	2
Phototherapy units	1	2
Blood gas machine	0	1 (in A&E), plus 1 lactate machine
Resuscitation trolley	1 (in delivery suite, not neonate specific)	1 (in the nursery – neonate specific)
Call bells-code blue/assist	0	4

# RANZCOG

## Honours and Awards



### Call for Nominations: Closing Date 30 June 2013

College Fellows are invited to submit nominations for the awards of Honorary Fellowship, Distinguished Service Medal and Certificate of Meritorious Service for consideration of the RANZCOG Honours Committee and Council in July 2013. Information on the categories of College awards is as follows.

#### 1. Honorary Fellowship

- 1.1 Medical practitioners, not already FRANZCOG, who have made an outstanding contribution to the study or practice of medicine in the field of women's health. In general this honour should be reserved for those who have not had their contribution otherwise recognised.
- 1.2 Persons who are not medical practitioners who have made an outstanding contribution to the study or practice of medicine in the field of women's health. In general this honour should be reserved for those who have not had their contribution otherwise recognised.
- 1.3 Fellows of renown of other Medical Colleges.
- 1.4 Persons who are not medical practitioners who have made an outstanding contribution to the work of the College.
- 1.5 The nominee must have made a contribution in a field related to women's health over and above that of his/her recognised peers in the field.

Honorary Fellowship is to be bestowed by Council on recommendation by the Honours Committee.

Honorary Fellows are not required to pay a registration fee or annual subscription and are not required to undertake continuing professional development. They are entitled to receive College publications.

Members or Associate Members of the College may be awarded Honorary Fellowship.

#### 2. President's Medal

This should generally be awarded once per Council term toward the end of that term, but there may be more than one recipient under exceptional circumstances. It is awarded to Fellows of the College who have made an outstanding contribution to the work of the College. Nominations for this medal are made by the President. It is awarded by Council on recommendation by the President and Honours Committee.

#### 3. Distinguished Service Medal

This is awarded to Fellows of the College who have made a significant contribution to College work. This may be a more frequent award than the President's medal. It is awarded by Council on recommendation by the President and Honours Committee. Awarding of a Distinguished Service Medal does not preclude awarding of a President's medal at a later date.

#### 4. Certificate of Meritorious Service

This is awarded to persons other than Fellows of the College who have made a significant contribution to College work. It is awarded by Council on recommendation by the Honours Committee.

#### Process for Nomination

- Nominations for Honorary Fellowship, RANZCOG Distinguished Service Medal or RANZCOG Certificate of Meritorious Service must be made by a Fellow of the College, and submitted in writing to the President by **30 June 2013**.
- Nominations must be kept confidential.
- Nominations must include full details of the reason for the nomination and a curriculum vitae.
- Nominations must be seconded by a detailed letter of support from another Fellow of the College.
- Either the nominator or the seconder must be a Councillor or a Regional Committee Chair.
- The decision of the Honours Committee is final and no further correspondence will be entered into.

For further information on the nomination and evaluation process, please contact:

Penelope Griffiths, Director, Corporate Services, ph: +61 3 9251 9030 or 9417 1699; fax: +61 3 9419 0672;  
email: [pgriffiths@ranzcog.edu.au](mailto:pgriffiths@ranzcog.edu.au) .

# Banana wine and cross dressing



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The story of performing caesarean section in 19th-century Africa has some surprising twists and turns.

Although exact records are lacking, it has been widely accepted in relevant literature that at some time between 1815 and 1821 a caesarean section operation was performed in Cape Town, South Africa, by a British military surgeon, Dr James Barry. While the date of this procedure is uncertain, the name of the infant, James

Barry Munnik, is well documented, the child being named for the surgeon. It has been further claimed that this was the first successful caesarean section in Africa – successful in that both mother and child survived – and also the first such successful caesarean performed by a British doctor.

Yet, while details of the operation are scant, the surgeon has received a great deal of attention in recent years. For it has also been claimed that 'Dr James Barry' was actually a woman, and was therefore the first British woman to become a qualified medical doctor.

The person who later became known as Dr James Barry was born to Jeremiah and Mary-Ann Bulkley, probably in 1789, in Ireland. At the time of birth it appears the child was known as Margaret Ann Bulkley. Mary-Ann Bulkley's maiden name was Barry, and her brother, James Barry was a well-known portrait painter at the time. In 1809, Margaret and Mary-Ann Bulkley travelled by sea to Edinburgh; from this point on no record exists of Margaret Bulkley, but a young (apparently male) James Barry was enrolled in the

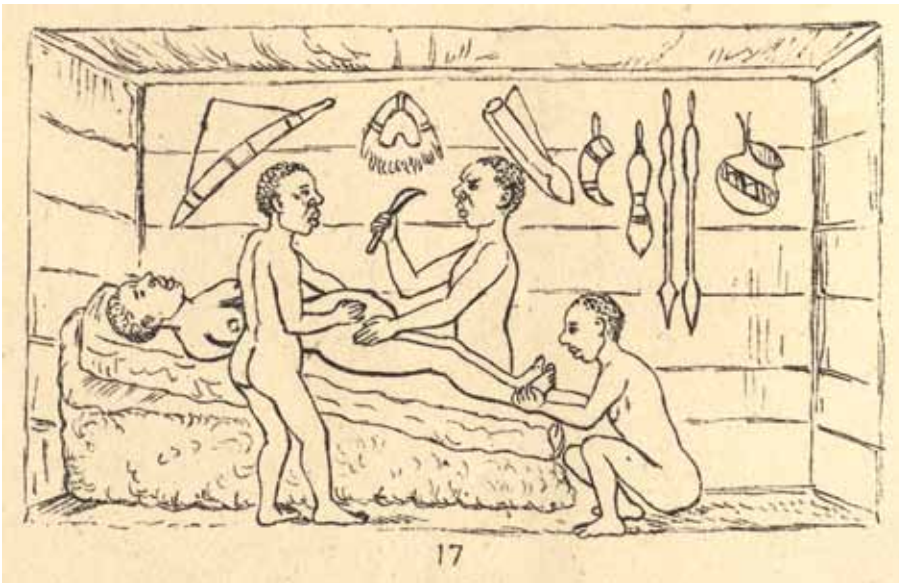
medical school of the University of Edinburgh later in 1809. James received his medical degree in 1812, and moved to London, becoming a pupil at both Guy's and St Thomas's hospitals, and successfully passing the examinations of the Royal College of Surgeons of England in 1813.

Later in 1813, Dr James Barry joined the British Army, serving first in South Africa. At some time between 1815 and 1817 he arrived in Cape Town, where he is said to have improved the water system as well as conditions both for wounded soldiers and for 'the native population'. He continued his medical career in the army until 1864, serving in Malta, Canada, the West Indies and during the Crimean War, and was frequently noted for his concern for the poor and suffering who came under his care. Throughout his time in the army, he was always accepted, and identified himself, as a man. Although his achievements in public health and medical administration were well recognised, it was also said that he could be impatient and tactless, and that he had a tendency to meddle in local politics, and it is known that he fought at least two duels.

Retiring from the service in 1864, he died in 1865 of dysentery, at which point the charwoman employed to wash his body after death reported to the Registrar of Deaths that the body was that of 'a perfect female'. Informed of this, the Army sealed the records for 100 years. In the mid 20th century, historians gained access to these records and there have been a number of biographies, plays and television documentaries on the subject of Dr James Barry. There have been claims that Barry was a normal female who had to disguise her gender in order to enter medical school, and was therefore the first British woman doctor. However, it seems more likely that James Barry had some form of intersex condition, and chose in his teenage years to identify as male.

But was the birth of James Barry Munnik really 'the first successful caesarean section in Africa'? There is in fact some evidence to suggest the original inhabitants of that great continent may have worked out the benefits and techniques of the operation well before more 'civilised' European practitioners.

In 1884, in the *Edinburgh Medical Journal*, Dr RW Felkin described at length an operation he had witnessed in Uganda in 1879, performed by 'a native surgeon'. The patient was a 20-year-old primipara in obstructed labour who, in the absence of the more conventional methods of anaesthesia by then widely used in Europe, was 'reduced to a state of semi-intoxication' by a large dose of banana wine. She was then tied to her bed with bands of cloth over her legs and chest, while an assistant held her feet. The surgeon, who would seem to have



Caesarean section being performed in Kahura, Uganda, as described by Felkin.



possessed more understanding of the principles of antiseptics than being promulgated by Joseph Lister than did many of Lister's own colleagues, proceeded to paint the woman's abdomen and wash his own hands with more of the banana wine.

He then made a rapid midline incision from umbilicus to symphysis, through the full thickness of the abdominal wall and part of the anterior surface of the uterus. Bleeding was dealt with by the cautious application of a red-hot iron to spurting vessels. The uterine incision was extended, the child extracted, in good condition, the cord cut, and placenta and blood clot removed manually. Uterine massage caused the organ to contract well and the iron was applied to deal with further minor bleeding. The uterine incision was not sutured but a 'porous grass mat' was placed over it and the woman turned on her front so that fluid could drain from the abdominal cavity.

Some short time later the woman was turned on to her back, the mat removed and 'the edges of the abdominal wound brought into close apposition, seven thin iron spikes, well-polished and resembling acu-pressure needles, being used for the purpose and fastened by a string made from bark cloth.' The wound was dressed with a concoction made from plant roots and firmly bound with a cloth. The woman, said Felkin, 'stood the operation in silence until the pins were placed.' Post-operatively the dressings were changed on alternate days and the pins gradually removed. There was very slight post-operative fever which quickly settled, the wound was well healed by day 11, and the patient appeared to have made an excellent recovery.

The first successful caesarean operation performed in Europe is widely acknowledged as being the caesarean hysterectomy performed by Edouardo Porro in Padua in 1876, both mother and

child surviving. Successful classical caesareans were first reported from Germany by Sanger and Kehrler around 1882. While by 1879 ether and chloroform anaesthesia were being extensively used in European and North American surgical procedures, there was still widespread scepticism about the practices of antiseptics and asepsis. So while the 'native surgeon' Felkin observed may have learned a certain amount about avant-garde European practice from missionary doctors, it would seem from the timing and details of Felkin's description that African practitioners had very likely developed their techniques of abdominal delivery quite independently, and much earlier than in Europe. Felkin himself concluded that these techniques had been employed for a very long time. Similar reports have come from Rwanda, where botanical preparations were used to anaesthetise the patient and promote wound healing.

So it seems that the identity of the original person to perform 'the first successful caesarean section in Africa' must remain unknown.

#### Acknowledgement

I would like to thank Ms Cheryl Brooking who first told me about the extraordinary life of James Barry.

#### Further reading

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# The Trainee's dilemma

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Consider a hypothetical situation: a level-three registrar in obstetrics and gynaecology telephones the on-call consultant for after-hours advice. The consultant is obviously inebriated. How should the Trainee handle such a situation?

## The legal perspective

Trainees are certainly placed in an awkward position when they call in a consultant (after hours) who is obviously affected by alcohol. Because of the high duty of care owed to a patient (both morally and at law), the safety and well-being of patients should be every medical practitioner's first priority, regardless of their seniority. In the case where a Trainee is presented with a consultant who is clearly intoxicated, it is in the best interests of the patient, the Trainee, their employer and the consultant, to send the consultant away, and endeavour to find another suitable medical practitioner to assist. A response of this nature is critical to avoid allegations of negligence and breach of professional duty by the Trainee.

'It is...conduct that could be reported to AHPRA, and is certainly a matter that should be reported to the hospital/employer.'

If the consultant refuses, or if further assistance is not available, the matter should be brought to the attention of the hospital/employer as soon as possible, and the matter escalated quickly through appropriate management channels. Every hospital should have clear procedures for escalation of issues of this nature.

The Trainee will have an obligation to their hospital/employer to follow these policies and endeavour to take steps to remedy the situation as best they can. Further, a consultant practising medicine while intoxicated or under the influence of alcohol or drugs is notifiable conduct under the mandatory reporting requirements of the National Law for Regulation of health practitioners.

Where the Trainee has successfully sent the consultant away, mandatory reporting may not arise. It only becomes relevant if the Trainee reasonably believes that the consultant has '**practised**' whilst intoxicated by alcohol or drugs'. If the consultant leaves, the requirement for mandatory reporting may be avoided. It is, nonetheless, conduct that could be reported to AHPRA, and is certainly a matter that should be reported to the hospital/employer.

Where a notification to AHPRA is made in good faith under the National Law, a Trainee will be protected by the indemnity provisions and will not be exposed to penalties that could be applied by any civil, criminal or administrative law process. The National Law also provides that notifications made in good faith cannot give rise to defamation proceedings, and will not be considered a breach of professional ethics.

If the consultant has practised while intoxicated (and therefore has not agreed to be sent away), the Trainee will be under an obligation

to make a mandatory report, or convince the hospital/employer to make a mandatory report – and failure to make a mandatory report may itself constitute a breach of professional obligations under the National Law.

It would also be appropriate for the Trainee to prepare a written report on all that occurred. This would be appropriate if only for the Trainee's own records, if not to constitute an appropriate report to the hospital/employer.

From a practical point of view, a Trainee who deals with an intoxicated consultant should raise the issue as soon as possible with a member of management on duty. This can help manage the incident in the short term, ensure that the consultant is not exposed to patients and help to ensure that the consultant gets home safely.

## The consultant's perspective

The foremost consideration in such a situation is the safety of the patients at present under the care of the registrar. A third-year Trainee should have already developed reasonable O and G skills, though will not be functioning at consultant level yet. It is imperative that further consultant cover be sought urgently. If it is an emergency situation, requiring consultant input, then the registrar should ring another obstetrician to seek help. They should explain the situation in general terms to the alternative consultant, and ask them if they are able to provide continuing back-up and assistance.

If there is no other consultant obstetric help available, the registrar must notify the Director of Medical Services, or their representative on call, and notify them of the situation, as it may be necessary to put the hospital on 'bypass' for O and G care, until back-up consultant cover is obtained.

'The consultant who was drunk may be a serial offender, and thus pose a significant risk to patients...prompt recognition and management of such a problem is vital.'

The registrar needs to ensure that there is adequate documentation about the situation, and should seek help from medical administration in the hospital, or from a medical defence organisation about mandatory reporting obligations under National Law. Ideally, the registrar should seek a meeting with the consultant on his/her return to work, and discuss the situation, and request an explanation. This is clearly something that many registrars would find confronting and difficult to do. The consultant who was drunk may be a serial offender, and thus pose a significant risk to patients and the people s/he is supposed to be overseeing. Prompt recognition and management of such a problem is vital.

# Photographs, x-rays, medical images and privacy



Michael Gorton AM  
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Clinicians need to ensure there is a documented record of consent when taking photographs of a patient.

In our current digital era, we have increasing access to instant, easy recording of images through mobile phones, as well as other digital media. The medical field is no exception. It is therefore important to recognise that there is no general right for medical practitioners to use

patient photographs, x-rays or other visual images, whether for education, research or otherwise.

Current privacy legislation introduces a set of ten National Privacy Principles, which establish the minimum standards for handling of personal information. Clinicians may be liable for fines of up to \$100 000 if they store or distribute clinical photos incorrectly. A medical practitioner can only use or disclose health information for the purpose for which it was collected, unless the individual's consent has been obtained – and not doing so may have serious consequences. (Recent research undertaken at a Melbourne hospital\* found that only a quarter of doctors surveyed had obtained appropriate patient permission to obtain clinical images.)

Use of clinical images for other purposes, such as education, without consent from a patient not only works against a sense of confidentiality for the patient, but may also have severe legal ramifications. Several recent cases illustrate this:

- An investigation has been carried out in Western Australia in relation to breach of patient confidentiality, after a newspaper published a photograph, obtained from a hospital's internal website, of a patient being treated at that hospital.
- A chief resident of general surgery at a US hospital faces disciplinary proceedings after taking photos of a patient's tattoo, using his mobile phone.
- An apocryphal story tells the tale of a surgeon who objected, when his colleague included x-rays in his PowerPoint® presentation at an educational conference, that used x-rays of the first surgeon without his consent. The surgeon giving the presentation was the treating surgeon.

Property of medical imagery is different to that of normal documents – the right of ownership of these images is also accompanied by a duty of confidence. Taking or recording an image does not necessarily mean ownership of the image either – in the public sector these photographs may become both the property and responsibility of the hospital.

These obligations are not necessarily new. Doctors have always had an obligation to maintain confidentiality in relation to patients

and patient information. A breach of privacy or confidentiality can also lead to a complaint of professional misconduct, and potential disciplinary proceedings before medical boards and authorities.

Photographs and other medical imagery can be used for many useful purposes, and are included in patient records as an addition to clinical care – and may be displayed to colleagues, trainees and others for treatment purposes. However, any use beyond the treatment of the patient runs the risk of a breach of privacy. A breach of privacy or confidentiality can lead to a complaint of professional misconduct, and potential disciplinary proceedings before medical boards and authorities.

'...the right of ownership of these images is also accompanied by a duty of confidence...in the public sector these photographs may become both the property and responsibility of the hospital.'

As technology improves into the future, clinical photography will also increase. It is important to be aware of the ramifications and consequences of using this imagery – and mobile apps such as the recently released PicSafe aim to guide medical practitioners in the safe usage and storage of such files.

It is also crucial to remember to gain the patient's consent before the images are used. The patient's consent should be recorded, and what the images will be used or potentially used for should be discussed with the patient. It is also acceptable under privacy legislation for a medical practitioner to have a Privacy Statement or privacy consent document (either signed by or given to the patient) that indicates that images may be used for research, training and education purposes – and allowing the patient to 'opt out' from this by indicating that such permission is not given. Practitioners operating in hospital environments should check their hospital's Privacy Statement or consent document to determine the extent of consent encompassed within these documents.

(\*Research conducted by Dr David Hunter-Smith in the Department of Surgery at Peninsula Health found that only a quarter of doctors surveyed had obtained appropriate patient consent to take clinical images.)

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# Accessory breast tissue



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This article presents the case of a pregnant patient who experienced significant discomfort from her previously inconspicuous axillary accessory breast tissue and reviews the aetiology and management of such presentations.

Accessory breast tissue – the presence of a nipple, areola or glandular tissue in addition to the normal pair of breasts – is an uncommon, but potentially painful and embarrassing, condition.

A 31-year-old Asian woman, gravida one para zero, booked into the antenatal clinic at 31 weeks gestation, having recently relocated to the area. She had an uncomplicated antenatal course, but was concerned about accessory breast tissue developing under her arms.

The patient had noticed this tissue as pale, bilateral axillary lumps when she was a teenager. She researched these herself, concluding that they were accessory nipples. She experienced mild, intermittent tenderness in association with some periods, but they did not otherwise concern her. However, at eight weeks gestation the patient noticed swelling under and around the nipples. As her pregnancy progressed, the accessory areolae darkened and breast tissue increased significantly in size and tenderness (see Figure 1).

The woman had a routine post-dates induction of labour at 41 weeks plus five days and proceeded to a vacuum delivery (for prolonged second stage of labour) of a healthy 3170g baby girl.

The woman had attended breastfeeding classes antenatally and was reviewed by the lactation consultant following delivery. She was advised not to stimulate the accessory breasts, as that may encourage milk production in them.

The woman was discharged home on day two postpartum, breastfeeding well. On day four, she complained of pain and swelling in her axillae, with milk leaking from her accessory nipples. She was advised to use ice packs and simple analgesia. The pain subsided after one week, however she continued to have one teaspoon of milk leak from each accessory breast, each feed. At the time of writing, her daughter was seven weeks old and continuing to breastfeed well. Unfortunately, the leakage from the patient's accessory breasts persisted.

The swelling, discomfort and lactation associated with her axillary polymastia have had a significant impact on the woman's quality of life. She is determined to have the accessory tissue removed prior to future pregnancies.

## Classification

Accessory breast tissue presents in many forms, from inconspicuous accessory nipples to fully formed and functioning supernumerary breasts. Classification has historically been according to the classes



*Figure 1. The patient at 41 weeks gestation, with significant polymastia.*



developed by Kajava (1915)<sup>1</sup> (see Table 2). However, authors more recently have adopted a simplified system, dividing accessory breast tissue into the following:

- Polymastia: glandular breast tissue in an organised ductal system, communicating with overlying skin.
- Polythelia: accessory nipples and/or areolae. The presence of an areola only or patch of hair only may be further categorised as polythelia areolaris and polythelia pilosa, respectively.
- Aberrant breast tissue: disorganised secretory tissue, unrelated to the overlying skin.<sup>2</sup>

Polythelia is the most common congenital breast abnormality, with an incidence of between two and ten per cent in the general population.<sup>3</sup> It is found more commonly in Native American<sup>4</sup> and Asian populations<sup>2</sup> and less frequently among Caucasians.<sup>3</sup> It is equally found in males and females.<sup>2</sup>

Polymastia is less common, with an incidence of 0.22 to six per cent in the general population.<sup>5</sup> Again, it is more common in Asian populations (particularly the Japanese)<sup>6</sup> and occurs in less than two per cent of Caucasians.<sup>7</sup> It is twice as common in females as in males.<sup>8</sup> Polymastia occurs bilaterally in one-third of affected persons and, if unilateral, is located on the right in 64 per cent of cases.<sup>9</sup>

### Aetiology

During the fifth week of gestation a thickening of ectoderm, known as the mammary ridge, appears on the ventral surface of the embryo. It correlates to a line from the axilla to the groin, called the milk line (see Figure 2). The mammary ridge regresses over

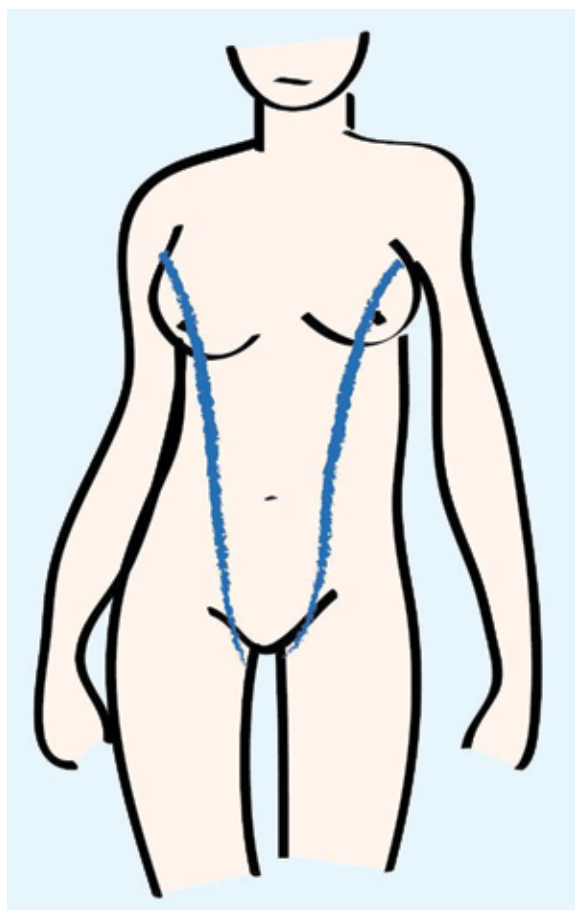


Figure 2. The milk line.

the following months, with the exception of paired tissue on the anterior chest, which forms normal, pectoral breasts. Failure of this regression may result in accessory breast tissue.<sup>10</sup>

Accessory breast tissue may occur at any point along the milk line. Polymastia is most commonly found in the axilla (with an incidence of 60–70 per cent), as it did in the case above. However, it also occurs in the sternal region and on the vulva.<sup>8</sup> Polythelia most frequently occurs in the sternal region.<sup>11</sup> Very rarely, accessory breast tissue may occur outside of the milk line, a phenomenon known as *mammas erratae*. Cases have been reported on the buttocks, neck, face, arms, hips and back.<sup>10</sup>

There appears to be some genetic contribution to accessory breast tissue, likely through heterogeneous inheritance, with ten per cent of patients having an affected family member.<sup>5</sup>

### Diagnosis

Accessory breast tissue is often inconspicuous until puberty or even pregnancy, when hormones – oestrogens, progesterones, prolactin and human placental lactogen, in particular – affect accessory breast tissue in the same way as in normal breast tissue. This may lead to development of the tissue, pain (especially during menstruation), restricted arm movement, cosmetic concerns, irritation from clothes and lactation.<sup>5,9</sup> Pregnancy-related symptoms often become more severe with subsequent pregnancies.<sup>6</sup>

Polymastia and (to an even greater extent) aberrant breast tissue is often misdiagnosed as a lipoma, lymphadenopathy, sebaceous cyst or hidradenitis.<sup>2,5</sup> Polythelia is commonly mistaken for a benign nevus.<sup>2</sup>

Tissue diagnosis is obviously the gold standard for accessory breast tissue. Pathologists may look for typical stroma, lobules and ducts, however these may be poorly organised in aberrant breast tissue.<sup>12,13</sup> The presence of oestrogen and/or progesterone receptors is diagnostic of breast tissue.<sup>14</sup>

### Complications

Accessory breast tissue is susceptible to the same disease processes as normal breast tissue, including malignancies, benign cysts, fibroadenomas (which often occur in conjunction with fibroadenomas in the normal breasts) and mastitis.<sup>10</sup>

The incidence of malignancies in accessory breasts has been reported as higher than that in pectoral breasts and accounts for 0.2–0.6 per cent of all breast cancers.<sup>7,13</sup> Authors have suggested this increased incidence may be due to 'stagnation' in the ducts. Ductal cancer is the most common type of accessory breast cancer, with infiltrating ductal cancer representing 79 per cent of accessory breast malignancies. Medullary cancer, lobular cancer and Paget's Disease also occur. The axilla is the most common site for accessory breast malignancies, accounting for 55–91 per cent of presentations.<sup>13</sup>

Women with accessory breasts should have them screened for malignancies, along with their normal breasts.<sup>14</sup> While mammography does not usually pick up axillary accessory breast tissue, oblique and 'exaggerated craniocaudal' views may achieve satisfactory images. On mammogram, accessory breasts have the same appearance as normal breast tissue, but are separate from the pectoral breasts. Similarly, accessory breast tissue appears the same as normal breast tissue on ultrasound.<sup>15</sup>

Although data are limited, accessory breast cancer appears to have a poorer prognosis than cancer in pectoral breasts. Authors have theorised that this is because the cancer metastasises to lymph nodes more frequently and rapidly than that in regular breast tissue.<sup>16</sup> However, others have suggested that the poorer outcomes are due to delayed diagnosis, attributable to diagnostic difficulties (especially relating to aberrant breast tissue), plus a lack of awareness in the medical community. This is supported by the finding that prognosis in accessory breast cancer does correlate to disease stage (which is often advanced when diagnosed).<sup>15</sup>

Polythelia has been associated with renal problems (such as supernumerary kidneys and renal carcinoma) in a number of studies, with one reporting an incidence of renal defects of between one and two per cent in the general population, but 14.5 per cent in patients with accessory breast tissue.<sup>5,10</sup> However, other studies show no correlation.<sup>17,18</sup> It has also been speculated that this association is only valid for certain populations.<sup>17</sup>

There is a controversial association between accessory breast tissue and cardiovascular disorders (such as pulmonary hypertension, cardiomyopathy, hypertension and conduction disorders). Other correlations suggested in the literature – but not proven – include vertebral disease, pyloric stenosis, testicular cancer and even familial alcoholism.<sup>17</sup>

## Management

For brevity, this section of the article will focus on the management of benign axillary accessory breast tissue, rather than the management of malignancies in accessory breast tissue, which are treated in a similar manner to pectoral breast cancers.<sup>15</sup>

There is no medical indication to remove benign axillary accessory breast tissue, although there are a number of aesthetic and

pragmatic considerations.<sup>6</sup> Studies have shown that the majority of patients presenting to surgeons for treatment have cosmetic concerns, while others experience difficulties with arm movement, engorgement during menstruation or are concerned regarding the potential for malignancy.<sup>18</sup> One plastic surgeon has advocated routine pre-pubescent removal of accessory breast tissue, to avoid glandular development and its associated complications.<sup>19</sup>

As recently as 15 years ago, management of axillary accessory breast tissue was largely by gross surgical excision. One study (of operations between 1993 and 2000) found a complication rate of 39 per cent, with unsightly scarring and residual tissue being the most common complaints. On the basis of the large number of patients presenting for cosmetic reasons, the authors of the study did not recommend surgical management.<sup>9</sup>

However, other studies – and particularly those published more recently – have reported higher patient satisfaction and lower adverse events. The more recent developments in surgical management include the use of liposuction (whether alone or after surgical tissue removal), utilising elliptical incisions along tension lines to reduce scar visibility and employing minimally invasive incisions.<sup>20,21</sup> One study also advocated tissue reduction of the normal breasts at time of accessory breast removal (utilising the same incision), where patients desired this.<sup>18</sup>

In 2011, the American Society of Plastic Surgeons published an algorithm for treatment of axillary accessory breast tissue (see Table 2). It advocates a combination of surgical excision and liposuction, according to the features of the tissue.<sup>22</sup>

The patient in the case described above clearly fits into Type IV of this management algorithm and, according to recent literature, would benefit from surgical excision of the breast tissue, adjacent fat and skin, with cosmesis enhanced by the use of liposuction.

## Conclusion

Accessory breast tissue, a fairly uncommon embryological defect, may present as inconspicuous polythelia or fully-formed polymastia. The latter in particular may cause significant discomfort and embarrassment for those affected. The breast tissue is also vulnerable to the same diseases – both benign and malignant – as normal breast tissue. It is therefore important for clinicians to be mindful of accessory breast tissue when investigating masses along the milk line (and particularly in the axilla). It is also important to consider the recent improvements in surgical management of accessory breast tissue when counselling patients. It is a combination of these factors that has led the patient described to seek referral for surgical excision, prior to her next pregnancy.

Table 1. Classification of accessory breast tissue

Class - Kajava (1915) <sup>1</sup>	Contemporary nomenclature <sup>2</sup>	Tissue present		
		Glandular tissue	Areola	Nipple
I	Polymastia	Yes	Yes	Yes
II		Yes	No	Yes
III		Yes	Yes	No
IV	Aberrant breast tissue	Yes (disorganised)	No	No
V	Polythelia	No	Yes	Yes
VI		No	No	Yes
VII		No	Yes	No
VIII (patch of hair only)		No	No	No

Table 2. Treatment of axillary accessory breast tissue. Adapted from Bartsich SA, Ofodile FA (2011).<sup>22</sup>

Type	Features			Treatment
	Size	Excess skin	Distinction from normal breast	
I	Barely visible	None or little	Separate +/- central core	Direct excision without removal
II	Small mass	None or little	Contiguous	Suction lipectomy
III	Visible mass	Present	Contiguous	Suction lipectomy with skin excision
IV	Large mass	Present	Separate +/- central core	Surgical excision of tissue and skin +/- suction lipectomy

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# Letter to the editor

## Pre-eclampsia

The article by Dr Barry Walters on severe pre-eclampsia and maternal death in *O&G Magazine* Vol 15 No 1 Autumn 2013 is timely. Dr Walters rightly highlights the often unpredictable and fulminating nature of pre-eclampsia.

I believe the question of urinalysis by dipstick for proteinuria in pregnancy needs revisiting.

RANZCOG no longer recommends urine screening in uncomplicated pregnancies. However, it remains vague about whether to test the patient who has generalised oedema, but whose blood pressure is normal. I have recently been involved in the cases of two young primigravid patients who developed fulminating pre-eclampsia over a short period of time. At their antenatal visits a few days earlier both had generalised oedema. Because the blood pressure was normal, the urine was not tested for protein.

When admitted, both patients had severe hypertension and gross proteinuria. One patient died from a cerebrovascular accident. The other had a craniotomy and clot evacuation and survived, but with considerable neurological deficit.

I admit that had both patients' urine been tested for protein at their last antenatal visit the test may have been negative. We will never know. However, as Dr Walters points out, unless we use all our monitoring skills, the diagnosis of pre-eclampsia is often made too late for effective treatment. Dipstick testing of urine for protein is a simple and inexpensive test. Surely, if it saves one life or prevents a number of cases of fulminating pre-eclampsia it is worthwhile.

A/Prof John Fliegner

MD, BS, MGO, FRCS, FRCOG, FRACOG



# Q&A

*Q&A* attempts to provide balanced answers to those curly-yet-common questions in obstetrics and gynaecology for the broader *O&G Magazine* readership, including Diplomates, Trainees, medical students and other health professionals.

**Q** *A primigravid woman at 32 weeks gestation presents to the birth suite with painful regular contractions. She has presented twice previously with the same complaint and each time been determined to have a closed, non-effacing cervix, a normal CTG and has been discharged home after 24 hours of observation. At her first presentation at 28 weeks she was given two doses of betamethasone. How should her pregnancy be managed?*

**Dr Carmel Walsh**  
Principal House Officer  
**Redland Hospital**

**a**

Threatened preterm labour (TPL) is a serious complication of pregnancy and should be treated according to best practice

guidelines.<sup>1</sup> While some women who experience preterm contractions will settle spontaneously, some will continue to experience painful contractions, without cervical changes, for the remainder of their pregnancy. The management of the 'irritable uterus' represents a dilemma in management for clinicians.

Any woman presenting with painful regular contractions should be offered adequate analgesia and assessed for imminent delivery. Physical assessment of the mother, including abdominal palpation and cervical assessment via a speculum examination, vaginal examination or a transvaginal ultrasound scan for cervical length (TVCL)<sup>2</sup> should be undertaken, as well as tests such as fetal fibronectin (fFN) detection to establish the likelihood of delivery.<sup>3,4</sup> Depending on gestation and local facility guidelines, it may be appropriate to consider tocolysis and steroid cover. A number of women will not demonstrate any of the features of labour and a diagnosis of irritable uterus may be entertained.

Irritable uterine activity may commence at any stage during a pregnancy and persist for its entirety or be only a transient experience. Inflammatory conditions, such as subclinical chorioamnionitis, upper genital tract infection and urinary tract infections or pyelonephritis, may be associated with irritable contractions.<sup>5,6</sup> Likewise, gastrointestinal problems, such as gastroenteritis with vomiting and diarrhoea or even significant constipation, may also trigger uterine irritability. Assessment should include investigations for inflammatory causes, genital and cervical culture swabs. Other causes for uterine irritability include subchorionic placental bleeding. Ultrasound scan for fetal growth and well-being and examination of the placenta for evidence of concealed bleeding may be performed in conjunction with TVCL assessment.

Identification and, where possible, treatment of underlying causes of uterine irritability may allow for complete resolution. Admission to the antenatal ward for ongoing observation and assessment is often warranted. Occasionally, contractions thought to be associated with TPL or uterine irritability may be the result of pseudo-labour, a poorly understood variant of conversion disorder, often associated with anxiety and emotional disturbance.<sup>7</sup>

For women experiencing ongoing uterine irritability without any obvious cause, antenatal care can usually proceed in the normal manner. Maintenance tocolysis is not recommended for uterine irritability.<sup>8,9,10,11,12</sup> Not only have studies demonstrated that they are of questionable value in terms of prolonging the pregnancy, but it is also suggested that women with uterine irritability may demonstrate resistance to commonly used tocolytics.<sup>13</sup> Vaginal progesterone may play a role in prolonging pregnancy to 34 weeks.<sup>14,15,16,17</sup> Further analysis is still required to determine if improvement in neonatal outcomes warrants this intervention for women with irritable uterus.

Uterine irritability is associated with a higher rate of preterm delivery than the general population (although lower than for women with other preterm labour risk factors).<sup>13</sup> It is possible that a woman with ongoing irritable uterine contractions may develop preterm labour, but fail to recognise it until 'too late'. Thus the question facing clinicians revolves around how to mitigate these risks.

Administering corticosteroids for fetal lung maturity is a routine part of managing preterm labour. It has been demonstrated that a single course of corticosteroids administered after 27 weeks is as efficacious as multiple 'rescue' doses.<sup>18</sup> It could be proposed that all women presenting with contractions after 27 weeks gestation be given corticosteroids at their initial presentation, regardless of cervical assessment or likelihood of imminent delivery, in order to ensure optimal fetal lung maturity.

Infants delivered prior to 37 weeks gestation are at increased risk from group B streptococcal infection and women in preterm labour should receive antibiotic prophylaxis.<sup>1,19</sup> Antibiotic cover needs to be initiated at least hours prior to delivery in order to have the full protective effect. The key to management remains careful surveillance.

Many women will self-refer for assessment due to concerns regarding the changing nature of their 'regular' uterine irritability, suspected ruptured membranes, bleeding or altered fetal movement patterns. For women with other risk factors for preterm labour, regular TVCL measurement may be necessary and repeat fFN assessment may be warranted.

Our primigravida is almost certainly experiencing an irritable uterus. She was given corticosteroids at her first admission at 28 weeks, and evidence suggests her baby will not benefit from any further

doses. Management at this presentation should consist of analgesia and routine assessment, including CTG monitoring. She should have cervical assessment incorporating swabs for fFN, vaginal and endocervical cultures. Cervical dilatation should be checked and urine analysis performed.

If it is determined she is in labour, she will require antibiotics and possibly transfer to an appropriate facility. If the assessment does not suggest imminent delivery, she should have an ultrasound scan arranged, including TVCL. Admission to the antenatal ward may be appropriate and any possible underlying causes of uterine irritability should be identified and treated.

Her ongoing antenatal care should involve careful assessment of uterine activity and causes of uterine irritation should continue to be explored. There is no indication for prophylactic tocolysis; however, vaginal progesterone may be of benefit. Her management should include assessment of any contributing psycho-social factors, in addition to providing reassurance that her concerns are being taken seriously.

Encouragingly, many women with this presentation will continue their pregnancy to term and deliver without complications.

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**RANZCOG members are invited to submit questions, tips or interesting cases to Q&A.**

**Please send entries to Q&A @ O&G Magazine via:  
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# Journal Club



Had time to read the latest journals? Catch up on some recent O and G research by reading these mini-reviews by Dr Brett Daniels.

## Desvenlafaxine for menopausal symptoms

While hormone replacement therapy is effective in reducing the vasomotor symptoms associated with menopause, there are some women in whom oestrogen is contraindicated or who choose not to take it. For these

women non-hormonal methods of symptom control are useful. These two recent papers, a meta-analysis and a 12-month follow-up of a randomised controlled trial (RCT) both report on the efficacy of the specific serotonin and noradrenaline reuptake inhibitor on reduction of hot flushes in menopausal women.

Sun et al.<sup>1</sup> report a meta-analysis of six RCTs and concluded that desvenlafaxine at 100 or 150mg/day significantly reduced hot flushes at up to 12 months. There was no evidence of an increase in cardiovascular, cerebrovascular or hepatic toxicity associated with desvenlafaxine use. Pinkerton et al.<sup>2</sup> report a 12-month follow-up of an RCT of desvenlafaxine 100mg/day. They report that significant decreases in hot flushes and self report measures of menopausal symptoms were all significantly improved in the desvenlafaxine group compared to placebo at three, six, nine and 12 months. It can reasonably be concluded that desvenlafaxine should have a place in the armoury of treatments for menopausal vasomotor symptoms, particularly in women for whom hormone replacement is contraindicated.

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## Caesarean scar thickness and uterine rupture

The decision to attempt a trial of labour after a previous caesarean section (TOL) hinges on the balance between the likelihood of a successful vaginal delivery and the risks inherent in TOL. One such risk is that of uterine rupture, which can have catastrophic consequences for the mother and baby. The RANZCOG statement on TOL cites the risk of uterine rupture in TOL as about 6:1000 attempts. Prediction of the risk of uterine rupture prior to labour has been the subject of research with induction of labour, a short interpregnancy interval (<18 months) and more than one previous caesarean section all being associated with an increased risk of rupture.<sup>1</sup>

Ultrasound assessment of the thickness of the lower uterine segment is one method proposed to predict the risk of rupture in an individual pregnancy, with the rationale being that a thin caesarean scar is more likely to rupture than a thick one. A recent Swedish review by Valentin<sup>2</sup>, and an earlier review by Jastrow et al.<sup>3</sup> both seek to examine the utility of this method. Jastrow's analysis included 12 studies with 1834 women undergoing TOL after ultrasound measurement of the lower uterine segment. In the studies, 1121 cases of uterine scar defect were identified. There is debate on whether measurements should be of the full uterine thickness or myometrial thickness only with both measurements being associated with risk of uterine scar defect.

For scar thickness to be a practical predictor of uterine scar rupture during TOL, protocols regarding measurement technique and cutoff values need to be defined. Unfortunately, both of these questions are

not yet resolved. Jastrow et al. suggest the cutoff for full uterine thickness is between 2.0 and 3.5mm, while for myometrium only it is between 1.4 and 2.0mm. Valentin suggests the preferred measurement is the full uterine wall at 35-40 weeks, with a cutoff of 3.5mm as suggested by Rozenberg et al. in 1996.<sup>4</sup>

1. RANZCOG. 2010. College Statement C-Obs-38. Planned vaginal birth after caesarean section.
2. Valentin, L, 2013. Prediction of scar integrity and vaginal birth after caesarean delivery. *Best Practice and Research Clinical Obstetrics and Gynaecology*, 27: 285-295.
3. Jastrow N, Chaillet N, Roberge S, et al., 2010. Sonographic lower uterine segment thickness and risk of uterine scar defect: A systematic review. *JOGC*, 3: 321-327.
4. Rozenberg P, Goffinet F, Phillippe HJ, et al. 1996. Ultrasonographic measurement of the lower uterine segment to assess risk of defects of scarred uterus. *Lancet*, 347:281-284.

## Advanced maternal age and pregnancy

Data from the Australian Institute of Health and Welfare reported that, in 2010, 23 per cent of mothers were 35 years old or over, compared with 17.5 per cent in 2001, while the percentage of mothers aged 40 and over increased from 2.9 per cent to 4.1 per cent<sup>1</sup> over the same period. It still seems uncommon that institutional practices explicitly acknowledge the significance of the effect of advanced maternal age on pregnancy outcome.

The study by Kenny et al. analysed a cohort of 215 000 singleton births between 2004 and 2008 in the northwest of the UK.<sup>2</sup> Of these women, 34 000 were aged between 35 and 39, while 7000 were aged 40 or over. Obstetric outcome measures obtained from a government obstetric database were compared between the 35-39 and >39 groups, compared to the group of women aged 20-29. Comparisons were adjusted statistically for parity, ethnicity, social deprivation score and body mass index.

Women in the groups both the 35-39 year and >39 year old age groups had an increased adjusted risk ratio for a number of adverse pregnancy outcomes compared to women aged 20-29. This includes an increased risk of large for gestational age babies, macrosomic babies >4.5kg, both emergency (>39 adjusted RR=1.63 (1.54-1.73) and elective (>39 adjusted RR=2.03 (1.93-2.13) caesarean sections, preterm (>39 adjusted RR=1.24 (1.13-1.37) and very preterm delivery (>39 adjusted RR=1.24 (1.01-1.53), and stillbirth (>39 adjusted RR=1.83 (1.37-2.43). There was not an increased relative risk of small for gestational age babies or neonatal death in the older age groups.

While this study has limitations in being based on hospital records and government data and in generalisability to an Australasian setting, it has the virtue of a large dataset and robust analysis. It should be noted that the risks reported by the authors are those after adjustment for parity and socioeconomic status. It is reasonable to expect that these findings should be incorporated into decisions regarding the obstetric care of women of advanced maternal age.

1. Li Z, Zeki R, Hilder L et al. 2010. Australia's mothers and babies 2010. Australian Institute of Health and Welfare.
2. Kenny LC, Lavender T, MvNamee R, et al. 2013. Advanced maternal age and adverse pregnancy outcome: Evidence from a large contemporary cohort. *PLOS ONE*, 8 (2): 1-9.



# Introducing CPD Online

Anna Kaider  
Senior Education Coordinator

The College is introducing a new CPD Online program to allow RANZCOG Fellows to meet their continuing professional development requirements in a manner intended to maximise flexibility and effectiveness.

RANZCOG has been at the forefront of providers of continuing professional development (CPD) programs among the Australian and New Zealand medical colleges, with Fellowship linked to a mandatory program of continuing education and recertification since the College's inception. However, with recent legislative changes and changes in requirements for CPD, it is important the College ensures its CPD program continues to be able to guide and support Fellows to maintain and improve their currency of knowledge and practice, promote improved patient care and safety and meet any new regulatory requirements that are introduced. To this end, the new CPD Online program will allow RANZCOG and its Fellows to do so in a manner intended to maximise flexibility and effectiveness for individual Fellows.

## Background

During 2008, the RANZCOG CPD Committee considered developments in relation to the regulation, governance and recertification requirements associated with CPD in Australia, New Zealand and overseas. At the July 2008 meeting, the Committee endorsed the trial of a revised CPD program for RANZCOG Fellows using a two-dimensional framework based on:

- Areas of Fellows' practice (based on 'Domains' of practice from the RANZCOG Curriculum); and
- Types of activities (essentially, those that can be considered 'passive' (CPD) or 'active' (PR&CRM).

It was concluded that a revised program aligned to the RANZCOG Curriculum would enable Fellows to choose activities directly linked and relevant to their current practice and to fundamental clinical competencies, such as those described in the RANZCOG Curriculum and on which attainment of Fellowship is based. It was also considered that such a program would provide a sound framework of clinical professionalism on which to base the continued development and maintenance of knowledge, skills and abilities of Fellows that was better suited to accommodating changing professional needs than the current CPD program, which is structured around different types of activities (such as meetings attendance and self-education).

Review of the current CPD program preceding the development of the College's new CPD program also led to an examination of the ongoing use of the term Practice Review and Clinical Risk Management (PR&CRM) to define such activities, with a decision in 2012 being taken to alter the term to Practice Audit and Reflection (PAR) in the new program.

The CPD Committee has consistently remained firm in the belief that all Fellows should be required to undertake an audit activity, following the quality cycle, including a reflection component, in each three-year CPD cycle. As the term 'audit' is included in the term 'PAR', the need to include it as part of one's professional development is now explicitly stated. It was also felt that the term was easier to understand and better reflected the different types of activities that could be included in this compulsory category.

The revised program was trialled in 2010, using an online platform. Volunteer Fellows utilised the framework to identify their professional development needs and formulate a professional development plan for the 12-month pilot period that was regularly reviewed and modified as necessary. The plan was recorded using the online facility and, with ongoing modification, became the Fellows' final record of their activities at the conclusion of the trial. Recommendations stemming from this pilot program informed the development of the new CPD program.

The framework underpinning the revised program is considered well suited to enabling individual Fellows to more easily plan, identify and undertake activities across the major areas of practice associated with being a specialist O and G medical professional. This ensures professional development occurs across the wider range of skills, knowledge and attributes considered to be integral to a practising RANZCOG Fellow today. It also allows individual practitioners to identify what activities that are most relevant and important to them at a particular stage of their professional career.

## The new CPD Framework

The Framework on which the new CPD program is based directly aligns the types of activities Fellows undertake as part of their continuing professional development to the RANZCOG Curriculum, the document that underpins the RANZCOG Training Program.

The RANZCOG Curriculum was introduced in 2004, with minor revisions to ensure currency in 2009 and 2013. The document describes the key competencies expected of a specialist O and G, specifying the knowledge, skills and professional qualities required to practice effectively in a changing women's health care environment. It comprises three domains: Clinical Expertise, Academic Abilities, and Professional Qualities. These domains encompass the medical and surgical competencies fundamental to practicing obstetrics and gynaecology, as well as the wider 'professional' areas, such as teaching, leadership and ethical conduct.

The framework developed from the RANZCOG Curriculum to underpin the new CPD program acknowledges, within any area of professional practice, activities may be undertaken that are either passive in nature, related primarily to knowledge acquisition, or active in nature, related to the implementation and/or improvement of practice-related initiatives. Thus, in the new CPD program:

- Professional development (PD) activities are those associated primarily with knowledge acquisition and which encompass a broad range of activities that Fellows participate in as planned or organised activities, as well as those undertaken within the context of normal daily work. Organised events include seminars, conferences and workshops, while those that form part of 'normal' daily work can include attending meetings, teaching, mentoring/supervision and research. These activities are focused on further developing knowledge and skills within defined educational contexts.

- PAR activities are those that involve engaging in audits of clinical and medical practice, reflecting on practice and developing, implementing and reviewing action plans for improvement. Fellows may participate in activities of a PAR nature within the context of the quality assurance programs that exist in the hospital(s) in which they practice, as well as those undertaken within their own practices, such as case reviews, audits and practice visits.

For example, undertaking a patient satisfaction questionnaire project asks Fellows to review and act to improve, where necessary, their communication skills (Clinical Expertise domain), and involves soliciting and accepting constructive feedback on practice (Professional Qualities domain). Clinical audits by definition involve reviews of professional practice (Professional Qualities domain) which require the demonstration of relevant medical expertise (Clinical Expertise domain) and typically involve acquisition of new or refining of existing knowledge and/or skill (Academic Abilities domain). The RANZCOG CPD Handbook and CPD Online user guide, both available through CPD Online, provide comprehensive lists of activities and the domains within which they fit in the new CPD Framework.

Table 1 shows the new two-dimensional CPD framework, with the three domains of the RANZCOG Curriculum described further in terms of the broader knowledge and skill competencies within each domain. Examples of PD and PAR activities across these domains are listed, including those that fit within more than one domain.

Table 1. The new CPD Framework Curriculum.

Domain	Competency	Examples of activities	
		PD	PAR
CLINICAL EXPERTISE	Demonstrate medical expertise in core areas of obstetrics and gynaecology	National and regional ASMs RANZCOG-approved meetings	Clinical meetings Audits of practice Workshops (for example, Fetal Surveillance Education Program)
	Demonstrate medical expertise in core areas of surgical procedure and care	Operating and/or performing procedures with a peer Surgical simulations	Clinical meetings Surgical performance audit Surgical skills workshops
	Demonstrate medical expertise in one or more advanced areas of obstetric and gynaecological care	Operating and/or performing advanced procedures with a peer Complex surgery workshops	Clinical meetings Audits of practice
	Communicate effectively	Develop/review patient information material	Patient/peer surveys Communication workshops Consent process audit
ACADEMIC ABILITIES	Learn independently	Planned learning projects (Masters, PhD) Reviewing/publishing articles, chapters, books	RANZCOG Practice Review Worksheet Audits of practice
	Teach and communicate effectively	Performing procedures with a peer Trainee supervision/mentoring Examining at RANZCOG written and oral examinations	RANZCOG oral examinations workshop
PROFESSIONAL QUALITIES	Provide effective team management and leadership in the workplace	Business skills workshops Chairing meetings/ conference sessions Reaccreditation of training hospitals/ units Selection/assessment of ITP/SIMG/ AoN applicants	Leading guideline/protocol implementation/review
	Conduct effective reviews of professional practice	Guideline/protocol development	Clinical audits RANZCOG Practice review worksheets
	Solicit and accept constructive feedback on practice	Communication skills workshops	Patient/peer surveys Clinical audits
	Exhibit ethical attitudes and conduct	Medico-legal workshops	Medical defence organisation activities
	Show commitment to the best interests of the patient and the profession	Sexual health/domestic violence workshops RANZCOG committee work Conference organising committee work	Accreditation/reaccreditation of RANZCOG training hospitals/units

### Key elements of the new CPD program

While based on a new framework and conducted through an online facility, the requirements of the new RANZCOG CPD program have much in common with the program they replace. The main features of the existing RANZCOG CPD program that remain in the new CPD Online program are:

- A three-year cycle (a triennium) of compulsory continuing professional development.
- Each participant, practicing on either a part-time or full-time basis, must undertake a minimum of 150 hours within the triennium. Subspecialists are required to accrue a minimum of 100 CPD hours in their area of subspecialty.
- A minimum of 25 hours in PAR, previously known as PR&CRM, must be undertaken.

New aspects that have been introduced in CPD Online are:

- A minimum of 25 hours must be accrued in each of the three domains described in the RANZCOG curriculum – Clinical Expertise, Academic Abilities and Professional Qualities – across the three-year cycle.
- CPD activities are recorded and tracked in an online format, CPD Online.

The online format enables Fellows to devise a CPD plan, monitor their progress through their CPD period and maintain an electronic record of planned and completed CPD activities across their three-year period. Tabs within CPD Online directly link Fellows to an Events Calendar, CPD record templates and other support resources. Fellows are encouraged to use the documentation facility to directly upload verification documents associated with each activity and store them electronically. Points statements, including Annual Points records, may be printed from a Fellow's individual profile. This is particularly useful for those who must provide evidence of ongoing professional development to regulatory bodies for recertification/registration purposes on an annual basis, such as the Medical Council of New Zealand (MCNZ), where the completion of specific activities is mandated.

### Implementation

Following completion of the online facility associated with the new program, CPD Online, the RANZCOG Board has agreed that:

- current Fellows who commence a new CPD period between 1 January 2013 and 31 December 2013 have the option of participating in the existing (paper-based) CPD program or moving to the revised program, including the use of CPD Online;
- all Fellows commencing a new CPD period on or after 1 January 2014 are required to participate in the revised CPD program, including the use of CPD Online;
- new Fellows with a Fellowship elevation date on or after 1 January 2013 are required to participate in the revised CPD program, including the use of CPD Online; and
- Fellows who are currently part-way through a CPD period have the option to convert to the revised CPD program, including the use of CPD Online.

All Fellows will be contacted via email in the coming weeks with further information specific to their CPD period and instructions for accessing CPD Online and support resources.

### Support

The new program is supported by the RANZCOG CPD Handbook, which describes the key elements to the new program, the associated requirements and includes a comprehensive list of activities across the three domains. The CPD Online User Guide document and online instructional video guide users step by step through the use of the online facility. These support resources, as well as CPD activity information flyers and templates, are available electronically in CPD Online. Demonstrations will also be made at RANZCOG events, such as Annual Scientific Meetings. As always, RANZCOG staff members are on hand to answer questions and provide assistance and support.

## Are you registered on the RANZCOG website under our 'locate an obstetrician/gynaecologist' link?

Can your colleagues locate you for referral purposes?

On the College website, two 'Register of Fellows' are published: a publicly accessible register of active Fellows in Australia and New Zealand and a restricted access register of all College members.

The PUBLICLY ACCESSIBLE 'Register of Active Fellows' lists your work address, phone number and brief practice details (for example, private and/or public obstetrics and gynaecology or area of subspecialty).

The RESTRICTED ACCESS 'Membership Register' lists the work contact details of members of the College who wish to be included and is accessible only by members of the College who have a website user name and password.

If you would like your work contact details to be included on either or both of the registers and/or would like to update your details already listed on the website, please contact:

Tracey Wheeler  
(t) +61 3 9417 1699  
(e) [reception@ranzco.edu.au](mailto:reception@ranzco.edu.au)

# Revisions to the FRANZCOG Training Program



Dr Peter White  
CEO

A revised FRANZCOG Training Program will be implemented from 1 December 2013 for Trainees commencing Year 1 of training, with transition arrangements in place for currently enrolled Trainees.

Training of medical specialists through a program that culminates in the awarding of a College Fellowship and recognition as a 'specialist' in the associated field of medical practice has long been one of the major core activities of the specialist medical colleges. Indeed, in the field of O and G, completion of the FRANZCOG Training Program is

accepted by regulatory authorities in Australia and New Zealand as the qualification that enables recognition and registration as a specialist practitioner in the specialty in both countries.

The current FRANZCOG Training Program was introduced in 2003, following a review of the program to that time. Recognition of developments in adult education and modes of practice within elements of the speciality led to developments that, for example, saw the Distance Education Program (DEP) give way to the more learner-centred Flexible Learning Program and the implementation of a training program based on and underpinned by the RANZCOG Curriculum document.

The training program in its current format is felt to have served the speciality well over the period since its implementation; however, in acknowledgement of the evolving nature of the specialist workforce and further developments in medical education, the College Council and Board in 2010 took the decision to undertake a review of the program in order to ensure that it continued, as best as possible, to meet the needs of the communities served by the medical workforce for which it trains specialists in the field of O and G.

To this end, a College working party was constituted to undertake a review of the program. The working party, chaired by the then Immediate Past-President, Dr Ted Weaver, began the task by undertaking consultation with over 200 individuals and groups considered to be both internal and external stakeholders, inviting comments in relation to the training program in its current iteration, including suggestions in relation to how the program

may be altered to enable it to continue to best meet the needs of all who are associated with its operation and its outputs. The responses received from the consultations informed the deliberations of the working party, which presented a series of recommendations to the College Council and Board in July 2011.

The major principles suggested by the working party for revisions to the program retained a training program of six-years duration that was split into an initial four-year component (to be designated Core Training), followed by a two-year component (to be designated Advanced Training). While the assessment components and other aspects of the training program remain largely intact, the program has been restructured with the intent of ensuring that it continues to produce a workforce appropriate to the needs of the Australian and New Zealand communities. The changes are also intended to ensure that Trainees entering the FRANZCOG Training Program are able to progress in a supported and flexible, yet accountable, manner through the program, while Trainees who are found to perhaps be unsuited to the specialty are given early and timely remediation that enables alternative career pathways to be identified where necessary.

The principles proposed by the working party were endorsed by the College Council and Board and were subsequently developed into a further set of recommendations that were endorsed in July 2012. All of the resultant recommendations were then incorporated into a set of regulations that will enable the revisions to the program to be operationalised for Trainees commencing FRANZCOG training from 1 December 2013, and which are available, along with other documents relating to the revised FRANZCOG Training Program, on the College website at: [www.ranzcog.edu.au/revised-training-program.html](http://www.ranzcog.edu.au/revised-training-program.html).

Of note in relation to revisions to the program to operate for Trainees entering the program from 1 December 2013 is:

- the change to timeframes for completion of components of the program based on Training Time (or Time in Training), as distinct from calendar time;
- earlier timeframes for sitting the MRANZCOG written and

## Summary

Revisions to the FRANZCOG Training Program designed to ensure the program continues to produce high-quality specialists that meet community healthcare needs will be introduced for Trainees entering FRANZCOG training from 1 December 2013. In order to ensure smooth operation of the training program for Trainees commencing from that date, as well as Trainees already in the program, some aspects of the revised program will also operate for existing Trainees. Detailed information in relation to the changes, including regulations to operate from December 2013 for all Trainees, are available on the College website at: [www.ranzcog.edu.au/revised-training-program.html](http://www.ranzcog.edu.au/revised-training-program.html), with further communication from the College through a range of sources to be undertaken as this year progresses.



- oral examinations, with the maximum number of available attempts at each examination reduced from four to three;
- the introduction of an Academic Stream that facilitates completion of a PhD concurrently with FRANZCOG training;
- the removal of 'Borderline' as an outcome for six-monthly summative assessment reports;
- the introduction of increased flexibility for Trainees, with the capacity to gain credit for any part-time training fraction between 0.5 and 1.0 FTE
- the introduction of training credit based on 'weeks' of completed training on an FTE basis, with the ability to gain credit for periods of training of a minimum ten weeks' duration;
- the requirements for completion of all requirements associated with Core Training prior to progression to Advanced Training to ensure a common certified set of competencies for all Trainees at the end of Core Training; and
- the development of Advanced Training Skill Modules (ATSMs) to guide the further development of Trainees during Advanced Training to specialist level in the context of their intended scope of practice.

As with any change to a training program such as the FRANZCOG Training Program, the College was aware that consideration needed to be given to the possible effect(s) of changes on Trainees already training prior to introduction of the revised program in 2013. While highly cognisant of the principle of not unfairly disadvantaging Trainees currently in the program, it did become evident during development of intended revisions that some aspects of the revised program may cause difficulty for Trainees and training supervisors if not introduced for existing Trainees. Similarly, it also became evident that other aspects of the revisions may, in fact, be so beneficial to current Trainees that to not make them available may be seen as unreasonable, although not of disadvantage relative to current arrangements. An example of the former consideration is the development of revised three-monthly formative appraisal and six-monthly summative assessment documentation (including the removal of Borderline assessments for the latter), while examples of the latter consideration are the increased flexibility to be made available to Trainees in the revised program in regard to credit for part-time training between 0.5 and 1.0 FTE, and the ability to gain credit for relatively 'short', but variable, periods of training in a six-month period associated with, for example, parental leave, by coupling these to longer periods undertaken prior or subsequent to the period in question.

As a result, a series of suggested 'transition' arrangements were developed in collaboration with the College Trainees' Committee for the consideration of the College Board and Council at their most recent meeting in March of this year. The arrangements, that were approved by both groups, have been incorporated into a revised set of regulations to operate from 1 December 2013 for Trainees currently in the training program. These regulations, which include the formation of a College body to consider the circumstances of Trainees who consider they are disadvantaged by any of the arrangements associated with the regulations in question, are also available on the College website at: [www.ranzcog.edu.au/revised-training-program.html](http://www.ranzcog.edu.au/revised-training-program.html).

Central to the transition arrangements and the associated regulations is the move to credit satisfactorily completed training based on FTE weeks completed within six-month blocks in order to enable a consistent approach for all Trainees enrolled in the training program. As a result, training requirements and

associated timeframes for aspects of the program, such as eligibility for the MRANZCOG examinations, will be based on weeks of satisfactorily completed training, rather than the currently used system of months of training. The maximum timeframes for completion of the training program for current Trainees will remain at eight calendar years for completion of the ITP / Core Training component and 11 calendar years for completion of all requirements of the program. The College is intending to write to all Trainees during the second half of the year outlining their individual circumstances in regard to the conversion of their months of credited satisfactorily completed training to the corresponding number weeks of training for the purpose of transitioning to the new regulations from December.

In conjunction with the development of regulations to enable the revised FRANZCOG Training Program to commence in December and new regulations to apply for existing Trainees from the same date, work has also been undertaken to revise the RANZCOG Curriculum document, which underpins and guides the training program and, as outlined in a separate article in this issue of *O&G Magazine* (see p77), the framework of which underpins the new College CPD program.

While taking the opportunity to ensure the ongoing relevance of all aspects of the curriculum framework, which guides the specific outcomes associated with the training program and, as result, the material that is assessable for Trainees, the major intention of the curriculum review was a reorganisation of the document to enable a clearer association to be made between the different elements of the document, including providing Trainees and others involved in the training program on a day-to-day basis (for example, training supervisors) with an improved mechanism to readily determine the outcomes associated with the different domains of the curriculum framework. In essence, the revisions to the RANZCOG Curriculum are intended to make the document clearer for everyday use, while remaining applicable to all Trainees, regardless of whether they are already undertaking FRANZCOG training or entering the revised program from December this year.

### Next steps

Having considered the need for revisions to the FRANZCOG Training Program and undertaken the work necessary to ensure their development and implementation for Trainees from December of this year, all associated with the process are aware of the need to ensure, as much as is practicable, that the revisions are communicated as well as possible to those who will be affected by them. This includes current and prospective Trainees, training supervisors and other groups internal and external to the College. For example, the College has already written to all jurisdictional health departments explaining the changes to be introduced and is seeking to meet with all such groups in an effort to further discuss the changes, as well as any other training matters considered pertinent.

This article is only one aspect of the communication process and the College will be communicating through email, conventional mail and its website further in relation to the changes as the year progresses. As well, it is intended to set up a dedicated College phone line to deal with enquiries that individuals and/or groups may have in relation to implementation of the revised FRANZCOG Training Program and its requirements.

# College Statements Update

## March 2013

A/Prof Stephen Robson  
FRANZCOG  
Chair, Women's Health  
Committee

The Women's Health Committee (WHC) reviewed the following statements in March 2013, which were subsequently endorsed by Council. College statements can be viewed on the College website.

### New College Statements

The following new statements were endorsed by RANZCOG Council and Board in March 2013:

- (C-Obs 49) Management of Obesity In Pregnancy

### Revised College Statements

The following statements were re-endorsed by RANZCOG Council and Board in March 2013 with significant amendments:

- (C-Obs 3b) Routine Antenatal Assessment in the Absence of Pregnancy Complications
- (C-Obs 25) Vitamin and Mineral Supplementation in Pregnancy
- (C-Obs 11) Management of Breech Presentation at term (REWRITE)
- (C-Obs 35) Prenatal Screening for Fetal Abnormalities
- (C-Gyn 10) Sterilisation Procedures for Women with an Intellectual Disability
- (C-Gyn 20) Polypropylene Vaginal Mesh Implants for Vaginal Prolapse (REWRITE)
- (C-Gen 17) Prophylactic Antibiotics in Obstetrics and Gynaecology

The following statements were re-endorsed by RANZCOG Council and Board in March 2013 with minor or no amendments:

- (C-Gyn 17) Termination of Pregnancy
- (C-Gyn 21) The Use of Mifepristone for Medical Termination of Pregnancy

- (C-Gen 7) Guidelines for Gynaecological Examinations and Procedures
- (C-Gen 8) Diethylstilboestrol (DES) Exposure in Utero

### New College Statements under development

- Substance Use in Pregnancy
- Postpartum Bladder Management
- Screening and Management of STIs in Pregnancy
- Joint Australian and New Zealand Guidelines for Management of Gestational Trophoblastic Disease
- Generic statement on Evolving Procedures

### RANZCOG Women's Health Services

Should you have any queries for the Women's Health Committee or the Women's Health Services department, please use the following phone number:  
(t) +61 3 9412 2920

### College website

#### College statements

Can be viewed at: [www.ranzcog.edu.au/womens-health/statements-a-guidelines/college-statements.html](http://www.ranzcog.edu.au/womens-health/statements-a-guidelines/college-statements.html). Should you have any difficulties with any documents from the webpage, please phone the College (t) +61 3 9412 2920.

### Resources for Fellows

This section includes local and international guidelines and articles of interest such as links to new titles on ACOG Committee Opinions and Practice Bulletins, SOGC Clinical Guidelines, National Institute of Clinical Excellence (NICE) guidelines and Department of Health and Ageing reports. Access at: [www.ranzcog.edu.au/members-services/fellows/resources-for-fellows.html](http://www.ranzcog.edu.au/members-services/fellows/resources-for-fellows.html).

## Need a break?

If you are a Specialist or GP Obstetrician in rural and remote Australia (ASGC-RA 2 to 5) you are entitled to receive the following funding for locum relief (per financial year):

- 14 days of locum support
- locum travel costs
- locum travel time

(03) 9412 2912 | [roals@ranzcog.edu.au](mailto:roals@ranzcog.edu.au)  
[www.roals.org.au](http://www.roals.org.au)



Providing funding to support  
rural Specialist and GP  
Obstetricians



The Rural Obstetric and Anaesthetic Locum Scheme is funded by the Australian Government

### Notice of Deceased Fellows

The College was saddened to learn of the death of the following Fellows:

Dr Albert Raymond Anderson, of Northern Territory, on 28 May 2010  
Dr Hong Leong Clement Chong, of NSW, on 8 December 2011  
Dr James Martindale Farrar, of NSW, on 23 October 2008  
Dr Grahame Harry Harris, of NSW, on 2 November 2012  
Prof David Henderson-Smart, Honorary Fellow, of Tasmania, on 7 February 2013  
Dr John Francis Hennessey, of Queensland, on 24 January 2011.

# Staff news

## New appointments



*New staff members from left to right: Janne Martnes, James Leermakers, Georgia James, Elise Sturgess, Kellie Hardy and Giri Nathan.*

**Janne Martnes** started with the College as a re-accreditation/Specialist Training Program administrative officer in February. Before this she was a client information line officer at the Australian Skills Quality Authority. A native of Norway, Janne holds a master of arts and cultural management degree from Melbourne University.

**James Leermakers** recently joined RANZCOG as an ICT coordinator. In this role, his main task is the planning and implementation of ICT projects, including a helpdesk ticketing system, the restructuring of ICT infrastructure and an email archiving system.

**Georgia James** started with the College in February as an administrative officer in the training services department. Previously, she was the publications assistant at the Australian Acupuncture and Chinese Medicine Association. Georgia holds a bachelor's degree in psychology from the University of Queensland.

**Elise Sturgess** has started at RANZCOG as an administrative assistant in the office of the CEO and President. She comes to the College from the Canberra Hospital where she worked in as a booking clerk. Elise has spent the last few years travelling, studying and working in various administration roles. Outside of her work at the College, she enjoys photography, particularly photographing weddings, families and children.

**Kellie Hardy** joined RANZCOG's Specialist International Medical Graduates team as program coordinator. Kellie comes from working at the Royal Australasian College of Surgeons, where she worked in the workforce planning and research department as the manager and project officer. She has a background in medical research, having

completed a master of science degree with the purpose of developing a novel human trophectoderm stem cell line and working in a number of medical research institutes.

**Giri Nathan** joined RANZCOG as an e-learning administrator, responsible for administration and management of the College's CLIMATE e-learning initiative as well as the Online Fetal Surveillance Education Program, Colposcopy Online Learning Program and Nuchal Online Learning Program. He brings to the role a wealth of experience gained in his previous role as a Moodle developer at Kaplan Australia. Giri is a passionate supporter of Essendon Football club and a proud father of two girls.

## Departures

**Nicole Blair**, administrative assistant with the NSW Regional Office, left the College in April. We wish her all the best for the future.

**Jeanette Wrench** resigned from her position as senior coordinator in training services in April to take up a position with the University of Melbourne. We wish her every success in her new role.

**Jayne Petricca** left her role in the subspecialties department in early May. We wish her all the best for the future.

**Annie Holdsworth** retired from her role as senior education coordinator at the College in May. We wish her all the very best for the future.

# Obituaries



**Graeme Alastair Bond**  
1958 – 2013

In order to become and continue to be a forward-looking organisation that operates according to the expectations of stakeholders, the College has required the expertise of its Fellows and other members, its staff, and other individuals who have skills that are not necessarily represented in these groups. It was in the capacity as a qualified legal practitioner that Graeme Bond became involved with the College. However, RANZCOG had always been a presence in his life, through his father Alec 'Chick' Bond a Foundation Fellow of RACOG, who was a member of the Australian Regional Council 1970–77 and Honorary Secretary of the Australian Regional Council 1975–77. It was with great sadness that the College learned of the untimely passing of Graeme on Easter Monday, 2013.

Over a period of more than a decade, Graeme provided legal advice to the College in regard to a range of matters, and served the College on bodies such as the ANZJOG Management Committee, the Publications Management Committee and the Jean Murray Jones Bequest Oversight Committee. He was a Director of the RANZCOG Research Foundation from 2003, serving as Deputy Chair of the Foundation from 2006, and Chair of the Finance Committee of the Foundation from 2009. As with all facets of his professional life, Graeme approached these roles with absolute professionalism, intelligence and a finely tuned sense of humour. Without exception, he was respected by those with whom he worked in relation to the affairs of the College and the Foundation.

Born in Melbourne and educated at Melbourne Grammar and Monash University, Graeme was a lover of sport, music, good food and the company of his friends. Graeme had a long association with the legal firm S.V. Winter and Co, more recently establishing his own successful practice, Bond Legal.

A celebration of Graeme's life was held at his beloved Melbourne Cricket Club shortly after his passing. Those who spoke on the day remembered Graeme as a generous individual who enjoyed life and who was always available to his friends and family when the need arose. Among many comments on the day the theme that was oft repeated was the ability of Graeme to sift through the issues relating to any matter that was the subject of discussion and deliver 'sage-like', wise advice that clarified the way forward for all concerned.

With his partner, Bev Munro, Graeme embraced life and they

formed a strong, loving and supportive partnership that enriched the lives of those fortunate enough to be welcomed into their lives. Bev is a long-serving College staff member who has herself done much to further the College as an organisation and the College extends its sincerest condolences to her at the passing of a highly respected colleague and friend.

**Dr Peter White**  
CEO, RANZCOG

**Dr Beryl Overton Howie QSO, DSc Otago, MB ChB, FRCS, FRACS, FRCOG, FRACOG**  
1924 – 2012

Born in Invercargill, educated at Epsom Girls' Grammar School, Beryl Howie gained a national University Scholarship and completed her Medical Intermediate at Auckland in 1944. While at Otago Medical School she boarded at St Margaret's College, becoming student president in 1947.

Following Sixth Year at Christchurch and graduating in 1949, she served as House Surgeon at Timaru before gaining a post at the Radcliffe Infirmary, Oxford, England, where she trained for her MRCOG. Under Sir John Stallworthy, it was a rigorous apprenticeship. In 1959 Beryl was appointed to lead the Department of Obstetrics and Gynaecology at the Christian Medical College (CMC), Ludhiana, Punjab, India. Three years later, promoted to full Professor within the University of Punjab, (becoming the first New Zealand woman medical graduate to hold a full medical chair), she played a key role in upgrading CMC from licentiate to MBBS standard.

Founded in 1894, by Dame Edith Brown, CMC was the first medical college for women in Asia; after 1953 men were also able to enter. Along the way she learnt to speak Hindustani and Punjabi. She was funded initially by overseas groups supporting CMC and, from 1963, by the Presbyterian Church of Aotearoa-New Zealand.

In 22 years at CMC Beryl delivered thousands of babies, taught undergraduates to provide quality care with limited resources, trained 90 to postgraduate diploma level and trained 29 to become doctorates in medicine. She modelled for her registrars, residents and students the compassion and competence needed to manage the difficult deliveries, all-too-often obstructed, seen daily in Indian hospitals. The training she gave meant her trainees coped well wherever they worked in India. Her concern went out into the community, and she involved the indigenous midwives, the dais.

Cervical cancer was common and treated with radium, and she was expert in the repair of vaginal fistula. From staff quarters to labour ward at the Old Brown Hospital was five minutes by bicycle at any time of night – in those days it was a busy street of Old Ludhiana, congested with rickshaws and bicycles, cows and cars. According to former student Dr TK Cherian (Head of Reproductive and Fetal Medicine, St Stephen's Hospital, New Delhi) 'I remember her evening rounds in the ward when patients could even share their personal problems and get solace in her loving words and soft touch. The magnitude of love and respect her patients had



for Dr Howie was evident the night she boarded the train from Ludhiana station – the platform was an ocean of her patients and their families.’

The New Zealand High Commissioner presented her with the Queen’s Service Order before she left India to return to New Zealand in 1981. Her textbook High-Risk Obstetrics, a practical handbook, was published by Macmillan in 1985. From 1984-89 she was Medical Advisor to Interserve, an international Christian network working across Asia, until she officially retired to Auckland in 1990. In 1989 she received an honorary Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Named after her at CMC is a new six-storied block housing the Obstetrics and Gynaecology Department, for which churches and other community groups in New Zealand raised the funds, matched by a grant from the New Zealand Government.

In her youth Beryl was an enthusiastic hockey player and also learned the cello. In retirement she resumed her interest in music, especially chamber music. She continued to actively support people serving overseas, as well as student groups. Beryl also had a

great love of children, whether nieces, nephews or the children of friends, and followed with warm interest babies she had delivered. That interest extended to the students she had taught, and to their children also. She charmed our children with her humour and with enthusiastic involvement in their interests.

Some 200 people came to her memorial service in Ludhiana. Former students, residents and registrars sent messages vividly recalling the competence, compassion and determination she modelled. These qualities and her commitment to people in need were based on her lifelong Christian faith, which was deep, personal and attractive.

She is survived by her brother, John Howie, and her nephews and niece, Hamish, Jock and Melissa.

This obituary was written by former colleagues David and Rosemary Troughton and Murray Laugesen of Christchurch. First published in the *New Zealand Medical Journal* Vol 126 No 1370 ([journal.nzma.org.nz/journal/126-1370/5564/](http://journal.nzma.org.nz/journal/126-1370/5564/)) and reproduced with permission.



**C-QuIP**  
Colposcopy Quality  
Improvement Program

## Web Portal

The Colposcopy Quality Improvement Program (C-QuIP) has been working with Solutions Plus, developers of state-of-the-art software packages for niche areas within the health sector in Australia and New Zealand. They have created a web-based data-collection tool for those certified colposcopists participating in re-certification and audit who wish to use an electronic format to enter their cases.

The software is designed to capture the requirements of the Standards in Diagnostic Colposcopy and Standards in Therapeutic Colposcopy and provide practitioners with a useful way to collect their data.

The C-QuIP data-collection web portal is now **LIVE** and ready to use.

Please take a look at our website at [www.cquip.edu.au/data-collection-forms/web-portal.html](http://www.cquip.edu.au/data-collection-forms/web-portal.html) for details on how gain access.