O&G
MAGAZINE

GLOBAL HEALTH

Vol. 22 No. 4 | Summer 2020
a **RANZCOG** publication

O&G MAGAZINE

Vol. 22 No. 4 Summer 2020

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O&G Magazine authorised by Ms Vase Jovanoska

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ISSN 1442-5319

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From the President

Dr Vijay Roach
President

The final issue of *O&G Magazine* for 2020 is dedicated to Global Health. The paradigm that surrounds this subject often focuses on the seemingly overwhelming dilemma of inequity, lack of resources and poor health outcomes. Recognition and quantification of the problems facing global communities around the world, particularly those in low-resource countries, is essential, but it's not the whole story. In this issue of the magazine, our authors also highlight the many positive and constructive steps undertaken by RANZCOG members. Advocacy for improved funding, social, economic, and political change, is an ongoing struggle. Improving outcomes through education, systems development and direct delivery of healthcare is the key to sustainable change.

The authors in this issue share their experience working in countries in our region and further afield. Perhaps the most important message that we can take from their work is that opportunities that arise from engagement with other people and cultures are bi-directional. In other words, as small, wealthy countries, distant from the rest of the world, Australia and New Zealand stand to benefit enormously from our engagement with other nations. Sharing our knowledge and expertise creates an opportunity for us to listen, and learn, in return.

Charitable work is complex and the articles in the Summer Issue explore the work of large organisations, small NGOs and individuals. It's important to go beyond superficial assumptions and gain a better understanding of how donations are spent, use and misuse of resources, and the potential unintended consequences of good deeds, including 'voluntourism'. In a world often polarised, economically and ideologically, we need to remain respectful of other cultures, constantly reminding ourselves to tread lightly, asking, not telling, advising, not instructing, listening more than we speak.

The centrality of women in every community means that the impact of preventable conditions such as cervical cancer and genitourinary fistulae are far-reaching, affecting the entire community, let alone the woman herself, often at a very early age. Access to contraception, abortion and adequate care during pregnancy and birth are expectations in our countries. In a globalised world, every woman is our daughter, our sister, our mother and our friend. Surely we want the best outcome for them too. The suffering and grief associated with disease and death is only contextually different in Sydney, Auckland or Port Moresby. The human experience is the same.

As 2020 draws to a close, the impacts of the global pandemic have brought into sharp focus the fragility of human health in the modern era. High-resource countries have not been immune to a virus that does not discriminate. Having said that, COVID-19 has further exposed the inequities in health between socioeconomic classes, race and gender. The poor, people of non-white ethnicity, and the elderly, have suffered disproportionally. The experience of the pandemic has differed dramatically for our members. Swift action in New Zealand has meant relatively few infections and deaths. In Australia, Victorians have suffered a prolonged and arduous lockdown while other States have been spared. While I've been unable to visit Victoria, I have been acutely aware of the emotional trauma experienced by our staff and members there. Obstetricians, gynaecologists, general practitioners, nurses and midwives have been forced to confront illness, death, prolonged and difficult working conditions and, above all, anxious uncertainty. That they're still standing is testimony to the human spirit. While we recognise their determination, words like 'heroes' and 'resilience' should be used with caution, if at all. Coming out of the pandemic will require ongoing understanding and support.

For RANZCOG this has been a year like never before. The challenges have been extraordinary but I'm actually not surprised that we have responded, adapted and, in fact, thrived. Adjustment to working from home, running webinars, exams, and meetings online, maintaining communication and camaraderie through a screen reflects an organisation with a deep, and genuine, culture. Articulation of our Organisational Values of Advocacy, Education, Excellence, Integrity, Kindness and Respect summed it all up. It's what we do! These values are embodied in RANZCOG's dedicated CEO and staff, Board, Council and Committee members, training supervisors, examiners, course coordinators and speakers. They're evident in our trainees who continued working, studying, and striving for excellence, as the rug was pulled out from under them. Our values are why we are who we are, the leaders in women's health in Australia and New Zealand.

As we head into summer and, hopefully, a time for rest and relaxation, uncertainty in global politics, the impacts of climate change, the risk of bushfires and the COVID-19 pandemic still hover above us. I thought that I'd leave you with a short story that reminds us of the value of the individual in front of us, the power of a simple act of kindness and the importance of generosity of spirit that transcends the vitriol of social media, harsh words and thoughts. Often we wonder what an individual can do when the issues seem so overwhelming.

On a wide and open beach, a massive storm has washed thousands of starfish on to the sand. An old man, tired and cynical, comes across a little child picking up the starfish, one by one, and throwing them back into the sea. Irritably he asks 'What are you doing? You can't save all of them. You can't make a difference to everyone'. The child bends down, gently picks up a starfish, places it in the water and says 'Well, it made a difference to that one'.

Thank you for your support, your guidance and your friendship during 2020. Take some time to hug your friends, and family, to enjoy the sun, and the sand, to savour life's simple pleasures. Remember that you make a difference. You matter and, together, we can change the world, one starfish at a time.

From the CEO

Vase Jovanoska
Chief Executive Officer

Welcome to the last issue of *O&G Magazine* for 2020. Every year around this time, there is usually that feeling in the air of the year tapering out a little, the festive and holiday season awaiting our enjoyment and the chance to reflect on the year past. Here we are, almost at the end of 2020. For most of us, especially in Melbourne, this month feels much like the last 7 months – the same.

To say the least; this year is a little different.

I find it fitting that the final *O&G Magazine* for 2020 is fortuitously themed around Global Health. In fact, 2020 has been entirely themed around global health with the world focused on the COVID-19 health crisis. The global pandemic, and our response to it, will be something that we reflect on for years to come. Did we do the right thing? Did we do our best? What did we learn?

One thing we have been reminded of, and that is embedded in our responsibility as a leader in women's health, is the obligation we have to our global neighbours and our commitment to helping improve women's health in the Pacific and beyond. The onus is on us to share our education, training and research support to aid capacity-building, collaboration, and advocacy in our developing nations.

Collaboration is integral to the College's efforts in improving women's health in the Pacific and this year, RANZCOG supported the COVID-19 response in the Pacific in partnership with local and regional organisations. In response to requests for assistance from Pacific O&G specialists for developing local guidelines at the onset of the COVID-19 pandemic, RANZCOG partnered with the Pacific Society for Reproductive Health (PSRH) to develop a guide on COVID-19 and pregnancy in resource-limited environments. The guide was distributed widely across the Pacific. The College is also currently developing a Global Health Experience Map, which presents a snapshot of the global health experiences of College members and trainees. This map will soon be accessible to members and trainees.

With the support of PSRH and the Pacific community, RANZCOG hosted a COVID-19 and O&G webinar series for the Pacific O&G workforce. Featuring presentations from RANZCOG, the University of Papua New Guinea, United Nations Fund for Population Activities (UNFPA) Asia-Pacific, Fiji National University, the Burnet Institute, the University of the Philippines-Philippine General Hospital, and Dhaka Medical College Hospital; the webinar series was well-received, with sessions attracting participants from across the Asia-Pacific region.

RANZCOG offers several Pacific scholarships to enable Pacific O&G trainees and specialists to attend RANZCOG events in Australia and New Zealand, improving their access to CPD and networking opportunities. These scholarships also help build the knowledge and skill base of the Pacific O&G workforce, benefiting clinical practice and improving healthcare provision to women in the Pacific. With the cancellation of many events in 2020, we hope that these learning experiences can be fulfilled in 2021 for our international trainees and specialists.

As we move towards the end of the year, in hopes of a better 2021, it is important for us to harness the opportunities for growth and learning that presented through the challenges of 2020. The year was one of ups and downs and never has it been more important to lean into each other and support our communities, peers and colleagues. With many restrictions in place, some areas affected more than others, we have all been so disconnected from one another but, on some levels, we remain even more connected than before in this age of accessibility.

Through virtual collaborations, we have formed mutually beneficial collegiate relationships; signing Memoranda of Understanding (MoUs) with the Canadian Society of Obstetricians and Gynecologists (SOGC), the Obstetrical and Gynecological Society of Malaysia (OGSM) and the Sri Lankan College of Obstetrics and Gynaecology (SLCOG).

In 2020, and perhaps at the perfect time, RANZCOG established the Wellbeing Working Group whose objectives are to establish a range of appropriate wellbeing initiatives and functions that provide ongoing support and assistance for trainees and members throughout their training and work lifecycle. The College acknowledges the immense pressure and risks that our frontline medical workforce has endured in 2020 and the importance of making sure they have the necessary supports around them.

In 2021, the College will also extend its support to our members and trainees, with the formation of a Mentoring Working Group. The working group will be tasked with developing a framework to help support trainees and members, by expanding their network and by fostering social and professional inclusion and information sharing and to support the career goals and wellbeing of professionals within the O&G profession. This includes early-career Fellows, SIMGs, trainees and members in difficulty or with special needs and rural and remote doctors.

Our ongoing commitment to global health will be on the world stage between the 24 to 29 October, when the International Federation of Gynaecology and Obstetrics (FIGO) and RANZCOG co-host the triennial 2021 FIGO World Congress in Sydney. The hybrid event will be one of the most important global academic events for our speciality with thousands of delegates from around the world uniting to learn, educate, share ideas, and express their experiences in women's health.

With so many important projects and opportunities on the horizon, I look forward to what 2021 brings the College and I wish you good health and happiness for the festive season and the new year.

LEADERS IN FOCUS

Dr Nisha Khot
MBBS, MD, FRCOG, AFRACMA, FRANZCOG

This feature sees Dr Nisha Khot in conversation with women's health leaders in a broad range of leadership positions. We hope you find this an interesting and inspiring read.

Join the conversation on Twitter
#CelebratingLeadership @RANZCOG @Nishaobgyn

Dr Sharron Bolitho
FRANZCOG

When Dr Kirsten Conan handed over this column to me, there were two regions she had not interviewed any clinicians from – Tasmania and South Island of New Zealand. I made it my mission to complete Kirsten's work by interviewing Dr Lindsay Edwards from Tasmania for my first feature. This interview, with Dr Sharron Bolitho, fulfils Kirsten's aim of representation from each state and territory of Australia and both islands of NZ. I first met Sharron at a PROMPT Train the Trainer course. We found that we both had children who were keen rowers. I admired the work Sharron was doing in the Pacific and wanted trainees and Fellows to know about it. In the years that followed, we have seen each other at various PROMPT-related courses and, of course, at RANZCOG's Global Health Committee meetings.

Our common interest in ensuring that women everywhere have access to safe maternity services has meant that we have stayed in touch despite distance and COVID-19. If readers of this column feel inspired by the articles they read in this issue and by hearing Sharron's story, please do get involved in global health initiatives. We are only as good as the sum of our parts. Each of us has a part to play to achieve the sum total of health for all.

What does your typical day look like?

A typical day starts with a breakfast of my all-time favourite foods poached egg, spinach (and salmon if I am lucky), watching the sun light up the southern alps at dawn. I cycle to work nearly every day. I have a full-time public hospital appointment. In addition to clinical work, I have educator, RANZCOG, Ministry work and departmental administration that fill my working day. My evenings have become much easier since my wonderful, long-suffering husband started preparing dinner with the help of 'My Food Bag' which has revolutionised my life from a 'decreasing stress at home' point of view! In the evenings there is usually time to catch up with family, including an adult son back home from College in Boston due to COVID, potter in my beloved garden, as well as do my Pacific work.

Why is cycling to work so important to your day?

I didn't learn to ride a bike until I was 40 – a consequence of growing up on top of a steep hill in Wellington. Cycling to and from work are two of the most important parts of my day. Cycling allows me to mentally transition from home to work and back again. I struggle with exercise unless it is a routine part of my day and cycling works perfectly for me. I particularly dislike driving to work in my car burning fossil fuel as cyclists whizz past me while I am stuck in traffic! Cycling is so much better for the planet and I like to encourage others to take it up too.

In the Māori world view, each tribe or subtribe (iwi/hapu) has a mountain (maunga) and a river (awa) to which they belong. I have the rare privilege of living on the maunga which my ancestors first saw and lived on when arriving in Aotearoa in 1860s and of riding along my awa to work. I often reflect on deeper and spiritual things while riding beside the river as this is the most peaceful part of the journey. So, as well as exercise, cycling gives me mental/spiritual space and connection to the land (whenua).

What leadership roles do you have?

I am the medical lead for the PROMPT obstetric emergency training program for Canterbury District Health Board (CDHB), as well as part of the NZ National PROMPT leadership team. I am involved in the wider leadership of all CDHB simulation training. I am on the National ACC Neonatal Encephalopathy (prevention) Taskforce Fetal Heart Monitoring working group. I am a FRANZCOG ITP and Advanced DRANZCOG supervisor. I am the Leader for Facilitator Training for the Pacific emergency Maternal and Neonatal Training Programme. I am on the RANZCOG Global Health Committee. While I was Acting Clinical Director, I led a project to revolutionise the way

we senior doctors work and I continue to assist the current CD in this area.

What prompted you to choose O&G?

I was always been fascinated by reproduction from very early on at medical school. I took a year out between preclinical and clinical years and spent six months in Bangladesh in obstetrics where I saw my first birth. I was so excited I couldn't sleep all night afterwards!

In my trainee intern year, I went back to do an elective in Bangladesh with my new husband. When I returned, I was asked to sit for the T R Plunkett O&G distinction viva. At the time, I really didn't want to as I had had no time to study! However, the T R Plunkett Prize was established following an endowment made by O&Gs throughout New Zealand in memory of Dr Thomas Plunkett, who happened to be my best friend's grandfather. His widow was my 'Auckland Gran' and used to present this prize. She had said to me, 'I have never presented this to anyone I know. If you go to medical school, I want you to get that prize – no pressure!' I knew she would be furious if I didn't even try so I went ahead and sat the exam and (no surprise) won!

Another key decision point in my career was when I was working as a house surgeon at the old National Women's Hospital. I had completed my Diploma in Paediatrics as well as Obstetrics and I was loving the work I was doing. Prof Colin Mantel called me into his office one day and said, 'Sharron, I think you should pursue a career in O&G'. I had recently got married and felt I couldn't have a family and pursue specialist training and do them both the justice they each deserved. To which Prof Mantel said, 'Let me introduce you to Lesley Mc Cowan, she is successfully doing both' and marched me straight into her office. The rest is history!

What message do you have for your younger self?

Know yourself; both strengths and weaknesses. These are inevitably different sides of the same coin. The flip side of our greatest strength is also our greatest weakness. Focus on your strengths. Manage your weaknesses.

Instead of trying to please everyone, focus on doing the right, kind and compassionate thing for the person before you.

Avoid spreading yourself too thinly. Just because you can do something and think you can do it better than someone else, doesn't mean you have to do it all. Let others use their strengths and develop their abilities. Focus on the things where you have a unique set of skills and passions and do that with all your heart.

'Put on your own oxygen mask first'. Self-care is essential, not a selfish luxury.

Finally, get over yourself. You don't have to be perfect. No one is. Just do your best!

Could you tell me a little bit about your work in Quality Improvement?

When I was the Tutor Specialist during my first three years of FRANZCOG, I became heavily involved in quality. My first SMO appointment had protected time allocated for quality improvement projects. I introduced monthly quality and education half

Dr Sharron Bolitho

days for the department, did all sentinel event reviews, met with families, made recommendations for change. A lot of recommendations involved communication and teamwork training and education and system change, obstetric emergency management and fetal heart monitoring skills improvement. I got to the point where I was utterly fed up with making the same recommendations over and over and nothing changing. I decided to change my quality focus and get involved with building a fence at the top of the cliff rather than just analysing all the mess at the bottom.

This helped me crystalise that my absolute passion is preventing avoidable maternal and perinatal mortality and birth injury. This prevention journey has taken me in unexpected directions, deep into systems work and issues, such as reorganising hospital system to provide adequate recovery time for SMOs, human factors issues training, team building, team-based apprenticeship, adult education focusing on practical skills and team/communication skills training and simulation.

How did you come to be involved in PROMPT and other multi-professional training?

A pivotal point for my involvement in multi-professional training was attending one of the first PROMPT Courses run in NZ by Dr Martin Sowter, RANZCOG PROMPT NZ Lead. My colleague, midwifery educator Tina Hewitt, attended the course with me. It was a lightbulb moment. In addition to individuals being proficient in technical skills including CTG interpretation, good multi-professional teamwork and communication are essential to providing effective timely care in an emergency. Practicing with your real workmates in your real work environment, rather than listening to a lecture and doing individual practice, makes the crucial difference. Just knowing how to play a team sport or even having good individual skills does not ensure good teamwork.

At the time, I was particularly impressed with the North Bristol Trust published outcomes several years after annual compulsory PROMPT was introduced. In 2006, they reported a 50% reduction in NE and 100% reduction in permanent brachial plexus injuries. These results have been sustained over the last 20 years and repeated in other centres who run this on an annual compulsory multi-professional basis. More recently, PROMPT programmes in Zimbabwe and Phillipines have reported a significant reduction in maternal mortality after introduction of the program. The Healthcare Improvement Studies Institute from Cambridge University have published an analysis of the 'positive deviance' of this centre. It is fascinating to read about how this programme which focuses on human factors has led to long-term, sustained culture change. Local sentinel event investigations as well as National PMMRC recommendations always include 'do more education and training'. I wanted to find something that was proven to be effective in improving clinical outcomes not just knowledge or attitudes. Here at last was something that combined all the aspects of quality improvement and very unusually, had published literature outlining their improved clinical results, not just improved post test scores for knowledge, skills and attitudes.

This is how I started on my journey into multi-professional simulation education in maternity care. Since then, I have attended intensive courses in simulation at Harvard, had a secondment to PROMPT Foundation in Bristol and a sabbatical in 2019 at CDHB Manawa Simulation Centre, which is associated with the Centre for Medical Simulation at Harvard.

How did you get involved with training and education in the Pacific Islands?

Like a lot of young doctors, I had a burning passion to 'save the world' by going to a low-resource setting and providing exemplary care. I chose the hardest place I could think of, which was Bangladesh, where I have spent almost a year at various phases of training. Over time, my thinking shifted. On reflection, while well intentioned, that scenario was all about me being a hero.

I have come to realise three things:

1. In order to have maximum positive effect on the health of mothers and babies, I need to be involved at a macro level in capacity building. This is twofold – providing training directly and, more importantly, training the trainer, enabling local practitioners to run their own programmes.
2. The Pacific is a family to which we have obligations. It is also a low-resource setting. I have become increasingly aware of Aoteaoroa's place as the southern-most islands in the Polynesian triangle and the reality that we are a Pacific Nation, with Māori tangata whenua being part of the Polynesian family. We also have the largest Polynesian City in the world and there is much fluidity of people, resources and money between Pacific Island countries and NZ. As Dr Vijay Roach, RANZCOG President, said at the most recent PSRH meeting 'We are all a Pacific Family'.
3. Due to a major health issue I could no longer commit to spending months or years in a difficult physical environment and that I would need to change to shorter visits.

After gaining these insights, I realised that the Pacific is where my focus could be. So I joined the Pacific Society of Reproductive Health (PSRH) 10 years ago and as my obstetric emergency training developed in NZ, I also became involved in workshops in this arena for PSRH. PSRH has produced its own training manual PEMNeT, and in conjunction with RANZCOG Education department, a Facilitators Guide. I am currently the Leader for Facilitator Training and am working with a predominantly Pacific-based team. You can read about this programme in this issue of *O&G Magazine*.

What would you describe as your greatest joys in training and education?

- The PEMNeT and PROMPT courses themselves, leading teams to run Facilitator Training and actual courses in the Pacific and Aotearoa.
- Seeing midwifery facilitators blossom and realise this is something they can do even when majority of participants are doctors.
- The human factor lightbulb moments such as:
    - the importance of clear communication, particularly in the remote referral setting
    - how working together as a team is needed for good care
    - that it is not a competition, junior doctors don't need to know everything and should use the experience of midwives and refer to resources in emergencies.
- Getting to know my Pacific-based colleagues, both Associate RANZCOG doctors and midwives. My admiration for the job they do in very difficult circumstances continues to grow.
- Getting to know the international PROMPT Faculty and Foundation members and work with them.
- Getting to know the Boston team and meet fellow simulation fans at the Centre for Medical Simulation Courses in Boston.
- Coconut crackers (AKA icebreakers) where we have had some hysterically funny moments.

Do you have some 'secrets of adulthood' to share with our readers?

'If you fail to plan, you plan to fail.' It is all about scheduling! I used to think that scheduling was a waste of my time but I now regard it as essential.

Prepare everything for the next day in advance, down to the detail of laying out clothes, making a healthy lunch etc. Don't leave stuff to be done in the morning before going to work because it always ends badly!

Get to bed at a reasonable hour. A good night's sleep really does make a world of difference to physical and mental wellbeing.

What lies ahead for you?

I would like to continue clinical work for as long as possible as I love the interactions with patients and being part of a multi-professional team and mentoring trainees.

However, over the years I have realised that the maximum impact I can have on preventing maternal and perinatal morbidity and mortality is by capacity building and training to affect systems so that it is easier for maternity health workers 'to do the right thing'. Hence, my focus for the future will be to continue to build future capacity, both in NZ as well as in the Pacific Island nations.

Editorial

Dr Alyce Wilson
MD, MPH, DRANZCOG
Public Health Medicine Registrar
& Research Fellow, Burnet Institute

The events of 2020 have cast global health into the spotlight. Extreme weather events, worldwide protests against systemic racism and a global pandemic have brought into sharp focus that global challenges can only be tackled through collective and collaborative efforts.

> When it comes to global health, there is no 'them', only 'us'
> – Global Health Council

This issue of *O&G Magazine* features a number of in-depth discussions on ongoing global health challenges, such as, ensuring all women receive respectful maternity care and recognising maternal health as a priority especially during COVID-19. Several articles also highlight how we can do global health better, such as, PEMNet and ONE-Sim, demonstrating the benefits of collaborative training. Stories like the remarkable 35-year-old (and counting) relationship between the Pacific Society of Reproductive Health (PSRH) and RANZCOG illustrate the collective power of working together to improve reproductive health in our region.

In the last 20 years, droughts, floods and bushfires have increased exponentially, with over 7000 extreme weather events recorded globally.[1] These environmental disasters have led to the loss of lives and livelihoods, land and wildlife. The Australian bushfires of 2019–20 burned 17 million hectares of land across NSW, Victoria, Queensland, ACT, Western Australia and South Australia, and over one billion animals were estimated to have perished in Victoria and NSW alone.[2]

The smoke from the Australian bushfires was so bad that, for multiple days, parts of Australia recorded the worst air quality in the world.[3] For pregnant women, exposure to bushfire smoke can cause respiratory complications, including breathing difficulties and coughing. Babies born to smoke-affected mothers have an increased risk of being small-for-gestational age and preterm,[4] as well as an increased incidence of respiratory infections and wheeze in childhood.[5] Maternity care providers in Albury, an area that was particularly smoke-affected during the bushfires earlier this year, have anecdotally noted an increase in fetal growth restriction, retained placenta and premature births.[6]

Australia and New Zealand (NZ) are often heralded as being some of the safest countries in the world to give birth, yet mainstream maternity systems based on traditional medical models continue to fail to meet the needs and values of Aboriginal, Torres Strait Islander, Māori and Pasifika women.[7,8] This is reflected in the substantially poorer perinatal outcomes that Aboriginal, Torres Strait Islander, Māori and Pasifika women continue to face. Between 2012–17, the maternal mortality ratio for Aboriginal and Torres Strait Islander women was 26.5 per 100,000 births, over four times higher than the ratio for non-Indigenous women (6 per 100,000).[9] In NZ, Māori women are overrepresented in maternal suicide rates. Between 2006–2016, approximately 60% of women who died by suicide in pregnancy or within six weeks of pregnancy were Māori women.[10] Culturally unsafe practices within maternity systems are a key barrier to accessing appropriate care,[11] and poor perinatal outcomes are higher among women who have encountered racism.[12,13]

It has been estimated that cervical cancer may be eliminated from Australia as a public health issue in the next 20 years.[14] The significant reduction in cervical cancer in Australia is the result of political commitments to national screening programs and the roll out of the HPV vaccination initiative. However, these gains have not been equal, with Aboriginal and Torres Strait Islander women still disproportionately affected by cervical cancer,[15] and in much of Africa, for example, cervical cancer remains the leading cause of cancer-related death in women.[16]

We cannot talk about global health without mentioning COVID-19. At the time of writing, the COVID-19 pandemic has seen over 41 million cases of COVID-19 and almost 1.2 million deaths globally.[17] Descriptions of COVID-19 as the 'great leveller'[18] and a 'virus which does not discriminate'[19] are simply incorrect. Individuals and communities which persistently lack social, economic or political power have been most affected by COVID-19. Higher rates of COVID-19 have been associated with insecure employment, income inequality, overcrowded living conditions and poor access to social support and health resources. In low- and middle-income countries, reproductive, maternal, newborn, child and adolescent health services have been severely disrupted leading to increased maternal and newborn deaths, less access to contraception, more unplanned pregnancies, and less immunisation services. It is estimated that over a six-month period, the pandemic may result in an additional 1,157,000 child and 56,700 maternal deaths.[20]

COVID-19 has exacerbated existing cracks in health systems and brought gender issues to the forefront. Women make up 70% of the frontline health workforce worldwide and generally have a higher level of carer responsibilities. The economic impacts from COVID-19 have been compounded for women who generally earn less, are more likely to have insecure employment, work part-time and carry the bulk of unpaid care work, which has increased with childcare and school closures.[21] Social and economic stressors, restricted movements and isolation have also seen a substantial rise in gender-based violence. A survey of 15,000 Australian women found that 4.6% of women – 8.8% of women in a relationship – had experienced physical or sexual violence from a current or former cohabiting partner between February and May 2020.[22] For a third of these women, it was the first time they had experienced physical or sexual violence in their relationship.

The events of 2020 have not only presented global health challenges, they have presented political ones. Politics is intimately linked to healthcare. For our field of work, political issues which involve sexual, reproductive, maternal, child and adolescent healthcare are especially in 'our lane'. Health care providers have long fought for women's health issues and policy change. In Australia and NZ, providers of women's healthcare, including RANZCOG, have been key advocates for abortion reform driving improvements in abortion service access, delivery, clinician training and campaigning for safe access zones around abortion clinics.

Healthcare providers can play an important part in building and supporting societal, economic and policy reforms to improve social conditions and counter health inequities. We can take individual and collective actions to ensure laws affecting human lives are informed by evidence-based policy.[23] Firstly, we can vote and vote with purpose. Your vote is your voice and your voice counts. Secondly, we can lobby our local representatives, write letters to the editor and opinion pieces, join advocacy groups and work with dedicated community-based organisations. Lastly and perhaps most importantly, speak out against implicit and systematic discrimination against race, gender, age, marital status, sexual orientation or expression, disability, and religious or political beliefs. Global maternal and newborn health challenges are challenges for us all. Social and political reforms are critical, and we all have a role to play.

'I believe that all those employed in the medical professions must undertake the difficult task of recognising, in all its implications, that, by definition, health work is political work.'
– Lowitja O'Donoghue

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Global maternal health: past and present

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In 1631, Mumtaz Mahal, the wife of Emperor Shah Jahan, died after a postpartum haemorrhage following a 30-hour labour with her 14th child. The response was a nation-wide two-year period of mourning across India, and the construction of the Taj Mahal in her memory.[1] Across the other side of the world, in 17th Century Sweden, the response of Queen Ulrika Eleonora to the burden of maternal deaths was to establish the first midwifery school and introduce a policy to train one or two women from every village in midwifery.[2] Notably, this strategy of community midwifery in Sweden resulted in that country's maternal mortality ratio (MMR), the number of maternal deaths per 100,000 live births, to come down to 230 by 1900. Sweden's MMR in 1900 was less than half of that of the UK or the US at that same time, (half a century before routine operative deliveries, blood transfusions and antibiotics were available) and well below that of many countries in 2020.

The story of the global response to address maternal deaths is a one of evolving approaches, competing initiatives, and major challenges in estimating the burden of disease.[3]

The first difficulty is accurately knowing the number of maternal deaths in a given setting. In Australia, where the MMR was 5 in 2017, we have comprehensive cause of death certification. The same is not true for low-income countries, where most maternal deaths occur. These are settings where civil registration systems are not in place, and reporting causes of death, particularly for out-of-facility deaths, is almost non-existent. In these settings, the MMR estimate is calculated from population-based survey data, local studies and modelling based on a range of parameters that are associated with improved maternal outcomes (such as the proportion of facility-based births, the GDP, the fertility rate). The most recent estimate for the global MMR is 211, a reduction of 37% since 2000. However, there are significant regional variations. North America is the only region where MMR is increasing (Table 1).[4]

A global MMR of 211 equates to some 808 women dying each day from preventable causes due to pregnancy or childbirth, 86% of whom live in Sub-Saharan Africa or South Asia. And three out of four maternal deaths are due to direct obstetric causes, including haemorrhage, eclampsia, sepsis, obstruction and unsafe abortion, the vast majority of which are preventable.[4]

The history of global responses to reduce maternal deaths in low- and middle-income countries dates from initiatives in the 1970s and 1980s focused on training traditional birth attendants (TBAs), locally recognised women who assisted at the time of birth but who had no formal health training. Realising that most hospitals, midwives and doctors were urban based where less than 10% of the population resided, the efforts were focused on training TBAs to do risk screening and encourage safer practices, the so called three cleans of a home birth 'hand washing with soap, clean cutting implement and cord tie, and clean surface'. By the late 1980s, the number of women dying as a complication of pregnancy and childbirth had not changed in 20 years. Risk screening was poorly predictive, and recognising that TBAs were in no position to manage a life-threatening complication, the focus shifted to supporting women to birth with the assistance of skilled birth attendants (SBA), a midwife or a doctor and a resultant shift to birthing in a health facility.[5]

By the late 1990s a set of process indicators had been developed including recommended population-based guidelines for the number of facilities able to provide Emergency Obstetric Care (EmOC) – where basic or BEmOC facilities provided care for women, including managing obstetric complications except for the provision of caesarean sections and blood transfusions, while comprehensive care (CEmOC) included all the signal functions of BEmOC with the additional provision of operative birth and blood transfusions.[6]

Such was the enthusiasm for this approach that in 2000, when the Millennium Development Goal (MDG) targets were being crafted, the maternal health target was set at an ambitious 75% reduction by 2015 against the baseline of 1990. The MDGs galvanised governments and donors to improve the coverage of care through a range of initiatives including health financing mechanisms to reduce the out-of-pocket spending on hospital maternity care, and scaling up rural services to improve geographic access. A number of global health initiatives were established.[7]

Country/Region	2000	2005	2010	2015	2017
East Asia and Pacific	114	100	86	73	69
Western Europe	8	7	6	6	5
Latin America and Caribbean	96	90	84	76	74
Middle East and North Africa	95	81	63	59	57
North America	12	13	14	17	18
South Asia	395	309	235	179	163
Sub-Saharan Africa	870	746	626	557	533
Australia	7	5	5	6	6
Least developed countries	763	635	520	442	415
World	342	296	248	219	211

Table 1. Global MMR trends. Source: WHO, UNICEF, UNFPA, World Bank Group and UNPD (MMEIG) - September 2019

The strategy of supporting SBAs with a functional health system resulted in significant progress and by 2015, while the MDG target had not been reached, an estimated 44% reduction in maternal deaths had been recorded, yet the increased coverage of antenatal care and facility-based births did not result in the expected reduction in maternal deaths. Over the last 10 years, there has been a renewed focus on how to improve the quality of care received, recognising that while the majority of women will now seek care at a facility at the time of childbirth – many may still be arriving at under-resourced facilities, 40% of hospitals in Sub-Saharan Africa do not have adequate water and sanitation supplies, and there are major health workforce shortages. The Sustainable Development Goals (SDGs), the agreed development goals for 2030, are aiming for a global MMR of 70 with no individual country having an MMR over 140. This requires a huge investment in not just supporting women to get to a facility for their birth, but ensuring that once she gets there, she receives high-quality care that is respectful and woman centred.

The risk of COVID-19 on further progress in global maternal health is significant. A recent WHO survey of 105 countries reported that 34% had had significant disruption to the provision of obstetric care in the first half of 2020, a combination of lockdown measures reducing access, staff being redeployed, and concerns regarding transmission that create fear and uncertainty in both providers and women and their families.[8] In the first three months of lockdown in Nepal, for example, across nine referral hospitals, facility-based births halved, stillbirths increased by 50% and neonatal mortality doubled.[9] Modelling a 40–50% decreased coverage of institutional births across 118 high-burden countries estimates an additional 56,700 maternal deaths.[10] There is a real risk of the pandemic reversing the progress made in the last 20 years.

> The litmus test of any health system is how women are treated at the time of childbirth.

Reflecting on the responses to maternal deaths that occurred in the 1600s in India and Sweden, the year 2020 presents an opportunity to build not a mausoleum, however glorious the Taj Mahal might be, but rather a network of high-quality health systems designed to meet the needs of women throughout their reproductive lives, regardless of where they live. In this way, the SDGs could be a realistic, achievable goal.

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Respectful maternity care: giving birth (in)to a better world

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What is respectful maternity care and why is it important?

Respectful maternity care is a critical but often neglected area of quality healthcare. Respectful maternity care is defined as '... care organised for and provided to all women in a manner that maintains their dignity, privacy and confidentiality, ensures freedom from harm and mistreatment and enables informed choice and continuous support during labour and childbirth.'[1] Yet the reality for many women is much different, with disrespectful and undignified care common in many health settings globally.

Among health professionals there is growing awareness of the importance of respectful maternity care. The realisation that respectful care is both a healthcare practice as well as a rights-based issue has helped to inform the understanding that that the provision of clinical care is only one arm of quality care. The other being the experience of care. Care which is kind, respectful and dignified is not an 'optional extra', it is an inextricable component of quality maternity care.[2]

The universal rights of childbearing women* speak to the intersection of respectful maternity care and human rights:

1. Freedom from harm and ill treatment
2. Right to information, informed consent and refusal and respect for choices and preferences including companionship during maternity care
3. Confidentiality and privacy
4. Dignity, respect
5. Equality, freedom from discrimination, equitable care
6. Right to timely healthcare and to the highest attainable level of health
7. Liberty, autonomy, self-determination and freedom from coercion[3]

In our busy professional lives, this might be the point where it can be tempting to cognitively 'tick the box' answering 'yes, I do that, good, what's the next article?' We'd like to encourage you to stick with us, we believe there's something in this for all of us, whether you've been practicing for a little or a long time.

What is the problem?

A recent systematic review by Bohren and colleagues presented an evidence-based typology of the mistreatment of women during childbirth which can be a result of human and/or systemic failures.[4] Practices that disrespect and mistreat childbearing women are a violation of women's fundamental human rights;[3] are directly related to poor maternal and neonatal outcomes; result in women being less likely to present to the same service for follow up or future care needs[4] and are associated with psychological distress in women.[5] The typology of the mistreatment of women during childbirth can be categorised into seven main classifications:

- Physical abuse – includes the use of force or physical restraint
- Sexual abuse – includes rape
- Verbal abuse – includes harsh language, threats and blaming
- Stigma and discrimination – based on sociodemographic characteristics, medical conditions
- Failure to meet professional standards of care – lack of informed consent and confidentiality, physical examinations and procedures, neglect and abandonment, coercion
- Poor rapport between women and providers – includes a loss of autonomy, ineffective communication, lack of supportive care

- Health system conditions and constraints – includes lack of resources, policies and facility culture

It should be noted that these mistreatment practices are not a consequence of providing maternity care in resource-constrained environments. Evidence confirms that maternal abuse occurs in all sectors, including low-, middle- and high-income countries, which means that this truly is a global issue.[4,6,7] A multi-country study which involved more than 2000 birth observations and community surveys in Ghana, Guinea, Myanmar and Nigeria found that over one-third of women experienced physical or verbal abuse, stigma or discrimination during childbirth.[8] Research in high-income countries has similarly found that mistreatment during labour and childbirth is unfortunately commonplace. Indigenous women, women of colour, women who are asylum seekers or refugees, single women, adolescent girls and those who are experiencing homelessness are disproportionately likely to experience disrespectful maternity care.[9]

A recent report into human rights violations in pregnancy, birth and postpartum during the COVID-19 pandemic lists sobering accounts of women being separated from their babies, not allowed access to support people, women being subjected to forced medical intervention and denied access to decentralised community based care.[10] Unfortunately, the reality is that we haven't needed a pandemic for these transgressions of rights to occur, they were commonplace well before COVID-19. Anecdotal reports are plentiful and evidence documents where women in Tanzania have been hit and yelled at during labour; women in Brazil deprived of skin-to-skin contact with their babies after birth;[11] women in Australia denied access to vaginal birth after a previous caesarean,[12] women in Canada being coerced into unnecessary interventions because the hospital needs beds for more women;[6] women in Nigeria subjected to vaginal examinations without consent,[8] women in New Zealand denied the right to privacy with pressure to accept medical students lined up to observe vaginal examinations, the list is long and compelling.

The drivers of mistreatment of women during pregnancy and childbirth are complex and involve people and systems. The cause for hope is that both of these are modifiable agents. There is no one profession or group of people identified as the source of the mistreatment. This means that we are all responsible both collectively and individually to challenge mistreatment where we see it happen in our workplaces. Bringing it closer to home where we can really affect change is to have the bravery to reflect on our own practice, asking 'how I can modify the way I engage with women to ensure respectful maternity care?' Even perhaps, 'how can I inspire it in my colleagues?' Remembering that respectful maternity care is a fundamental and necessary component of quality maternity care.

The second identified agent of the mistreatment of childbearing women is health systems. The industrialisation of healthcare is no different to the industrialisation of any other sectors, it relies on the systems efficiencies of standardised units.[14] Many of us will have encountered cases where a woman's care is impacted due to systems-based 'efficiency' requirements such as where labour is augmented because bed space is needed; or an instrumental birth offered to just help the baby (and staffing) out before a shift change; or women being induced earlier than needed because there's no space in the induction book next week when it might be more clinically appropriate; Aboriginal women having to fly hundreds of kilometres away from Country and cultural supports because there are no services available to them; clinical consults conducted in less-than-private settings because all the rooms are full; women denied access to labouring in water because 'we don't do that here'. We also need to embrace implementation research which centres women's voices and goes beyond the biomedical, encompassing public health and the social sciences to identify effective and feasible interventions to improve respectful maternity care.

Both the women to whom care is provided and the professionals providing the care are anything but 'standardised units.' We each hold unique values and beliefs that intersect with our cultural, social and spiritual influences. Industrialisation relies on the commodification of humans where we are but one more 'link in the chain' of systems efficiencies. Whilst there is evidence and recognition of the negative impact of systems-centred care on women, another consequence is vicarious trauma to the health professionals who are required to provide care in these constrained systems. Rates of burnout and psychological distress are climbing among obstetricians and midwives.[15,16] Calls for 'professional resilience' are being challenged in the context of the dehumanising outcomes of systems-centred care for both the consumers and providers of healthcare.

What can we do?

There are some tangible ways that we can address the barriers to respectful maternity care that will not only result in quality care for women but quality, rewarding work environments for all health practitioners.

The first step is individual awareness of the ways that respectful maternity care could be implemented or enhanced within our own practice. Confronting unconscious bias where we have been conditioned to align with systems-based priorities rather than providing respectful, woman-centred care is both challenging and important. This level of critical appraisal of our own practice requires bravery but is necessary in order to effect change at a broader level. Supporting respectful maternity care in our colleagues' work is also an important step to reinforcing positive change in the clinical environment which improves maternal and newborn outcomes and also leads to increased work satisfaction.[17,18]

Provoking change in well-established hierarchical maternity systems might seem an even greater challenge than individual change but the reality is, it can, and must, be done. There have been swift and radical changes to maternity care in the past year in response to the global COVID-10 pandemic. It is timely to consider and seize the opportunity to create the systems that will support us well into the future by examining how we can construct frameworks that will support respectful maternity care.[19,20]

Providing respectful, woman-centred maternity care is quite literally the way to change the world. The realisation of practices and systems that uphold women's human rights will bring justice and equity long overdue to women around the world. Remembering the privilege that it is to work with women in this most fundamental of human acts of giving birth serves as the impetus to ensure that the respectful, quality maternity care that we provide will result in better outcomes for all women

and their babies. When we improve outcomes and quality of care for mothers, we improve the health of families, communities, society and our world – one woman at a time.

*** Inclusivity Statement:** *We recognise that individuals have diverse gender identities. Terms such as pregnant person, people who give birth and parent are sometimes used to avoid gendering birth, and those who give birth, as feminine. However, globally many women are also marginalised and oppressed, as such, we have continued to use the terms woman, mother or maternity. When we use these terms, it is not meant to exclude those who give birth and do not identify as women.*

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Volunteering or voluntourism?

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In her annual leave as a second-year resident, Julie went on a three-week holiday to a Pacific Island Country. Among island-hopping, diving and swimming, she decided to visit the local hospital to see if she could 'lend a hand'. Julie had just completed a rotation in O&G in Australia, and was planning to apply to the College for a training position.

On arrival at the hospital, she met the only local O&G consultant and was taken on a tour of the birth suite. Julie was surprised by how busy the staff were – there didn't seem to be enough of them to manage all the labouring women!

As the consultant was required to attend a hospital meeting, Julie was left as the only doctor on the birth suite. The staff seemed overwhelmed, so she decided to assist by performing examinations, administering medications and undertaking simple clinical tasks such as cannula insertion.

Having enjoyed her experience, she returned the next day in the hope of more extensive involvement in patient care. Some of the obstetric cases were really challenging, and everyone seemed so grateful for her help and advice!

Global health volunteering is growing in popularity. While volunteers can make valuable contributions to international development, poorly executed assignments carry a risk of harm. This article considers the good, the bad and the ugly of international volunteering in global women's health (GWH), and highlights the ethical challenges associated with voluntourism.

Volunteering and voluntourism

Volunteering for international development involves voluntary participation, without monetary reward, in activities that support sustainable development priorities. Best-practice programs focus on locally identified needs, and are undertaken in partnership with the host community.[1]

This model of volunteering stands in contrast to voluntourism, a form of travel in which tourists participate in unpaid work. Although there is no agreed definition, voluntourism is sometimes referred to as 'holidaying with a purpose'.

Participants in voluntourism typically engage in brief, one-off activities that are not associated with longitudinal, capacity development programs. Stereotypical examples include foreign tourists visiting orphanages or schools in low- and middle-income countries (LMICs).[1]

In global health, activities that potentially constitute voluntourism include medical electives; delivery

of donated medical equipment; and 'missions' to perform service delivery, teaching or research in developing settings.[2,3] Whether or not these 'short-term experiences in global health' (STEGH) are ethically justified depends on both individual and program factors.[4]

The case study above illustrates voluntourism in GWH. While Julie's desire to assist is admirable, 'helping' in this way is ethically complex. She, like other voluntourists, may inadvertently do harm in various ways, which could outweigh any short-term benefits.[3,4] Ethically, good intentions are not enough – the principle of beneficence requires actions that actually translate into positive outcomes (or at least have a high probability of doing so, based on evidence and experience).

The good

The benefits of responsible global health volunteering are well documented.[1,5] For host communities, the positive effects extend to patients (eg. access to medical services provided by skilled volunteers) as well as health professionals (eg. enhanced capacity through teaching and training). As discussed below, benefits are maximised when volunteering arrangements conform to best practice, and are associated with reciprocal, longitudinal development programs.

For volunteers, commonly reported benefits include improved cross-cultural understanding and a deeper appreciation of the social determinants of health. Additionally, volunteering assignments provide an opportunity to gain skills in resource-limited clinical care.[5,6]

In O&G, some clinicians participate in STEGH to gain exposure to surgery and pathology that is rarely encountered at home. An example is the practice of doctors from high-income countries travelling to Africa to perform obstetric fistula repairs.[7] Missions of this nature require close scrutiny to ensure they are ethically justifiable. Any benefits to foreign volunteers should be considered an 'added bonus', not the justification for the volunteering activity.

The bad and the ugly

Volunteering programs that lack robust design, implementation and monitoring arrangements have the potential to cause harm. STEGH, as opposed to long-term volunteering for international development assignments, are more likely to fall into this category.

There are a number of specific risks relevant to GWH. At a clinical level, patients might suffer if they receive care that is inappropriate in the context. For example, imagine that Julie encountered a woman in labour with a complete breech, and arranged a caesarean section. While this may be an appropriate course of action in a developed setting, in a resource-limited environment, operative delivery would place the mother at a significantly increased probability of death. The risk of maternal mortality following caesarean section in a LMIC is 100 times greater than in a high-income country, mostly related to postpartum haemorrhage and sepsis.[8]

Clinical risks are amplified when volunteers act beyond their scope of practice and do not seek local credentialing or registration. This practice is unfortunately common, and is more likely to occur in the context of poorly supervised programs.[4] The ephemeral nature of STEGH also contributes to this risk, because short-term assignments do not allow the volunteer to develop an adequate understanding of local approaches and culture. This is particularly important in GWH because sensitive areas of reproductive health practice, such as contraception and termination, are heavily influenced by religious and cultural norms. Failure to acknowledge resource limitations can also be problematic, leading to unintended consequences with clinical implications (Table 1).

At institutional level, poorly executed STEGH can be burdensome for host communities and undermine local capacity. In addition to the tangible harms described above, these types of practices serve to disempower communities and perpetuate a sense of dependence.[1] Alongside improved health, respecting and promoting the autonomy of host communities is an important ethical goal in itself. Poor volunteering

Image by SOLS 24/7 via 'Voluntourism - What's Wrong With It?'

Table 1. Potential unintended consequences in GWH volunteer activities.

Activity	Potential unintended consequences	Mitigation strategies
Stand-alone, surgically oriented visit involving service delivery +/- surgical mentoring	Consumption of local surgical equipment (eg. sterile drapes and other surgical consumables), compromising capacity for other operations and procedures	Ensure adequate planning, including extensive consultation with all local collaborators Co-ordinate with other visiting surgical teams The team brings their own drapes and equipment, ensuring they don't create a disposal burden for the host community
Stand-alone, education-focussed visit involving short course training	Removal of clinicians from clinical duties, leaving no one available to provide service delivery	Plan and collaborate with local partners Develop an attendance roster and run several iterations of the program so that all relevant clinicians can attend the training
Visit to donate medical goods and equipment	Costs for maintenance and/or disposal are prohibitive Undermining of local procurement processes, breeding dependence Equipment can't be used because of poor access to consumables, a reliable power supply or appropriately trained staff	Follow best practice guidelines in medical equipment donations

behaviours arguably perpetuate a neo-colonial approach to global health, amplifying power imbalances and compromising local ownership.[1,9]

Does this paint too bleak a picture of voluntourism? After all, as Julie might say, 'Surely some help is better than none'. The problem is that Julie, and other voluntourists, are blind to the hidden long-term adverse effects, such as creating a belief among host communities that local providers are ineffective.[10] These impacts accumulate, such that they can outweigh any short-term benefits for individual patients or local clinicians.

Advocates of voluntourism might also contend that communities can always decline the volunteer if they are concerned about long-term effects, but this ignores the fact that many host communities lack sufficient autonomy to refuse external support.[10] Additionally, in high-context and relationships-based cultures (where meaning is often communicated through non-verbal cues and implicit messaging), individuals may say 'yes', but actually mean 'no'.[11]

Voluntourism also carries risks for the volunteer. Clinicians who engage in poorly designed volunteering programs potentially leave themselves vulnerable, especially in the setting of volatile workplaces and limited cultural understanding.[1,5]

For Julie, specific risks might include needle-stick injury and confrontation with local staff members. While accepting some level of risk to self in order to help others is a good thing (and arguably part of the internal morality of medicine), taking on risk to self when it might do more harm than good to others just doesn't make sense.

Towards responsible volunteering

For these reasons, it is vital that the GWH community adopts high ethical standards in relation to international volunteering. O&G practice, by its nature, involves care of vulnerable patient groups, and GWH programs must ensure women and their communities are protected.

It is also important that senior O&G clinicians set the right example for junior colleagues. A recent survey of O&G trainees in Australia and New Zealand identified that 88% were interested in undertaking GWH work in the future. This finding has stimulated valuable discussion regarding the need for ethically robust GWH training programs.[6]

Fortunately, clear standards for international volunteering have been developed by the Australian Council for International Development.[1] Additionally, several other guidelines are available to inform safe approaches to STEGH and global health training.[4,12]

Shah et al, for instance, have published a framework that seeks to optimise outcomes and mitigate risks from STEGH.[4] They suggest a principles-based approach with individual and program-level responsibilities.

At individual level, volunteers should be culturally sensitive; join programs with long-term work plans; thoroughly understand local context and guidelines; arrange all appropriate registrations and insurances; and possess the requisite clinical skills and experience, with insight to their limitations. Meanwhile, programs must have clearly articulated objectives; focus on capacity building; facilitate collaboration with local clinicians and other visiting programs; recruit volunteers with appropriate skills and attributes; ensure participant preparation and debriefing; and regularly evaluate their performance.[4]

There are many opportunities for GWH volunteering that are consistent with these principles. These include deployments through established humanitarian organisations (such as Médecins Sans Frontières), College-linked surgical projects (such as the Pacific Island Program) and long-term development initiatives through the Australian Government. One such model, supported by RANZCOG, is profiled in Box 1.

Box 1. SIGISSP: example of a safe and effective volunteering model.

Solomon Islands Graduate Intern Support and Supervision Project (SIGISSP)

SIGISSP places advanced trainees with RANZCOG (and other speciality training programs) at the National Referral Hospital in Honiara, Solomon Islands, for 6–12-month terms. Trainees provide ward-based supervision for junior doctors, contribute to teaching programs for Cuban-trained interns and participate in quality improvement activities. Trainee-led quality improvement projects have included the development of a National Standard Treatment Manual in O&G and a comprehensive audit process for maternal mortality. The program is facilitated by Australian Volunteers International and funded by the Australian Government through the Australian Volunteers Program.[6]

Conclusion

As interest in GWH increases, it is essential that the O&G community maintains high standards in international volunteering. Volunteers can make valuable contributions, but only if they participate in robust programs that emphasise mutuality and sustainability. By following best practice guidelines, O&G clinicians can ensure their GWH activities are safe, ethical and effective.

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Living ethically and effectively in a global world

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I teach a course called Practical Ethics at Princeton University. I include, as part of the coursework, readings on global poverty containing estimates of how much it costs to save the life of one of the millions of children who die each year from diseases that we can easily prevent or cure. In 2009, a student, Matt Wage, used such an estimate to calculate how much good he could do for others in his lifetime. Wage was planning to become a professor, and used a ballpark figure on the average income he was likely to earn each year and the assumption that he would donate 10 percent of it to a highly effective non-profit. He discovered that he could save about one hundred lives. He thought to himself, 'Suppose you see a burning building, and you run through the flames and kick a door open and let one hundred people out. That would be the greatest moment in your life. And I could do as much good as that!'

Wage did not become a professor. Instead he set himself on a path to saving a hundred lives, not over his entire career, but within the first year or two of his working life and every year thereafter. In the years up to his graduation, Wage had done a lot of thinking about what career would do the most good. Over many discussions with others, he decided to take a job on Wall Street. On a higher income, he would be able to give much more, both as a percentage and in dollars, than 10 percent of a professor's income. One year after graduating, Wage was donating a six-figure sum – roughly half his annual earnings – to highly effective charities.

Wage is part of an exciting new movement: effective altruism. The definition of effective altruism that appears in Wikipedia is: 'a philosophy and social movement which applies evidence and reason to determining the most effective ways to improve the world.' Effective altruism is based on a very simple idea: we should do the most good we can. Obeying the usual rules about not stealing, cheating, hurting and killing is not enough, or at least not enough for those of us who have the good fortune to live in material comfort, who can feed, house, and clothe ourselves and our families and still have money or time to spare. Living a minimally acceptable ethical life involves using a substantial part of our spare resources to make the world a better place. Living a fully ethical life involves doing the most good we can. According to Wage, counter-intuitively, he could do the most good on Wall Street.

O&G specialists may not make as much money as high-fliers on Wall Street, but they also avoid the kind of unethical practices that were revealed only too clearly as a result of the global financial crisis of 2008–9. Most still earn enough to make substantial charitable donations and still live very comfortably. As Wage's example illustrates, we should not think of effective altruism as requiring self-sacrifice, in the sense of something necessarily contrary to one's own interests. If doing the most you can for others means that you are also flourishing, then that is the best possible outcome for everyone. As O&G specialists fulfil their duty to save and improve lives at work, the ideas of effective altruism can help them do the most good through their charity choices as well.

Doing the most good is, admittedly, a broad idea that raises many questions. Here are a few of the more obvious ones, and some preliminary answers.

What counts as 'the most good'?

Effective altruists will not all give the same answer to this question, but they do share some values. They would all agree that a world with less suffering and more happiness in it is, other things being equal, better than one with more suffering and less happiness. Most would say that a world in which people live longer is, other things being equal, better than one in which people have shorter lives. These values explain why helping people in extreme poverty is a popular cause among effective altruists. A given sum of money does much more to reduce suffering and save lives if we use it to assist people living in extreme poverty in developing countries than it would if we gave it to most other charitable causes.

How do effective altruists decide where their donations will do the most good?

Effective giving is both an art and a science in which the heart and the head work in synergy to make giving decisions. Yet data indicates that in the USA, only 38% of donors research non-profits before making giving decisions, and only 9% of donors compare different non–profits, so most of us are giving from the heart alone. We often base our giving decisions on emotions, such as if a friend or family asks us to support a cause or if a loved one has suffered from a disease or if a local organisation asks us to support members in our community. While it cannot be denied that a personal emotional connection to giving is imperative, truly making an impact requires us to base our giving decisions on an objective analysis of what works, and what does the most good per dollar donated.

The quality and availability of research on the effectiveness of individual charities has risen dramatically over the past few years, largely due to the existence of GiveWell, a research organisation set up in 2007 precisely to fill the vacuum that existed previously. The outcome of this research is freely available online.[1] Other organisations, such as The Life You Can Save[2] (which I founded after the publication of a book with that title)[3] draw on GiveWell's research but broaden the criteria for recommending a charity. Choosing between different causes (for example, global poverty, reducing animal suffering, protecting the environment, reducing risks of human extinction) is the subject of vigorous discussion on websites associated with effective altruism.

Why is it important to evaluate the effectiveness of charities? Is it not sufficient to know that a charity is 'not a fraud'?

It is important to identify what different organisations actually achieve for each dollar they receive. This is because some charities provide hundreds or even thousands of times greater impact per dollar than others – and when I say this, I am not comparing a fraudulent charity with a genuine charity, but comparing one genuine charity with another genuine charity.

Consider this example: It costs about $50,000 USD to train a guide dog that will help a blind person in the United States – a very good cause. However, for much less than $50,000, you can help prevent people from becoming blind because of trachoma, which is the most common cause of preventable blindness globally, and you can help restore sight to people who are blind because of operable cataracts. The cost for preventing blindness from trachoma has been estimated to be around $7.14, and trachoma can also be treated by surgery for an estimated cost of $27–$50. Similarly, older people who become blind because they have developed cataracts can restore their sight through a simple surgery costing as little as $50. In other words, for the cost of placing one guide dog with one blind person, you could instead donate to an organisation like Seva[4] or the Fred Hollows Foundation[5] and provide surgery to restore sight to at least 1000 people who cannot see, or prevent a similar number of cases of blindness from trachoma.

Effective giving requires you to grapple with the question of where your donation could do the most good, and to give to areas where you could maximize your impact, as not all charities are created equal.

Can you give some examples of what effective non-profits accomplish through donations?

There is still a lot of work to be done in evaluating the effectiveness of various programs. However, giving to an effective non-profit can ensure that even a small donation does a lot of good. If you are considering donating to a charity recommended by The Life You Can Save, you can use the organisation's Impact Calculator[6] to show what the amount you donate will achieve. Based on current estimates, a $50 donation could:

- Deliver treatments through the Schistosomiasis Control Initiative[7] or Evidence Action's Deworm the World program[8] to protect an estimated 100 or more children from parasitic worm infections, preventing life-threatening conditions including bladder cancer, kidney malfunction, spleen damage, and anaemia.
- Deliver, through the Global Alliance for Improved Nutrition[9] or the Iodine Global Network,[10] a year of iodised salt for an estimated 500 people, improving health and protecting against iodine deficiency disorders such as brain damage.
- By means of Evidence Action's Dispensers for Safe Water program,[11] provide safe drinking water to an estimated 40 community members for one year.
- Take care of the annual costs of high-quality healthcare for two patients in remote Nepal offered by Possible,[12] including home visits and surgery, with no fee-for-service at the point of care.
- Enable One Acre Fund[13] to supply a farm family of six with inputs such as seeds, fertiliser, training, and market access support, to increase production and profits by an average of 50% in a single season.

Why act altruistically?

For some people, the reason for helping others is obvious: it is what we ought to do, and part of living an ethical life, and there is no need for saying anything more. But some are more sceptical. They want to know what they will get out of it. Fortunately, recent research in psychology has justified an ancient philosophical response to that question, one that is as old as Socrates: living ethically is a better way of living for us too. Helping others, living in accordance with our most fundamental values, and being generous, is a way of giving meaning to our own lives and finding fulfilment in what we do. Effective altruists directly benefit others, but indirectly they often benefit themselves.

I thank Anam Vadgama for research and editorial assistance with this article.

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Further reading

1. www.givewell.org/
2. www.thelifeyoucansave.org/
3. www.thelifeyoucansave.org/the-book/
4. www.thelifeyoucansave.org/best-charities/seva/
5. www.thelifeyoucansave.org/best-charities/fred-hollows-foundation/
6. www.thelifeyoucansave.org/impact-calculator/
7. www.thelifeyoucansave.org/best-charities/schistosomiasis-control-initiative/
8. www.thelifeyoucansave.org/best-charities/evidence-action/
9. www.thelifeyoucansave.org/best-charities/global-alliance-for-improved-nutrition/
10. www.thelifeyoucansave.org/best-charities/iodine-global-network/
11. www.thelifeyoucansave.org/best-charities/evidence-action/
12. www.thelifeyoucansave.org/best-charities/possible/
13. www.thelifeyoucansave.org/best-charities/one-acre-fund/

Contraceptive implants improving health in PNG

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Improving access to contraception is one of the safest and most cost-effective methods for lowering maternal morbidity and mortality, so much so that expanding access to reliable contraception for women has become an international priority of the Sustainable Development Goals for the coming decade.[1-5] However, the impact of family planning on maternal health has not been comprehensively outlined for the Asia-Pacific Region where approximately 13,000 maternal deaths continue to occur each year, representing nearly 5% of the annual global maternal mortality burden.[6]

Papua New Guinea (PNG) is an archipelago nation with the highest maternal mortality ratio of all countries outside of Africa, estimated between 250 and 700 per 100,000 live births in 2014, depending on regional rurality.[6,7] Although contraceptive prevalence among married women aged 15–49 years in PNG has increased from 24.5% in 1990 to 36.5% in 2016, in rural areas it is much lower, especially for modern methods (21%). This is significant because 85% of PNG's population are rurally dwelling and the majority (>90%) of maternal deaths occur in these locations. The total unmet need for contraception in rural areas also remains high at 44% with little change in the preceding decade.[8-10]

Long-acting reversible contraception (LARC), including contraceptive implants and intra-uterine devices, have been consistently shown in the literature to be the most cost-effective, safe and reliable methods of contraception to limit pregnancy exposure and achieve adequate birth spacing.[11,12] Access to LARC, however, remains heavily limited in PNG owing to a complex interplay of logistic, social and cultural barriers.[6,8-10] Outreach programs co-ordinated by non-government organisations, including Rotary Australia International and Marie Stopes International, in association with volunteer and local health services in PNG, have tried to alleviate some of the access barriers by bringing the implant services to the communities.[13] These programs educate women about the implants, insert them free of charge and train local health workers in insertion and removal techniques to promote capacity building and program sustainability.[13]

RANZCOG is committed to improving reproductive health in the Asia-Pacific Region and actively promotes and facilitates volunteer networks that link doctors across Australia, New Zealand and the Pacific, with a particular emphasis on enhancing support at the grassroots level.[14] Since 2012, a number of RANZCOG representatives have been involved in outreach programs that have provided over 80,000 contraceptive implants to women in 12 rural provinces throughout PNG. Supported by the RANZCOG New South Wales Regional Committee Trainee Research Scholarship, we set out to evaluate the clinical efficacy and cultural acceptability of implants within a locally serviced rural population on Karkar Island, and the impact that introduction of implants has had on maternal and neonatal health in this setting.

Findings

We used both qualitative and quantitative methods to examine the acceptability of receiving implants through this program, as well as follow up the women and the community to document the ongoing use of implants, and assess the impact that increasing access to reliable contraception had on maternal and neonatal health. Twelve month follow-up data confirmed high continuation rates and satisfaction scores with the implant: 97% of women

still had the device in situ at the time of follow up and 92% reported being 'very happy' with it.[15] Three quarters of women did not experience any side effects and of those who did have side effects, the majority complained of irregular bleeding though only 2% of those with irregular bleeding reported it to be bothersome enough to have the device removed. The most common reason for women removing the device prior to twelve months was to resume childbearing (50% of removals).

When we studied the association between introduction of the implant on Karkar Island and specific birth outcomes using time-series analyses, we demonstrated a significant reduction in all causes of maternal and neonatal morbidity.[16] The annual rate per 1000 births of severe haemorrhage, maternal sepsis, low birth weight and prematurity decreased between 56% and 74% following introduction of the implants. The rate of some outcomes (severe haemorrhage and sepsis) were beginning to decline prior to introduction of the implants but the rate of these outcomes fell more quickly after implants were introduced. The number of women with high-risk characteristics who gave birth (i.e. parity ≥4 and inter-pregnancy interval <12 months) also declined by at least 50%, which may have contributed to the observed reductions in other adverse pregnancy outcomes. We are unable to comment on the association between implant introduction and maternal/neonatal mortality rates owing to the low number of deaths recorded in hospital databases. In the absence of any other major reproductive health initiatives being introduced to Karkar Island around the study period, it is likely that many of the observed reductions in adverse pregnancy outcomes are associated with use of the contraceptive implant.

In addition to the listed benefits associated with implant use, our findings have also identified potential barriers to ongoing implant uptake that program developers may need to negotiate going forward. Interviews with women, men, health workers and prominent community members revealed that owing to deeply ingrained and gendered societal norms, men were most influential in the decision-making process around implant use, though they did not directly receive information about implants. There was also a community-wide lack of awareness about implants which lowered community trust in the method and deterred health workers from promoting their use. Future awareness programs would therefore likely benefit from having more extensive coverage throughout the community and engaging men and other influential community members in implant education and promotion.

Conclusions

Findings from this body of work provide encouraging evidence to support expanding access to contraceptive implants among rural communities in PNG. This is likely to be the fastest and most cost-efficient way to boost contraceptive prevalence rates in line with targets set by the Sustainable Development Goals (i.e. CPR of 50% by 2030). Twelve-month follow-up data confirm high levels of clinical efficacy and community acceptability with the implant. However, our qualitative findings point to the need for ongoing community education as being critical to sustaining implant uptake in the future. In particular, future programs need to be sensitive towards the complex relational gender dynamics between men, women and key community members that impact on contraceptive choice.

It is important also to consider how best to address inequities in access to sexual and reproductive health services, particularly amongst adolescent and sexually active unmarried women, that are driven by a lack of youth-friendly clinics, limited comprehensive sexuality education, and social, cultural and religious mores that inhibit communication with peers and adults about sexual health. Given that the numbers of these population sub-groups are growing, there is an urgent need for future research to specifically evaluate their contraceptive preferences, as only then will the SDG goal of 'universal access to sexual and reproductive health and rights' be achievable.

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ONE-Sim: global health education program

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The unmet need

Maternal and neonatal mortality continues to place a substantial burden on resources in low- and middle-income countries. Most maternal deaths worldwide occur in low-resource settings, and many are due to preventable causes such as postpartum haemorrhage, infection and pre-eclampsia. On the other hand, common causes of global neonatal deaths include perinatal asphyxia, prematurity, low birth weight and sepsis. Perinatal asphyxia itself accounts for close to one million neonatal deaths around the world every year. Despite decline in recent years, maternal and neonatal mortality rates, particularly in India and parts of Africa, continue to remain high.

There are a number of factors that contribute to maternal and neonatal outcomes. One of the key factors is training of obstetric and midwifery teams, and students in independent silos.[1] An approach to maternity team-based interprofessional learning (in students and clinicians) has been shown to improve relationships between teams,[2] which contributes to improved clinical care. A significant factor which influences mortality rates is the lack of training provided to healthcare workers in poorly resourced and remote settings, where transfer to larger referral centres may be challenging. Compared to high-income countries, low–middle-income countries (LMICs) also experience a shortage of doctors and nurses in relation to their population. Public health institutions range from specialised urban hospitals to rural primary health centres in these countries, but some households still visit unqualified private providers for healthcare. Even amongst those with qualifications, the support from experienced medical professionals can be low in rural and remote settings. Medical and nursing educational institutions in small towns, centres in LMICs may have scant facilities, expertise and opportunities for clinical exposure during training, as well as a lack of continuing education, skill maintenance and collaborative team culture, which have been implicated as barriers to providing adequate healthcare.

The educational program

In an attempt to address the education gap that exists for childbirth emergencies in LMICs, obstetrician, Dr Arunaz Kumar and neonatologist, Dr Atul Malhotra developed an education package, ONE-Sim. Dr Kumar is an educational researcher and has a PhD in simulation-based interprofessional obstetric education, while Dr Malhotra is a clinician scientist and educator. The Obstetric and Neonatal Emergency Simulation (ONE-Sim) interprofessional workshops are now a part of medical, nursing and midwifery undergraduate and postgraduate education at Monash University, Melbourne, Australia, and a number of centres in LMICs (onesimeducation.com). The workshops focus on common obstetric emergencies including obstructed labour, fetal distress, shoulder dystocia, neonatal resuscitation, and postpartum haemorrhage. ONE-Sim provides local healthcare professionals – obstetric and paediatric doctors, nurses, midwives, and students, education about dealing with complex childbirth and newborn care issues, through hands-on experience using simple simulation technology and team-based scenario design. Through a 'Train the Trainer' workshop design, the ONE-Sim program also aims to empower local healthcare staff who can then further impart the training within their own workplace in a flexible way that suits the birth setting.

The ONE-Sim workshops use low technology, low-maintenance mobile equipment that can be packed in a suitcase. It can be transferred across locations and made accessible to distant sites, with a quick set up to implement obstetric and neonatal training for multi-professional teams. These include medical and midwifery staff and students, and other healthcare workers involved as birth attendants. Participants are afforded hands-on experience of managing birth emergencies using simulators, with focus on scenarios relevant to their individual setting, improving communication and teamwork skills in addition to addressing technical and problem-solving proficiency.[3]

Equipment

A Prompt Flex simulator (Limbs and Things, Bristol, UK) and neonatal resuscitation baby (Laerdal Medical, Stavanger, Norway) are used as simulation equipment. These are packed together in a suitcase and are easily portable from site to site, requiring 15–30 minutes to set up prior to the workshop.

Workshop

The ONE-Sim workshop is a 4–4.5-hour training session conducted at each site by the lead facilitators in conjunction with local medical facilitators. The design and content of workshops is developed based on an iterative convergent design, using feedback from the clinical site leads regarding each site's available facilities, scope of practice and local protocols to direct clinical management. The ONE-Sim faculty would spend some time prior to the workshop understanding the work-based arrangements, facilities for birth attendants and referral process involved for each site. They would also interact with both the junior and senior medical-midwifery staff regarding the roles of birth attendants and back-up arrangements available in case of an emergency. This background work assists in developing rapport with the local senior clinicians who co-design the scenarios and co-facilitate the teaching and debrief sessions.

On the day of the workshop, at the start of the session, the simulation is conducted for the senior medical and midwifery clinicians who later co-facilitate the session with the ONE-Sim faculty. The objective of co-facilitation is to engage learners better, by providing direct translation of the teaching through senior medical-midwifery staff in the local language, and to develop a home-based interprofessional medical-midwifery faculty for conducting future in-house training workshops.

Following demonstration of birth on the simulators and familiarisation with the equipment, participants undergo independent skills training with stations on conducting normal labour, recognising and managing obstructed labour, breech birth, shoulder dystocia and postpartum haemorrhage, and resuscitation of an asphyxiated newborn, with feedback provided at each skill station. The initial experience of conducting an uncomplicated vaginal birth helps in familiarisation with the simulation equipment and encourages immersion in the simulation scenarios that follow. Participants then practise management of obstetric and neonatal emergencies on the simulators in teams during scenarios facilitated by the ONE-Sim faculty with the help of the trained senior medical-midwifery

Figure 1. ONE-Sim scenario in action in an Indian hospital.

Figure 2. Online ONE-Sim scenario in action during the COVID-19 pandemic.

clinicians. The scenarios include a variety of team-based clinical situations, including some where conflict between teams is anticipated. This prompts discussions about management and the divisions of responsibility and is helpful in encouraging a team-based learning approach. Finally, participants contribute to a discussion of clinical and debrief, again conducted with the help of medical-midwifery clinicians who also provide translation in local language where needed, emphasising key learning messages from the workshop.

The research impact and vision

Over the last five years, the ONE-Sim program has continued to grow and expand. ONE-Sim workshops are now run for medical and midwifery staff[3] and students in Melbourne[4] and overseas.[5] There are workshops being conducted in new centres, towns and cities across India every year. The impact of the ONE-Sim program has been extensively evaluated for sustained learning and translation to practice.[6] Workshops are also run in a number of countries in the Asia-Pacific region and Africa (especially Malawi) by collaborators and organisations. COVID-19 interrupted international travel and the ONE-Sim global health education program, but after a brief hiatus, we were able to conduct the ONE-Sim program virtually through an online platform.[4] There are workshops now run every month for Australian students and health professionals, and for centres around the world. Simulation in healthcare (possibly with added online components), provides us with limitless, flexible and widespread options for education and training, and will continue to be a vital component of effective healthcare.

The ONE-Sim team endeavours to extend the program globally through its flexible learning design. The workshop can be adapted for varied healthcare settings and participants ranging from undergraduate medical and midwifery students to obstetric, neonatal clinicians, midwifery practitioners and other healthcare workers providing maternity care. The ONE-Sim team continues its effort to recruit budding obstetricians, paediatricians and midwifery practitioners to further build and strengthen the team with a view to translate its vision into reality.

Acknowledgements

The rest of the ONE-Sim team – Dr Nisha Khot, Dr Pramod Pharande, Dr Jennifer Hocking, Avi Malhotra.
Funding support – Royal Australasian College of Physicians, Bill & Melinda Gates Foundation, Overseas Medical Graduates Association (Vic) and the medical fraternity in Melbourne.
Collaborators – ASHA Charity, Pangea Global Health Education and local collaborators in various countries.

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PEMNeT: preventing deaths in the Pacific

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'Three women die every day in the Pacific region of pregnancy and childbirth-related causes. This is meant to be the start of life, but for so many it ends here. Most maternal deaths in the Pacific are due to preventable causes, maybe up to 80%.'

These startling headlines opened a Pacific current affairs report on national television in Aotearoa-New Zealand (Aotearoa-NZ) to highlight the launch of the 'Pacific Emergency Maternal and Neonatal Training' (PEMNeT) Programme in 2016. Thirty–five doctors and midwives from 11 Pacific Island Countries (PICs) attended the inaugural PEMNeT Facilitator Training workshop in Auckland. This programme was led by Prof Aiono Alec Ekeroma, who recently received the award of the 'Officer of the NZ Order of Merit' for his services to Women's Health. PEMNeT is a sustainable Pacific 'home-grown' programme that trains Pacific maternity health leaders to run their own multi-professional 'hands-on' courses for obstetric/neonatal emergencies. You may well ask why a new course was needed as there are many obstetric emergency training programmes available already. The Pacific Society of Reproductive Health (PSRH), which is the leading multi-professional regional society for women's health, perceived there was a need for a programme that has these features:

- **Pacific-focused**: tailored to Pacific-based workforce needs, particularly the remote islands and low-resource settings.
- **Sustainable**: by training 'in country' facilitators (ie. not reliant on traditional model 'fly in/fly out' external providers).
- **Standardised**: providing consistency of management across PICs as the Pacific-based workforce is quite mobile (pre COVID-19).
- **Culturally appropriate**: using Pacific adult learning methods, moving away from didactic lectures to more 'talanoa' (group work/discussion), hands-on skills acquisition and role play.
- **Human factors focused**: specific teamwork and communication training for emergencies, due to published evidence for this type of training significantly decreasing maternal mortality in low/middle-resource settings, and neonatal outcomes in high-resource settings. PSRH acknowledges the support and input of the PROMPT Foundation and Aotearoa-NZ PROMPT Team in this area.

Programme development was originally supported by the RANZCOG Global Health Committee (GHC) and the RANZCOG Education Unit, along with the 'Send Hope not Flowers' Charity, Counties Manukau DHB, and NZ Ministry of Foreign Affairs and Trade. Ongoing support has also been provided by the Australian Department of Foreign Affairs and Trade through the RACS Pacific Islands Programme as well as other regional funders. PROMPT faculty have supported the resource development and facilitator training programme, particularly Prof Tim Draycott (PROMPT Foundation Medical Lead), Dr Sharron Bolitho (author), and Dr Martin Sowter (Aotearoa-NZ NZ lead).

PEMNeT is a key RANZCOG-supported strategy to reduce maternal and perinatal mortality in the Pacific Region. RANZCOG's vision in global health is 'to improve the health of women and their families, particularly in our geographical region'.

Newly trained Vanuatu PEMNeT Facilitators with their first course participants, supported by PEMNeT Faculty.

In 2017, RANZCOG Global Health Committee (GHC) published the document 'Improving Women's Health in the Pacific'. The first two of 10 priorities in this document are:

'**Priority 1:** Reduce maternal and perinatal mortality.'

'**Priority 2:** Strengthen the skills of birth attendants and improve women's access to health facilities for supervised birth.'

What has happened since then?

In 2017, at the PSRH Biennial conference in Vanuatu, Dr Sharron Bolitho led a team of 10 midwives and doctors to run a three-day PEMNeT Facilitator Training Workshop for 50 Pacific delegates and was appointed leader of Facilitator Training at that time. Since then, various 'in country' facilitator training workshops and PEMNeT courses have been held, and some PICs are awaiting rollout.

Mortality rates differ across the Pacific region. As noted in the GHC document, 'deaths are highest in Papua New Guinea, Solomon Islands, Vanuatu and Kiribati'. PICs have differing physical resources, health workforce and geographical constraints and so the programme has been implemented at varying rates with varying amounts of external support required across the 11 Pacific countries that attended the inaugural Facilitator Training in 2016. Here are some country progress updates.

Kiribati were early adopters, originally lead by Charge midwife Toonga Tieii and Dr Ioanna Beiatau with assistance from Dr Sharron Bolitho. An outreach visit to remote Kiritimati Island by Dr Baranika Toromon, Toonga Tieei and Dr Sharron Bolitho was very well received and the first CPD in maternity for this unit. Kiribati is a low resource country with significant geographical challenges and Dr Sharron Bolitho was impressed with how much they managed to do with so little.

Samoa was also an early adopter and the Samoan team led by Dr Tapa Fidow, and midwives Robyn Yuen and Tiara Tuulua, have a very successful programme and PEMNeT is compulsory annual professional development supported by the Ministry of Health. In 2019, the Samoan team ran a joint session on PEMNeT with Dr Sharron Bolitho at the NZ Society of O&G Conference in Upolou. The Samoan team advised that the staff are keen to do the programme as it meets their learning needs and that there has been an improvement in many aspects of maternity care.

Vanuatu. Many of the Vanuatu team were so busy running the PSRH conference in 2017 that they missed out on PEMNeT Facilitator Training at that time. So the PEMNET leaders Dr Errollyn Tungu and Charge midwife Annie Serel requested a Vanuatu-specific training in 2018. Dr Sharron Bolitho led a team consisting of Pacific midwives Toonga Tieei, Annie Jatobatu, and NZ-based FRANZCOG Dr Jenny McDougal and midwife Beatle Treadwell who, although kiwis, grew up in Vanuatu. This consisted of a three-day Facilitator Training course, followed by the new facilitators running their first PEMNeT Course for their colleagues. This model of running a course immediately following training was a success in both Kiribati and Vanuatu. Many of the facilitators were 'terrified' (own words) before running their first course, mainly because they were midwives and their first course participants were mostly interns (junior doctors). It was a sheer delight for the faculty to see the confidence of the new facilitators grow. After the course, one said 'I never believed I would be able to, but I can do this!' Following this training, in 2019, we had a very successful rollout to all six widely dispersed island provinces of Vanuatu. A highlight for authors Errollyn and Sharron was the rollout to remote Tanna Island, famous for its accessible live volcano. A national review was held following the rollout at the end of 2019 and, although too early

to see changes in health statistics, Charge midwife Annie Serel presented the following information to Ministry of Health Officials and funders:

- Improved networking within each province
- Improved referrals; less than previous years and better structured referrals and handover
- Improved communication with antenatal NGO clinics in Efate
- Improved confidence and knowledge in emergency skills of the facilitators and participants
- Attracting more staff to train in midwifery

As PEMNeT is still a young programme, some PICs are awaiting in country facilitator training and rollout. For example, the Tongan team had asked for facilitator training and roll out in June 2020, but this has been deferred due to COVID-19.

Although COVID-19 has disrupted facilitator training, PEMNET programme development is ongoing, in particular:

- The PEMNeT Course Manual and PEMNeT Facilitator Guide are being reviewed to produce a second edition. Dr Sharron Bolitho is coordinating this, and many Pacific-based colleagues are editing and reviewing the manual. Also, RANZCOG Education Unit assistance has been approved for revision of the accompanying Facilitators Guide.
- Plans are underway for the next whole Pacific PEMNeT Facilitator Training to be run as a preconference workshop associated with the PSRH Conference planned in Samoa mid-2021.
- The PSRH team is in the process of establishing a Pan Pacific Faculty able to assist with facilitator training workshops in neighbouring PICs. Our vision is to build capacity amongst Pacific-based health professionals so that not only does each country have facilitators to run their own courses, but there is a Pan Pacific Faculty able to train more facilitators and coordinate support across the Pacific. In this way, PEMNeT will become a truly sustainable Pacific-led programme.

In closing, the final words are from recent PEMNet course participants in Tanna, Vanuatu:

> 'Reading books is often a barrier for learners, but the way you present (this course) is relevant, much better and has greater impact'.

> 'This is one of the most enjoyable workshops I have ever attended because there's scenarios, role plays, discussions, comments and experience (and so it) makes me understand well the practical side of it. I would like to encourage you to keep going in organising this kind of training. It helps me a lot.'

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Pacific society of Reproductive Health https://psrh.org.nz. Workshop coordinator: ropeti.gafa@psrh.prg.nz, Acting CEO: k.okesene-gafa@auckland.ac.nz, PEMNeT Facilitator Training Leader sharron.bolitho@cdhb.health.nz

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10 years of an Australian-Balinese education endeavour

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It is now 10 years since I first visited the island of Bali, Indonesia, with my colleague A/Prof John Svigos. John has written previously for *O&G Magazine* of his global health experiences, and I have him to thank for introducing me to his beloved friends and colleagues in the O&G department at Sanglah Hospital, Denpasar. (*O&G Magazine*, Vol. 15 No. 2, Winter 2013)

Over the last 10 years, along with others from Adelaide and across Australia, I have visited annually and have never tired of the rich experience and unsurpassed hospitality that always awaits us. From the minute we step into the arrivals hall of Denpasar airport, until we get back onto the plane at the end of the visit, we are inundated with hospitality, collegiality and a feeling of welcome that I have not experienced anywhere else.

In 2010, as a relatively new consultant and maternal-fetal medicine (MFM) trainee, I (somewhat bravely) accompanied John on a small-scale visit where we undertook to assist our Indonesian colleagues in setting up a MFM training program for Denpasar, Malang and Surabaya. Our team now frequently comprises more than 20 clinicians, including obstetrician/gynaecologists, midwives, neonatologists, neonatal nurse practitioners, anaesthetists, infectious diseases specialists and trainees of all the above. The efforts undertaken are only possible with the wholehearted support and contribution from all of the health professionals that take part, and the importance of diversity and multiprofessional teamwork cannot be overstated.

Since the first visits, we have developed a multidisciplinary team from across Australia who themselves as individuals and smaller discipline teams have ongoing relationships and liaison with their counterparts in Indonesia. Ultimately a strong collaboration developed between the maternity and neonatal care providers from both countries, where we used an academic meeting format as a platform for education of various types around different areas of maternal/neonatal/perinatal and gynaecological care. We have, as time has passed, stepped out of our traditional 'academic meeting' program (the Bali International Combined Clinical meeting) and blended more small group workshops and teaching sessions. Towards the end of last year, a small group of us made an extra visit to plan a mostly simulation-based program for 2020, having had success with that type of teaching in previous meetings. Of course, we were not able to attend in May 2020, and with the global pandemic still disrupting our lives, there is no way of predicting when we will return in person.

While we visit with the guise of education, rather than practicing clinically, this is by far only a small aspect of our experience.

> We learn far more than we can ever teach, we receive more than we can conceive of giving, and we grow more than skills, we also grow relationships and awareness.

If I had to choose something that was the outstanding feature of my time working alongside both my Australian and Indonesian colleagues, it's the benefit of developing relationships within our own team and with our Indonesian colleagues, as well as awareness of the reality of working as a health professional in Indonesia.

On developing relationships, I reflect on Johns words, 'Be prepared for a long-term commitment if you wish to make a lasting contribution'. It has ultimately only been feasible to do anything effectively by making a long-term commitment, and simply going back year after year. This, I think, sends a message, that we want to work with and alongside our Balinese colleagues, and that this isn't a short-term fad. This year is the first year I haven't been to Bali since 2010 and, if I am honest, I don't know what the future holds for our alliance, but I hope we can somehow come back together in person and enjoy each others company.

Relationship is also an important part of the 'local' team development. Somehow the higher temperatures, high humidity and a few games of pool volleyball at the end of a long day seem to provide a catalyst for cross-generational and cross-discipline relationships. From my perspective, I have treasured the small moments in which there have been opportunities to share, learn and laugh with each other. To be honest, I have never loved hierarchy, so am happy wherever we can, at least for a short time, just be sitting side by side, sharing the same experience.

On the matter of hierarchy, we have had to come up with creative solutions in our teaching programs. As John referred to in his article, 'interactive teaching by a senior specialist did not work, as their trainees were concerned about the loss of face if they got things wrong. We overcame this by getting our trainees to come along and do the hands-on teaching, which proved to be a master stroke with clear advantages for both groups in terms of learning and team building.' A few years in to my visits, even I became too senior to teach the junior medical staff, so the solution became to upskill our trainees in hands-on teaching, and they would then lead the small group teaching program.

Relationship building and, in fact, role modelling, has always been key in the way our team is set up and functions. We have since early days included midwives and neonatal nurse practitioners in our team and at least tried to show how in our setting we work alongside each other, and value the others' skills. This is not always the case in Indonesia, and we have actively worked towards including the local midwives in the program of teaching.

I am passionate about training and developing our next generation of obstetricians and gynaecologists. Having had the experience of visiting Bali as a very junior FRANZCOG, I could see what I hadn't had the opportunity to experience during my training, and henceforth have always been keen to include trainees in the team. In this issue of *O&G Magazine*, two of my colleagues, Dr Priya Umapathysivam and Dr Sarveshinee Pillay, speak of their experience, so I will let you read their story too. They and other trainees have, I think, had a unique opportunity to see and learn alongside Indonesian colleagues, and then to reflect and bring back a different point of view when they come home.

My final thought is something I have considered around the benefits of travelling and actually seeing where other people are. For me, work and travel have always been closely linked, I have been blessed to visit many places in the world as a result of various aspects of my job. I think I was struck early on with the visits to Bali, and also with other activities like accreditation visits for RANZCOG, that there is so much value in just going to the place and seeing where people work and live. I am conscious that my perspective and approach to global health is not the same as others, but I hope this insight will be helpful to others who are curious or interested.

Benefits and risks of global health experience for trainees

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A multidisciplinary team from around Australia have participated in the Bali International Combined Clinical Meeting (BICCM), held annually in Denpasar for the last 10 years. These meetings are a collaboration between Indonesian and Australian maternity and neonatal care providers and provide a platform for us to learn from and offer maternity and neonatal education and training. We have participated in the meetings since 2018. Unfortunately, this year marks the first year that we have not been able to attend due to the coronavirus pandemic.

The collaboration between maternity care providers in Bali and Australia was founded by A/Prof John Svigos in 1998, with the aim to improve the maternal mortality rates in Bali. He nurtured trust and formed professional relationships with Sanglah Hospital's O&G Unit, initially as a solo effort for the first decade and in the second decade with a multidisciplinary team of junior and senior obstetricians and trainees, midwives, neonatologists, infection disease specialties and anaesthetists mainly from Adelaide. A/Prof Rosalie Grivell has been the successor to A/Prof John Svigos in continuing these strong affiliations with Sanglah Hospital's O&G Unit, and in coordinating the annual BICCM.

Travelling to Denpasar with A/Prof Rosalie Grivell and many of our multidisciplinary colleagues has been, and will continue to be, an exciting time in our O&G training. It gave us a first-hand opportunity to gain an appreciation of a different medical system and to understand the sorts of improvisations needed when working with different technologies and in societies with different access to medical resources. BICCM opened up an opportunity for us to experience medicine in a different cultural context. We know that culture plays a pivotal role in people's willingness to seek and accept medical care, and if we can understand the interaction between culture and medicine, then we can help our culturally and linguistically diverse patients navigate our healthcare system. Australia is a multicultural nation and thus experiences like these provide us with perspectives that we can apply to our local practice, especially when treating patients from different cultural and linguistic backgrounds.

Each year, the meeting has a different focus and specialists volunteer their time to provide contemporary information and training. The presentations given by Australian and Balinese specialists highlight that resource availability and active management of diseases is vastly different. Interesting discussions ensue about the treatment approaches that provide women and their babies with the best evidence-based care practicable, within the obvious constraints of a developing country. This year we wanted to focus on Tim Sim (Team Simulation) training, as this was successful in previous years, illustrating the complimentary roles of the multidisciplinary team. Peer-to-peer teaching is a way for us to overcome the hierarchal

workforce structure in Bali as A/Prof Rosalie Grivell has mentioned in her article. The meeting provides us with the opportunity to engage with new colleagues from Indonesia as well as allowing us to network and appreciate the role each team members plays in the local setting. Training in the field of O&G in Indonesia takes four years. Their trainees do not get paid a salary, instead their work is seen as a service to the hospital while still having to pay their training fees. Their junior trainees observe for many years before hands-on experience in the field. Hearing their stories, you cannot help but feel a sense of empathy, but also gratitude for being a trainee within RANZCOG.

We also partake in tours of the hospital, visiting their labour ward, special care nurseries and antenatal and postnatal wards. It was interesting to see that of the 13 patients that were on the postnatal ward the day we visited, two women had vaginal births, 10 women had a caesarean section and 1 woman had a caesarean hysterectomy. However, keep in mind that Sanglah Hospital is the largest tertiary level referral hospital in Bali and, generally speaking, would care for the very sick antenatal and postnatal women. The tour of the nursery also struck a chord. Newborn babies are kept away from their mothers due to risk of infection. Well and unwell babies are kept together in the nursery and the very unwell babies whose parents can afford medical treatment are kept in their neonatal intensive care unit. We also sit in on their weekly perinatal morbidity and mortality meeting. An eye-opening and heart-wrenching meeting for us all and a major driving force of why we choose to go back every year; highlighting the lifelong goal for our team in reducing the maternal and neonatal mortality rates in Bali. This endeavour has made us particularly aware of the fortunate situation we find ourselves in every day, with the high standard of healthcare provided in Australia at no cost to the patient or their families.

On a different note, not only were we able to participate in the educational content of the conference and visit multiple different local health facilities, our very friendly hosts made sure we also had a chance to participate in social events and visit culturally important local sites. Every year, our Balinese colleagues host a 'family dinner' in which we are privileged to experience and participate in their rich culture of dance and music while enjoying their flavourful cuisines. It is a time for all of us to drop the formalities and sing and dance together on the beautiful beaches of Bali as friends.

Despite all the wonderful work that the Balinese and Australian teams have achieved, there is still a long way to go. With Indonesia being the world's fourth most populous nation, access to maternity care is limited, especially for those women in rural and remote regions. Achieving and sustaining meaningful global health changes takes a lifelong commitment as evident by the works of A/Prof Rosalie Grivell and A/Prof John Svigos, and we are very fortunate to be alongside them on this journey.

Cervical cancer prevention in the Pacific

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In May 2018, the Director-General of the World Health Organization (WHO) announced a global call to action towards the elimination of cervical cancer as a public health problem, defined as being achieved when the incidence is below 4 per 100,000 women-years. This is an ambitious aim; rates in Pacific Island Countries currently range between 10–30 per 100,000 women-years. The highest incidence is in the most populace country, Papua New Guinea, where the incidence is even higher amongst those infected with HIV.

Progress toward a consensus on tackling the incidence of cervical cancer in the Pacific has been greatly accelerated by the announcement in 2019 of the WHO 'Draft Global Strategy towards the elimination of cervical cancer as a public health problem.'[1] This strategy is based on three principles, which WHO aims to be met globally by 2030:

1. 90% of girls fully vaccinated by age 15
2. 70% of women screened with a high-precision test at 35 and 45 years of age
3. 90% of women with cervical pre-cancer or invasive cancer receive treatment

This WHO draft guideline is predicted to achieve elimination of cervical cancer as a public health problem by 2090.

Implementing this guideline across the Pacific will be problematic. There is currently no organised program for vaccination other than sporadic projects, and the cost of human papillomavirus (HPV) vaccine varies markedly across the region, from US$30–150. This cost is prohibitive to low-income countries, but UNICEF has committed to supplying vaccines across the Pacific for five years from 2021.

Screening with cytology has been difficult, as samples generally must go offshore for processing, leading to significant delays. Patients with abnormal cytology have to be located at a later date. Colposcopy is not available in most Pacific Islands, and generally leads to further delays since histological specimens take even longer to process than cytology. Delays of three months are usual. Visual inspection with acetic acid (VIA) was touted as a cheap and effective alternative, although VIA positivity has been shown to be associated with the presence of HPV 16 but not other HR-HPV types.[2]

Primary screening with HPV testing is more promising, not only because of its greater accuracy, but it is far easier to conduct in remote settings. This test can be performed using a portable, battery-operated GeneExpert (Cepheid) system, enabling on-the-spot analysis of samples with results available within an hour. These units are often already available in many Pacific Countries where they are used to test for TB, HIV and other infectious diseases. It utilises a Polymerase Chain Reaction (PCR) test, the 'high-precision' test recommended by WHO.

Not only does this have a high specificity and sensitivity for the detection of HR-HPV, but has been shown to be as accurate when performed on self-collected samples as clinician-collected[3] eliminating the need for a speculum examination, a major barrier to screening in Pacific Islands.

The advent of thermal ablation for treatment of screen-positive women has made treatment easier since it is portable and requires neither mains electricity nor a gas supply.[4,5]

A 'screen-and-treat' approach, whereby women who screen positive for high-oncogenic-risk HPV receive immediate treatment with a modality such as thermal ablation of the transformation zone, may seem misguided to those of us in high-income countries due to the risks of preterm labour after treatment for cervical disease. It is true that an unknown number of women will be over-treated, but the older screening age and use of an ablative technique for treatment in most instances will minimise this risk. 'Screen-and-treat' is felt to be the most feasible approach to ensure that screen-positive women receive treatment.

In order to address the specific concerns related to implementing the WHO Draft Guidelines in Pacific Island Countries, a meeting of interested parties was held in Suva from 5–6 December 2019. It was organised and facilitated by the Pacific Society for Reproductive Health (PSRH).

Despite challenges with organisation and limitations on travel due to the measles epidemic in Samoa, the meeting was well attended with delegates from Papua New Guinea, Vanuatu, Solomon Islands, Kiribati, Federated States of Micronesia, Fiji and Samoa. A number of organistions were represented: PSRH, Papua New Guinea Obstetrics and Gynaecology Society, Fiji Obstetrics and Gynaecology Society, Papua New Guinea Institute of Medical Research, Cervical Cancer Prevention in the Pacific, The Pacific Community (SPC), VCS

Pacific delegates and experts on meeting, Suva, Fiji, 5–6 December 2019. Regional Cervical Cancer Prevention and Control.

Foundation, RANZCOG, Kirby Institute at the University of New South Wales, Family Planning Australia, Australian Cervical Cancer Foundation, Fiji Cancer Society, Fiji National University, University of Otago, National University of Samoa and Victoria University. Also present were representatives of the United Nations Population Fund and the United Nations Children's Fund.

Presentations were heard from key speakers, and each country representative had the opportunity to describe the current state of vaccination, screening and treatment in their country, along with recognised barriers to moving forward.

It was agreed that any approach should involve vaccination against HPV, screening for, and treatment of, cervical pre-malignancy, and treatment of established disease. Some modification of the WHO draft guideline was felt appropriate to enable small nations to screen in multiple-age cohorts.

The meeting agreed to the following principles:

1. Support for the global target to achieve elimination of cervical cancer as a public health problem, noting the current high burden of cervical cancer in the Pacific and the current lack of adequate vaccination, screening and treatment.
2. In line with the WHO draft targets for 2030, in the Pacific the targets are:
    - 90% of girls are fully vaccinated against HPV by 15 years of age
    - 70% of women have had an HPV screening test between 30–39 years of age and a second HPV test between 40 –49 years of age (Tests to be 10 years apart)
    - 90% of women identified with cervical pre-cancer and cancer have received appropriate treatment and care
3. Support for the principles of equity in striving for the elimination of cervical cancer in the Pacific so that no woman or community is left behind
4. Support for the principle of meaningful collaboration between Pacific Island nations in planning, procurement and knowledge sharing

The necessity to establish an adequate registry of vaccination, screening and treatment for the prevention of cervical cancer, with potential linkage to a cancer registry, was also recognised.

There was also commitment to urging Pacific Island governments to include HPV vaccination in existing immunisation schedules and to establish a treatment centre for cervical cancer, including radiotherapy, to act as a referral hub within the Pacific.

Of course, none of this will be possible without the appropriate political will and funding, but this consensus will go a long way to highlighting to communities and governments the urgent need to implement the required initiatives to save Pacific women and their families from needless suffering and premature death from this preventable disease.

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Access to sexual and reproductive healthcare

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As COVID-19 continues to spread and take up oxygen, figuratively and literally, sexual and reproductive health (SRH) services are suffering. There are many reasons for this: women avoiding care due to fear of infection or the inability to have a companion, lockdowns, reduced capacity to pay for services as well as to provide them. And there are now worrying predictions that this will lead to increased death and suffering for women globally,[1,2] concerns backed up by our own early data and experiences.

International medical-humanitarian organisation Médecins Sans Frontières (Doctors Without Borders/ MSF) has been part of the COVID-19 response in more than 70 countries. We've developed new activities to prevent spread and provide patient care, and adapted to keep our pre-existing projects open – including our SRH services, so that we could continue caring for marginalised women and girls in countries such as Afghanistan, Kenya, Malawi, Pakistan and Yemen.

Here, we share some of MSF's recent experience in four essential services: maternity care; safe abortion care and family planning; sexual and intimate partner violence; and cervical cancer prevention. We also highlight the devastating intersection of COVID-19 with conflict in the most fragile settings.

Global reductions in maternity care

In a recent qualitative study, maternal and newborn health professionals in 60 low- and middle-income countries (LMICs) described disruptions across the spectrum of maternity care.[3] MSF has not been immune: for antenatal care alone we have already seen visits decline by 22% from April to June 2020 compared to the same period in 2019.

Despite our commitment to keeping services running, it has been a continuous struggle. When a staff member in our hospital in Peshawar, Pakistan, tested positive for COVID-19 in April, almost half our workforce had to quarantine. We had to close our doors on new admissions, transfer our patients to a public hospital close by, and inform our networks that we would be out of action. It took six weeks to reopen, with separate pathways for positive and negative patients and increased bed spacing.

Other organisations are also struggling. For UNFPA, a funding crisis forced it to suspend reproductive healthcare in May in 140 health centres in Yemen, leaving just 40 in operation and forcing risky delays in care – with, it reported, 'tragic consequences.'[4]

By June, Roopan, working in one of our maternity hospitals in northern Yemen at the time, was witnessing similarly fatal effects: women arriving too severely ill to save, due to fear of COVID-19 and health centre closures.

Despite the unpredictability of the disruptions, we have remained determined to keep our maternity doors open, decentralise as much as possible, and support others to do so too. We have rearranged services to make them safer, invested in personal protective equipment and additional training, and kept communities abreast of how to safely find the care they need.

Family planning and safe abortion care: already neglected, particularly hard hit

According to Guttmacher Institute modelling in 132 LMICs, a 10% decline in use of SRH services resulting from COVID-19-related disruptions could result in

James, an ambulance driver in MSF's sexual violence care and emergency medical service project in Nairobi, Kenya, prepares to respond to a night-time call. May 2020. © Paul Odongo

'an additional 15 million unintended pregnancies, 3.3 million unsafe abortions and 1000 maternal deaths from unsafe abortions in the 12 months following the start of the pandemic.'[1]

Family planning and safe abortion care have long faced barriers to prioritisation. We are deeply concerned that our own strengthened efforts in these two areas will be dragged backwards. Comparing the first two quarters of 2020 in MSF, we've seen declines for both family planning consultations and terminations of pregnancy: 18% and 17% respectively.

In Rustenburg, South Africa, however, our collaboration with the Department of Health proved its strength when we successfully advocated to reinstate abortion services as 'essential' after they were categorised as 'elective' and cut from hospitals and community health centres.

Yet not all women could access care in time. Our colleague, Kgaladi Mphahlele, recalls a 35-year-old woman who requested a termination at MSF's clinic in June, 27 weeks pregnant. It was her third attempt. 'She was initially booked for... the first day of the national COVID-19 lockdown and she couldn't get to the clinic for her appointment. She came back a week later but was turned away by the security guard working for the Department of Health, who told her there were no terminations taking place... She pleaded for me to help as she was not currently working and she had children at home to support. But it was too late... We provided her with counselling and connected her with a social worker.'

Victims of violence more hidden than ever

There is no doubt that for victims of violence, the barriers to accessing care have only grown despite increases in demand. The Australian Institute of Criminology surveyed 15,000 women aged 18 and over earlier this year, and found two-thirds of those experiencing physical or sexual violence did so for the first time, or suffered an escalation.[5] There is limited data in LMICs, but a recent survey on the effect of stay-at-home orders in Bangladesh on 2424 women found that emotional or moderate physical violence had escalated for more than half of those subjected to it before the lockdown.[6]

For MSF, we haven't seen increased presentations for care, but this is almost certainly because of reduced mobility. Where we have hotlines, and where victims can access phones, for example, in Nairobi's Eastlands area, we hear their distress and have endeavoured to change our models of delivery to provide as many options as possible. In Nairobi, granted permission to continue our 24/7 ambulance service despite the night curfew, we decided to start delivering the medications normally dispensed at our clinic. And across similar projects we've created new hotlines or expanded existing ones, to provide tele-care for psychological first aid as well as ongoing counselling.

An uncertain future for preventing cervical cancer

In March, we were faced with some tough choices, and weighing up the long-term versus short-term risk to life and shortages of PPE and staff, we decided to remove cervical cancer screening from our essential list. Providers we collaborated with were making similar decisions. In Zimbabwe, the 'test and treat' screening we supported was suspended and staff re-allocated by the Ministry of Health. In Manila's slums, where we partner with local non-governmental organisation Likhaan, we also had to cut back due to strict community quarantine that persisted for months.

What we did maintain was lifesaving surgery for early-stage cancer in Malawi. Only operating since December 2019, the surgical arm of our comprehensive program already had a backlog of cases that it was unconscionable to put off. We have since been able to resume screening, but there will be some future cases of cervical cancer from these stoppages that could have been prevented.

As if a pandemic wasn't enough! The double burden of conflict and COVID-19

In countries affected by ongoing conflict, such as Yemen and Afghanistan, the pandemic has only amplified these already fragile contexts, and the fragility of life.

This was illustrated chillingly in MSF's maternity hospital in western Kabul, which opened in 2014 to care for the marginalised Hazara community in Dasht-e-Barchi district. Due to COVID-19, MSF had already had to cut back from an average of more than 1300 deliveries per month, limiting admissions and bed occupancy to improve spacing and other IPC measures.

Then on May 12, without warning, armed assailants attacked, killing 24 people including staff, mothers and children. All maternal and newborn care ceased, creating an immediate vacuum of care. Unable to ensure the future security of staff or patients if it reopened, MSF made the difficult announcement that it would permanently withdraw from the hospital on June 18.

The Department of Health has since announced it will take over the facility but, in a context of already having to divert limited resources due to pandemic pressures, there is grave uncertainty as to the future welfare of pregnant women in Dasht-e-Barchi.

How can we remain effective during COVID-19?

MSF will continue to provide and advocate for SRH services as essential. We will continue to send O&Gs and midwives to our projects where those specialties are not available locally, to provide, and to train others to provide, lifesaving care to women. We will pursue the burgeoning opportunities of self-managed care, increasing our investment to help women overcome access constraints.

To the broader healthcare community, we call on stakeholders from service providers to policy makers to get involved in trying to ensure that we don't see major reversals in the worldwide progress in women's health over the last 20 years. And we call on you, dear reader, to advocate for SRH services, for access to contraception and safe abortion and protection from violence; to volunteer to provide services and to train others whether overseas, locally or in our region. We may not be able to save every life, but together we can work to mitigate the pandemic's indirect effects so that no woman or girl is left behind.

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The post-natal ward of MSF's Dasht-e-Barchi maternity hospital in Kabul, Afghanistan, where an average of 1300 deliveries were assisted every month before a brutal armed attack in June 2020. December 2019. © Sandra Calligaro

PSRH & RANZCOG: our collaborative relationship

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Board Member, PSRH

It is my privilege to write this article of the remarkable relationship between the Pacific Society of Reproductive Health (PSRH) and RANZCOG since 1991. In 1995, the first inaugural PSRH conference was held in Port Vila, Vanuatu. Since then, PSRH has continued to grow. We are most grateful to the continuous support of RANZCOG, its members and our Pacific Island members, in building and strengthening this relationship.

Our history

The idea of a Pacific reproductive health organisation was first raised during a discussion between a Pacific RANZCOG fellow, Dr Rajat Gyaneshwar and RANZCOG fellow colleagues Drs Brian Spurrett, Roger Gabb, and Jeremy Oats during an O&G workshop in 1991 in Sydney, Australia. In 1993, the concept of a Pacific Society of Reproductive Health was conceived at a meeting that was funded by AusAid and organised by the Fiji School of Medicine to discuss this concept further. There was a strong belief that RANZCOG and reproductive health providers in the Pacific could work effectively and collaboratively to improve sexual and reproductive health in the Pacific. PSRH was set up as a vehicle for professional networking between Australian and New Zealand specialists and their Pacific counterparts. The concept was nurtured in RANZCOG by Mrs Carmel Walker, supported by Drs Rajat Gyaneshwar and Wame Bravalilala (Fiji) and the late A/Prof Brian Spurrett, together with Roger Gabb and Jeremy Oats. After a two-year gestation, the first PSRH inaugural meeting was held in Vanuatu in 1995, funded by AusAid.

How far we have come

Since the inception of PSRH in 1993, in Suva, Fiji, PSRH have organised 13 consecutive biennial conferences in different Pacific Island countries as outlined below.

Year	Host Town, Country	Participants
2019	Port Moresby, Papua New Guinea	341
2017	Port Vila, Vanuatu	323
2015	Suva Fiji	336
2013	Apia, Samoa	280
2011	Honiara, Solomon Islands	280
2009	Auckland, New Zealand	170
2007	Apia, Samoa	130
2005	Nadi, Fiji	110
2003	Nadi, Fiji	100
2001	Madang, Papua New Guinea	90
1999	Suva, Fiji	80
1997	Apia, Samoa	70
1995	Port Vila, Vanuatu	50
1993	Suva, Fiji (Inception)	25

The year 2020 marks 35 years of this amazing relationship, and our incredible journey.

PSRH – who we are, our vision and mission

PSRH is now a Charitable Trust (not-for-profit-organisation) set up to provide support and professional development for reproductive and neonatal healthcare professionals in the Pacific. PSRH, although initially nurtured by RANZCOG, have over the years become more independent with its own secretariat. It embraces midwives and nurses who are key providers of women and child healthcare in the Pacific. The vision of the Society is: 'To develop and strengthen the health professional workforce and build institutional capacity that responds adequately to the reproductive health needs of Pacific Island countries'.

PSRH Board. Front row: Karaponi Okesene-Gafa, Gunzee Gawin, Mary Sitaing.
Back row: Roy Watson, Tagiyaco Vakaloloma, Pushpa Nusair, Prof Alec Ekeroma (PSRH Head of Secretariat), Mary Bagita, Nancy Pego, Uluai Tapa Fidow.

PSRH works collaboratively and in partnership with RANZCOG, donor organisations namely UNFPA, SPC, UNICEF, PIPs (through RACs), governments, universities and other non-government organisations. We aim to strengthen and build workforce capacity in the Pacific, share knowledge, encourage personal development and increase job satisfaction in one's own Pacific environment. In working together, we can also assist with policies, input into guidelines and develop interventions to improve reproductive health outcomes for women and families in the Pacific region.

We encourage you to browse our website psrh.org.nz

Current PSRH Board, Secretariat and our members

There are nine members of the Board (President Dr Gunzee Gawin [PNG], two Vice Presidents Dr Karaponi Okesene-Gafa [NZ], Mrs Mary Siating [PNG midwife], Dr Roy Watson [Australia, treasurer], Mrs Tagiyaco Vakaloloma [Fiji, midwife], Dr Pushpa Nusair [Fiji, ex-officio, previous president], Dr Mary Bagita [PNG], Ms Nancy Pego [Solomon Islands], Dr Tapa Fidow [Samoa] and Dr Errollyn Tungu [Vanuatu]). The Secretariat was recently changed from the previous Head of Secretariat (HOS) Aiono Prof Alec Ekeroma to Dr Okesene-Gafa, who took over as the Acting HOS from May 2020. Other members of the secretariat include Suzanne Mikaele (admin officer), Ropeti Gafa (project coordinator), Hemant Patel (IT support) and Theresa Mittemeier (Pacific Journal of Reproductive Health manager) and Ben Mikaeke (volunteer).

Over the years, PSRH has become increasingly recognised by governments and other key related organisations as a body of influence and actions, with significant knowledge to aid health core planning in reproductive, sexual and neonatal healthcare in the Pacific. PSRH has slowly increased its membership base across all groups (doctors, midwifes, nurses, community health workers, researchers) and encouraging students to join.

Our journey together

We have been blessed to share this journey with RANZCOG throughout the last 35 years, and long may it continue.

PSRH has a representative in the RANZCOG Global Health Committee (GHC). A memorandum of understanding exists between RANZCOG and PSRH where RANZCOG outlines their support for PSRH including some financial support for PSRH activities. PSRH submit a twice-yearly report to the RANZCOG GHC.

During COVID-19, PSRH members have been able to access RANZCOG COVID-19 updates. In August 2020, RANZCOG in partnership with PSRH hosted the COVID-19 O&G webinar series featuring those in the Pacific and Pacific rim, Australia and UNFPA. The series of three webinars was facilitated by Dr Rebecca Mitchell (GHC), 'An introduction to COVID-19 in pregnancy for resource-limited environments'. This was well received.

RANZCOG seeks to provide excellence in women's health by training, accrediting and supporting specialist service providers in the Pacific. RANZCOG has provided scholarships for Pacific specialists and trainees for skills development workshops and

PSRH conference PNG, July 2019.

conference attendance. As a result of training and accreditation process, most Pacific specialists are associate members of RANZCOG. This recognition of Pacific specialists by RANZCOG is much appreciated. Several Pacific midwives have benefitted from a RANZCOG initiative and DFAT funding to attend leadership training courses in Australia and New Zealand. This has strengthened nursing and midwifery leadership in the Pacific.

Several RANZCOG Fellows have assisted with workshops delivered to Pacific Island countries as part of professional development. Workshops included ultrasound, colposcopy, intrapartum care, perineal care, hysteroscopy, oncology, urogynaecology, fetal medicine, research, emergency maternal and neonatal training, and others. Workshops are provided 'in country' depending on country request or during the pre-conference workshops prior to the biennial scientific meetings.

RANZCOG trainees are also encouraged to take part. A good example was that almost eight years ago a Melbourne trainee spent a period of her training in Fiji. She has subsequently visited on many occasions, conducted pre-exam courses and a cervical cancer screening program pilot. The trainee worked with local counterparts to pilot a screening tool using HPV testing and point of care management using colposcopy and cervical ablation.

Our joint PSRH-RANZCOG call to action

The Pacific needs Fellows to be involved to assist in a substantial way. PSRH is a vehicle for that involvement.

Become a member; your membership helps subsidise membership rates for low-income Pacific members. Donations also welcome.

Attend the Biennial Conferences (i.e. PSRH Samoa 2021 Conference on 28 August – 3 September 2021). Your attendance helps financially, but more importantly, you will meet your Pacific colleagues and share the benefits of networking. You can also help with pre-conference workshops.

Make yourself available to assist with RANZCOG/PSRH projects such as workshops, assist through clinical locum type appointments, mentoring Pacific trainees and junior specialists.

If you're interested in the advancement of PSRH, contact us and be a volunteer.

More information on our website **psrh.org.nz** or contact the author **kara.okesene-gafa@psrh.org.nz** or or admin officer **suzanne.mikaele@psrh.org.nz**

Prioritising care in Asia-Pacific during COVID-19

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After working in global health for over 20 years outside of Australia, what continues to disturb me are the huge inequities between and within countries. The 'haves' and the 'have-nots'. There are those that can and do access healthcare, including sexual and reproductive healthcare, and then there are those who just cannot due to a variety of reasons including prohibitive out-of-pocket costs they would incur for seeking care, and a lack of essential infrastructure such as lack of roads and transport to take them to a health facility including in an emergency. These imbalances in access to quality and respectful care and health system fundamentals that I had taken for granted, like well trained and supported health professionals, functioning supply chains for life saving medicines and referral systems to ensure women would get the care they need to prevent them from dying during childbirth, continue to drive the work we do.

Ending preventable maternal and newborn mortality remains an unfinished agenda in the Asia-Pacific region, with 10 women dying every hour in pregnancy and childbirth. Many countries will need to double, or more than double, their current annual rates of reduction of mortality to ensure sufficient progress toward national targets and the global Sustainable Development Goal 3 (SDG) with its vision of optimal health for all. Even if considerable progress was made between 1990 and 2017, with countries in Asia-Pacific reducing the regional maternal mortality ratio (MMR) by 56% (compared to a 35% reduction in maternal mortality at the global level), absolute numbers of maternal deaths remain staggering in many countries of the region and a call to act must be sounded louder, and more urgently, than ever.

The majority of countries in the Asia-Pacific region are in Stage 3 of the obstetric transition,[1] a complex stage where the 'tipping point' occurs. In these countries, we can see continued high maternal mortality due to direct obstetric causes. The health

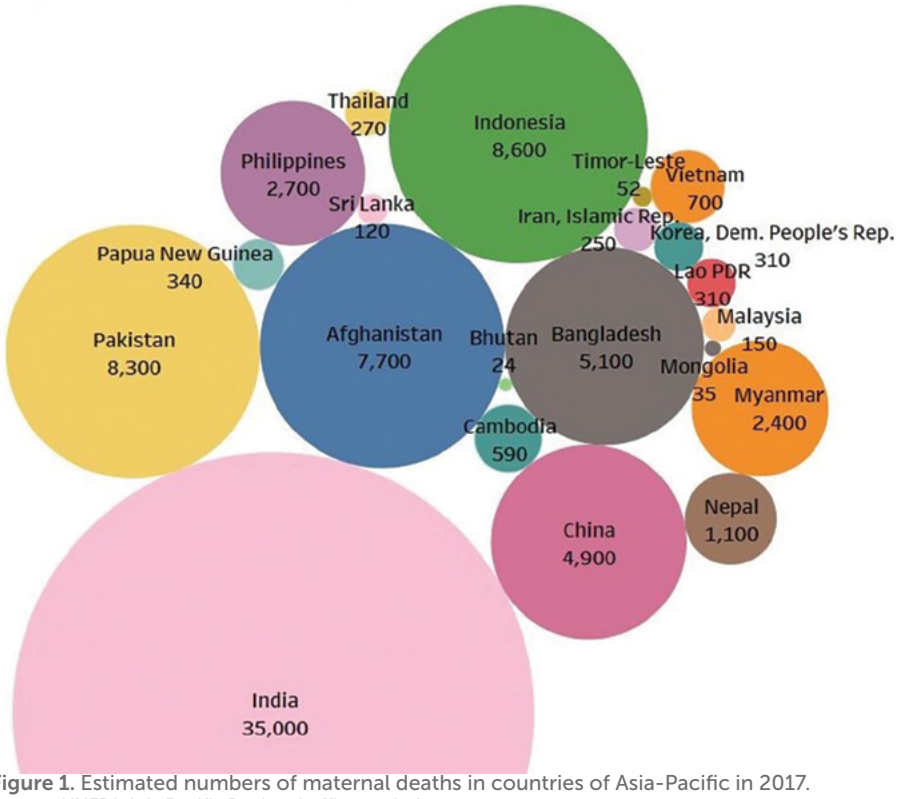

Figure 1. Estimated numbers of maternal deaths in countries of Asia-Pacific in 2017.
Source: UNFPA Asia Pacific Regional office analysis

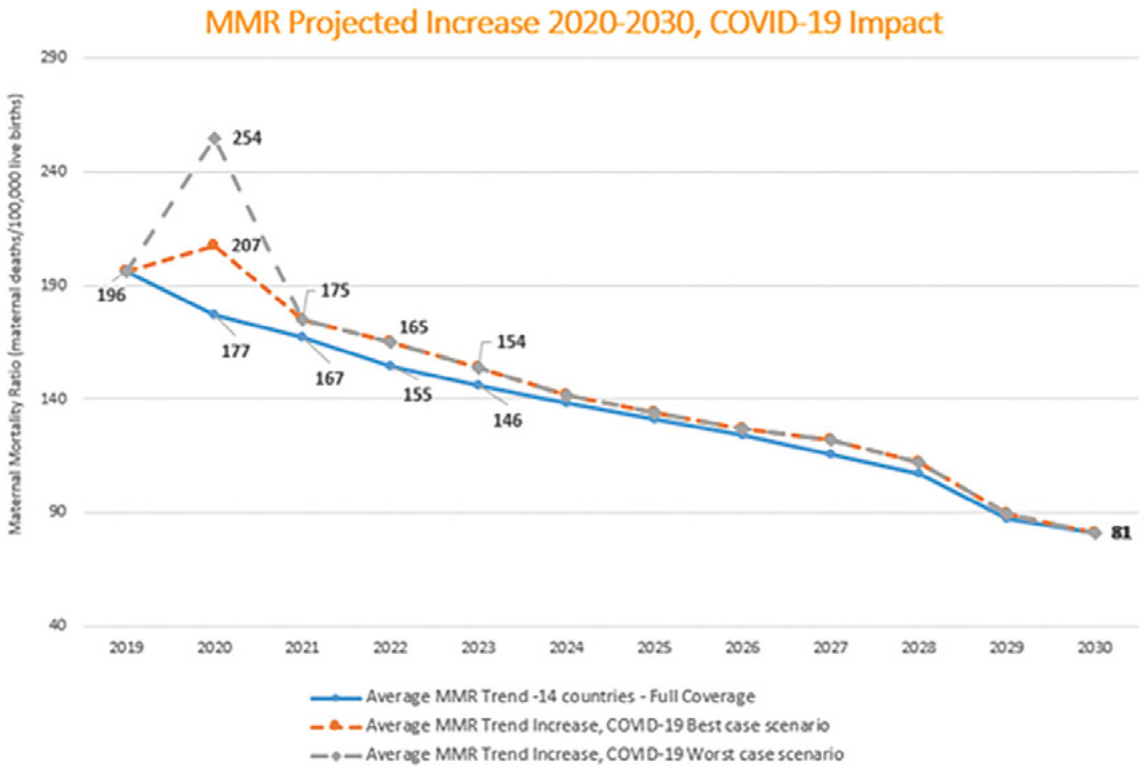

Figure 2. Potential increase in maternal mortality ratios and maternal deaths in 2020, due to a decrease in access to skilled birth attendance and deliveries in health facilities. Source: UNFPA Asia Pacific Regional Offices analyses

service provision characteristics of 'too much too soon and too little too late' are all too prevalent and we have some countries where women struggle to access a lifesaving C-section, and then others where it has become the norm. We are also seeing other consequences like iatrogenic fistula. Although a greater proportion of women are able to reach facilities for delivery, access remains an issue for much of the population. The role of referrals and intrahospital issues, like overcrowding and lack of emergency stabilisation prior to referral, is critical as we can see women often die due to delays in receiving adequate care once they reach the health facility. In these countries, the focus needs to be on quality of care, including skilled birth attendance by qualified midwives, and access to emergency obstetric and newborn care, including the life-saving functions that can only be performed by properly trained and equipped obstetricians and anaesthetists, as this is a major determinant of health outcomes in this stage.

The remainder of countries in the region, including Maldives, Malaysia, Thailand, Vietnam, Sri Lanka, Fiji, Tonga and Samoa, are in Stage 4 of the obstetric transition. This stage, which is characterised by moderate to low maternal mortality, low fertility and indirect causes of death, particularly non-communicable diseases like hypertensive disorders, demands greater attention to the cause of mortality. In this stage, over medicalisation is a threat to quality and health outcomes. The focus for countries in Stage 4 needs to be on improving the quality of care, eliminating delays within the health system, addressing over medicalisation and target pockets of inequity within the country.

COVID-19 and maternal mortality in Asia-Pacific

One of the greatest concerns since the start of the COVID-19 pandemic has been the potential and actual decrease in women seeking care during their pregnancy and delivering safely with a skilled birth attendant in a health facility, as we know these have a significant impact on maternal and newborn mortality. Ministries of Health, global health agencies including UNFPA and civil society and non-governmental organisations have worked hard to improve access to these services in past decades, and now we see these are threatened by COVID-19 related disruptions.

Antenatal attendance has decreased in many countries in the Asia-Pacific region, and there are variations in patterns of attendance within countries, highlighting persisting inequities. The result is that high-risk pregnancies and danger signs for the mother and fetus are not detected and thus not acted on quickly enough to save the life of the mother and prevent preterm birth and stillbirths.

Some women are choosing to deliver their babies at home without a skilled birth attendant and with no emergency ambulance system for referral in place. This will result in maternal deaths and sets countries back in terms of reaching the SDG targets on maternal health.

The graph below uses modelling estimates to project the impact of reductions in percentage of deliveries conducted in an institution and with a skilled birth attendant in 14 high-priority countries of the Asia-Pacific region. The graph models a potential decrease of 20% or 50% (best- or worst-case scenarios) in those services, compared to the latest average

baseline. In both scenarios, the risk countries are facing for increased maternal deaths is clear, if we do not act urgently to ensure all women seek care, and that services are provided by skilled birth attendants in properly staffed and equipped hospitals.

The right to respectful maternity care at all times

'All pregnant women, including those with confirmed or suspected COVID-19 infections, have the right to high-quality care before, during and after childbirth. This includes antenatal, newborn, postnatal, intrapartum and mental healthcare.' World Health Organization, 2020.

Reductions in numbers of women seeking care have been caused by both fear around the perceived risks of infection with COVID-19 if a pregnant woman seeks care at a health facility, and due to the various interpretations or laws around restricted movement or 'lockdown'. Pregnant women's access to health facilities has also been reduced during COVID-19 due to changes in availability of public transport including local motos, rickshaws and tuk-tuks as options to transport pregnant women to facilities. Pregnant women with disabilities face even greater barriers and restrictions in trying to access health services at this time.

Financial barriers to access healthcare have been exacerbated due to COVID-19, particularly in countries where social protection does not cover pregnancy care and also where not all segments of the population have financial risk protection schemes to enable them to access healthcare without catastrophic out-of-pocket expenditure. Many people have lost jobs and with no stable source of income and continuing living expenses for families, pregnant women's access to healthcare during pregnancy is threatened.

The impact on acute care services in settings with under-resourced health systems has been substantial. Countries and all stakeholders need to make efforts to maintain and protect maternal health systems. Maternity services should continue to be prioritised as an essential core health service and, within that, maternity care providers and the maternal health workforce need to be protected so that they can provide safe and effective maternity care to women.[2]

Ending preventable maternal mortality in every country in our region remains of critical importance and deserves continued attention and technical and funding support for many countries. Prioritising the most left behind populations requires substantial effort and focus of all actors. We have come a long way in the last decade but we have much more work to do if we are to reach the goals and targets set in the SDGs and in global and national strategies to end preventable maternal and newborn mortality and morbidity. The challenge of responding to the COVID-19 pandemic has placed additional strain on the health systems in countries and made our efforts to end preventable maternal mortality even more complex than before. The good news is that we know what must be done – even if that is not easy! Tailored and country-specific approaches are required to address inequities within and between countries and a focus beyond coverage of health services to quality – even during a pandemic. Let us strive all the harder then, as we traverse this Decade of Action in achieving the SDGs that underpin the 2030 Agenda with their vision of truly leaving no one behind.

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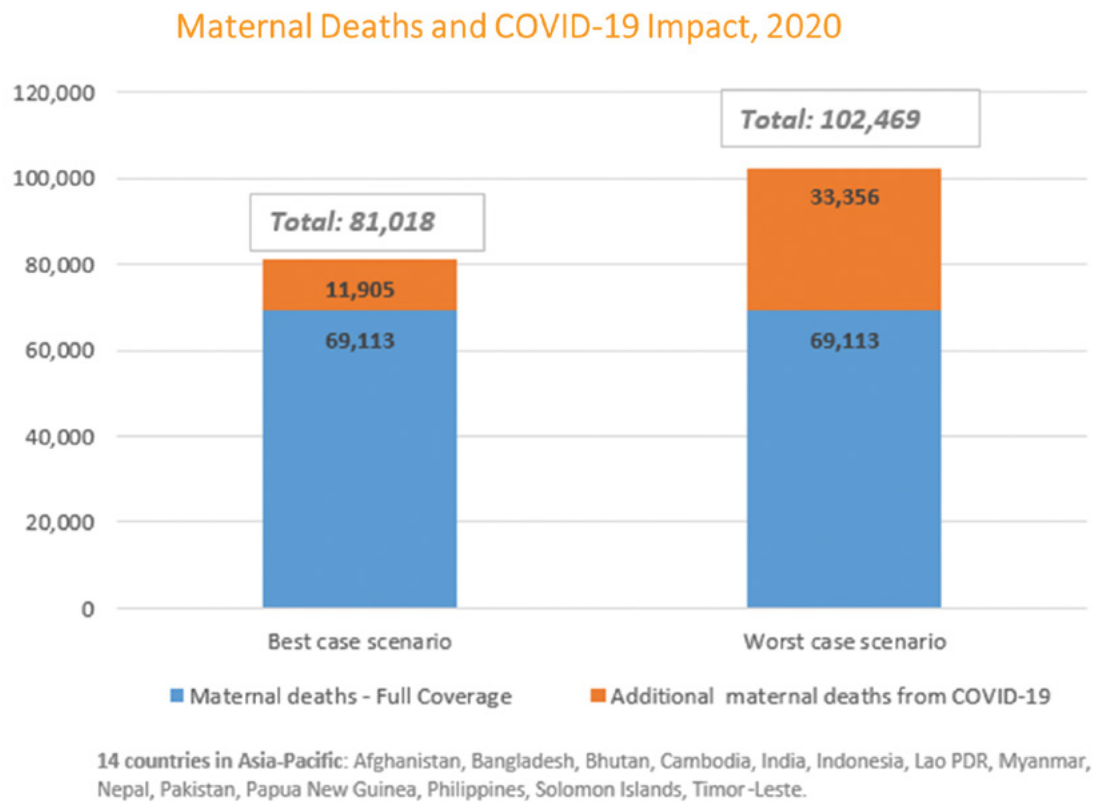

Figure 3. Potential increase in maternal mortality ratios and maternal deaths in 2020, due to a decrease in access to skilled birth attendance and deliveries in health facilities. Source: UNFPA Asia Pacific Regional Offices analyses

12 years in Mongolia: challenges and pitfalls

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In 2009, we were invited by our anaesthetic colleagues to join them on their annual trip to Mongolia to see if we could help establish a laparoscopic gynaecology service. Our knowledge of the country was so limited that we had to conduct internet searches to find out some basic facts about the country, including the capital city Ulaanbaatar (known to everyone as 'UB'). We could have little idea how this would evolve over the following 12 years.

Mongolia had previously been under Soviet-backed communist leadership from 1924 and was known as the Mongolian People's Republic. The country achieved independence after a peaceful democratic revolution in 1990. They had no formal medical system until the 1920s.

We knew that one of our senior colleagues, Dr Jeffery Tan, had travelled there several times in the 1990s to provide gynaecological training and support for local doctors. Our first trip began with what seemed to be a straightforward request to perform the very first laparoscopy at the First Maternity Hospital. As the day unfolded, we were to become aware of what an ordeal teaching new surgical techniques would become. We were presented with a room full of donated overseas equipment in various degrees of working order, and a gynaecologist who had spent a year preparing for the day when her hospital would allow her to perform a diagnostic laparoscopy. Dr Unurjargal (known to all as 'Unur') had spent a total of six months training in Thailand and France to prepare herself and had procured, from several charitable sources, the 'laparoscopic stack' and associated equipment. She told us that she had secured a cylinder of CO_2 from the 'black market', and when we asked how she knew that it was CO_2, she replied, 'because it's written on the cylinder in texta'.

Unur's English language skills were sufficient for us to communicate (she was also fluent in Russian and French), yet she was also acting as translator for everyone else in the theatre. There were at least 30 people in the theatre including anaesthetists, 'biomedical engineers', nurses, hospital administrators and gynaecologists. We were fortunate to have an Australian anaesthetist, experienced in general anaesthesia for laparoscopic surgery, as we had been told that laparoscopies had only been performed at other hospitals under spinal anaesthesia. The landmark event took just over four hours (the diagnostic laparoscopy revealing a normal pelvis, much to our delight) and was deemed a success. We later discovered we had made the local television news. This style of teaching, with language difficulties and multiple translations has been a hallmark of our challenges with teaching and learning.

After this initial successful trip came a welcome invitation for future visits. We were aware that other foreign doctors and organisations had visited at different times, but what was clearly lacking was a co-ordinated approach to this aid, and its success was highly dependent on the motivation, medico-political connections and language skills of the doctors at the various hospitals. The First Maternity Hospital had received many well-intentioned donations of medical and surgical equipment from overseas, but lacked the skills and resources to use and maintain the equipment. We were, for example, surprised to see a collection of 'Harmonic Scalpels' in a cupboard, but no sign of the (expensive) unit to drive them.

What has become evident to us is that Dr Unurjargal is the 'local champion' for improving healthcare for women in UB. She had a clear vision for expanding the services available in her hospital and had the support of those around her to enable change. This has been the key to our ongoing success and allowed us to move forward.

CO_2 cylinders.

Dr Davaajav Unurjargal.

In 2011, Dr Unurjargal, with the help of the WHO, organised the first laparoscopic training centre, with a dry lab and video links to theatre so that the participants could watch simple laparoscopic procedures and practise simple laparoscopic skills. The opening was televised on Mongolian TV, so we were instant celebrities. Each year we have been able to introduce something new, but also help build on skills they were already integrating into their practice.

We hosted the first 'live animal laparoscopic surgery training' lab in Mongolia in 2012. We organised and ran the first hysteroscopic workshop in Mongolia in 2018, with participants happily resecting peeled grapes with a bipolar resectoscope. In 2019, we held their first gynaecological cadaveric workshop.

This has now become an annual visit for two weeks each year in the Mongolian summer by a diverse group of self-funding doctors including O&Gs, anaesthetists, neonatologists and GPs as well as peri-operative nurses, midwives and biomedical engineers. The 12–15 team members co-ordinate their diaries and develop complimentary teaching and education programs that aim to provide education and support to our colleagues in a low-resource country. Some volunteers have been able to travel each year, and some have joined us for one or two trips, but each contribution has been highly valued.

Over the 12-year period, we have refined our understanding of cultural awareness and sensitivity. Our relationship perhaps began like many others in the form of 'medical tourism' but has developed into a much deeper collaboration based on trust (that we will continue the connection) and exchange of ideas rather than the concept of us providing donated equipment or making changes that are not effective or realistic once we depart.

In 2018, Drs Samantha Hargreaves, Emma Readman, Kym Jansen and Phil Popham (anaesthetist) were presented with the Silver Friendship (Nairamdal) Medal by the Mongolian president, the highest honour bestowed upon a foreign citizen by the Mongolian Government, for their contributions to strengthening the collaboration between their country and Mongolia through their work.

For the last four years, and with the exclusive financial support of The Epworth Foundation, we have also included a scholarship program for two Mongolian doctors who are able to spend three months as observers in Australian public and private hospitals in Melbourne, with visits planned to New Zealand in the future. This has been a popular and highly sought-after scholarship by doctors of all levels in Mongolia.

Whilst in Mongolia for two weeks, we are able to provide education and support in many areas:

- Gynaecology: in particular supporting minimally invasive gynaecological surgery and women's health.

Four Australian doctors receiving Silver Friendship medal (Nairamdal). From left: Dr Davaajav Unurjargal, Dr Philip Popham, G.Bayasgalan, Dr Kym Jansen, Kh.Battulga (Mongolian President),Dr Emma Readman, Dr Samantha Hargreaves, Z.Munkh-Od.

- Obstetrics: has focused on simulation-based training and emergency obstetrics.
- Perioperative nurses: have introduced and continue to reinforce WHO 'time-out' checklists and documentation, instrument and pack counting and safe sharps handling.
- Anaesthetics: have focused on laparoscopic surgery and obstetric anaesthesia. The communication between individuals and teams in a surgical setting is demonstrably different in different cultures but underpins our discussions with the Mongolians in terms of improving patient safety and outcomes. We are able to continue these teaching efforts by short video presentations as well as our presence in the operating theatre with one-to-one teaching.
- Neonatologists: provided training in neonatal resuscitation and management of common neonatal problems such as jaundice and sepsis.
- Biomedical Engineering: there was huge demand for maintenance and repair of medical equipment, some of which was donated but lacked local power connections or fittings to enable use. One example was a phototherapy unit which was in working order but lacked the correct mains plug. The sterilisation unit in theatres at the First Maternity Hospital had been unusable for some of 2019 and required a spare part that was not accessible until our biomedical engineer was able to source it.

Primary care in Women's Health is an area to which we have limited access since our exposure is mainly hospital-based health care. There are many cultural and political constraints and differences that we are only now beginning to understand. The cultural significance of their isolation as a country, and individual physical isolation in a vast and sparsely populated country with extremes of weather is something that we continue to learn about with each trip.

Our visits are based around The First Maternity Hospital, which is the busiest obstetric unit in Ulaanbaatar with about 13,000 deliveries each year. We then travel with the team from First Maternity hospital to the most remote regional areas where they have requested our input and support.

We have been able to demonstrate and enact the concept of 'Train the Trainer', particularly when going to visit the remote regional centres. We now have a more supervisory and observational role. This model has worked extremely well from a language and cultural perspective.

Regional junior doctors also have the opportunity to apply for a three-month rotation to UB to learn further laparoscopic skills; however, it is clear that this model of exchange is of short duration and is inadequate to build enough expertise to develop a laparoscopic service outside a major city.

We have set up an organisation in partnership with the Mongolian doctors, The Mongolian Australian Medical Affiliation (MAMA). Through this entity, and with the national recognition that the Silver Peace Medal has provided, we now hope that we are in the next phase of our collaboration with the Mongolian O&G community.

We are planning to become involved in training the O&G community more broadly, perhaps by developing locally appropriate training workshops, and focusing on surgical culture training and history taking skills. We are also providing them with an audit tool to help their and our understanding of surgical requirements.

Unfortunately, it is highly likely that the COVID-19 pandemic will set back the progress we have been making in Mongolia. Mongolia has had less than 300 cases and no deaths but is vulnerable to the pandemic, not only because of its proximity to China and Russia, but also due to its own inadequate healthcare system.

From our point of view, we have learnt a lot about ourselves as Australian medical professionals. We have found that going away with a group of people with similar goals and outlooks can give insight but also deep friendship. We have also developed a real appreciation for our different skillsets, and that has given us trust between ourselves which has continued back in Australia.

Finally, we have learnt as much medically as they have. This sounds like a cliché, but it is completely true. Their capacity to adapt and use fewer resources is very important for us to see. They are also very happy to trial new things that have pushed us to the edge of our comfort zones, which is great. It is a true collaboration.

The Mongolian and Australian team.

FIGO 2021: the challenges of bringing it to Australia

Prof Steve Robson
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Chair, FIGO 2021 Local Organising Committee

Every three years, FIGO – the *Fédération Internationale de Gynécologie et d'Obstétrique* – holds its global meeting. In October of 2021, that meeting will be hosted in Sydney by our College. That is quite a responsibility and an incredible opportunity to put Australia, New Zealand, and the Western Pacific in the global spotlight for women's health. With the COVID-19 pandemic it is also a major challenge.

FIGO has a global focus, aiming to promote and develop and share the science underpinning advances in the physical and mental health of women across the world. Its vision (Figure 1), adopted in the 1950s, remains the same to this day. The FIGO organisation was the brainchild of a Swiss O&G, Hubert de Watteville, who drew together 42 international societies in 1954. Today, that group of societies and colleges has grown to 132, all committed to 'ensuring that women of the world to achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives.'

The path to where we are

The fifth FIGO congress was held in Sydney back in 1967, more than a half-century ago and a dozen years before our local Australian and New Zealand Colleges existed – at the time we were a Council of the RCOG. The most recent congress, held in Rio de Janeiro in 2018, attracted over 11000 delegates. It is difficult to convey adequately the experience of meeting, speaking, building networks, teaching and learning with people committed to women's health from all points of the world. In many respects the wealth of enthusiasm, knowledge, and passion for women's issues is almost overwhelming – there are so many events and speakers that it can be difficult to choose.

Our College bid to become host of FIGO 2021 was a process lasting several years and led by some of the most senior Fellows in the country. Our bid was supported by Business Events Sydney and the NSW Government, who provided financial and other support, and shared the vision of a uniquely South Western Pacific event. The final vote was held during the FIGO Congress in Vancouver in late 2015. It was an exciting process and I spent much of that meeting walking around with an Australian expatriate who wore a koala suit and posed for selfies with delegates. The hot and sweaty koala suit had tiny eyeholes and afforded poor vision, so I had to guide him as he navigated the trade display hall by holding his hand. Spending several days in Canada, strolling hand-in-hand with a giant koala, was quite an experience.

"To promote the development of science and assist in scientific research work relating to all fields pertaining to gynecology and obstetrics:

- to further the attainment, by all appropriate means, of a higher level of physical and mental health of women, mothers and their children
- to develop and improve the exchange of information and ideas in the field of gynecology and obstetrics
- to contribute to the improvement of teaching standards in the profession
- to promote international co-operation and facilitate relationships between national medical bodies of the profession."

FIGO Constitution, 26th July, 1954

Figure 1. The FIGO Constitution, adopted in the 1950s, remains the same to this day.

Wherever you are in the world, you can be part of FIGO 2021

Once our College had won the bid, it became clear just how daunting a task we faced in running such a massive meeting. The only meeting that had come close to the anticipated size of FIGO 2021 was our joint meeting with the RCOG held in Brisbane in April of 2015, attracting over 2000 delegates. That meeting had been a major success, but for the FIGO Sydney meeting, we had to plan for as many as four times that number of delegates.

At the time of our bid, the old Sydney Convention Centre had been demolished for more than a year to make way for the new facility – the $1.5 billion International Convention Centre. We had no physical facility to show anyone at the time, although the virtual tour was impressive. The new centre, located on the footprint of the old building on Darling Harbour, is one of the most incredible conference locations on the planet. With cutting edge technology, impressive spaces and facilities, and staggering views and accommodation on site, the venue for FIGO 2021 could not be better.

Giving life to the global voice

A FIGO world congress is a breathtaking event in scale and vision: it is as much a cultural event as it is a scientific and biomedical conference. The many languages, customs, and the different focus of so many participants are exciting but, at the same time, can be overwhelming. One thing that Australians and New Zealanders excel at, though, is welcoming travellers and making friends. I think this is one of the reasons there is so much excitement about the meeting being held in Sydney. College Fellows, diplomates, and trainees at all levels will be sought out as friends and have the chance to build enduring global partnerships.

One of the key responsibilities of our local committee is to deliver the 'Fellowships program.' The program is a highlight of any FIGO congress and aims to bring up to 30 emerging leaders in women's health research and practice from developing countries to hospitals and research centres across Australia and New Zealand in the lead-up to the FIGO 2021. The program is fully funded by the Australian Government through the Department of Foreign Affairs and Trade, for which we are extremely grateful. International participants will stay, and likely form long-term mentorship and collaborative bonds, with College members. They will visit and observe activities, learn and teach, then return to their homes. FIGO Fellowship participants commonly go on to take global leadership roles in women's health.

For College members less familiar with FIGO, it is a common misconception that FIGO activities are solely aimed at low- and middle-income countries. Improving women's lives in areas where problems such as fistula and cervical cancer are common are vital for obvious reasons. The lives of millions of women, and their families, can be made better with concerted but relatively 'low tech' actions. Yet FIGO has a much broader focus: cutting edge technologies from genomic analysis to robotic surgery also are on the agenda. More generally, issues important to all of us wherever we live – reproductive rights, intimate partner violence, political empowerment – are grist to the FIGO mill. FIGO congresses encompass such a broad range of issues that few areas of women's health and wellbeing are not covered in detail.

Off the page and onto the stage

The local organising committee includes members not only from our College but representatives from nursing and midwifery – the great majority of women's healthcare globally is provided by nurses and midwives. The Scientific Committee is Chaired by Prof Frank Louwen from Germany, and includes advisors from around the world. The Central Organising Committee is Chaired by Prof Andre Lalonde, based in Montreal. It includes members from both South and

North America, Europe, the UK, Australia, and South East Asia. For this reason, arranging Zoom meetings is a considerable challenge taking into account the multiple time zones – for the Australians, these meetings are held close to midnight.

Unsurprisingly, the COVID-19 pandemic has had a major effect on planning and has added a layer of hitherto unimagined complexity to organisational arrangements. Even with the most optimistic outlook on travel 'bubbles' and vaccines, it is clear that quarantine times and costs, and the likely effects on cost and availability of international travel, will impose a severe effect on our ability to run an in-person global meeting. However, and as the experience now of a number of other international meetings of similar scale has shown, a hybrid meeting has the potential to open a meeting up beyond any past experience. Hybrid meetings – where in-person attendance is complemented by virtual attendance – are likely to open up a breathtaking level of engagement barely imagined before the pandemic. Instead of 10,000 delegates in one place, it is easy to imagine 100,000 attendees freed from the difficulties of travel and its costs, time zone, and language barriers. The scientific program being built now is looking to maximise the potential of this disruption.

FIGO has a focus on bringing together people from both high- and low-and-middle-income countries to build a global team to advance women's health. In reality, many potential participants from disadvantaged parts of the world faced great challenges in attending. Pivoting to an hybrid format – part in-person but with a virtual embrace – is likely to make FIGO the truly global voice for women.

Improvements in communications technology have seen a total reinvention of the conference format, with high-quality vision and sound, instant interaction, and development of virtual communities barely thought of a year ago. Fortunately, Australia is seen as a safe destination and for many potential participants who have not been able to travel for extended periods, Sydney is likely to be a very attractive destination. For this reason, with FIGO 2021 still a year away, we are anticipating the congress as being one of the first major international meetings after the onset of the pandemic. The international experience of COVID-19 will mean that technology is brought to bear to maximise the health and safety of participants who attend.

Beyond the usual women's health issues, this will be the first major conference where research studies of COVID-19 in pregnancy will have mature data, so a major component will concern the pandemic, its outcomes and management. We are anticipating enormous interest in presenting COVID-19 related research and using these data to build a global knowledge base to inform ongoing care and to prepare for the next, inevitable, pandemic.

You can find out more about the Sydney meeting at figo2021.org and members of the local organising committee would welcome the opportunity to speak with you about your meeting. We all are excited about meeting you, welcoming you to FIGO, and joining you at the greatest show on earth for women.

International Convention Centre Sydney: the venue for FIGO 2021.

Q&A

For the broader *O&G Magazine* readership, balanced answers to those curly-yet-common questions in obstetrics and gynaecology.

Q A woman with a previous caesarean section and anterior placenta praevia is referred with a suspicion of placenta accrete. What components are required for planning someone's birth with placenta accrete spectrum (PAS) disorder?

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A

Placenta accreta spectrum (PAS) disorders encompass both adherent (placenta accreta) and invasive placental pathology (increta and percreta). PAS abnormalities have increased in tandem with the rise in caesarean delivery rates with a near 10-fold increase over the last four decades.[1] The majority of cases of PAS result in preterm birth, one-in-two require hysterectomy, involve a major obstetric haemorrhage and/or transfusion, and one-in-three need ICU admission. Thus, PAS is now recognised as a major cause of obstetric morbidity requiring multidisciplinary, coordinated care and delivery planning.

Prenatal diagnosis

Antenatal suspicion of the possibility of an abnormally adherent placenta is crucial as maternal and perinatal outcomes are optimised when planned birth occurs in units where there is expert surgical and anaesthetic expertise, intensive care and transfusion facilities available.[2] Despite the variability of PAS abnormalities, obstetric ultrasonography performed by skilled operators is highly accurate in making the diagnosis. Hence, if there is concern about the appearance of the placenta, referral to a specialist imaging unit is recommended.[3]

The International Society for Ultrasound in Obstetrics and Gynaecology have published guidelines that detail ultrasound features necessary for diagnosis.[4] These include multiple vascular lacunae within the placenta, loss of the normal hypoechoic placental/myometrial interface (clear zone), abnormalities of the uterine serosa/bladder interface, the presence

Table 1. Considerations in the management of PAS disorders.

Pre-operative
• Prenatal consultations by relevant speciality/subspeciality (anaesthetics, gynae-oncology)
• Plan specific timing of delivery
• Plan location of delivery and associated logistical support (ICU, cell saver, blood bank)
• Maximisation of pre-operative haemoglobin
• Consideration for temporary relocation of patient and family closer to surgical centre or provide information regarding plan in the presence of bleeding
• Consider maternal steroids
• Blood cross matched pre-operatively
Intraoperative
• Consideration of peri-operative ultrasound to help plan surgical approach
• MDT consultation within OT (team huddle, operative set up, use of appropriate equipment, haemostatic agents, and discussion of remedial measures in the event of heavy bleeding for uterine sparing surgery)
• Confirm the presence of cell saver and blood bank/blood products
Postoperative
• Debrief and careful post-surgical care
• Prolonged DVT prophylaxis after surgery
• Follow up planning if conservative or uterine sparing techniques used

Table 2. Management strategies for PAS disorders. (adapted from Fox et al)[3,8,9]

	Conservative management (placenta in-situ)	Uterine-sparing surgical techniques	Caesarean hysterectomy
Goal	Retain fertility; reduce surgical morbidity	Reduce surgical morbidity; retain fertility	Definitive therapy
Requirements	1–12 months follow up (mean ~6 months)	50% or less of anterior myometrium involved, no lateral or cervical invasion	Expert surgical skillset
Risks	• Delayed haemorrhage (51%), Sepsis, Disseminated intravascular coagulopathy • Subsequent hysterectomy (20–58%) • Recurrence: 22–28%	• Require complete hysterectomy (0–33%) • Low recurrence ~ 2% • Follow-up post-surgery (Triple P) ~ 2 months to assess complete placental resorption	• High rate of maternal morbidity ~ 40% (blood loss and urinary tract injury) especially with placenta percreta

of myometrial thinning or placental bulging and increased vascularity of colour Doppler.[4] Although the mainstay of diagnosis is ultrasound, Magnetic Resonance Imaging (MRI) is a complementary imaging modality and may have a role to play in cases of posterior PAS disorders and placenta percreta.[2]

Management after prenatal diagnosis

Access to skilled multidisciplinary team (MDT) usually requires referral to, and birth in, a tertiary facility. Given the significant risk of high volume blood loss and preterm birth, there is a need for adult and neonatal intensive care facilities, rapid transfusion blood bank access and the availability to a multidisciplinary surgical team with PAS disorder experience comprising obstetricians, neonatologists, anaesthetists, and expert pelvic surgeons.[3] Ideally, once an at-risk patient is identified, MDT review and counselling should be undertaken as soon as possible, particularly if support may be required from colorectal and vascular surgeons and/or interventional radiologists.

At our institution, the diagnosis of PAS immediately triggers a standardised approach involving referrals to the gynae-oncology and anaesthetic teams. Additionally, an ICU bed is booked, extended theatre time with cell saver access is arranged and the blood bank is notified to ensure that patient-specific blood is available. The involvement of gynae-oncologists is driven by local expertise and evidenced by retrospective case-series suggesting the presence of a gynae-oncologist at the beginning of a PAS case is associated with reduced blood loss.[5]

When should delivery be planned?

There is a wide variation in timing of birth for these women ranging from 34–38 weeks.[2,3,6,7] In all cases, planned birth is essential as this approach has been shown to have lower maternal and perinatal complications compared to emergency care.[7] The timing of birth needs to be balanced against the possibility of an acute, out-of-hours admission and its attendant issues. As stated, planned preterm birth reduces the likelihood of an emergency presentation; however, this must be weighed against the increased risks of iatrogenic prematurity and its implications for the neonate.

The risks of unplanned preterm birth are higher in women with risk factors such as previous preterm birth, prior antepartum-partum haemorrhage, and in the presence of prelabour rupture of membranes.[3] Thus, planned delivery between 34+0 and 36+0 weeks may be reasonable in women with significant risk factors for preterm birth. In those without risk factors, planned birth between 36–37 weeks gestation is feasible.[3]

Adjunct pre-operative planning

PAS disorders are associated with heavy bleeding and optimisation of maternal medical conditions, especially anaemia, prior to delivery is indicated.

Although there is no evidence for antenatal hospitalisation of asymptomatic patients,[3] tailoring care to individuals with specific requirements such as geographical isolation will sometimes mean relocation closer to the time of delivery, particularly where PAS co-exists with placenta praevia. Along with surgical planning, early involvement of social workers may assist in the organisation of accommodation and support structures.

In view of the likely need for preterm operative delivery, steroids for fetal maturity are considered as close as possible to the planned date of surgery.

Is a caesarean hysterectomy always required?

Generally, attempts to remove even a mildly adherent placenta increases the risk of haemorrhage. Therefore, options of management of PAS fall into one of three main categories: conservative management, uterine-sparing surgical techniques and caesarean hysterectomy each with their advantages and attendant risks (see table 2).

Retrospective studies of uterine-conserving techniques demonstrate relatively high rates of infectious and bleeding morbidity during prolonged monitoring and follow up. Expectant management alone has yielded variable success rates defined by uterine conservation of 60–85% with about 6% chance of significant maternal morbidity.[3]

One approach in carefully selected patients is partial resection of the affected placental bed. These include the one-step resective-conservative surgery which consists of resecting the invasive accreta area and placenta en-bloc followed by immediate uterine reconstruction.[10] Another novel uterine-sparing procedure for PAS disorders is the Triple P-procedure: Perioperative placental localisation, delivery of fetus above upper border

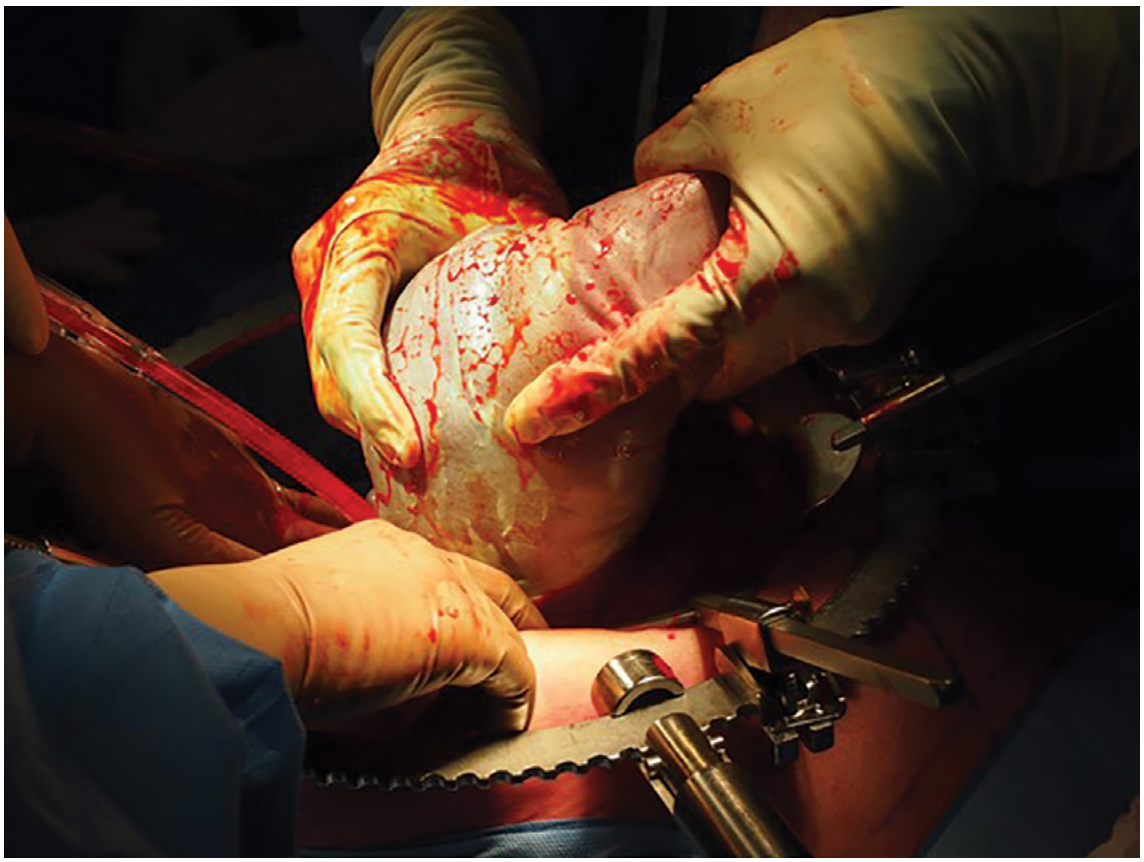

Figure 1. Breech extraction of a fetus during an elective caesarean hysterectomy. A Brookwalter self-retaining retractor system is used here to provide improved operative access.

of placenta, Pelvic devascularisation and Placental non-separation with myometrial excision.[11] Reduced rates of maternal morbidity and hysterectomy have been shown in small series comparing triple P to other uterine-preserving approaches and caesarean hysterectomy.[12,13] In contrast to cases of caesarean hysterectomy, most uterine-conserving surgery series have involved obstetricians with PAS expertise as primary surgeons with support from gynae-oncological colleagues. Local resection therefore appears reasonably successful and feasible and could be considered in carefully selected cases.[3,9]

Whilst some novel techniques are promising, caesarean hysterectomy with placenta left in-situ remains the generally accepted approach in guidelines and is done by 50–70% of clinicians in global surveys.[6] This includes when PAS is suspected during routine caesarean section.[6]

What are the key intraoperative considerations at a caesarean hysterectomy?

Intraoperative planning begins with anaesthetic setup and is usually either a combined spinal-epidural or general anaesthetic. Historically, most patients with PAS disorders were managed with general anaesthesia. However, more recent experience supports the safety of regional anaesthesia with several studies indicating lower or no difference in haemorrhage-related morbidity, improved early neonatal respiratory outcomes, the capacity for the woman to be awake for birth and the capacity to convert to general anaesthetic if required.[3]

A recent meta-analysis demonstrated that administration of tranexamic acid before CS delivery reduced intra and postoperative blood loss with no increase in thromboembolic events.[14] Although these trials did not specifically address PAS disorders, discussion about the pre-operative use of TXA in the surgical management of PAS disorders should be considered. Oxytocin is not provided due to the possibility that partial separation of the placenta may lead to increased blood loss. However, in the event of heavy bleeding its use along with other uterotonic agents and TXA is recommended.

Women are ideally placed in a dorsal lithotomy position or legs straight but parted position to allow access to the vagina and easier assessment of vaginal blood loss.[3] Peri-operative ultrasound assessment of fetal lie and placental location is undertaken, prior to commencement of the incision or intraoperatively using a sterile ultrasound probe, to plan the hysterotomy incision distant from the placental bed.

At our institution, a midline skin incision is routinely employed for our PAS cases, although studies have employed both midline or wide transverse incisions depending on many considerations including the location of the placenta, planned hysterotomy site, maternal habitus, likelihood of operative complications and institutional protocols.[3] After peritoneal entry, the hysterectomy is commenced prior to hysterotomy: the bladder is mobilised as low as possible, round ligaments are ligated bilaterally and pelvic sidewalls opened. Where possible, ureters are identified and lateralised. If frank invasion of the bladder is suspected, ureteric catheters are placed to assist later dissection steps and, in some cases, deliberate cystotomy is performed.[5]

The fetus is delivered by either a transverse or vertical uterine incision usually in the fundus above the placental implantation site, followed by clamping

of the cord close to the placenta and uterine closure (Figure 1). Hysterectomy proceeds until the level of the cardinal ligaments when a narrow Deaver retractor is placed in the vagina to identify the anterior vaginal fornix. The anterior vagina is then opened, and the hysterectomy finished in a retrograde fashion (Figure 2).

Continuous intraoperative appraisal of blood loss and patient volume status is crucial, along with the use of cell-saver and utilisation of massive transfusion protocols as required. The role of pre-operative pelvic artery balloon catheter placement remains controversial and is not utilised at our institution. Access to arterial embolisation peri-operatively, whilst not often required in cases of caesarean hysterectomy, may be useful for conservative or uterine-sparing surgical approaches.

Post-operative care includes analgesia, vigilant post-operative monitoring, thromboprophylaxis, debriefing and follow-up of uterine preserving cases.

In summary, the high-risk nature of PAS deliveries requires a systematic approach to management. Pre-operative diagnosis of the type and extent of PAS is crucial, after which, a thorough discussion of the options of management should occur incorporating both the experience of the clinical team and the patient's wishes including her desire for future fertility. Careful pre-operative planning and care in a centre with an experienced MDT, immediate availability of blood products, access to adult and neonatal intensive care are all essential to optimise outcomes for both mother and baby in PAS disorders.

We would like to thank Dr Nimithri Cabraal and Prof Sailesh Kumar for their review of this article prior to submission.

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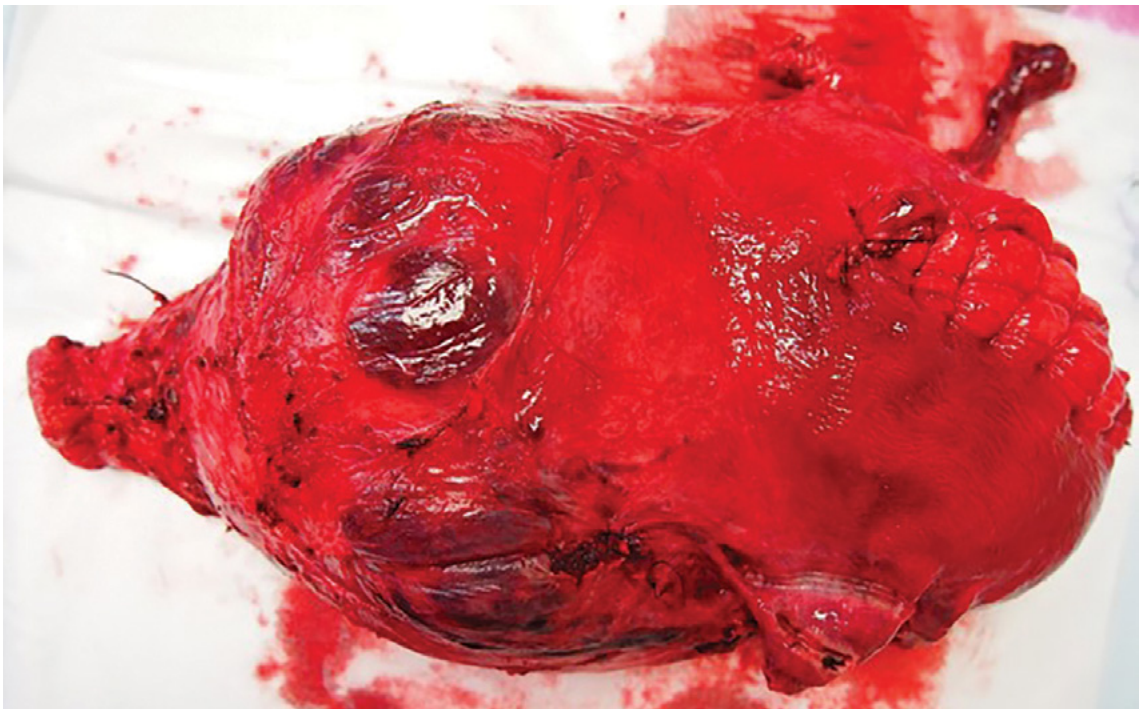

Figure 2. Uterus following caesarean hysterectomy for PAS. Of note: the midline fundal hysterotomy for delivery of the fetus and the extensive area of increta extending from the right anterolateral wall towards the left lateral wall.

Obituaries

Dr Paul Sutherland
1946–2019

Paul was warm and inclusive in his professional and personal life. He had a strong concept of obstetric practice being about working with midwives, respecting women's autonomy and empowering women through their birth experience.

Paul grew up in New Zealand. After medical school in Otago and resident years in Christchurch, Paul worked in Hong Kong in general practice before spending six months with the NZ Army Surgical Team in Vietnam. Paul commenced his obstetrics and gynaecology training in Southampton in 1974, obtaining membership of the British College in 1978.

Paul subsequently moved to Australia and, in the early 1980s, with British specialist qualifications, built up a busy practice in Sydney as a GP obstetrician and gynaecologist. Paul supported home-birthing in the late 70s and early 80s. He had admitting rights to King George V (KGV) Hospital as a GP obstetrician such that women could be transferred there under his care. With an appreciation of Paul's approach to obstetrics, he was encouraged to obtain Australian O&G qualifications. In 1985–86 Paul undertook extra registrar training at KGV in order to obtain Fellowship of the Australian College (FRANZCOG) in 1986. At this time, the birth centre model of care was being conceptualised. Increasingly women sought a more homely environment in the hospital, with continuity of care by a small team of midwives and obstetric backup. The KGV Birth Centre opened in 1990, with Paul as its first medical consultant.

Paul's gynaecology practice thrived in the early 80s, in the home-birthing days, and continued to do so in private specialist practice after he obtained FRANZCOG. He undertook further fertility training and enjoyed fertility practice as well as general O&G practice for years to come.

Enthusiasm and curiosity characterised Paul. He loved exploring new dimensions, in work and in life generally. After retirement from private practice, Paul enjoyed many regional locums. Paul's enthusiasm for his children, art, travel, yoga and meditation, and even keeping snakes and fish, was that of a man who loved life.

Paul is remembered as a colleague and friend whose striking, and at times flamboyant, demeanor and interests sat uniquely alongside his sensitive and compassionate professional practice. As a loving father of Susan, Nicky, Hannah, David and Sam, grandfather of Sophie, Joshua, Annah, Luca and Sofia, brother of Lorraine, partner of Helen and friend of many, he is deeply missed.

Dr Sue Jacobs

Dr Francis Clement Chapman
1932–2020

In May this year we lost one of the true gentleman obstetricians of Sydney, Dr Francis Clement Chapman. Frank grew up in the country at Taree and undertook secondary education at Shore Grammar on the North Shore. He obtained a Commonwealth Scholarship to do Medicine at the University of Sydney from where he graduated in 1956. After graduation he completed his O&G training at St George Hospital, apart from the standard stint in the UK in Reading at the Royal Berkshire Hospital and the Battle Hospital to hone surgical and obstetric skills 'practicing on the Poms'. He was a generous man and subsequently he would visit his Australian registrars in London on his trips back and take them out for scrumptious meals at the Dorchester Hotel where he would order his favourite red wine, a Chateauneuf du Pape.

It was St George Hospital where he established his long-term practice. It was also there that he found his life partner, Anne, who became a vital part of his success.

He delivered thousands of babies in the St George/Sutherland area over his 50 years of practice. He had a series of families where he had delivered both mother and daughter and even grandchildren. He was a very skilled obstetrician and a very able teacher. He taught all his registrars the art of manual rotation of the head. He seldom used forceps except a pair of Wrigley's to lift out the baby's head. Frank was loved by the junior staff. They always knew he was available for support. He was a consultant who, even in the middle of the night, would come immediately when contacted. Medical students and nursing students would look to Frank for tuition which he freely gave. He was always generous with his time despite having a busy private and public practice. He played a significant role in the evolution of St George Hospital maternity service from a cottage hospital to a major teaching centre over his career.

Frank had many interests outside of medicine. The most significant was his passion for music. He was a highly competent violin player, and in later years became a violin maker, with his goal of making the perfect copy of a Stradivarius. He would frequent the Chinese market in Campsie in search of the best horse glue for his violins. He painstakingly produced 10 violins and two cellos and was working on his third cello at the time of his passing. There are stories at St George of Frank entertaining the midwives and labouring women by playing his violin on Labour Ward while waiting for a delivery.

He will be remembered as a kind gentle man, highly proficient in his specialty and generous to all within the profession and in the community. We will miss him, this giant teddy bear with an infectious grin.

He leaves behind Ann, his two sons, grandchildren and two great grandchildren.

Prof Michael Chapman

Dr Robert Francis Ogle
1958–2020

Robert was born in Turkey of English parents. His father, a successful businessman, travelled a great deal and Robert's early years were spent travelling through Europe.

He was a student at St Aloysius College where he excelled in his studies and also tennis. He then went to Sydney University graduating in medicine in 1982. He achieved FRACOG (later changed to FRANZCOG) in 1996.

In 1997, he travelled to London where he was Senior Clinical Research Fellow and subsequently, Senior Lecturer and Consultant in Maternal-Fetal Medicine and Obstetrics at the Royal Free Hospital and University College where he was involved in early studies of genetics, fetal medicine and pioneer studies in Nuchal Translucency.

Returning to Australia in 1999, he became a staff specialist and conjoint senior lecturer in Maternal Fetal Medicine and Clinical Genetics at Liverpool Hospital. In 2001, he was appointed as senior staff specialist in Maternal Fetal Medicine and Molecular and Clinical Genetics at Royal Prince Alfred Hospital (RPAH).

From 2009, he was Director of RPA Women and Babies and from 2012 he was Director of Women's Health, Neonatology and Paediatrics SLHD.

Robert was an author of almost 50 research papers, in 12 of which he was the lead.

He loved RPAH with a passion, his life was the hospital. Six days a week (Sunday was his day of rest) he could be found either in the fetomaternal unit or at his desk.

Robert was devoted to the public hospital system, to his staff, the trainees and most of all his patients, who loved him dearly.

His passing has left a great void in the hospital. He was the soul of the RPAH O&G Department.
A cancer that was thought to be cured returned with a vengeance to claim his life with a sudden ferocity. Gone too soon!

Dr Louis Izzo, Dr Mona Marabani and Dr Jason Ting

Remembering Our Fellows

Our College acknowledges the life and career of Fellows that have passed away:

- **Mr Hugh James Tighe**, Vic
  8 October 2020
- **Dr James Edmond O'Connor**, Qld,
  1 July 2020
- **Dr Yen-Yung Yap**, SA,
  5 September 2020