Africa edition

In this issue:
- The call to end FGM for good
- Fistula – a preventable condition
- Cervical cancer – a global problem
- A woman’s right to better health care
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Advocacy has a crucial role to play in improving women’s health and is the theme of this edition of International News. Advocacy means speaking out, campaigning for better global health, building collaboration and pushing for change.
Welcome to International News

In this edition of RCOG International News we cover issues affecting women’s health globally, but especially in sub-Saharan Africa – Female Genital Mutilation, obstetric fistulae, child marriage and cervical cancer. All these conditions cause significant morbidity and the latter, high mortality. Cervical cancer is second to maternal mortality as the commonest cause of death of young women globally. This edition coincides with the 1st Africa Regional FIGO conference in Ethiopia where these vitally important areas will be further highlighted.

How can we tackle these problems? Many of these women do not have access to healthcare and those who do are managed in low-resourced institutions by health workers who are ‘fire-fighting’ the day-to-day problems of emergency obstetrics and gynaecology, often set against a background of poor pay, morale and working conditions.

Advocacy can be carried out at all levels - local, national and international. At a local level, community education about women’s health issues can make very significant differences to reproductive health and the uptake of healthcare services. On a national and international level, advocacy organisations such as the White Ribbon Alliance (a grass-roots organisation for maternal health), aim to help engage and keep accountable public institutions and policymakers, in order to change policies and improve resource allocation towards women’s health. Their efforts to increase the shortfall in funding for maternal health at the G8 summit have had politicians thinking and pledging greater resources to tackle MDG 4 and 5. Advocacy at this level can make a real difference by targeting the policymakers and the donors.

Awareness should not be confused with advocacy, society is well informed of the scale of these problems in reproductive health. However, women’s health goes beyond pregnancy to address the huge burden of gynaecological disease borne by women, which affects not just quality of life for the sufferer but also her family and community, affecting a woman’s ability to care for her family or carry out daily tasks of living or work. Ill health adversely affects the economic potential and development of the family or community.

The articles in this edition remind us, as healthcare professionals, of the burden of need and the necessity of action to improve the lives of women living with disability and disease by improving access to effective, high quality care and treatment and ultimately to the prevention of unnecessary suffering.

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Professor Alison Fiander FRCOG
Chair of Obstetrics and Gynaecology, Cardiff University, UK, Co-editor RCOG International News and Chair RCOG Global Health Policy Advisory Committee

Mr David Nunns FRCOG
Gynaecological Oncologist, Nottingham, UK, Co-editor RCOG International News and Chair Nepal Liaison Group
Introduction

This edition is a call to you, our colleagues, to be the voice of change. Governments must listen to you, the experts, to find the solutions to save more women’s and children’s lives.

Professor James Walker FRCOG
Outgoing Senior Vice President, Global Health

The RCOG has a strong bond with the African continent. A large number of our Fellows and Members come from the region, not to mention those from the UK who currently work there. They are represented by our International Representative Committees in places such as Egypt, Ghana, Nigeria, South Africa, Sudan and Zimbabwe as well as through the UK-based Liaison Groups who serve areas such as Egypt, Ghana, Nigeria and Sudan.

This puts the RCOG in a unique position when it comes to leading the call for the improvement to women’s healthcare and women’s rights in Africa. Our African colleagues are exposed to the plight faced by many women in some of the poorest countries on a regular basis and they have first-hand experience of helping to save the lives of mothers and their babies who face health issues no woman need suffer in the UK.

Tied to this is the need to speak out against acts of oppression such as child marriage and Female Genital Mutilation (FGM), both of which have a significant impact upon a girl or a woman’s health; both lead to life-threatening health complications and psychological trauma.

My hope is that as you read this edition you will be moved to advocate for better women’s healthcare provision in Africa.

My term of office as Senior Vice President for Global Health finished at the end of September, when I handed over to Dr Paul Fogarty FRCOG. A great achievement for RCOG Global Health in the last few months has been the creation of the first Global Health Strategy. I am very proud to have been part of its creation and look forward to seeing how it develops.

Looking back on the last three years, it has been amazing how far we have come.

• We have continued to grow our sustainable volunteer programme alongside our partners, VSO and the Ugandan Maternal Hub.

• The MTI (Medical Training Initiative), which enables international trainees to work for two years in the UK gaining a wealth of experience, has developed further. We currently have over 100 trainees from over nine countries in the scheme.

• There has been great expansion of our international MRCOG Examination centres with new exams now running in Nigeria, Bangladesh and China.

• Joined to this there has been significant development work towards RCOG Examination training centres in places such as India, China, Nepal, Argentina and the Gulf.

• We have established four Global Health Committees which will be fundamental in taking forward the Global Health Strategy.
As a world-leading organisation in women’s health, the RCOG is well placed to increase advocacy for women and their right to better healthcare.

We look to our International Representative Committees around the world and the UK-based International Liaison Groups, as well as our International Council Representatives, to lead the way to help the RCOG meet the need of women’s healthcare within their countries. All our Fellows and Members, wherever they work in the world, are increasingly contributing to the work that we do.

I am proud to hand over at this exciting time to Paul Fogarty. The future is bright and the RCOG will be there.

Dr Paul Fogarty FRCOG
Senior Vice President, Global Health

I am delighted to be taking on the role of Senior Vice President, Global Health from October 2013.

The Global Health Unit will build on the new structures to increase the global uptake of the full range of RCOG products and I look forward to working closely with all of the Committees, our international representatives and the elected International Fellows on Council to achieve this.

The exciting and ambitious RCOG Global Health Strategy will be launched in London on the 24th October 2013 and used to guide the focus and delivery of our activities over the next five years. We will develop our range of global services, making our expertise available across the world. Consistent quality; local solutions.

Our capacity to undertake international work can be improved by increasing our faculty, improved funding and collaborating with influential partner organisations. We would encourage Fellows, Members and trainees to get involved at every level - from teaching and volunteering to developing contacts with potential donors and partners.

The College’s international activity is aided through external funding and donations. As we take the Global Health strategy forward, we will be working with external funding bodies to work in-country with the shared aim of improving women’s lives. The recent appointment of a Director of Development will allow funding mechanisms to be put in place to facilitate much of our new streams of activity.

In order to support the provision of sustainable effective care we need to develop further creative partnerships. We are continuing to work closely with existing partners such as the Liverpool School of Tropical Medicine, the London School of Hygiene & Tropical Medicine and PROMPT Maternity Foundation. We are also discussing additional exciting partnerships with large international charities.

As the Lead Officer on the India agenda, Chair of the RCOG World Congress Committee and, as an external examiner, I have been fortunate to develop close relationships with many international organisations. The RCOG has established strong working partnerships with many other national O&G societies and we hope to work even more closely together to fulfil shared objectives.

The RCOG is committed to developing its international work and the Global Health Unit will focus activity on successfully fulfilling our strategic aims. The GHU will build on the current successes of the College and take the RCOG to the next level of international influence working with our global partners to improve maternal health worldwide.
Female Genital Mutilation (FGM)
Now is the time to eradicate the practice forever

An introduction to FGM
Alexandra Harriet Coxon
4th year medical student, Cardiff University, UK

Female Genital Mutilation (FGM) or female circumcision is the traumatic cutting and remodelling of the female external genitalia. Records suggest that FGM has been practised for over 2000 years. It is thought that the practice began in the countries by the Red Sea and, since then, has radiated throughout Northern Africa. Today it is most commonly practised in the Eastern and Western horns of Africa, with over 90% prevalence in Somalia, Guinea, Djibouti and Egypt(1). Since the early 1990s there has been increasing international pressure to stop the practice of FGM, but despite substantial progress, with FGM being made illegal in many countries, today there remain 28 nations(2) that still routinely carry out FGM on young girls. It is thought that over 3 million girls(2) aged between 0 and 15 years are at risk each year.

Types of FGM
There are four main types of FGM. Type I is the complete or partial removal of the clitoris and/or the prepuce. Type II is the complete or partial removal of the clitoris and the labia minora. Type III is the complete removal of the labia minora and labia majora and apposition of the cut edges such that the urethra is obstructed and the vaginal opening is reduced. Type IV describes any other harmful procedure to the female external genitalia, and may include piercing, pricking, cauterising and scraping. None of the procedures confer any health benefits.

The procedure varies between countries as well as there being regional differences. For example in Egypt, where the prevalence is over 90%(1), FGM can be performed in hospitals by qualified healthcare professionals. However, elsewhere, in more remote communities it may be carried out in the girl’s home by a village elder with a non-sterile razor blade or a piece of broken glass without anaesthesia. Many of these girls consequently suffer life-threatening sepsis or post traumatic stress disorder.

The trauma of suffering FGM
FGM has many complications both short and long-term. Immediately after it has been carried out, girls may suffer with infection, urinary retention and haemorrhage, while more long-term consequences may include chronic pelvic pain, recurrent urinary tract infections and keloid scarring. There are frequently complications during pregnancy and childbirth that need to be considered, especially in those with Type III

Figure 1: Eaton J (2013) The Western Understanding of FGM in the Developing World [Online]

where the opening of the vagina is reduced, but also in any woman with FGM due to the psychological impact of the trauma, which may be problematic during childbirth or examinations. The RCOG Green Top Guideline - 53 provides extensive advice on the management of obstetric and gynaecological problems that may be encountered in individuals with FGM. You can read this by visiting the RCOG website.

International pressure to end FGM
Presently, strong international pressure by the World Health Organization and the United Nations is being put on countries where FGM is still legally practised. The 1997 document, issued by the WHO and UN (among others), ‘Eliminating female genital mutilation’, has increased the pressure on governments, leading to the practice being made illegal in 24 previously practising countries(2). Continuing international pressure and improved public health education will help to further reduce the number of women subjected to FGM each year, hopefully seeing its practise completely eradicated.

References:
2. UNICEF global databases (2011)
We must show zero tolerance to Female Genital Mutilation

Professor Amr El-Noury FRCOG, FRCS(Ed), MD
Chairman of the RCOG International Representative Committee in Egypt

I am writing to urge fellow women’s healthcare clinicians, both in our continent and all over the world, to safeguard girls at risk of female genital mutilation (FGM).

It is hard to believe that 140 million women worldwide have already undergone genital mutilation and around two million women undergo FGM annually. Most of these procedures are carried out in 28 African countries, where in half of these countries the majority of girls were cut before age 5. In the other countries, most cutting occurs between 5 and 14 years of age.

There are several reasons given for practising this extremely harmful female genital cutting. However, in most societies, the main reason for FGM is a cultural tradition to control girls’ sexuality. Those who demand or perform these procedures often believe, or try to convince themselves, of the religious support, though no religious scripts prescribe the procedure and, in fact, most religious people and religious institutions do not support it and ask for its elimination.

FGM: A violation of basic human rights

FGM is a violation of human rights for these poor young girls and women to be. It is seen by many as a form of oppression of women. It is without doubt a form of child abuse where many forget or ignore the considerable damage to health and the harm it inflicts on girls and women. These procedures not only have no health benefits, they also have short and long term health implications on girls and women. The short consequences are excruciating pain, bleeding, shock, injury, infections and even death.

The UN, WHO, United Nations Population Fund (UNFPA) and United Nations Children’s Fund (UNICEF) are particularly important partners in the effort to eliminate this practice. The Royal College of Obstetricians and Gynaecologists (RCOG) condemns the practice of Female Genital Mutilation and, with other organisations, is committed to eradication through pressure on governments and by education of health workers worldwide.

An increasing trend towards the medicalisation of FGM is observed in some countries such as Egypt and Kenya. This medicalisation of FGM (in the belief that complications occur less frequently) is a matter of deep concern and one should remember that this is an offence.

Our duty to girls at risk

We, RCOG Fellows and Members and wider health providers, have a duty to take every opportunity to intervene to prevent and eliminate FGM. We need to ask the questions to understand the reason behind the practice of FGM. We need to give evidence of the short and long-term harm to the girls and women who have this inflicted upon them. Ultimately, we need to counsel not only mothers but also the wider family. For instance, when a mother who has undergone FGM gives birth to a baby girl, we should take the opportunity to explain the reasons why the child should not be mutilated in the same way as she (the mother) was, explaining the harm that can come from the practice. We should always consider other girls and women in the family who may be at risk of FGM. Handling objections should be supported by law and also by religious support to convince the perpetrators that it is a terrible practice that must be stopped. We should also share such information in good faith with the local safeguarding networks so these girls can be monitored and protected by social services. Such an approach follows the life-course model of health and social care that the RCOG advocates.

Re-suturing (reinfibulation) should not be performed; it is illegal for any professional to do this in the UK. This requires careful counselling and discussion with the woman. We should not hesitate to provide medical care and counselling and support for girls and women who are victims of FGM and deal with them in a sensitive and professional manner. All women must be treated with kindness and sympathy and they and their relatives should not be judged. Engagement with families and communities will be required to achieve a long-term abandonment and eradication of FGM.

I hope that you will give consideration for a zero tolerance to female genital mutilation/cutting and consider the issues raised in this article. I would encourage you to familiarise yourselves with the actions that should be taken to eliminate this harmful practice and safeguard girls at risk to protect current and future generations of girls and women in Africa and worldwide.

For a full reference list for this article please see the online version of International News in the International section of the RCOG website.
My Way of Saying No!

Marie Bryon and Céline Gautier
Groupe pour l’Abolition des Mutilations Sexuelles (GAMS)

No one is ignorant of the risks, but Female Genital Mutilation (FGM) persists. In spite of social pressure, some people are brave enough to bear witness against this tradition. One photographer and two journalists noted down their words to create a 32 portrait exhibition.

It reminds us that saying no to FGM is still, in 2013, an act of courage.

Here are selected extracts from the people they met.

**Mohamed Alakama Doumbouya from Guinea**

Mohamed (photo above) is considered a progressive Imam. He has lived in Tripoli and Tokyo and speaks English. He is the head teacher of a mixed school and heals ‘diseases caused by the devil’. Mohamed is against female genital mutilation:

“I haven’t read in the Holy Koran that it was recommended. FGM causes divorces. Men whose wives have been cut have problems in bed. I know it. My wife has been excised too. They cut the part necessary to make love.”

And yet he turned a blind eye to his eldest daughter’s cutting…

“The Japanese told me: ‘What? You remove their clitoris? And why don’t you cut their noses or ears off?’ I was ashamed.”

**Toure Coumba, from Mali/France**

Toure (photo above) was cut when she was 12 and grew up to become co-founder of GAMS (Groupe pour l’Abolition des Mutilations Sexuelles) France in 1982. She promised herself she would never let her daughters endure what she had been through.

“When I started the fight, it was inconceivable that an African woman would reject traditions. People insulted me and I was attacked. Since then, important steps have been taken but people’s mentality changes slowly. Mothers were told that the cut was a source of femininity and of fertility; that it boosted sexuality; that girls who weren’t cut were of easy virtue. So they do it for their daughters’ sake, believing it is God’s will. They don’t know they are mistaken. They are not savages or barbarians. They just don’t know that the fundamental difference between women who have been cut and those who have not, is pain. An entire life of pain.”
Men, women, African, European, urban or rural, all of them speak up against this custom that marks women’s bodies and souls forever.

Ahmedali Nadima, from Djibouti/Belgium

“My daughter was a premature baby. She weighed 1.3kgs. Three days after she was born, my mother-in-law wanted to have her cut. I was afraid my daughter would have the same life I had. I’ve been overly dependent on medicine during menstruation. I was in pain during my wedding night, despite my husband’s kindness and patience, and I’ve been cut to give birth to my daughter … I said ‘no’ to my mother-in-law, but she was ready to do anything to save her family’s honour. My daughter could have been cut at any moment; no one would have accused the culprit. Only my husband was on my side. He was tied up and beaten. I understood I couldn’t save my daughter. So I ran away. It takes courage to fight against something. But aren’t all women brave when their child’s life is at stake?”

Aïssatou Diallo, from Guinea/Belgium

Four years ago, Aïssatou left her country to save her daughters from FGM

“I still remember the pain of my own cutting like it happened yesterday, because I saw a young girl die in front of me, and others whose lives have been cut short because of this; I couldn’t let this happen to my daughters. But over there, my sisters-in-law had the same rights to my daughters as I do. They were determined to preserve the family’s honour. My daughters were constantly threatened, I was beaten. After years of fear and rejection, when all hope and strength had almost left me, I left. Today, my daughters are safe, I feel alive again. But I want to fight for the 3 million little girls that are threatened each year. My dream? To be able to say, ten years from now: ‘I am one of the last women to be cut.”

“Female Genital Mutilation, My Way of Saying No!” is the result of a collaboration between GAMS Belgium and La Boîte à Images, bringing together photographic and journalistic expertise and knowledge of female genital mutilation. Two journalists and a photographer travelled to meet women in Africa (Senegal, Djibouti, Guinea) and migrant women in Europe (Belgium, France, United Kingdom); they also met men who, in their own way, are standing up to the practice of FGM.

FGM: Spotlight on East Africa

Louise Robertson,
Operations Co-ordinator, 28 Too Many

Last month, a new report on female genital mutilation (FGM) by UNICEF estimated that globally, more than 125 million women have undergone FGM and that as many as 30 million girls may be at risk. FGM is usually carried out by non-medically trained excisors and frequently results in severe physical and emotional trauma. Although predominantly an African practice, FGM has been reported in more than 40 countries and medical professionals in countries with no history of FGM are increasingly coming across the practice as people migrate.

28 Too Many, a UK based anti-FGM charity, was founded in 2010 by Dr Ann-Marie Wilson to help eradicate FGM by providing much needed research and information, enabling local activists and organisations to make the sustainable changes essential to end the practice for good.

Helping countries to make policies on FGM eradication

Earlier this year, 28 Too Many published detailed ‘Country Profiles’ of FGM taking place in Kenya and Uganda and have an ambitious programme to complete profiles for each of the 28 countries in Africa where FGM is practised. The Country Profiles detail FGM in each country and provide a contextual background within which FGM occurs. Each report also contains an analysis of the current situation and a set of recommendations for action to enable all those with a commitment to ending FGM to shape their own policies and practice to create enduring change in communities that practice FGM. The next Country Profile is on FGM in Ethiopia and will be published later this year, and you will be able to access this through the RCOG website.
There are many challenges ahead in the fight to eradicate FGM in East Africa and some of these are highlighted in the stories told by women from the Southern Nations Nationalities and Peoples Region (SNNPR) during a women-only coffee ceremony and discussion on gender equality organised to celebrate International Women’s Day 2013. One woman talked about the dilemma faced by hospitals and health professionals attending to girls requiring urgent treatment from haemorrhage and other complications arising from FGM and also women presenting with childbirth complications caused by FGM. These cases should be reported to the local law enforcement agencies but, in her experience, this was rarely done as there is a fear that, if it was known that a hospital or doctor was reporting FGM, then girls and women needing care would not be taken there and the mortality rate from FGM would increase. Another woman told that she had not wanted her daughters to be cut but her husband insisted as it was the custom and it would bring shame on the whole family if the girls did not have FGM. These are just two examples of the everyday impact of FGM and there are indicators that change is happening.

A positive future

In the last two decades laws have been passed criminalising FGM and campaigners, health care professionals and educators have made significant progress in the fight against FGM in Ethiopia. Most notable amongst the campaigners is Bogaletch Gebre who was awarded the King Baudouin Prize in Belgium in 2013 for her ground-breaking work and she has also helped highlight the issue internationally. Using an approach based on community discussions, Bogaletch Gebre recognises that laws against FGM are only part of the solution. In many places where cutting is outlawed, it is still practised but in secret.

“It doesn’t stop when they superficially raise their hands, or when religious leaders say ‘we declare it will stop’, it has to come from inside the community. It has to be discussed over and over again, in the African tradition. That’s how change comes.”

Bogaletch Gebre
(New York Times, July 2013)

As a result of the anti-FGM campaigns FGM among girls and women (15-49 years of age) has declined from around 80% in 2000 to 74% in 2005 (DHS/MICS surveys). Encouragingly, recent reports on the work...
of KMG Ethiopia (founded by Bogaletch Gebre) and a 2013 report on FGM in Ethiopia by Save the Children indicate further reductions in FGM prevalence and hopefully this will be confirmed in the next national survey.

28 Too Many’s reports and other information on FGM are available as a free resource in the research section of their website http://www.28toomany.org/fgm-resources/country-profiles/.

Dr Wilson will be returning to Ethiopia in 2014 to share this new research and to learn more about what is changing attitudes and behaviour towards FGM. 28 Too Many believe that FGM can be eradicated through a combination of research, developing outcome-focused, evidence based change strategies, capacity building in law enforcement and frontline professionals who come across cases of FGM and sustained funding for long term anti-FGM programmes to achieve this aim.

“Our dream is that a woman does not cut her daughter, then as a mother that daughter does not cut her own daughter; and as a grandmother, that she will not cut her granddaughter/other in the community. Over three generations (36 years) major change will happen; over five generations (60 years) FGM could be eradicated across Africa.”

Dr Ann-Marie Wilson, Founder, 28 Too Many

Thanks to 28 Too Many research volunteer Charlotte Morris and VSO volunteer Kimberley Mackinnon for their contributions to this article.

Photos courtesy of Kimberley Mackinnon.

Pelis’s story

This story was collected by Professor Alison Fiander in Tanzania during a sabbatical, working in a hospital repairing Obstetric Fistula and other childbirth trauma. Pelis developed a third degree perineal tear during her first delivery as a complication of the scarring left by female circumcision, such that the perineum was unable to stretch during delivery. She also had marked urethral hooing. This was successfully repaired and refashioned in February 2012. Pelis was advised to deliver in hospital next time and ideally by elective Caesarean Section.

NAME; Pelis Julias Mwalimu
AGE; 21 years old
EDUCATION; Primary school
OCCUPATION; Farmer
When were you affected by fistula? On 22 December 2011

What happened! What was the cause of Fistula?
It was my first child and I delivered at Mpwapwa. I had a terrible tear because of Female Genital Mutilation (FGM). It happened when the baby was coming out. The baby tore me all the way to the anus and then I could not pass stool.

How was the baby?
The baby was alive.

How did you feel when you realized that you were badly torn?
I felt extreme pain. I could not sit and walking was also a struggle.

How did they (the doctors) attempt to treat the fistula?
They did not do anything at the hospital.

Do you have any hopes for the future?
I hope to be cured and to have another baby in future.

Do you have any other thoughts about fistula?
Women should rush to hospitals for treatment. They must completely stop Female Genital Cutting practices.
Millions of mothers worldwide are suffering and dying from treatable conditions.

Discover how the RCOG, a world leader in women’s health, is working globally to improve health care to save more women’s lives.

www.rcog.org.uk

The RCOG – A truly global College

- We have RCOG International Representative Committees in 30 countries.
- We have RCOG Liaison Groups in 9 different countries and more being formed in 2014.
- We run the RCOG Part 1 and Part 2 MRCOG Examinations around the world. There are 18 different examinations centres outside the UK for the Part 1 MRCOG and 15 Part 2 MRCOG.
- Trainees from the following countries are currently taking part in the MTI (Medical Training Initiative), training in the UK and working towards their Part 2 MRCOG: Egypt, Hong Kong, India, Kenya, Malaysia, Myanmar, Pakistan, Sri Lanka, Sudan and Trinidad.
- The RCOG fully supports UK doctors wishing to volunteer around the world and has helped individuals to work in Ethiopia, Gambia, Kenya, Sierra Leone and Uganda.

Find out more: www.globalhealthinfo@rcog.org.uk
Fellows and Members in Africa can join the RCOG Sub-Saharan Africa Linked In Group to discuss ideas and share information. Request to join the Royal College of Obstetricians and Gynaecologists in the Groups section under Interests: www.linkedin.com

Dr Sophia Webster, a UK-based obstetrician, is currently flying her own plane through Africa delivering maternal healthcare. Follow her incredible journey called ‘Flight for Every Mother’ here: www.blogflightforeverymother.com/the-days-as-they-unfold/

There are RCOG Fellows and Members in 19 different African countries

The two African countries with the most FRCOGs are Nigeria and South Africa
Cervical Cancer
A global problem

Cervical cancer is the most common cancer in women in 29 of the 54 countries in Africa.

The current state of cervical cancer in sub-Saharan Africa

Rose Ihuoma Anorlu FMCOG, MRCOG, FWACS, MPH
Oncology & Pathological Studies Unit, Department of Obstetrics & Gynaecology, College of Medicine, University of Lagos, Nigeria

In 2008, 75,827 women were diagnosed with cervical cancer and 50,571 died from it, giving a mortality incidence ratio of 66.3% for Africa. The highest incidence rate in the world in 2008 was observed in Guinea (56.3/100,000). It is projected that in 2025 there will be 130,034 new cases of cervical cancer and 87,495 deaths. These figures may be a gross underestimate as, in 2003, only four of 46 countries in Africa had useable data on cause of death, and only 8.3% of African countries had population based cancer registries.

Treatment of invasive cervical cancer in Africa

Treatment of cancer continues to be a major challenge in many sub-Saharan African countries, due to poor access to healthcare, and lack of surgical facilities, skilled healthcare providers and radiotherapy services. Facilities for adequate clinical management of those cases who do present at a stage where therapy might be successful are often lacking or very inadequate. Currently, almost all the centres for treatment of invasive cervical cancer are found in urban areas. About 70% of Africans live in rural areas. In 2010, the $1.25-a-day poverty rate in sub-Saharan Africa was 48.5%. Follow-up of patients after treatment is poor because many cannot afford the cost of transport to urban areas.

Effective management of women with invasive cervical cancer requires a multidisciplinary approach involving gynaecologists, surgeons, radiation and medical oncologists, as well as pathologists, medical physicists, technicians, oncology nurses and counsellors. These specialists are lacking in many places across the continent.

Surgery

Those women who have cervical cancer present late in healthcare facilities where effective treatment can be offered. In Lagos, Nigeria, less than 10% of cases were operable at the time of presentation. In most places across the continent, patients who do present early do not have the appropriate surgery because certified gynaecological oncologists and general gynaecologists trained in performing gynaecological cancer surgery are few. Additionally, the low volume of operable cases has affected the experience in performing and teaching young doctors the standard surgery for this disease.

Radiotherapy

Most patients with cervical cancer in Africa present at an inoperable stage. Chirenje et al. found that in 70% of patients with cervical cancer, in Zimbabwe, radiotherapy was the most common treatment modality. Barton et al. using data from Globocan 2002, reported that 55% (range 47–61%) of new cases of cancer diagnosed in Africa had an indication for radiotherapy. Radiotherapy machines are not available in many countries in spite of the high demand for radiation treatment for cervical cancer in Africa. In 2010, 29 of 54 African countries had no teletherapy facilities and only 20 had brachytherapy resources (high-dose rate or low-dose rate). In 2012, Ethiopia had only two radiotherapy machines for over 80 million people. Besides few machines in the region, those that are available are second-hand, obsolete and old; and frequently do not function.

In addition, there is a shortage of trained staff such as radiotherapists and medical physicists as well as essential materials. In 2008, there were only 20 radiation oncologists serving the entire Nigerian nation of about 167 million people. Where radiotherapy is available it is unaffordable to many.
The majority of patients suffering severe cancer pain do not have access to adequate morphine doses due to stringent narcotic regulatory laws by governments.

Radiation with concomitant chemotherapy (chemoradiotherapy) is now regarded as the standard treatment for cervical cancer. This treatment modality, however, is difficult to apply in Africa due to co-morbidities, cost, economic factors and very advanced disease at presentation. Only 47 (15.1%) of 314 women in Uganda with cervical cancer were eligible for chemoradiation because of hydronephrosis and anaemia. Gichangi et al., found HIV positive women had a 7-fold higher risk of multisystem toxicity and 2.2 times higher risk of treatment interruptions and of pelvic disease control failure compared with those who were HIV negative. In 2010, 68.56% of people living with HIV/AIDS worldwide were in sub-Saharan Africa and about 60% of them were women.

Palliative care

Palliative care is a very important aspect in the management of cervical cancer because of advanced stage at presentation. In 2010, palliative care was available in 13 of the 54 African countries. Trained professionals in this area are lacking in many places. Pain is reported in several studies as the most common presenting symptom in many cancer patients in Africa. In 2012 oral morphine was available in only 17 countries. Poverty, poor infrastructure, lack of health care workers adequately trained in palliative care and low priority accorded to palliative care by African governments are still obstacles to effective palliative care in sub-Saharan Africa.

Cervical cancer, a preventable and potentially curable disease, is still associated with a very high mortality and morbidity in sub-Saharan Africa. The disease is still yet to be recognised as an important public health concern by governments in the region. They must have the political will and absolute commitment towards the prevention, early detection and treatment of this disease.

The disease takes the lives of many women in Africa at a stage when they are most relevant to their families economically and socially. The treatment modalities for the disease are still unavailable, inaccessible and unaffordable for many patients in sub-Saharan Africa. Cervical cancer must be given the same priority, in terms of political will and commitment, like HIV, tuberculosis and malaria by governments in the region towards its control.

For a full reference list for this article, please see the online version in the International section of the RCOG website.
Uganda: advocacy and community mobilisation lessons for cervical cancer vaccination

Scott Wittet
Lead for Cervical Cancer Advocacy and Communication, PATH

The World Health Organization (WHO) projects that without immediate action, the global number of deaths from cervical cancer will increase by nearly 80 percent over the next decades, mainly in low- and middle-income countries. Two important interventions are currently available to prevent cervical cancer: vaccination of young adolescent girls to prevent infection and pre-cancer screening and treatment for adult women. Both are necessary and should be part of comprehensive country programmes. This article focuses on vaccination, but also offers resources to learn more about screening and treatment.

Two vaccines to prevent human papillomavirus (HPV) infection, the primary cause of cervical cancer, are now approved for use in most countries. Low- and middle-income countries often face significant obstacles to integrating new vaccines into their national immunisation programmes, meaning that the people living in these countries must wait many years for access to life-saving interventions currently available in higher-income settings. From 2006 to 2012, the international charity PATH set up the ‘HPV Vaccines: Evidence for Impact’ project to help policymakers and planners worldwide make informed decisions regarding regional and national vaccines. Uganda was one of the four countries chosen by PATH for the project. In that country, cervical cancer accounts for 40 percent of all cancers and over 80 percent of women with cervical cancer are diagnosed with advanced disease. Through a demonstration project conducted in 2008–2009 in selected districts, HPV vaccine was made available to more than 10,000 girls. The Uganda project was implemented by the Uganda National Expanded Program on Immunization (UNEPI) of the Ministry of Health, with technical support from PATH, and operations research was conducted by the Child Health and Development Centre (CHDC) and PATH.

The data resulting from the project provided critical evidence to the government of Uganda about when and how best to introduce cervical cancer vaccine nationwide. The experience of Uganda will also be helpful to other countries in the African region.

This article presents six important lessons related to advocacy, policy, community mobilisation and communication for policymakers and programme managers looking to shape their own HPV vaccination programmes.
Lesson 1: Vaccine uptake can be improved by providing evidence-based education and outreach at least one month before immunisation begins.

This project found that vaccine acceptability among different stakeholders changed over time, from, in some cases, initial reluctance or unwillingness to participate in vaccination to willingness and even enthusiasm. Parents reported that they were initially reluctant to have their daughters vaccinated because they did not know about cervical cancer or understand the purpose of the HPV vaccines. As they learned more, they became less reluctant. Giving parents time to understand and accept the information was therefore a beneficial strategy.

Lesson 2: Visible endorsement by national and district government leaders is critical to community acceptance.

The pilot vaccination programme in Uganda was planned and implemented by the government. This not only involved the immunisation unit of the Ministry of Health, but also included officials in the Ministry of Education and Sports, members of Parliament, and even support from the First Lady of Uganda. In addition, leaders in health and education at the district level helped plan educational activities, participated in radio talk shows, organised meetings at local levels, and mobilised local leaders.

Lesson 3: Additional support is needed to ensure that remote areas are reached by educational outreach activities.

Stakeholders in harder-to-reach communities often reported that efforts to educate and prepare the community in advance were inadequate. For example, where homes were located very far apart, local leaders were not provided with sufficient transport to reach them all, or roads were made impassable during the rainy season. Advance planning could help address these obstacles.

Lesson 4: Teachers and health workers play complementary roles in raising awareness in communities.

Both the education and health sectors played important roles in community outreach. For example, teachers thought that the talks by health workers were the most informative communications strategy by far. They reported that health workers explained how to prevent cervical cancer very clearly, in ways that were “not easy to forget” and “eye-opening,” and health workers were able to answer questions. Community leaders also highlighted talks from health workers as the most informative strategy. Girls who were fully vaccinated mentioned that health workers who came to schools helped them understand the need for vaccination.

In turn, teachers played an important role in educating girls about cervical cancer and the importance of vaccination. As one girl reported, “Our teacher went to the sub-county headquarters… she came back with booklets and gave them to us to read and take home to our parents”. Teachers confirmed that they not only worked with girls, but also helped to educate their fellow teachers who had questions and, in some cases, organised meetings for parents at school.

Lesson 5: Information on preventing cervical cancer, HPV vaccination, and the three-dose schedule are key building blocks for community education messages.

Parents’ initial sceptical feelings about HPV vaccine were lessened by key messages about the severity of cervical cancer and the vaccine’s ability to prevent it. The belief by parents that vaccines are generally good for health, facilitated acceptance of the HPV vaccine programme. Even parents who did not have detailed facts about cervical cancer understood that advanced cancer had no cure and that it could be prevented through vaccination; this was sufficient to convince them that their daughters should be vaccinated.

Information about the three-dose schedule was also crucial to ensuring that girls would be fully vaccinated. For example, the father of one partially vaccinated girl in Ibanda district reported that he had
temporarily moved his family to a neighbouring district after his daughter had received her first dose of HPV vaccine. By the time they returned to Ibanda, HPV vaccinations had ended for the year. While he was willing to have his daughter receive the HPV vaccine, he simply didn’t realise until later that there were three doses and that she would miss two of them.

Lesson 6: Making comprehensive educational materials with simple language and graphics widely available can help raise awareness.

The printed educational materials distributed for the project were reportedly very informative (you can download these materials from the RHO Cervical Cancer Library—see resources at the end of this article). In particular, respondents appreciated that the language in the materials was simple and the pictures were clear and understandable. Teachers and community leaders felt that the materials made it easier to explain to others about cervical cancer and the need for vaccination to prevent HPV infection. To ensure appropriate distribution of print materials at all levels, an effective and efficient distribution strategy should be developed early, and materials should be ready for dissemination well in advance (e.g., one month) of vaccination sessions.

Conclusion

Uganda is now well-placed to be a leader in Africa regarding experience with HPV vaccine as a prevention strategy for cervical cancer. Acknowledging the debt that the rest of the continent owes to Uganda for this groundbreaking work, one colleague from Zambia noted that improving cervical cancer prevention in Africa is like climbing a snow-covered mountain (see quote above).

There are plenty of rocks and crevasses barring the way, and sometimes you lose your shoes! But with these new data from Uganda, I can see a rope being lowered down from the summit. Uganda is already up there, ready to help us on our way to the top!
Every year almost 250,000 women in developing countries die of cervical cancer, whereas such deaths have become rare in high income countries with a good screening programme(2).

directly with any of the professionals), the family turned for advice to a medical friend in the UK. She consulted a specialist in gynaecology, and by getting some of the additional details, the specialist was able to advise what would be the preferred treatment option in the UK. This confirmed the recommendation of the National Cancer Hospital, so the family, reassured, went back there for treatment.

Before Meena could start her chemo and radiotherapy, there was a delay of several weeks, while a politically-motivated strike of the hospital administrators was resolved. Not an unusual situation in this new democracy, where hospitals are often political bargaining chips.

A lack of care and support

Eventually she was able to start treatment, which, checking back with the UK specialist, did seem to be clinically up to international standards. What was not quite up to those standards, sadly, was the communication of hospital staff with the patients, so that the whole experience was even more frightening and disorienting for Meena than it need be. It was only made bearable by the unstinting support of her children and wider family (fortunately, she could stay with a niece near the cancer hospital, which is about 8 hours travel from Nayadanda.) It also helped that she had a British friend who had recently had similar cancer treatments in the UK and who visited and shared her experiences.

Nevertheless, the treatments (and lack of palliation of side effects) left her very ill; she had lost a lot of weight (as well as her hair) and didn’t quite believe that she would ever get better; so she had little motivation to eat well and increase her activities. Only a prolonged stay at her daughter’s house and the discovery that her symptoms did get better eventually persuaded her that maybe this wasn’t the end of her life, and finally she started to make a good recovery. Now, almost 2 years after her treatment, she feels as well as ever, has resumed all her previous activities and looks forward to seeing her grandchildren grow up.

The need for better education

Meena’s story illustrates the difficulties faced by cancer patients who live in a low income country with an underdeveloped health system. There is no national cervical screening programme in Nepal and very little information for women about cervical cancer. Although there are some internationally supported initiatives to improve this, they haven’t yet reached the more remote rural parts of Nepal.

It is quite likely that Meena would have sought medical help even later in her illness if she had not had family who could advise and support her and pay for travel and medical expenses: 80% of women diagnosed with cervical cancer in Nepal die from it, because they seek help too late – and an unknown number die without ever seeing a health professional(1).

Only the lucky survive

Even when patients reach hospital and when appropriate treatment is available (and affordable for them, which is also not always the case), there are still barriers: in a largely privatised system, it is hard to know which doctor to trust, while in the government system, although clinical standards are good, essential supportive or palliative care is often non-existent, due to high pressures and low accountability. Women who survive cervical cancer in Nepal are the extremely lucky minority.

*Name changed

References

1. Data from National Cancer Hospital, Bharatpur, Nepal; personal communication
Obstetric Fistula
A preventable condition still causing suffering and shame to thousands of women

A call to action for Obstetric Fistula
Dr Fekade Ayenachew Akilu
Obstetrician and Gynaecologist, Fistula Surgeon
Medical Director, Hamlin Fistula Hospital, Addis Ababa, Ethiopia

The challenge of obstetric fistula (OF) has been known for centuries, and still occurs today. It is arguably the most serious morbidity resulting from obstructed labour. Not only does it leave the woman with grave acute and chronic physical handicap but has considerable immeasurable psychosocial impact.

Obstetric fistula represents a 'near miss' maternal death and major morbidity for women who survive difficult and complicated labours in remote areas with poor access to, or deficient, medical services. The occurrence of obstetric fistulae is indicative of how inefficient these services are at delivering optimum maternal care. The cost of treating these women has to be seen not only in the context of providing treatment for the condition itself, but also against the cost of protecting the irreplaceable role of the mother in the home and in the community. There are overt humane, social, economical, as well as demographic merits in averting the suffering of our women.

The need to address misconceptions
Although there have been substantial advances in meeting the MDG targets, maternal health remains a challenge in many parts of the world. Observation of the first ever Global Fistula Day on May 23rd 2013 represented an opportunity for stakeholders to call for the mobilisation of resources to bring an end to the suffering of women from obstetric fistula. It also provided a platform for much needed advocacy about this tragic maternal health problem in order to create awareness and address misconceptions. Replicating these efforts at regional and national levels in order to individualise strategies that suit specific geographic, socioeconomic and cultural environments is crucially important. The encouraging attention given by governments to prioritise maternal health; economic development and growth of infrastructure in developing countries, and emerging technologies with the potential to change people’s lives in underprivileged areas, will hopefully entice concerned professionals and stakeholders to devise and engage in activities that alleviate the unreasonable suffering of women.

Over the past decade, more than ever before, much has been done in a more concerted way to tackle this complicated medical problem.

Different approaches are being implemented to facilitate the access to treatment for fistula sufferers. Delivering a comprehensive package of surgical repair; psycho-social support, rehabilitation and reintegration remain the mainstays of restitution of the lives and dignity of women suffering from OF. Lack of appropriate establishments and specially-trained personnel to deliver these services remains a challenge. All such programmes are required to consider active case identification and referral and access to treatment for women surviving obstructed labour. This is not only to optimise the utilisation of available resources but also to give such survivors a future. However, prevention of OF should be the ultimate goal for maternity and fistulae services to avert obstructed labour, which puts mothers at risk of dying or surviving only with major birth related morbidity. Needless to say, healthcare professionals and those working to improve maternal health must act to put an end to obstetric fistulae and be the voice for the voiceless under our care.

Obstetric fistula in Africa
Dr Amy Keightley

I have recently come back from six months volunteering in Uganda with the Maternal and Newborn Hub supported by the RCOG. I was mainly based in Hoima Hospital, a regional referral hospital in the west of the country, close to the border with the Democratic Republic of Congo.
During my time there I saw many women presenting acutely with obstetric fistulae. Only 42% of women in Uganda give birth with a skilled birth attendant\(^1\), and as a result, obstructed labour is commonly not identified. Often having been in labour for days, women attended the hospital, walking or on motorcycle taxi, having already lost the baby and exhausted. In these situations, ruptured uteruses were not uncommon and the women were lucky to escape without a hysterectomy and with their lives. It was normally about four days later that the fistula became evident, either faecal material or reduced urine output into the catheter or just the woman feeling ‘wet’. Unfortunately, the only help I could offer to the women at this point was to wait for the next fistula camp that attended, where doctors with the relevant expertise could try to restore their continence. Being unable to help with the repair myself, I spent much of my time working on fistulae prevention, teaching the midwives, students and doctors about the proper use of the obstetric partogram. I took every opportunity to encourage the proper completion of the partogram on the labour suite in order to identify obstructed labour early. I also did a large amount of teaching with nursing and midwifery students both in the classroom at the new ‘Hoima School of Nursing’ and in practice when they rotated through the maternity department. In general, the management of obstructed labour once a patient arrived at the hospital was good, but often the damage had already been done in the community.

The low value of women in society

Women do not receive this level of attention and care due to the low value of women in society. Money is not spent on them in order that they can access health services. In addition, women are less likely to be educated and do not recognise that they require assistance. Empowering women has the benefit of allowing them to access family planning services. By choosing the size and timing of their pregnancies both they and their children will be healthier. The incidence of obstetric fistula is greatest in the youngest mothers where their bodies lack the physical maturity to safely deliver a baby. Raising the value of women in society will improve access to family planning, reduce forced early marriage and reduce the rape of children and young women, which in turn will reduce the prevalence of obstetric fistula.

References

Mwanaidi’s story

The following story was collected by Professor Alison Fiander during a sabbatical working in CCBRT’s (Comprehensive Community Based Rehabilitation in Tanzania) Disability Hospital in Dar es Salaam, repairing Obstetric Fistula. Mwanaidi’s first labour at the age of 15 became obstructed after she tried to deliver at home. It is likely that her pelvis was inadequately formed as a teenager and she suffered the physical and psychosocial morbidity of an obstetric fistula. It had a profound effect on her relationship with her husband.

The occurrence of obstetric fistulae today is the most shameful atrocity towards humanity that healthcare providers and our failed health systems create.
Part of the solution to obstetric fistula has to be increasing the proportion of women giving birth with a skilled attendant and the transfer of women to hospital early when slow progress is identified.

Other stories about fistula can be viewed online in a previous issue of International News dedicated to the subject of obstetric fistula in the International section of the RCOG website.

NAME; Mwanaidi Amir Shemahimbo
AGE; 25 years old
EDUCATION; Primary school
OCCUPATION; Farmer
When were you affected by fistula?
Ten years ago.

What happened! What was the cause of fistula? The baby was too big and they took me to the hospital when I could not deliver. At Korogwe hospital they pulled the baby out after applying anaesthesia which wore off after five hours and the urine started leaking. When I told the doctor he advised I should go to Moshi, Kilimanjaro for treatment. We did not have money so we decided to have treatment at home. But eventually I did not get any treatment at all. Then a lady mentioned about the hospital's treatment because she was cured.

How was the baby? I had a still birth.

How did you feel when you realised you were leaking urine?
It was a big problem because my husband wanted to leave me because of this condition that irritated him and he was getting fed up because of the smell of urine.

How did they attempt to treat the fistula? They referred me to Moshi but I could not go because my finances were low.

Do you have any message for other women with fistula?
This problem is treatable. Women should not suffer unnecessarily and then give up. If I meet anyone with this problem I will tell them to come to Dar es Salaam for treatment.

Do you have any hopes or plans for the future? With God's help I will be cured and in the future I intend to visit hospital for treatment.

Do you have any other messages about fistula? People should be careful to follow what doctors advise them about their health.

Medical summary
Mwanaidi Amir Shemahimbo has one living child. Her first labour aged 15 years in 2001 was obstructed; she spent two days at home and was then taken to a hospital, where she had vacuum extraction of a stillborn baby. She developed a large VVF with the ureters on the edge. She delivered normally a second time in 2003. Mwanaidi underwent successful fistula repair in February 2012.

Raising the voices of girls and young women affected by child marriage and fistula

Elizabeth Gezahegn King
Africa Programme Manager, FORWARD (Foundation for Women's Health, Research and Development)

“I don’t know my childhood and I became a mother without playing like a child and this has affected me so much. I became a wife and a mother and raising a child is so expensive normal costs such for food, cloth and medication and when the child reaches for education the cost will include those for books, uniform wear and pens are really difficult to cover.” – a 14-year old Girl from Amhara region, Ethiopia.

In 2012 FORWARD and Profutures Development Initiative, Ethiopia developed a rights-based support programme for young women and girls who have been affected by child marriage. The programme was developed to respond to the impact of child marriage on child brides and child mothers in the Amhara region. Child marriage affects up to 41% of girls and young women under 18 in Ethiopia, and in the Amhara Region where our programme was based, 80% of girls are affected by child marriage.

While there is increasing work being done globally to prevent child marriage, our work with partners has enabled us to identify that child brides and child mothers currently require support and attention in order to improve their lives and rights to good health, capacity to make a livelihood – and play a role in preventing further generations from becoming child brides.

Our history and our approach
FORWARD has been working for the last 30 years to create a world where women and girls have the capacity to enjoy their full sexual and reproductive rights, are able to access safe and quality maternal care and are able to live free of violence.

We have campaigned, advocated and provided services to support women and girls affected by female genital mutilation (FGM), child marriage and maternal health issues such as obstetric fistula.
PEER and FORWARD programmes

In 2008, FORWARD began using PEER (Participatory Ethnographic Evaluation Research) to explore the impacts of child marriage, FGM, obstetric fistula and teenage pregnancy on the lives of girls and young women based in Africa and the UK.

PEER is a qualitative, participatory research methodology. It is particularly effective for working with marginalised groups in order to understand behaviour, beliefs and risk perceptions from an insider point of view. The method is particularly strong in producing insight into sensitive topics such as sexual behaviour, gender relations, power dynamics within households and communities, and barriers and motivates to behaviour change.

FORWARD has used the PEER process to empower over 300 young women and girls by training them to become peer researchers and experts among their communities in Ethiopia, Ghana, Liberia, Nigeria, Sierra Leone, Tanzania and the UK.

Empowering girls to share their story

“No child should be a child bride”

PEER has been an invaluable tool for our work with child brides and child mothers in Gondar, Northern Ethiopia. Twenty-two girls between the age of 13 and 18 who were or had been child brides were trained as peer researchers and experts on child marriage in their community. These girls then interviewed two of their peers (child brides/mothers). The girls interviewed had been married as young as seven years old and up to the age of fifteen years old. Most ‘knew nothing’ about the agreement.

The girls painted a picture of a life that is ‘very weak and in poverty’; for many a continual struggle to put food on the table and ‘win the struggle with life’. Many spoke of the very traditional cultural norms that resulted in them feeling ‘confined to the home’, and ‘suffering from a huge burden of domestic work’.

Gender inequality defines all aspects of the girls’ lives and excludes them from involvement in decisions that impact on their lives - particularly hard to bear for many girls when it comes to being taken out of school and being married ‘too young’ and against their will.

“I was married at the age of 13. I stayed with my in-laws for two years. I gave birth to a baby when I was about 15 years old. Now I have five children.”

Our research shows that many of the girls spoke about their ‘lost childhood’, being forced to grow up too quickly and deal with adult issues ‘before they are ready’.

“I honestly think it (sex) is the greatest struggle I have ever seen in my life. I felt like I bled a gallon when he did it to me first time. I was in so much pain for two weeks. It is painful in general.

“I bleed and get bruised during intercourse because he does it without my will.”

We also learned that many of the girls struggled with the physical impacts of multiple childbirths during childhood, and were haunted by the prospect of raising children at a young age.

Early this year, we used the PEER study as a tool to learn and understand the experience of 45 women and girls affected by obstetric fistula living in Bo district, Sierra Leone. We trained 15 young women affected by fistula to become peer researchers and ‘champions’ among their community. Each young woman interviewed two other women affected by fistula.

The girls gave recommendations to reduce the impact of fistula:

“Some of us need more than one operation for the repair. Because there are not many specialist doctors, we have to wait up to six months for the next operation. We need to have more specialist doctors that can do type I, II, III and IV repair in our country.”

“We need to have health centres for each village so that pregnant women can go the health centre rather than going to the TBAs.”

“Most women don’t know much about fistula and its treatment so there needs to be more sensitisation programme in the villages.”

Our research shows that although some of the women managed to access health services, most services do not have resources and the capacity to deal with the women’s situations.

Empowering girls and young women to conduct research on the issues they are impacted by has enabled FORWARD to develop programmes that make a tangible difference to the lives of women and girls. It also has the power to better inform health professionals and governments to provide services that truly take into account the needs of women and girls.

Come to meet Elizabeth Gezahegn King on Thursday 3rd October at 1:30pm at the RCOG exhibition stand during the FIGO congress.
Empowering women
The crucial link between women’s rights and their health care

Advocacy for change
Professor Lesley Regan FRCOG

There is widespread recognition that maternal health is critically important, not only to prevent death and disability in women from pregnancy-related causes, but also to protect their children and to establish sustainable economic development in their communities. A key strategic goal of the RCOG is to promote global advocacy for women’s health and childbirth by supporting the provision of universal access to reproductive healthcare.

As Hillary Rodham Clinton reminded us recently, “nations that invest in women’s employment, health, and education are just more likely to have better outcomes. Their children will be healthier and better educated”. The President of Liberia, Ellen Johnson Sirleaf, drew our attention to the fact that African women bear an unacceptably huge burden of disease and death and argued that women’s socioeconomic improvement is essential for better health outcomes. She ended her Nobel Prize acceptance address with the rallying call: “A nation thrives when mothers survive; we must strive to keep them alive”.

In 2009, the UN Human Rights Council acknowledged that preventable maternal mortality is a human rights violation and convened an expert meeting to prepare guidance for governments on the application of human rights to resolve these problems. As governments renewed their efforts to reduce maternal mortality, health advocates started using human rights mechanisms to make governments honour their commitment to ensure access to services essential for reproductive health and wellbeing.

2009 was also the year when I was asked to chair the first RCOG Women’s Advocacy committee. At our inaugural meeting we agreed that the purpose of advocacy is to change people’s minds and persuade them to act differently. For the Fellows and Members of the RCOG this means trying to change the way that women are treated from a political, religious and societal viewpoint in order to make a sustainable improvement to maternal mortality and morbidity and the status of women in their local communities.

The worth of a woman’s life

It is a sobering fact that of the 350,000 women who are destined to die in childbirth during 2013, 80% could be prevented by adopting measures that lie within the financial resources of the communities in which they live. This means 280,000 young women whose deaths would be avoided if the leaders of their societies could be persuaded to act differently.

Advocacy for women’s health is as much about improving the position of women in society by engaging political will, raising gender status and ensuring better access to education, as it is about providing medical resources. In fact I would suggest that sourcing clinically skilled health care workers and medical supplies is by far the easier part of the equation.

Advocacy for change

The world media has recently focused on several high profile cases of women whose human rights have been tragically violated. Such as the case of the teenage Indian girl who was brutally assaulted and gang-raped on a Delhi bus and later died from her injuries. Or Malala Yousafzai, the inspirational 16 year old girl from Swat in Pakistan who was shot by the Taliban because she wanted to uphold her human right to attend school and receive an education. We read these stories and feel sickened and outraged but we must channel this anger into positive actions to prevent these tragedies from recurring.

Human rights are an important tool in the fight to improve the status of women in society because they embody a shared set of values that have been enshrined in law. Infringements can be litigated in countries that subscribe to them, which include most European countries.

Of course, many women whose rights are being infringed live in countries where poverty is endemic, illiteracy is the norm and the rule of law seems to be absent. No amount of medical resource can turn the tide as effectively as educating those women to understand what they need to do to access the healthcare they require and thereby become the protectors of their own human rights and those of their children. How many women in the world know that their country has obligations to provide them with information and access to family
“Women are not dying of diseases we cannot treat… they are dying because societies have yet to decide that their lives are worth saving”

Professor Mahmoud Fathalla, Chair of the WHO Advisory Committee on Health Research

spacing and contraception? The pioneering work of Professor Antony Costello, the Director of the University College London Institute for Global Health and his teams in setting up cost neutral women’s community support groups in the developing world, has clearly demonstrated that empowering women to take charge of their own and their families’ health is an enormously valuable strategic tool with the added advantage of a ripple effect. A Lancet 2013 meta-analysis of trials in various settings showed that low-cost interventions reduced the mortality of mothers by a half and their children by a third.\(^1\)

**Human rights abuse – a global issue**

Poverty may often exacerbate the consequences, but rights issues are certainly not resolved in the developed world. For example, violence against women is a problem in most societies, with serious reproductive health consequences, yet the number of clinicians who enquire about violence routinely is disappointingly low, even in countries where guidelines and recommendations have been in existence for nearly two decades. The woman who stood unsupported for 11 hours to filibuster the Texan Senate this year in order to obstruct an oppressive abortion law was defending the human rights of women in one of the wealthiest countries in the world. In the UK, the determined campaign of Jasvinder Sanghera to halt the tide of forced child marriages among UK citizens demonstrates that we cannot assume that these human rights abuses only occur in poverty stricken communities. They are happening everywhere and we must continue to spotlight them in order to persuade everyone involved that these practices cannot and will not be tolerated in our global society.

The application of human rights is critical to the success of global strategies to improve maternal and newborn health because human rights shift understanding of maternal deaths as mere misfortunes that are expected to happen into injustices that the state is obliged to remedy.

Of course the practical application of human rights is best done through collaborations with professional medical associations and technical agencies such as the WHO to ensure the use of relevant medical and public health expertise and to maximize the chances of favourable local government and political responses.

Furthermore, human rights provide tools to hold governments legally accountable for their failures to address the preventable causes of maternal mortality and to distribute medicines that are essential for reproductive health such as hormonal contraception and misoprostol to reduce postpartum haemorrhage.

**Our obligation**

Advocacy for women is an obligation for all of us engaged in reproductive health care. However, if doctors and other health care professionals are going to rise to the challenges and meet the obligations that their role in society imposes, they need educating to do so. This means that in both their undergraduate and postgraduate training they have to be taught how to embed human rights principles into every aspect of their delivery of women’s reproductive health. The dedicated members of the FIGO women’s sexual and reproductive rights (WSRR) committee, that I have the privilege to chair, have developed a teaching syllabus that can be accessed on the FIGO or the GLOWM websites.\(^2\)

Our goal is to turn the tables on traditional approaches and shift the teaching of Human Rights and Women’s Reproductive Health (HRWH) from a marginal to a mainstream position in the learning process for all health care professionals. The result is a competency-based educational approach that simultaneously advocates for human rights and health, by developing standards for performance and tools for training teachers and students in both the classroom and clinical settings. The competencies are currently described for medical students; however, the materials and approach could easily be adapted for use in training a wide variety of health care and legal professionals.

This FIGO-HRWH project has been piloted in many venues and the materials have been received enthusiastically by a wide variety of lay and professional audiences: the teaching tools are easily understood and adapted to local needs. Without exception, workshop participants, using the human rights checklist gain insights into their own health and the fundamental relationships between rights and health outcomes. This is an unparalleled opportunity to educate the doctors of the future to practise in such a way that makes women’s human rights inseparable from women’s healthcare. We believe that our novel teaching program will help to pave the way for a step change in education and healthcare that will benefit women worldwide. Please come and help us make it happen.

“Imagine a world where all women enjoy their human rights. Take action to make it happen”

(1998 UN Campaign for Human Rights)

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1. [https://iris.ucl.ac.uk/research/personal?upi=AMDLC04](https://iris.ucl.ac.uk/research/personal?upi=AMDLC04)
2. [http://www.glowm.com/figo_taskforce](http://www.glowm.com/figo_taskforce)
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