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Registered Charity No. 213280
Introduction from the Senior Vice President, Global Health

This is an exciting time for global health in the College. We have increased the support structures within the Global Health Unit and are currently developing a global health strategy which we’ll be launching later this summer. It will guide how and where we use our resources over the next five years.

As the world leader on standards for women’s reproductive health and with around half of our membership living outside the UK, it makes perfect sense for the College to expand its global work. From our expertise in education and training, developing standards and guidelines and providing support in high-need countries, the College has much to offer.

We also have a key role to play in advocacy and empowering women worldwide. As doctors, RCOG Members are in a powerful position to speak out against injustices such as female genital mutilation and forced marriage. It can take a lot of courage to stand against the cultural tide but that’s how change will be effected – one woman at a time, one community at a time. It is an ongoing challenge and we will be exploring ways of communicating key messages through individual Members, courses, workshops and conferences.

Delivering on our strategy

Our approach to global health has changed to help us to deliver our strategy. The Global Health Board (which I chair) now has four committees reporting to it and you can read all about their work in this edition. We also have a Global Health Unit that is staffed to support implementation of our strategy.

We have International Representative Committees and UK-based Liaison Groups, all working to improve women’s health care and influence change. We are actively working with other Royal Colleges towards a more joined-up approach, and we are looking at how we can work in partnership with the American and Canadian Colleges to raise standards internationally.

We are also looking at how we can further improve our support for volunteers in preparing them for their placement and their return, and we’ll be using the feedback from some of the people featured in this edition to learn from their experiences. If you are interested in volunteering but can’t go away for a long period, we are going to be developing a range of short-term placement opportunities. We need to increase the number of Faculty involved in training to deliver global health-based courses, too.

Funding our work

Our international work relies largely on external funding and donations. We can always use extra funding and, as we take our strategy forward, we will be working with external funding bodies to work in-country to improve women’s lives.

We also want to use the extensive network of contacts that our Fellows and Members have across the world, and I would ask that you look at who you know who might be a potential sponsor for the College’s global work. We would like to hear from the many Fellows and Members who carry out volunteer work already on how the RCOG can work with them and help with what they are doing.

We are a global family and together, we can help to improve the human rights, education and health care standards of women everywhere and save the lives of mothers and their babies across the world.

Professor James J. Walker FRCOG
Chairman of the Global Health Board
This edition focuses on the global health work of the RCOG which coincides with the reorganisation of the International Office into the Global Health Unit and the development of the Global Health Committees through which the RCOG’s Global Health strategy will be developed.

The first themed edition was dedicated to the subject of obstetric fistulae and is available to read on the RCOG website.

In this edition
First, we will introduce you to the staff of the Global Health Unit and to the differing Global Health Committees: the Global Health Collaboration Committee; the Global Health Grants and Projects Committee; the Global Placement Committee; and the Global Health Policy Advisory Committee.

The RCOG Liaison Groups are formed by diaspora working in the UK who liaise with local national societies to improve women’s health in their home countries. Several of the chairs of the respective groups write about the activities of their group in this edition of International News.

Dr Sonia Barnfield MRCOG is the RCOG’s Global Fellowship Officer and she writes, along with a trainee obstetrician (Rachel Ion) and midwife (Anna Stealey), about volunteering overseas and of their experience working within the Ugandan Maternal and Newborn Hub.

Professor Nynke van den Broek provides an update of the Making It Happen (MIH) programme coordinated by the Maternal and Newborn Health Unit (MNHU) at the Liverpool School of Tropical Medicine (LSTM). The programme aims to reduce maternal and newborn mortality and morbidity by increasing the availability of Skilled Birth Attendance and Essential (Emergency) Obstetric and Newborn Care. In 2007, the MNHU and the RCOG developed a standardised three-day ‘skills and drills’ training package in Essential Obstetric Care and early Newborn Care. This has been introduced into 12 countries worldwide and is subject to continuing evaluation. The LSTM also runs a Diploma course Reproductive Health in Developing Countries accredited by the RCOG.

Mr Laurence Wood FRCOG introduces a pilot project which involves mentoring non-physician practitioners or assistant medical officers in Tanzania, by those nearing or newly retired UK consultants, recognising the huge wealth of experience that such volunteers can draw upon.

This is an exciting time for the RCOG’s global health work with opportunities to partner and collaborate with other organisations: the common cause being to improve women’s health globally.

One example is the obstetric anaesthesia charity, Mothers of Africa, based at Cardiff University, which focuses on the anaesthetist’s contribution to maternal health. Cerys Richards and Tei Sheraton, anaesthetists from Wales, outline their successes in Liberia and some of the important lessons learnt along the way.

Another example is the charity Maternal and Child Health Advocacy International (MCAI) who have introduced emergency obstetric and neonatal care courses to Liberia, Professor Brigid Hayden FRCP and Professor David Southall OBE MD FRCPCH outline the work they are undertaking in Liberia, funded through THET including future plans to train selected midwives in obstetric surgery.

There is still plenty to be done to improve maternal and newborn health globally and we welcome discussion of the topics raised in this edition of International News.

Get in touch with us
We would also like to take this opportunity to encourage Members and Fellows to join the RCOG LinkedIn group and RCOG regional groups to take part in discussions related to the RCOG’s global health mandate.

Professor Alison Fiander FRCOG
Co-editor International News and incoming Chair RCOG Global Health Policy Advisory Committee

Mr David Nunns FRCOG
Co-editor International News and Chair Nepal Liaison Group
The RCOG Global Health Unit: Who we are

Rachel Cooper  
Director, Global Health Unit

Rachel Cooper is the College’s Director of Global Health. Rachel works closely with the Senior Vice President (Global Health), Vice President (Education), Officers and Executive Directors to develop and implement the College’s global health policy according to geographical and subject strategic priorities. She leads the research and development of international education initiatives, including needs analysis and evaluation. With Officers and Directors, Rachel develops the College’s fundraising, grants application and sponsorship strategy in global health and advises on the disbursement of College grants, awards and restricted funds. She manages relationships with key external partners and contacts, such as the Department for International Development, THET, Liverpool School of Tropical Medicine, DH International, Academy of Royal Colleges’ International Forum, VSO, Gates Foundation, the United Nations Population Fund and so on. Rachel supports and liaises with the Chairs of the International Representative Committees and RCOG Liaison Groups to ensure the implementation of the constitution, and attends meetings as required. She is responsible for the effective operation of the Global Health Board and its four new Subcommittees: Global Health Policy Advisory, Global Collaboration, Global Grants and Projects, and Global Placement.

Key tasks for me will be finalising the Global Health Strategy and operating plan, including strengthening the RCOG’s approach to health needs assessment and programme development, to help us better prioritise our global activity.

Loraine Rossati  
Interim Director, Global Health Unit

I have joined the RCOG during Rachel’s absence on maternity leave. For the last five years I have been a commissioning manager in an inner London Primary Care Trust, leading on offender and forensic mental health services. I have NHS, local and central government programme and grants experience, as well as international experience gained through UN-related work to raise standards in prison services and improve Human Rights for people in detention in countries such as Kyrgyzstan, Pakistan and Libya.

Rachel is currently on maternity leave.

Binta Patel  
Manager, Global Health Unit

I joined the department some ten years ago when Dr Matt Carty was the Senior Vice President and it was his vision that led to the College establishing the International Office, which is now the Global Health Unit.

My main responsibilities are to coordinate and assist the Global Health Director with the development of the RCOG’s Global Health Strategy. This includes joint RCOG partnerships with London School of Tropical Medicine (LSTM) and Volunteering Services Overseas (VSO).

In addition, I track the visits of our Fellows and Members to overseas countries as well as the activities of other organisations, with a view to establishing new collaborative projects and meetings. I maintain links with our International Representative Committees and liaise closely with the RCOG Liaison Groups and their local specialist societies, again, to develop new contacts and relationships.

I also liaise closely with those organisations that are able to donate medical equipment to low-resource countries and respond to Fellows and Members working in areas that have the greatest need of these donations.

Another part of my role, in conjunction with the Director of Global Health, is to maintain the financial records of the Global Health Unit and the allocation of funds to various projects.

Finally, I am responsible for three of the Global Health Unit’s Committees: LSTM/RCOG Joint Partnership Management Group, Global Grants and Projects Committee and the Global Collaboration Committee, as well as organising the Annual International Representative Chairmen’s Meetings.
Suzie Boyd  
Out-going Grants and Projects Manager  

I joined the Global Health Unit in November 2011 and took over the management of a United Nations Population Fund-financed project on evidence-based guideline development in Eastern Europe and Central Asia. In 2012, we created a course on ‘The Development and Implementation of Clinical Guidelines’ and gave a master class to 12 delegates from Kazakhstan, Moldova and Romania. In 2013/14, the first courses will be taught in these countries by the delegates from the master class with assistance from the RCOG faculty that developed the materials.

I was also responsible for the Eurovision project, which involved running seminars and workshops for overseas obstetric and gynaecology societies, usually as part of their annual congress. In 2012, we ran a Eurovision conference in Antalya, Turkey and this year we are holding one in Romania.

For the last two years, I have run the RCOG’s Schools’ Art Competition on the themes of ‘The Art of Motherhood’ (2011) and ‘Mother and Child’ (2012). Some seriously talented young artists submitted some stunning work on both occasions, which was then displayed around the RCOG in London.

I have now left the Global Health Unit to start a new role as Projects Manager, working closely with the Honorary Secretary of the RCOG and the CEO on a wide range of projects.

Elizabeth Rafii-Tabar  
Administrator, Global Health Unit  

I joined the Global Health Unit in June 2012 and I am hugely enjoying being part of this department. A large part of my work involves managing the Medical Training Initiative (MTI); a scheme to enable overseas doctors to train in the UK for two years. The aim of the scheme is for international trainees to experience NHS training and enhance their clinical skills.

I help administer the International Representative Committees and liaise closely with them to promote the RCOG’s work in the countries they represent. In addition, I provide assistance to the RCOG volunteering programme. This includes dealing with queries from those interested in our volunteer work and supporting our Global Fellowship Officer to promote the volunteering opportunities the RCOG can provide. Joined to this is my work supporting the RCOG Global Placement Committee. This newly formed Committee is part of the underlying structure of the work of the Global Health Unit. The MTI and volunteering schemes both come under its sphere of work.

Finally, I am responsible for the International section of the website and I manage our Global Health LinkedIn pages. These have been set up to enable our Fellows and Members based overseas to build links and networks with others working in their regions. They have both become useful tools to allow the Global Health Unit to reach further out to our Global Fellows and Members.

Go to www.linkedin.com and search for Royal College of Obstetricians and Gynaecologists in the Groups section.
The Global Health Committees: What we do

The Global Health Collaboration Committee
Chair: Mr Shane Duffy MRCOG

The RCOG’s International Office was first established in 2006, committed to improving women’s health internationally and this has now become the Global Health Unit (GHU). The development of the GHU has been in response to the increased call for the RCOG to lead on women’s health not only here in the UK but in countries all over the world.

With increased global collaboration in the last 12 years some progress has been made to achieve the Millennium Development Goals (MDGs) 4 and 5 (MDG4: to reduce by two-thirds the under-five mortality rate and MDG5: to reduce by three-quarters the maternal mortality rate). However, there are still an estimated 2.6 million stillbirths, 3.1 million neonatal deaths, 360,000 maternal deaths and 250,000 deaths from cervical cancer that occur globally each year. Many of these deaths are avoidable and they signal a major unmet need in women’s health.

The Global Health Board has established four new committees to help with the implementation and development of its work, looking at policy, collaboration, grants/projects, placements and the International Representative Committee and Liaison Groups.

I am delighted to have the opportunity to chair one of these: the Global Health Collaboration Committee. This is a joint enterprise and as it develops we hope to engage many more Fellows, Members and trainees in the work of the GHU.

The RCOG is in a unique position, as it has a comprehensive understanding of the needs of women’s health and the solutions required to address these needs.

The members of the College live and work in over 100 countries. At the heart of the future work of the GHU is expanding the collaboration with these members to make change a reality and bring to life the best in women’s health care. So much good work is achieved by the College’s Fellows and Members – not only in the health settings where they work but also at regional, national and international levels. The expertise, work and dedication of our Fellows and Members has resulted in the RCOG being seen as a world leader in global women’s health and places the RCOG at the centre of the solution to the many challenges that exist worldwide.

In a world with many voices and competing priorities it is important that our College takes the lead on how to provide evidence-based improvements to women’s health not only here in the UK but also internationally.

Much work has already been undertaken to develop the GHU’s strategy and over the coming months we plan to align the activities of the GHU with this strategy. This will ensure that the work and collaboration with other global parties is focused and achieves the outcomes that we believe make a real impact on women’s health. The Global Health Collaboration Committee held its first two meetings in January and April and we have a packed agenda over the next year.

I do hope that you will share with us our deep, collective, determination to improve women’s health and the clinical practice of obstetrics and gynaecology in the UK and across the world. So much good work is achieved by the College’s Fellows and Members – not only in the health settings where they work but also at regional, national and international levels. The expertise, work and dedication of our Fellows and Members has resulted in the RCOG being seen as a world leader in global women’s health and places the RCOG at the centre of the solution to the many challenges that exist worldwide.

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The Global Health Grants and Projects Committee
Chair: Dr Daghni Rajasingam MRCOG

The Global Health Grants and Projects Committee was formed in 2012 under the new Global Health Unit (GHU) at the RCOG. Within the terms of reference, this Committee will provide support and overview to grant applications, oversee project management and delivery of successful grants and secure new funding streams from potential donors.

The work of this Committee will be closely aligned to the strategic aims of the GHU; enhancing the modernisation of the RCOG to meet the needs not only of its Members and Fellows but also its aspirations to be the charitable organisation for global women’s health. The RCOG is uniquely positioned to push forward this agenda in comparison with other Royal Colleges, as it has a significant proportion of international members.

The GHU, under the leadership of the Senior Vice President (Global Health), held a workshop in December 2012 to set its strategic direction and priorities. The Chairs of the Committees, International Representatives from Council and permanent staff from other RCOG directorates contributed to this session. The energy and enthusiasm was palpable; the huge scope of work currently undertaken and the desire to scale up some projects was impressive. However, there was also an understanding that we could increase the impact of the GHU by prioritising our vision and ensuring secure funding mechanisms.

The Global Health Policy Advisory Committee will be accountable for delivering this vision in conjunction with the Chairs and the GHU. Additionally, the Global Health Grants and Projects Committee will support and sustain the aims of the Collaboration Committee, Global Placement Committee and the Global Health Board.

As many academic institutions are initiating and extending their global health agenda, there is an opportunity for the RCOG to facilitate coordination of women’s health activities to avoid activity duplication and to maximise the impact of the work. The development of UK/global hubs will be one mechanism of achieving this.

The appointment of the Director for Development, Ann Tate, is particularly exciting and timely for this Committee. Building new partnerships, both within the UK and with in-country non-governmental organisations will be a key aspect to achieving the goal of securing new funding streams. Many of the established grant-giving bodies expect applicants to have significant local knowledge and intelligence. The RCOG already has an excellent international reputation with a recognised global brand for teaching and training. We now need to maximise this potential. Successfully creating these new relationships and sustaining established ones will need investment in time but ultimately will provide a wider, more secure base for the activities of the GHU.

Many multinational businesses have allocated corporate social responsibility budgets, whose main aims will be capacity building, training and initiating sustainable change within local communities. I anticipate the RCOG GHU becoming an established and trusted partner to help deliver the goals of some of these budgets. There will be opportunities for corporate volunteering schemes, which could be supported alongside NHS volunteering schemes.

Last but not least, another important and relatively new funding stream will be from high net-worth individuals. The RCOG networks, through its Members and Fellows, have access to individuals who want to support global causes. Several of the established work programmes of the GHU will appeal to such individuals and we are working on a ‘menu of options’ to help encourage donors to support women’s health.

As Chair of the Global Health Grants and Projects Committee, I am optimistic that the restructuring of the GHU, the appointment of the Director of Global Health and prioritisation of our strategic aims will enable the GHU to thrive in the present global economic climate. In the UK, we have become the first country to spend 0.7% of our gross national income on foreign aid. I have no doubt that the RCOG will lead in providing a model of effective and sustainable global health delivery from the UK.
Despite the great social, financial and logistical pressures they face, that they have managed to enhance quality of care in their settings, colleagues as to how best to deliver care in the developed world given World Upside Down – we can undoubtedly learn from our clinical Turning the programme to enjoy the journey as well as the destination.

There is an old maxim: ‘People don’t care how much you know, until they know how much you care’. This is not just playing with

I have genuine interest in medical education and global public health and I have travelled widely as part of my involvement in training in some of the world’s poorest countries. During my term of office, I am looking forward to working with RCOG Officers and colleagues. We will be supported by Binta Patel (BPatel@rcog.org.uk) and Elizabeth Rafii-Tabar (ERafii-Tabar@rcog.org.uk). I am confident that I will learn much from all members of the GPC and together we will make a difference in as many people’s lives as possible.

There is an old maxim: ‘People don’t care how much you know, until they know how much you care’. This is not just playing with words but describes the fundamental value of building trust in our collaborations with partners in the UK and abroad. My intent is to help all colleagues who would be part of our placement programme to enjoy the journey as well as the destination.

To conclude, I paraphrase Lord Crisp from his book Turning the World Upside Down – we can undoubtedly learn from our clinical colleagues as to how best to deliver care in the developed world given that they have managed to enhance quality of care in their settings, despite the great social, financial and logistical pressures they face.

To put forward your ideas for discussion to this Committee, please contact the Global Health Unit: globalhealthinfo@rcog.org.uk

The Global Placement Committee
Chair: Mr Hani Fawzi FRCOG

I am honoured to chair the RCOG Global Placement Committee (GPC) which, in support of the UK’s international development objectives, aims to create opportunities to foster exchanges of professional colleagues between UK health establishments and health institutions abroad. In that context, the GPC caters for three main groups of colleagues:

- International Medical Graduates to be matched with training fellowships in the NHS and Health Boards
- UK trainees and medical students volunteering for Out-Of-Programme educational opportunities overseas
- Members and Fellows of the RCOG (worldwide) engaging in short- or medium-term placements.

In supporting placements in the UK and overseas, the GPC will develop courses and literature to facilitate the learning and practice of medicine in the ‘partnership’ country. The material will be delivered in liaison with the RCOG Education Directorate and other national/international organisations.

It is envisaged that the International Representative Committees, RCOG country Liaison Groups, other national professional associations and the wider membership of the RCOG will be involved in the activities of the GPC. Central to the administration of the GPC is the establishment of a database of opportunities for placements in the UK and abroad. I would like to take this opportunity to ask you to get in touch with the GPC (at globalhealthinfo@rcog.org.uk) if you are keen to participate and provide a placement for a colleague in the UK or abroad.

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The Global Health Policy Advisory Committee

Chair Elect: Professor Alison Fiander FRCOG

The RCOG’s global health strategy is evolving, developing and expanding as outlined by the Chairs of the Global Health Committees: the aim being to better address women’s health needs on a global scale while at the same time supporting Members and Fellows working around the world.

The RCOG Global Health Unit works closely with other professional bodies and NGOs to raise awareness of global maternal and infant mortality, with a particular focus on the Millennium Development Goals 4 and 5. By working with other organisations, the RCOG champions the rights of women and their families at all levels. As a membership organisation for professionals at the frontline of maternity care, the RCOG experiences the problems of maternal and infant mortality at the forefront of practice, making it an ideal advocate in calling for more action to prevent maternal deaths and morbidity, and promote sexual health and wellbeing.

We recognise the need to build on our strengths such as education and training, standard setting and guideline development, but also the need to focus and build partnerships for sustainability and long-term effectiveness and change. This is a continuing learning process and the Global Health Policy Advisory Committee would be happy to receive input and discussion from Members and Fellows worldwide as to how best we can achieve our goal of reaching towards universal women’s health and mitigating against morbidity and disability; physically, psychologically and emotionally.

As an example of an issue impacting upon many women’s right to sexual health and wellbeing, the RCOG hosted(under the guidance of Professor Lesley Regan) an event marking International Women’s Day on 8 March 2013, which focused on ‘violence against women’ and ‘forced marriage’ and their sequelae. This was extremely effective and moving and highlighted a highly important issue affecting many women today, including many in the UK. Professor James Walker, RCOG Senior Vice President (Global Health) said, [On International Women’s Day]… ‘we need to celebrate the achievements of women worldwide. However, there is still a wide disparity between those who have a say and those who still do not. Alongside empowering women through education and employment opportunities, there is also the need to ensure that we have the infrastructure to support women suffering from acts of physical and psychological harm.’

It is becoming ever more apparent that improving the status and education of women is key to resolving many of the problems affecting not only low-resourced countries but the whole globe in terms of health, economic, environmental and societal wellbeing and sustainability. There is much to be done and it is therefore vital that the Global Health Unit, its new Committees and partnerships, together with Fellows and Members worldwide work closely together to realise a global health strategy that improves women’s health and the practice of obstetrics and gynaecology across the world. The Global Health Policy Advisory Committee will seek to advise on priorities for women’s health globally, focus RCOG resources and activities upon priority countries, while building partnerships to improve women’s health and wellbeing worldwide.
Bringing RCOG courses near to you

With over 50% of members living in countries outside the UK, RCOG is reaching out around the world and bringing our courses directly to you.

Are you interested in delivering an RCOG course in your country?

Our courses offer:
- Recognised RCOG branding
- RCOG certificate of attendance to all delegates
- Provision of all course material
- Training the Trainers course for Practical Skills and MRCOG Final Preparation

Find out which courses you can run:

**Practical Skills**

Our practical skills courses range from basic skills for safe surgical techniques to multi-professional training in various hospital and rural settings. These courses train the trainers to teach safe techniques to colleagues and future doctors, with the aim of reducing preventable harm to mothers and their babies.

Courses include:
- Basic Practical Skills in Obstetrics and Gynaecology
- PROMPT (PRactical Obstetric Multi-Professional Training)

**MRCOG Final Preparation**

MRCOG Final Preparation is designed to refine the candidate’s examination techniques to improve their chances of passing the exams and achieve Membership of the Royal College of Obstetricians and Gynaecologists.

Courses include:
- Part 1
- Part 2 Written
- Part 2 Written and OSCE Combined
- Part 2 Written and OSCE Consecutive
- **NEW** Enhanced Revision Programme: A blended virtual learning product developed to support candidates sitting the Part 2 Written exam but who do not have access to resources based at the College. The programme combines: 15-week virtual classrooms, online lectures for pre-course learning, homework and a face-to-face course.

**Theoretical Scientific Courses**

We deliver a varied programme of 60 theoretical training courses in London. Video conferencing offers the opportunity for delegates to hear the latest advances in their field, participate in live discussions and gain CPD/CME credits, while minimising the time and cost of travel.

Find out more about delivering an RCOG course in your country.
Contact Navin Jaitly at the RCOG on +44 20 7772 6460 or njaitly@rcog.org.uk
The RCOG Liaison Groups are made up of the diaspora of national doctors resident in the British Isles, or doctors (living anywhere in the world) with a strong interest in a specific country, who wish to support the development of women’s healthcare in that region.

There are currently nine groups and each has close links with their overseas colleagues through the International Representative Committee or National Societies. There is much activity from the groups as a result of the close working relationships that have been nurtured. In this section we highlight each group’s current activities, priorities and plans for the future.

To get in touch with any of the RCOG Liaison Groups, please send an email to the Global Health Unit: globalhealthinfo@rcog.org.uk

Bangladesh Liaison Group
Mr Ashfaq M Khan MRCOG

What we do
The Bangladesh Liaison Group (BDLG) is one of the youngest additions to RCOG’s global health team. Like every other Liaison Group, it was formed by expatriate British (and non-British) Bangladesh Fellows, Members and trainees of the RCOG. To improve our efficiency and effectiveness, our Liaison Group welcomes non-executive members from medical communities of other disciplines and also opens its membership to non-medical disciplines.

The goal of the BDLG is to strengthen the relationship between the RCOG and healthcare providers in Bangladesh through effective dialogues and a multidisciplinary approach to improve women’s health in Bangladesh in order to achieve the Millennium Development Goals.

Over the last year, our executive members have tried to build up an effective relationship with the local RCOG International Representative Committee, universities and medical colleges to begin our next phase.

Priorities of the group
We have set out the following objectives:

• To facilitate and improve educational and training links between the RCOG and Bangladesh, the RCOG International Representative Committee and the Obstetrical and Gynaecological Society of Bangladesh.
• To promote better use of evidence-based knowledge and effective tools to improve maternal and neonatal health services in Bangladesh.
• To provide assistance in exchanging skilled personnel through the Medical Training Initiative scheme.
• To raise awareness of women’s health among Bengali-speaking people worldwide.

Plans for the future
Assistance to Bangladesh Cancer Screening and Colposcopy Service (working with National Body):
The National Centre for Cervical and Breast Cancer Screening and Training at BSM Medical University (BSMMU) in Dhaka is helping the Bangladesh government in developing a cervical cancer screening programme based on ‘Visual Inspection with Acetic Acid’ as the primary screening test and planning for further scale-up of the services towards ‘Upazila’ (sub-district) level. Until now, most of the districts of Bangladesh have at least two centres for cervical and breast cancer screening (over 100 centres countrywide). We have agreed to support this programme by assisting them in procuring surgical equipment (diathermy machines, loops and insulated speculae). We will also provide local training by UK-certified colposcopists. The BDLG has already sent surgical equipment for local colposcopy clinics through the BSMMU Cancer Screening Unit. We are planning to support this programme as one of our long-term projects.

Supporting postgraduate trainees:
The BDLG has organised clinical observerships for seven Bangladesh doctors in the last 18 months (September 2011 – March 2013). This has given them the opportunity to understand and experience the British healthcare delivery system. We plan to expand this programme further in the future.

Supporting postgraduate education (establishment of women’s health libraries):
The BDLG will facilitate the establishment of women’s health libraries at Dhaka, Sylhet and Chittagong. It will be a joint venture between the BDLG and local authorities/institutes. The local authority will provide a site and staffing and the BDLG will facilitate procurement of books, secure cheaper deals for information technology support and pay subscription fees for e-library/journals. The BDLG is trying to secure sponsors and donors for this project.
**Improvement of maternity service:**
The BDLG, working with a local non-governmental organisation (NGO), People’s Oriented Program Implementation (POPI) and UK-based NGO, Learning 4 Life (L4L), is making a positive contribution to improve the rural maternity health services. Dr Yasmin, Honorary Treasurer of the BDLG, recently visited two such centres in remote areas of Bangladesh. She was accompanied by two senior midwives who helped to train local traditional birth attendants, nurses and paramedics. The team stayed there for three weeks. We have plans to organise four to five such training sessions a year.

**Improvement of clinical governance in Bangladesh:**
An agreement was made to assist the BSMMU and RCOG local committee to develop evidence-based effective clinical guidelines to improve patient care and experience in women’s health. This project will be implemented in multiple phases. Initially we are going to work in four pilot sites:

- A tertiary centre (university hospital)
- Two secondary centres (medical college hospitals)
- A primary care unit (through an NGO-run unit in remote rural areas).

A specialised subgroup was formed within the BDLG to facilitate this project. In the second phase, we are going to encourage local authorities to get involved in clinical audits and quality improvement measures. Two half-day workshops were organised by the BDLG and Women’s Medical College (Sylhet) on good medical practice and clinical governance. Dr S Begum, Honorary Secretary, was the keynote speaker.

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**Egypt Liaison Group**

**Mr Ayman Elnaqa FRCOG**

**What we do**
The Egyptian Liaison Group (ELG) was officially formed in October 2008 although Egyptian consultants in the UK have been scientifically active in Egypt for much longer. Currently over 65 UK-based Egyptian consultants and Specialty and Associate Specialist Doctors (SAS), work through the Egyptian Representative Committee (ERC) of the RCOG. Our Steering Committee (five members) was elected by identified Egyptian consultants in the UK and currently comprises Mr Ayman Elnaqa (Chair, Wolverhampton), Mr Ahmad Sekotory (Secretary, Manchester), Mr Sherif Abdel Fattah (immediate previous Chair, Bristol), Dr Mohamad Allam (Glasgow) and Mr Mohsen Hassan (London). Our time is given on a voluntary basis.

**Courses in Egypt**

- **The Part 2 MRCOG course:** run annually since 2001, with practice of all types of questions. It includes coaching regarding specific UK practice issues.
- **The Basic Practical Skills course:** three courses per year since 2009.
- **The PROMPT course:** October 2010, given by Professor Tim Draycott and his team.
- **A postpartum haemorrhage course:** January 2011. Three courses were run in different locations by Professor Arulkumuran, Professor B Lynch and Mr Essam El-Hamamy. This was held again in Cairo and Alexandria in April 2013.
- **Obstetric haematology and 3D/4D ultrasound courses** are being organised for 2013.

The 2013 Basic Practical Skills Course; students and faculty

**Combined ERC/ELG Scientific Conferences in Egypt**

- **First conference:** February 2010: 16 UK-based Egyptian consultants.
- **Second conference:** March 2012: 18 UK-based Egyptian consultants.
- **Third conference:** March 2013: 28 UK-based consultants and several other consultants from the USA and Australia.
UK training opportunities

- Several ST3 jobs have been arranged for Egyptian trainees through the MTI (Medical Training Initiative).
- MD scholarships.
- Clinical attachments (Pre-Part 2 MRCOG).

Priorities of the group

Our priority is to enhance the healthcare and wellbeing of women in Egypt, through the ERC, and in accordance with the crucial international role of the RCOG, by:

- Promoting evidence-based medicine through scientific conferences and courses.
- Helping in postgraduate training through clinical courses and RCOG mandatory courses.
- Providing UK training opportunities.
- Helping to develop guidelines.

The ERC/ELG with the help of the RCOG successfully organised an RCOG Egypt Day on 14 September 2012, the recommendations of which will help in achieving our future aims and plans.

Plans for the future

- To help the ERC establish an RCOG-approved continuing professional development programme.
- To offer Advanced Training Skills Modules (ATSMs) for senior Egyptian trainees.
- To establish exchange training programme in Egypt for UK trainees.
- To establish exchange training programme in the UK for Egyptian trainees.
- To collaborate with other Liaison Groups in establishing unified courses for the less resourced countries.

Mr Ayman Elnaqa Chair, Egyptian Liaison Group
Consultant Urogynaecologist and Obstetrician,
Royal Wolverhampton NHS Trust

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Ghana Liaison Group
Dr Paul Mensah FRCOG

What we do

When the Ghana Liaison Group (GLG) formed three years ago in 2010, it had, as one of its principal aims, the mobilisation of healthcare professionals in the diaspora of Ghanaian descent (and non-Ghanaians) to complement the efforts by Ghana to reduce her unacceptably high rates of maternal and newborn mortality and morbidity. The programme that the GLG had in mind was Life Saving Skills in Emergency Obstetrics & Newborn Care (LSS EO & NC); a tried and tested programme that has shown and continues to show very impressive results in various countries as part of the UK Department for International Development (DFID) funded “Making It Happen” (MIH) programme. LSS EO & NC programme has now taken off in Ghana thanks the joint efforts of the RCOG and the Maternal & Newborn Health Unit of the Liverpool School of Tropical Medicine (LSTM).

Extensive consultation has taken place over a period of three years between a range of stakeholders in Ghana and potential funding agencies (Ghana and UK) through the Maternal & Child Health Unit of LSTM and the Global Health Unit of the RCOG. This consultation involved the author travelling to Ghana on four separate occasions to meet up with Responsible Officers of the Family Health Division and the Director-General of the Ghana Health Service, some Regional Directors of Health and the World Health Organization (WHO) in-country office in Ghana. One other meeting that gave the GLG such a boost was organised by Binta Patel, Manager of the RCOG Global Health Unit, involving the President of the RCOG, Dr Tony Falconer FRCOG, His Excellency the Ghana High Commissioner to the UK & Ireland, officers of the GLG, and media representatives.

The delivery of the programme and its funding had a further boost during the evaluation of Phase 1 of the MIH programme in Liverpool in March 2012. In attendance from Ghana were representatives of the Ghana Health Service, WHO and the Christian Health Association of Ghana (CHAG). The Ghana delegation opted for the whole MIH package of which the LSS EO & NC is a very important part. This was followed by a three day stakeholders meeting in July 2012 at the Ghana College of Physicians & Surgeons in Accra, Ghana. At this meeting, a programme of activity was agreed. Three regions of the country were selected for the initial delivery of the course namely, the Central, Northern, and Western Regions to be preceded by two courses for senior personnel already involved in the delivery of the Safe Motherhood Initiative programme. In September 2012, I was an invited speaker together with the secretary of the GLG at the Annual General & Scientific Meeting of the Ghana Doctors & Dentists Association (UK) held in Bangor, North Wales. Those in attendance were given an update of the MIH programme for Ghana but the main focus of the meeting served as a recruitment drive for trained obstetricians and experienced midwives to volunteer as facilitators and attend the LSTM for refresher courses to help deliver the programme, not only in Ghana, but in other parts of the
Attention is now being focused on the three regions mentioned above. In the first two weeks of March 2013, two courses were delivered in Cape Coast, the capital of the Central Region. The agreed venue was the newly opened Clinical Skills & Diagnostic Centre of the University of Cape Coast, which provided a stimulating learning and teaching environment. Between April and June 2013, two further courses have taken place for each of the Northern and Western Regions. Over the next two to three years, it is planned to deliver these courses to the rest of the ten regions in the country, training enough local trainers in the process to make the programme less dependent on external faculty.

**Priorities of the group**
Although much of the activity of the GLG has been focused on maternal health, this has not distracted us from other important health needs of women in Ghana. In 2010, the GLG, working collaboratively with the Ghana Representative Committee of the RCOG, secured the Sims Black Travelling Fellowship. Mr David Farquharson, a Consultant Gynaecological Oncologist at the Royal Infirmary in Edinburgh visited Ghana to focus upon gynaecological cancers. I travelled to Ghana to support David, and together we met many representatives of the Medical Schools, the Ghana Health Service, the Ghana College of Physicians & Surgeons, the Ministry of Health, the Ghana Health Services, the Society of Obstetricians & Gynaecologists of Ghana and the College of Health Sciences.

**Plans for the future**
The target year for the Millennium Development Goals (MDG) is 2015. Can Ghana achieve MDG 4 & 5 relating to maternal and newborn health? Only time will tell but there is no doubt that the various governments of Ghana over the last couple of years have put in efforts towards that goal. The GLG working with the RCOG and LSTM, supported through the DFID-funded MIH programme and collaborating with the Ministry of Health of Ghana and the Ghana Health Service, hopes that efforts will bear fruit.

There is still an urgent need for more course facilitators to come on board. Ghana is a lovely country, and the name is almost invariably linked with hospitality, no matter where you are in the world. Volunteering to work alongside the GLG is a step that will never lead to regret. We are ready to welcome all on board but especially appropriately trained personnel of Ghanaian descent or a connection in the diaspora to give something back to their country.

**Dr Paul Mensah FRCOG**
Consultant Obstetrician/Gynaecologist
Chairman, Ghana Liaison Group
Volunteer Facilitator, Maternal & Child Health Unit,
Liverpool School of Tropical Medicine.

**India Liaison Group**
**Dr Rajalaxmi Walavalkar MRCOG**

**What we do**
The India Liaison Group of the RCOG was established in July 2011 and has around 90 members to date. The group acknowledged the vastness and diversity in India and the fact that there are varying efforts by a large number of organisations towards improving women’s health. Hence, the first step was to establish working partnerships and links with these organisations. We currently have established links with the All India Co-ordinating Committee of RCOG (AICC), Federation of Obstetrics and Gynaecology Societies of India (FOGSI), Indian College of Obstetrics and Gynaecology (ICOG), Indian College of Maternal and Child Health, Government organisations of various states, non-governmental organisations (NGOs) and the Foundation for Research in Community Health, India.
Priorities of the group

The group is part of the CALMED (Collaborative Action in Lowering Maternity Encountered Deaths) project of the International Rotary. The project offers hands-on skills training, capacity building, initiating a public awareness in reducing delays (3 Delays model) in emergency treatment, planning and identifying care pathways from the remote villages to accessing institutional obstetric care. The first pilot of this project is under way in the tribal area of Jawahar in India at the time of writing.

The Foundation for Research in Community Health project is currently appraising available maternal and child health and other guidelines in India using a tool prepared by the National Institute for Health and Clinical Excellence. Members of the Liaison Group are helping with this process and the second stage of the project will involve guideline development in the form of flowcharts for use in rural areas aimed at promoting evidence-based practice.

The India Liaison Group visited the Jan Chetna Manch initiative, a charity-run hospital that carries out work to improve maternal health in Chandankiari, a rural area in Jharkhand, north India, in May 2012. They ran a teaching programme to promote safe birth and lifesaving skills for local births. Further teams are scheduled to follow to continue the work.

The India Liaison Group was involved in a PROMPT (Practical Obstetric Multi-Professional Training) showcase conducted in India and discussions are currently under way looking into the feasibility of PROMPT implementation in India. Discussions about running obstetric skills and drills training are under way with medical colleges, NGOs and local obstetrics and gynaecology societies in Himachal Pradesh, Nagpur and other areas of India.

Charity camps for prevention and screening for cancer and maternal medicine workshops in association with Raipur Medical School, Madhya Pradesh are being organised this year. Charity fertility camps have already been conducted in Nagpur. Working with the International Representative Committee of India (North Zone), an ‘Introduction to research methodology’ course has been developed, organised and conducted in Delhi and faculty and support for various other courses has been extended.

Group members have been actively involved with colposcopy camps and training workshops to support the ICOG initiative of reducing cervical cancer and in liaison with senior professors at Calcutta Medical College and ICOG; a colposcopy panel and further cancer detection camps will be conducted this year.

Various educational projects have been conducted and completed in India by the Liaison Group. The Group was involved in the production and implementation of the Part 2 MRCOG Enhanced Revision Program in India. Various members of the Group are faculty for RCOG Parts 1 & 2 MRCOG courses in the North, West and East Zones of India. Towards standardising ultrasound training in India the group is working with ICOG and FOGSI in setting up a structured fellowship. Along the same line, developing structured training modules for already existent ICOG fellowships or alternatively introducing RCOG Advanced Skills Training Modules (ATSMs) for Indian trainees is being investigated. The Group has been instrumental in procuring clinical attachments for electives for UK trainees in India. Lastly, a landmark achievement for the Liaison Group has been the combined MICOG (Membership of the Indian College of Obstetrics and Gynaecology) -MRCOG courses and exam with ICOG. This seals a powerful partnership between FOGSI, ICOG and RCOG.

Plans for the future

The Liaison Group’s vision and work is focused on MMR (Maternal Mortality Ratio) reduction programmes, education initiatives, surgical and colposcopy camps. For further information about any of our projects and to be involved please contact any office bearer of the Liaison Group.

Contact details are available on the India page of the RCOG website (visit the Global Health Community page in the International section)

Dr Rajalaxmi Walavalkar MRCOG, Chair, India Liaison Group

Research Fellow, Homerton University Hospitals NHS Foundation Trust
Iraq Liaison Group
Mr A Rahim Haloob FRCOG

What we do
MRCOG courses
During 2011, the Iraq Liaison Group (ILG) started to have more input into Iraqi medical education, offering training in obstetrics and gynaecology. The RCOG decided to reinstate the Baghdad Centre and in 2011 we travelled twice for the Part I and 2 MRCOG Examination and a post-examination workshop in Gynaecological Endoscopy at the Al Yarmouk Medical College.

In March 2011 and after a 30-year suspension of the MRCOG examination centre in Baghdad, I led a small group of ILG members (Ali Nakash, Aethele Khunda and Nada Saber) to travel to Iraq where we conducted a three-day review and update in obstetrics and gynaecology prior to the RCOG examination. The aim was to show our College commitment to raising standards and to improve the pass rate in Part 1 and 2 of the MRCOG exam. Following the exam we organised workshops and other education activities and reviews. We also offered consultation for unusual cases.

On behalf of the ILG and in association with the Iraqi International Medical Association based in Sharjah, UAE, we were able to organise and deliver two Part 2 MRCOG revision courses in Sharjah. The first consisted of two back-to-back courses running for a whole day each and was held on 7–8 April 2012. The course was a replica of the Royal Free Hospital Part 2 MRCOG Revision Course and was run under the auspices of Miss Susan Tuck and Mr Zakaria. Each course simulated the Part 2 MRCOG OSCE examination circuits. The format consisted of setting out three examination circuits of ten stations in each. A third course took place on 25–27 April 2013.

Practical obstetrics and midwifery multidisciplinary training programme
This two-day course from 25 – 26 March 2012 was organised by Miss Rezan Kadir in Erbil, Kurdistan. The course focused on the role of midwives in modern obstetrics. Senior British midwives attended the course and gave lectures on organisation, protocols, obstetric emergencies and neonatal life support. There were two workshops for training on the management of obstetric emergencies and neonatal life support drills.

Laparoscopy and hysteroscopy courses
In November 2012 we went to the Southern Province of Basrah where we conducted simulator training in laparoscopy and hysteroscopy and a hands-on laparoscopic surgery over three days and an OSCE course for one day.

Basic colposcopy course
This was a two-day course held on 31 October - 1 November 2012, organised by Miss Rezan Kadir in Erbil, Kurdistan. It focused on the role of colposcopy in modern gynaecology. Three UK speakers were invited who gave presentations on the subject of colposcopy, cervical smears and cervical cancer. There were also practical sessions during which candidates were shown how to use a colposcope in addition to interactive digital video, still images, discussion of cytology, colposcopy and histology.

Fertility workshops
We held two three-day workshops, back to back, organised jointly with an in vitro fertilisation (IVF) centre in Baghdad on 4–9 November 2012. The first workshop was for embryologists concentrating on the practical aspect of fertility laboratory techniques and the second was for gynaecologists with an interest in infertility and assisted conception, with an emphasis on clinics, management of IVF/intracytoplasmic sperm injection treatment cycles, theatre work for egg retrieval and embryo transfer and laboratory work. Nearly 80 patients were seen as part of the workshops and many leaflets and guidelines were introduced or amended to suit the work of assisted conception in Iraq. We were invited to contribute to an educational workshop for one day organised by Al Kindy College of Medicine in Baghdad. Three lectures were delivered in assisted conception, medical education and embryology. I delivered lectures on 8 March 2012 to 80 gynaecologists entitled ‘Recent advances in induction of ovulation and assessment of infertile couples’. This meeting was organised by the Iraqi Fertility Society. I travelled to Najaf 200 miles west of Baghdad on 9 March 2012 by invitation from Kufa College of Medicine to hold a one-day course in IVF and laparoscopy in assisted conception, and 20 gynaecologists from Najaf, Karbla and Hila provinces were in attendance.

Urogynaecology workshops
Mr Aethele Khunda went to Baghdad as a part of an Intercollegiate ILG sponsored meeting and representing the ILG, organised a three-day urogynaecology workshop in Baghdad Medical City Hospital. During this he carried out both operating and clinical sessions on a number of Iraqi patients in addition to giving one lecture on urogynaecology at the Al-manor Melia Hotel.

These activities could not have been done without the dedication and commitment of the local Iraqi gynaecologists, nurses and midwives who worked hard during these workshops and attended with amazing punctuality even during the official holidays and weekends.
Priorities of the group
The priorities of the ILG are education and training for the MRCOG, as well as furthering new advances in the science of obstetrics and gynaecology.

Plans for the future
Our plans are to improve the Part 2 MRCOG pass rate by using pre-examination workshops, OSCE training, online mock exams and online video OSCEs. We are keen to train local doctors in new advances in obstetrics and gynaecology through workshops in fertility, urogynaecology and minimal access surgery. There are ‘skills and drills’ classes planned for nurses and midwives and we plan to provide regular contributions to medical colleges’ scientific meetings. This year we are travelling to the Southern Province of Basrah, on the Arabian Gulf to be hosted by the University of Basrah Medical College for a hands-on operative hysteroscopy workshop over two days. Communication, organisation and even equipment have been prepared in the UK and around 20 gynaecologists will be participating in the workshop. We have collected instruments over the last year and are taking some equipment on loan making it a real, practical and hands-on exercise for the local Iraqi gynaecologists.

The ILG activities and contributions could not have been achieved without the dedication and hard work of our members. My full admiration goes to our Secretary, Mr Ali Al Nakash, without whose dedication and hours of work we could not have achieved all we have done so far. He was instrumental in the creation of our websites (www.passmrcognow.com and www.iraqliaisongroup.webs.com) and special online educational programmes to provide material, answer queries and help candidates for The Part 1 and 2 MRCOG exam. Ali and I have spent time organising the workshops in Iraq and prepared for pre-MRCOG courses to help candidates for RCOG examinations. I would like to thank my colleague and fellow member of the ILG, Mr Aethele Khunda, who has contributed to the ILG by participating in the teaching, training and education of Iraqi gynaecologists taking him away from his young family. His contributions are much appreciated by the Iraqis.

It goes without saying that our younger members Dr Nada Sabir and Dr Nada Hammed are promising young doctors who are keen to be at the heart of our programme and their contribution is already recognised and appreciated. I am hoping to see more input from other young members in the future.

Lastly, my thanks to past chairmen Mr Zakaria and Mr Ali Kubba for their advice and help throughout the last two years.

Mr A Rahim Haloob FRCOG FFFP
Chair of Iraqi Liaison Group
Consultant Obstetrician and Gynaecologist, Basildon University Hospital
Honorary Professor of Obstetrics and Gynaecology, Basrah College of Medicine, Basrah, Iraq
Honorary Professor of Obstetrics and Gynaecology, Kufa Medical College, Najaf, Iraq

Nepal Liaison Group
Mr David Nunns FRCOG

What we do
The Nepal Liaison Group (NLG) is involved with training/education and initiating strategic actions for the development of women’s health in Nepal. It acts as a facilitator with the local International Representative Committee (IRC), which is currently chaired by Dr Malla. The health needs assessment is carried out by the IRC and the NLG acts as a facilitator working under the RCOG umbrella. At the moment there are around seven members of the IRC.

Basic practical skills course
Two RCOG branded courses were carried out in April 2011 and March 2012 with 12 delegates per course at Maternity Hospital, Kathmandu. The NLG acted as facilitator. It was highly valued by delegates and trainers and aims to become self-sustaining in 2013.

Work with non-governmental organisations
Although not strictly related to work with the IRC, the work of the non-governmental organisations (NGOs) involves several NLG members travelling to Nepal for short-term placement work. Activities include:

Gynaecological surgical camps
The NGO International Nepal Fellowship provides medical assistance mainly in the form of prolapse surgery to rural areas in the west and far west of Nepal. The camps project takes a mobile surgical gynaecology camp to different rural areas twice a year (see: www.inf.org.np/camps).

Fistula training
Shirley Heywood FRCOG lives and works in Nepal and provides an obstetrics and gynaecology service to the women in the Surket region in the far west. She works with the International Nepal Fellowship and also mentors junior doctors in obstetrics in rural areas. She has taken on the problem of urinary fistulae in the mid-western area and has run several camps for women.

Cervical cancer prevention
PHASE Worldwide is a UK/Nepal-based NGO providing primary health care in rural communities with its network of trained health workers. The colposcopy group of PHASE aims to provide a pool of high-quality trained colposcopists in the Kathmandu valley in conjunction with local gynaecologists. Activities include: workshops, regular colposcopy clinics and exchange visits between the UK and Nepal (see: www.phaseworldwide.org). A work plan for 2012/13 has been funded by THET/UKAID.
Family planning/education
Kate Yarrow, an obstetrics and gynaecology trainee, set up the Doctors for Nepal project in rural Nepal. The overall aim of the charity is to improve health care in rural Nepal, primarily by providing scholarships to medical students from impoverished backgrounds who would otherwise be unable to attend medical school (see: www.doctorsfornepal.org).

Priorities of the group
Education through courses and hands-on mentoring through short-term visits remain a continuing activity within the group. There is a major need for education and training on prolapse in the country. Advanced prolapse is endemic, related to poor obstetric care, high parity and lifting heavy loads. We are working with the local gynaecologists and the RCOG to develop a programme to tackle the challenges of advanced surgical management of prolapse. If you are interested in joining our group please contact us via the globalhealthinfo@rcog.org.uk email address.

Plans for the future
The membership of the IRC is small and few doctors in Nepal plan to take the MRCOG in the near future. Our plans are to work with the local specialist societies in the country to develop and facilitate links with the RCOG.

David Nunns FRCOG
Chair, Nepal Liaison Group
Consultant Gynaecological Oncologist, Nottingham University Hospitals

We have successfully sent members to participate in teaching and workshops at the West African College of Surgeons in every course organised since our inception. We have also sent external examiners to their examinations.

The absence of a Part I MRCOG centre in Nigeria was a big hindrance to trainees who wished to participate in the MTI (Medical Training Initiative) of the RCOG. Along with SOGON we initiated negotiations with the RCOG and the British Council in Nigeria to open a Nigerian centre. The first examination was held at Abuja in September 2012.

We have worked hard with members of the RCOG International Representative Committee in Nigeria to sharpen the criteria for entrance into the MTI. This has taken several meetings but we have agreed all key issues.

Our education committee led by Mr B. Ola has worked hard with the West African College of Surgeons and SOGON in the area of curriculum development, namely:
• Reviewing the core postgraduate obstetrics and gynaecology curriculum.
• Setting up special interest training in West Africa.
• Subspecialist programmes in West Africa.

In December 2011, we hosted ‘Nigeria Day’ at the RCOG in London. This international conference focused on maternal health in Nigeria and developing countries with speakers drawn from both sides of the Atlantic. The conference was hugely successful and has been adapted by other Liaison Groups.

In collaboration with the Liverpool School of Tropical Medicine (LSTM) and Liverpool Associates in Tropical Health, we negotiated sponsorship of nearly £250,000 from Johnson & Johnson International to teach Life Saving Skills (LSS) and Emergency Obstetric Care (EOC) to frontline delivery suite staff in Nigeria. The members of our group have been working hard to deliver the module. The programme was so successful in its first term that Johnson & Johnson extended the sponsorship for a...
further term. This has become a massive programme and has now been rolled out in several developing countries funded by the Department for International Development. The RCOG and Nigeria Liaison Group Members also teach LSS and EOC in other areas of Nigeria and parts of the world.

Priorities of the group
We are conscious of the poor results obtained in the Part 1 MRCOG examination held in Nigeria in September 2012. To enable the project to succeed in the long run, there is an urgent need to improve the pass rate. At the moment we are planning to start a Part 1 MRCOG course in Nigeria and are working very closely with the SOGON and the RCOG African Representative to achieve this.

We are in the process of organising a ‘Train the Trainers Course’ for Nigerian consultants to improve attitudes towards teaching at postgraduate level. This is another joint initiative with SOGON.

In conjunction with the RCOG International Representative Committee in Nigeria we are also negotiating clinical update attachments for Nigerian practising consultants. This will enable consultants in Nigeria to visit the UK to spend time with the units of their special interest and observe practice. It will provide a great opportunity for them to advance clinical practice and be able to influence practice back home in Nigeria.

Plans for the future
Nigeria is a very large country with serious health issues. The RCOG can play a major role at different levels to improve women’s health of the nation. It is, however, necessary to choose realistic targets, as it is absolutely impossible to achieve the Millennium Development Goals without full government support. The RCOG can, through its networks (SOGON, Medical Association of Nigerian Specialists and General Practitioners (MANSAG), local Colleges, etc), engage the government in dialogue, solicit areas of cooperation and help build the blueprints for future improvements in maternal and child health in Nigeria.

We are already involved with the local colleges in curriculum development for postgraduate education. There is room to expand this and have more input into undergraduate and postgraduate education and beyond (e.g. midwifery, nursing, Traditional Birth Attendants (TBAs) etc). Members can engage with medical schools and arrange exchange programmes for undergraduate medical students.

The LSS EOC could be expanded to involve both federal and state-owned institutions in Nigeria. The benefit of this would be enormous in reducing maternal mortality. Other successful programmes in Nigeria (e.g. the Abiye programme in Ondo State of Nigeria which is fully supported by the government) can be under-studied, supported and rolled out to other states. Once we have good uptake of the Part 1 MRCOG examination, attention could pass on to organising the Part 2 MRCOG examination and courses in Nigeria.

The RCOG should continue to organise and participate in Nigerian events and conferences, including practical workshops, hands-on skills and educational modules in areas of special interest.

Mr V N Chilaka FWACS FRCOG
Chair, Nigeria Liaison Group
Consultant Obstetrician & Gynaecologist, Royal Derby Hospital

Pakistan Liaison Group

Dr Yasmin Sajjad
MRCOG Chair

Dr Ifat Ataullah
MRCOG Secretary General

Recent activity
The first ever RCOG Basic Practical skills course in Peshawar, Pakistan was conducted by the Pakistan Liaison Group (PLG) in April 2012. A second successful course with Skills and Drills in Obstetrics & Gynaecology was also conducted in Peshawar, Pakistan in April 2012.

Priorities of the group
Our priorities are to:

• Improve maternal and perinatal mortality and morbidity in Pakistan in conjunction with the RCOG. Currently the maternal mortality rate in Pakistan is 276 per 100,000 live births compared to less than 10 per 100,000 live births in the UK. It will be difficult to achieve the UK level but efforts should be made to improve the current situation through training of local doctors and birth attendants.
• Educate and train obstetricians and gynaecologists in Pakistan in safe surgical techniques and obstetric emergency skill drills to help save the lives of women and children in Pakistan.
• Promote awareness among clinicians in Pakistan of maternal health.
• Bring together members of the RCOG including other Liaison Groups so that we can work more efficiently and complement the work of others.
• Educate and train Pakistani doctors, facilitating work experience and preparation for examinations such as the MRCOG exams.
• Improve membership and participation in the group.

Plans for the future

There are plans for further courses to be conducted in Pakistan in September/October 2013. We also have plans for collaboration with other RCOG Liaison Groups for training in emergency obstetric care, with the potential for PLG members to assist with this in the future. How this will function in the future is still in the early phase of discussion.

Dr Yasmin Sajjad MRCOG
Chair, Pakistan Liaison Group
Consultant Gynaecologist and Andrologist, Department of Reproductive Medicine Unit, St Mary’s Hospital, Central Manchester University Hospitals NHS Trust, Manchester

Dr Ifat Ataullah MRCOG
Secretary General, Pakistan Liaison Group
Consultant Obstetrician, Kingston Hospital

What we do

As a sub-Saharan African country, Sudan shares and suffers many of the health problems prevalent in that region. Many years of little investment in healthcare have resulted in a dysfunctional health system dominated by the growing problems of maternal and newborn morbidity and mortality. Unfortunately, the poor and underprivileged continue to suffer most and the gap in health service provision, expectations and standards of care in the country as compared to those in Western Europe including the UK, remains so shamefully wide.

The situation in the region in particular creates significant moral and ethical dilemmas for the international professional community in general. These dilemmas and conflicts are intensely felt by diaspora groups of professionals in the UK who were born and grew up in the region, trained there or have other special links that allowed them to see and appreciate the difficult situation on the ground. This was one of the main drivers for the creation of the RCOG Sudan Liaison Group (SLG) in 2006. Additionally, Sudan is one of the countries where strong links exist with Fellows and Members of the college based in the UK and Ireland.

The SLG aims to streamline and focus its members’ individual efforts and help strengthen the links with the professional community of obstetricians and gynaecologists in the Sudan, as well as the local RCOG Representative Committee in Khartoum.

The RCOG excels in the area of training, education and setting the standards for women’s healthcare. This area has provided the focus for the group to carry forward the College’s international mission and, at the same time, provide technical assistance that will, it is hoped, improve the local capacity for women’s health provision in Sudan. Conversely, the group’s background and links were helpful for greater understanding of the local political, cultural and religious issues that are indirectly affecting maternal and child health in Sudan.

Being one of the first Liaison Groups, the SLG is now well established, having a membership of approximately 125 comprising consultants, obstetrics and gynaecology specialists and trainees mostly based in the UK and Ireland and mainly Sudanese diaspora.

Past activities and achievements

These include the establishment of Khartoum as an MRCOG examination centre; participation of external examiners for the local MD with the Sudan Medical Specialisation Board (SMSB) and undergraduate exams at Sudanese universities; establishment of local faculties for emergency obstetric training and perineal repair training and basic surgical skills and colposcopy courses (February 2011). We have also held clinical guidelines and risk management workshops for specialists (June 2011).

The SLG has facilitated partnerships with international fora for advocacy and training eg the International Urogynaecological Association (February 2008), World Association of Perinatal Medicine (October 2008), International Federation of Gynecology and Obstetrics/International Gynecologic Cancer Society (February 2010) and White Ribbon Alliance (February 2011).

SLG recent activities include Advocacy through training workshop (February 2012), Maternal mortality registry and confidential enquiries workshop (February 2012), Basic Life Support and training workshops for midwives (in Arabic Language – February 2012 and February 2013) and Laparoscopic and Minimal Access surgery for specialists (February 2013).
For the last seven years since it was established, the group’s activities have been facilitated through the SLG office and mostly delivered by members on a voluntary basis throughout the year. The RCOG Global Health Unit and Council Officers have been very supportive and have attended some of our activities in Khartoum.

**Priorities of the group**
Through capacity building of obstetrics and gynaecology specialists, trainers, trainees and midwives, the SLG strategy can focus on education and training. It has also adopted an advisory role engaging with the Ministry of Health in Sudan for the purpose of influencing women’s healthcare provision. SLG members are not involved in direct patient care or service delivery.

**Plans for the future**
In the coming years, the SLG will focus on the training needs of the rural areas of Sudan outside the capital Khartoum. The group also aims to establish a visiting fellowship scheme for holders of the local Sudanese Diploma in Obstetrics and Gynaecology to attend 5–6 week educational attachments in the UK.

The SLG has a unique opportunity and is well placed to influence the course of women’s health provision in Sudan. The group’s greatest and indispensable asset is the link and relationship that is now well established with Sudan’s obstetrics and gynaecology professional community. It is a bond created and protected over recent years by colleagues and members of the SLG, working with SLG aims and commitments in mind. The aim is to achieve collaboration and cooperation with local stakeholders and to lobby the political authorities in order to advance worthwhile projects and raise the profile of women’s health issues. It is hoped that these activities will lead to real change on the ground over time and this in turn will improve maternal and child health in the country.

**Mr Ahmed Elias FRCOG**
Chair, Sudan Liaison Group
Consultant Gynaecologist and Obstetrician,
St Peter’s Hospital, Chertsey, Surrey
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The World Health Organization (WHO) has forecast a global shortfall of 4.2 million health workers by 2015. The health workforce crisis is a critical constraint to progress in many lower and middle income countries. Without an adequately trained and appropriately distributed health workforce, countries cannot run effective health systems or meet the basic human right of access to essential health care.

A recent presentation by the Ugandan Ministry of Health to the inauguration of the ‘Uganda–UK Health Workforce Alliance’ (12 February 2013) indicated an increase in maternal mortality in the period 2006–11 in Uganda from 435 to 438/100,000 births.

Although there is no single, universally accepted definition of volunteering, here we broadly define it as any healthcare professional whether undergraduate, postgraduate or retiree, who voluntarily takes time out of their schedule to share knowledge and skills with those typically in resource-limited settings and receives a local stipend or no remuneration in return.\(^1\)

Volunteering overseas can be an extremely rewarding experience, and many transferable skills can be gained to bring back to the NHS. There are many opportunities for volunteers overseas with many different organisations. Volunteering can range from just a few weeks to many years. Many of us have skills to give, whether we are still in training or coming to the end of our careers.

Most UK professionals volunteer by taking time out of training, annual leave, study leave, career breaks or a sabbatical.\(^1\)

There are many benefits to NHS staff working in complicated and challenging environments helps to consolidate and develop a range of clinical, managerial, leadership, cultural and educational skills, which are beneficial and transferable to the NHS. Additionally, there are obvious benefits to the overseas healthcare system; appropriate and well-executed activities carried out by competent individuals within a wider strategic context set by developing countries can add value.\(^1\)

The following section describes the Sustainable Volunteering Project in Uganda. The project is coordinated by a consortium of Uganda–UK Health Partnerships known as the Ugandan Maternal and Newborn Hub. We also hear from two volunteers currently in Uganda.

### The Ugandan Maternal and Newborn Hub

The Sustainable Volunteering Project (SVP) promotes long-term volunteering within the Health Partnership environment. It is funded by UKAID through the Tropical Health Education Trust Health Partnership Scheme. The Hub builds on a framework of health partnerships involving hospitals, universities and professional associations in the UK and Uganda. The Hub is hosted by the Liverpool–Mulago Partnership (see: [www.liverpoolmulagopartnership.org](http://www.liverpoolmulagopartnership.org)).

The Hub includes nine partnerships between UK and Ugandan hospitals and health centres. The SVP recruits professional volunteers from a range of disciplinary backgrounds including obstetrics, anaesthetics, midwifery, nursing, biomedical engineering and social science in response to clearly identified and shared needs within the Hub. Additionally, as each centre is a partnership, short-term visits and support are gained from the partnership hospital in the UK.

The focus is on effective knowledge exchange and implementation rather than on service delivery. This places an emphasis on multidisciplinary and multinational team-working and on carefully structured placements. The principle of co-presence is central to the project – volunteers should be working alongside Ugandan colleagues whenever possible.
Volunteers are able to share ideas and successes, and visit each other’s centres, which helps to prevent some ‘reinvention of the wheel’. Additionally, a workshop is held every six months to allow all the volunteers to come together, present their projects and share ideas.

We hear from two volunteers in Uganda currently, an obstetrics and gynaecology registrar (ST4) and a midwife:

Rachel Ion is a ST4 in Obstetrics and Gynaecology who has been on a six-month placement and she writes:

For the last six months, I have been in Kisiizi, in rural southwest Uganda. I have also been privileged during this time to visit a number of other sites across Uganda, learning from other volunteers’ experiences and sharing my own. The emotional and psychological support we have been able to give one another has been a definite benefit of volunteering in this way. Volunteering with a view to making sustainable change is quite different to being ‘an extra pair of hands’. Reviewing current outcomes, questioning existing practices, working with local professionals to find solutions and then trying to implement new practices is challenging and sometimes feels like you’re fighting a battle every day! Having others in the country working to the same goals and being able to share these frustrations and find solutions together has been invaluable. Knowing that women and babies die simply because the resources are not what they are at home in the UK can be difficult and we have been able to support each other at these particularly distressing times.

On a more practical note, visiting other sites and seeing how similar problems have been tackled at different locations has been extremely useful. Within my first few weeks, I visited Bwindi Community Hospital to explore how a
‘mothers’ waiting home’ such as the one they had there, might decrease maternal and neonatal morbidity in Kisiizi by allowing women to await labour closer to the hospital. Additionally, the visit showed me that our hospital’s family planning service could be considerably expanded and I have been working on achieving this for several months now. Having seen the difference in organisation that buying new files for the ward’s patients’ case notes had made in Hoima, I have done the same for Kisiizi, with significant improvements in note keeping and efficiency. Attempts to introduce maternity early warning scores at different sites (Kisiizi, Mbarara and Mulago Hospital in Kampala) have hit similar obstacles and the Hub volunteers are working together to create a unified tool that could potentially be used nationally.

Guidelines, where available, are more difficult to find than in the UK and volunteers have been able to assist one another when online material has been located by disseminating it within the Hub by use of a ‘dropbox’. When volunteers in conjunction with local staff had developed guidelines, these have been shared among Hub volunteers, where appropriate, to avoid ‘re-inventing the wheel’ and promoting common care pathways throughout the country.

I have thoroughly enjoyed my time in Uganda. There have been many challenges and at times it has been very difficult, but I’ve learnt a lot about service improvement, teaching and resource allocation.

The people of Uganda are very warm and welcoming, keen to learn and many are working hard to change things for the better. It has been a privilege to be able to work alongside them in this way for the last six months and I would highly recommend the Hub’s programme as a way of supporting individuals to try and affect sustainable change.

Anna Stealey, a midwife who is spending three months in Uganda, writes:

Arriving anywhere like Kampala to work as a health professional provides an overload of information to process – from choosing an area of care on which to focus your skills (for there are many), to not falling down a pothole on the way to the labour ward…

Back home in Bristol making changes to practice is a multidisciplinary decision. Involving health professionals from each area can only enhance the implementation of change; a principle we have tried to adopt in Kampala.

I am working with Hub paediatric nurse Kerstin Norman, to provide training in neonatal resuscitation to community health centres. My expertise in resuscitation is at the point of birth whereas Kerstin’s is based in the Special Care Baby Unit thus addressing resuscitation within different environments and time frames.

Many overseas organisations arrive in hospitals like Mulago and want to teach resuscitation in the way their country teaches it – it becomes a minefield of different opinions and only provides confusion for the hospital! To ensure consistency and sustainability we are working closely with two Ugandan midwives who are practice facilitators in resuscitation. Agnes and Damalie have ten years of training experience but do not have the capacity to provide formal training to the other midwives. So, they provide the training to their peers. We provide them the platform and the tools with which to do it.

I am also working closely with Hub obstetrician Dr Jo Sinclair in improving the triage area in Mulago Hospital – from on the job training for admission observations to providing a new drugs trolley – we hope to make this a more effective working area for the team.

Based in Kampala, six of us live together (two midwives, an obstetrician, a paediatric nurse, a neonatologist and a social scientist). We are not all directly linked to the Hub and each is staying for different amounts of time, however, our common aspiration ensures there is constant discussion and decision making around the dinner table!’

Reference

Dr Sonia Barnfield MRCOG RCOG Global Fellowship Officer Consultant Obstetrician and Gynaecologist, Southmead Hospital

For more information on the Ugandan Maternal and Newborn Hub please email: admin@liverpoolmulagopartnership.org

Alternatively there is information on volunteering projects on the RCOG website, International section.
The Maternal and Newborn Health Unit at the Liverpool School of Tropical Medicine

Professor Nynke van den Broek

Each year, an estimated 300,000 women die during pregnancy, childbirth or the first six weeks after giving birth. 95% of all maternal deaths occur in South Asia and sub-Saharan Africa annually.

At the turn of the century, nearly 190 countries signed up to the Millennium Development Goals (MDGs).

**Millennium Development Goals (MDGs)**

- MDG1: Eradicate extreme hunger and poverty
- MDG2: Achieve universal primary education
- MDG3: Promote gender equality and empower women
- MDG4: Reduce child mortality
- MDG5: Improve maternal health
- MDG6: Combat HIV/AIDS, malaria and other diseases
- MDG7: Ensure environmental sustainability
- MDG8: Develop a global partnership for development

As a leading global centre of excellence for maternal and newborn health, the Maternal and Newborn Health Unit (MNHU) at the Liverpool School of Tropical Medicine (LSTM) aims to improve the availability and quality of healthcare for mothers and babies, contributing to the global reduction in maternal and newborn mortality and morbidity, and to improvements in quality of life. This can be achieved by partnering strategically with governments and global agencies; ensuring lessons learnt are shared across national boundaries to inform policy and practice; planning for the proactive growth of our research, technical assistance and teaching; designing and implementing innovative, evidence-based healthcare packages and new frameworks for the evaluation of effectiveness. The MNHU offers unique expertise in using the rigorous discipline of research to inform teaching and technical assistance programmes to improve the health of mothers and babies globally.

**The key thematic areas of the MNHU are:**

- Skilled Birth Attendance
- Quality of Care
- Maternal Morbidity
- Essential (Emergency) Obstetric and Newborn Care.

**Research:**
In the developing country setting, the MNHU team uses quantitative and qualitative research methodology to measure the effectiveness of complex interventions, providing evidence that can inform policy and practice.

**Technical Assistance:**
Through long and short-term technical assistance, the MNHU team actively supports in-country programmes that aim to strengthen the healthcare delivery system for maternal and newborn health.

**Teaching:**
The MNHU has extensive experience in curriculum design and delivery of teaching programmes and currently runs the following:

- Masters programme in International Public Health with a specialisation in Sexual & Reproductive Health delivered in partnership with the RCOG
- Diploma course in Reproductive Health Developing Countries accredited by the RCOG
- PhD studentships.

**The Making it Happen Programme**
The MNHU acts as the global coordinating and evaluation centre for the Making It Happen (MiH) programme, funded by the Department for International Development (UKAID).

The MiH programme aims to reduce maternal and newborn mortality and morbidity by increasing the availability and improving the quality of Skilled Birth Attendance and Essential Obstetric and Newborn Care (EOC & NC).

**This is achieved by:**
- Delivering a country-adapted, competency-based training package to improve healthcare providers’ capacity to manage women with complications at the time of birth and provide early newborn care.
- The introduction of Quality Improvement methodology (maternal aid, perinatal death audit, standards based audit).
- Strengthening of monitoring and evaluation in target healthcare facilities in the ten countries currently participating in the MiH programme.

**The Essential Obstetric Care and early Newborn Care training package**
In 2007, the MNHU and the RCOG developed a standardised three-day ‘skills and drills’ training package in Essential Obstetric Care and early Newborn Care (EOC & NC).

The course is designed to cover the five major causes of maternal death in developing countries – haemorrhage, sepsis, eclampsia, complications of obstructed labour and abortion – as well as maternal and newborn resuscitation and early newborn care. All the signal functions of Essential (or Emergency) Obstetric Care are included in the training package.

**The signal functions of emergency obstetric care (EOC)**

**Basic EOC services**
1. Parenteral antibiotics
2. Parenteral oxytocic drugs
3. Parenteral anticonvulsants
5. Removal of retained products (eg by manual vacuum aspiration)
6. Assisted vaginal delivery (vacuum delivery)
7. Newborn resuscitation using bag and mask

**Comprehensive EOC services**
All included in Basic EOC (1–7) plus:
8. Caesarean section
9. Blood transfusion
By the end of 2011, Phase 1 of the MIH programme had trained almost 3000 healthcare providers and 200 National Facilitators in five countries across South Asia and sub-Saharan Africa: Sierra Leone, Bangladesh, India, Kenya and Zimbabwe. The trained healthcare providers rate the course highly (a score of 8–9 out of 10).

Results of MIH Phase 1 evaluation
Knowledge and skills of all cadres of healthcare providers significantly improved after the training (P<0.001) and research shows that healthcare providers demonstrate an uptake of their new skills with real change in their clinical practice. There is increased confidence in providing care; improved teamwork and communication; and more enthusiasm to provide better quality of obstetric and neonatal care.

Quotes from participants:
‘A pregnant woman came in. After the first delivery we discovered there was another baby which we had not known about. We learned about how to detect and deliver the second twin during the training. Previously the doctor would come, but now we managed on our own.’ Nurse, Upazila Health Complex, Bangladesh

‘Our midwives have been able to carry out assisted vaginal deliveries using the vacuum extractor with very good outcomes. This has prevented unnecessary caesarean sections and long delays before women get a caesarean section with the risk of further complications.’ Doctor, Sierra Leone

‘Now we work much better together. The nurse-midwives know what we know so we don’t need to tell them what to do all of the time. The coordination and communication is much better.’ Doctor, District Hospital, Ghana

There was an increase in the number of women delivering in the target facilities (Skilled Birth Attendance) of 30% on average, as well as an increase in the number of women recognised to need and documented to receive emergency obstetric care (40%). Similarly, the number of stillbirths was reduced on average by almost 15%. More than 80% of all target health facilities increased the number of signal functions available at their facility (hospital or health centre). Maternal case fatality rates were reduced by 20–30% on average at 12 months after completion of training.

MIH Phase 2
Phase 2 of the MIH programme began in March 2012 and has increased the scope of the programme to work in six new countries: Ghana, Tanzania, Malawi, Nigeria, South Africa and Pakistan, as well as continuing the important work began in the Phase 1 countries.

In 2012, work began to build support for the programme among Ministries of Health in these countries, professional associations and other key stakeholders.

Work plans and budgets have been drawn up for each country and delivery partners subcontracted to assist in the activity. In several countries, LSTM partner offices have been or will be set up.

By January 2013, delivery of the LSTM–RCOG EOC & NC training package (or a country-adapted package) has already begun in ten of the Phase 2 countries.
In 2012 alone, 772 healthcare providers were trained using the EOC & NC training package, and 230 more have been trained as Master Trainers.

The MNHU is headed by Professor Nynke van den Broek, who has been leading research in the area of maternal and newborn health for over 20 years.

**Professor Nynke van den Broek Head of LSTM’s Maternal and Newborn Health Unit**

Two months that will change your life

**Mr Laurence Wood FRCOG**

The setting is a beautiful and peaceful country with a friendly and caring population. Tragically, chronic ill-health and death related to childbirth are the problems. Are you part of the solution? Have you always had a hankering to lend a hand in a developing country, but could not see how to do it without uprooting from family, friends and activities in the UK? Are you an experienced obstetrician – perhaps one about to retire while still bursting with passion and experience? Read on.

Tanzania is one of the most beautiful and peaceful countries in Africa. Three times the size of Germany, its population is smaller than England’s. In from the coastal plains, the high plateaus and good rainfall in season make for a perfect climate and a potentially productive land. The highlands of the North and South, the great lakes of the Rift Valley and the awesome game reserves attract many visitors. In the 50 years since independence there has been no war, no guerrilla terrorists and no revolution. In the mainland, Christians and Muslims live and work side by side. HIV rates are lower than 10%. And yet life expectancy is 30 years less than in the UK, and maternal and perinatal mortality are among the worst in the world.

At least 30 women per day die in childbirth, making a lifetime risk of death from childbirth of 4%. (The figure in the UK is 0.02%.) The five main causes are eminently addressable: bleeding, sepsis, obstructed labour, eclampsia and unsafe abortion. Each maternal death deals a disproportionate blow to the village from which the woman comes – who will look after the other children and perform the relentless tasks of daily living? Furthermore, for every woman who dies in childbirth there are at least 20 more who suffer from injury, infection and disability, with vesicovaginal fistula being the most significant chronic consequence. The figure for death to babies is barely known, but one estimate is that 45,000 neonates annually die perinatally. An unknown number suffer cerebral palsy.

The roots of the problem are familiar and many. Desperately poor roads, inadequate access to transport, poor education, inadequate awareness of pregnancy complications, comorbidity and extreme poverty mean that women seek access to help when often already seriously ill or moribund. Decentralisation is therefore key to tackling the issues. A fundamental

To find out further information about the MNHU or to become a volunteer facilitator to deliver the LSS EOC & NC course please visit the website: www.mnhu.org or call +44 (0)151 705 2500.
problem, however, is that there are simply far too few skilled obstetric personnel. There are only a few hundred obstetricians in the entire country. Even the number of doctors is so limited that many hospitals and birth centres have none. The Tanzanian Ministry of Health and Social Welfare has been proactive in supporting task-shifting; non-medical staff have been trained in delivery suite skills for many years, and important initiatives have shown the extraordinary effect that this can have. Nevertheless, there are still not enough skilled and experienced staff.

The Ministry is dedicated to the reduction of maternal mortality by 75% by 2015, and hopes to convert half of the country's 600 Health Centre (HC) birthing facilities to become ready for caesarean section and immediate care of the seriously ill. This capability is designated Comprehensive Emergency Obstetric Care (CEmOC). The staff who would be performing this function are non-doctors who have been through a two-year training programme to become an Assistant Medical Officer (AMO). Where AMOs do CEmOC, the anaesthetic is often delivered by a trained nurse, or by a Clinical Officer, which is one level below an AMO. AMO training has been going on for a generation and some AMOs have decades of experience in busy, understaffed hospitals, which receive referrals from the periphery. However, these AMOs are not nearly enough to populate a country-wide network of HCs. Although many other AMOs have been trained already, a large number have had little practical experience of caesarean section, even in the training years, because they currently work mainly medically rather than surgically, in HCs with no CEmOC facility.

Basic EmOC includes vacuum extraction and can in theory be done at HC level by a nurse or midwife where facilities and staff training allow. However, vacuum is much underused and nurse-led HCs refer complicated deliveries to district hospitals or regional hospitals. This often involves much time, distance and expense. In the rural areas especially, emergency transfer is often associated with poor outcome. The solution to this impasse clearly lies in staff training, and huge steps have already been taken by initiatives led by or involving for instance the Ifakara Institute; the Making it Happen (MiH) initiative; Maternity Africa and the Barbara May Foundation; the Association of Gynaecologists and Obstetricians of Tanzania (AGOTA); and the Bloomberg Maternal Health Initiative. The problem, however, will be in the support of any newly trained AMOs when they go back to their base. Training is not a substitute for experience, and many situations in which newly trained AMOs will find themselves would scare even the most experienced UK consultant. They will need a friend; a wise head; a skilled hand.

For further information contact Laurence Wood at: email.lozza@gmail.com

If you are a retired Fellow or Members of the RCOG, we welcome you to join our Retired Fellows and Members Society Group on LinkedIn.

Visit www.linkedin.com and search for Royal College of Obstetricians and Gynaecologists in the Groups section.

Mr Laurence Wood FRCOG
Ex-Obstetric Lead, University Hospitals Coventry & Warwickshire
Mothers of Africa is a medical education charity whose aims are to help train and educate healthcare workers in sub-Saharan Africa to care for women during pregnancy and childbirth. The charity was founded in 2004 by a group of Welsh anaesthetists after Professor Judith Hall, a consultant anaesthetist at the University Hospital of Wales, Cardiff, attended the World Congress of Anaesthesia in Paris in 2004. She was moved to hear Professor Martin Chobli talk of the high risk that mothers in his native country of Benin and other sub-Saharan African countries face during childbirth. Twelve months later, in May 2005, Dr Paul Clyburn and Professor Hall boarded a plane to Cotonou, the first city of Benin, and the charity’s first international link was established.

Since the charity was born, trained anaesthetists from Welsh hospitals have travelled to countries such as Benin, Togo, Ethiopia, Tanzania, Zambia and Liberia. During the visits they have been able to impart their vast collective knowledge, skills and experience in order to help support the training of healthcare workers in these countries. As a result, the charity is helping to contribute to the fulfilment of the World Health Organization’s Millennium Development Goals. However, Mothers of Africa will only provide input at the invitation of local people, with the aim of working alongside them to develop appropriate training for their own healthcare settings.

Liberia: an example of the charity’s success

One of Mothers of Africa’s most active projects is in Bong County in Liberia, West Africa. Liberia’s healthcare system, as well as its economy and infrastructure, were left decimated by many years of brutal civil war. As a result of this, conflict hospitals were destroyed, equipment was lost and vital healthcare providers – including doctors, nurses and midwives – were either killed or were forced to leave their native country. To compound this further, there was very limited ability to train people during the wars – the School of Anaesthesia in Monrovia was unable to continue training anaesthetists and the school in Phebe struggled with frequent enforced ‘moves’ of the hospital to safer areas. As yet, their system has not fully recovered. This has resulted in very few trained anaesthetists in Liberia; indeed there is currently no medically qualified anaesthetist in the country. Doctors and specialist surgeons in Liberia are extremely scarce and grossly overworked. In Bong County – an area 60% the size of Wales – there are only five doctors and three hospitals, with two of these being very close to each other. Some areas of the country fare even worse. This, together with the poor quality of roads in the country and lack of access to transport, has resulted in countless women having to travel for (in some cases) several days to reach a hospital despite being in pain and critically unwell. Unfortunately, many women and babies don’t make it, and those who do may be too unwell to be saved.

In 2005 Liberia had 42 nurse anaesthetists – however, many of these were over 50 and therefore approaching the end of their career, bearing in mind that the average life expectancy of this country is 56. With the support of Mothers of Africa the School of Anaesthesia in Phebe Hospital, Bong County has been able to train additional nurse anaesthetists, so that in 2012 there were 60 anaesthetic nurses practising in the country. This will be improved on further with the graduation of a further eight from the school in March 2013. However, there is still work to be done: in hospitals that do not have trained anaesthetists then anaesthetic care is either provided by untrained personnel, by surgeons acting in a dual role or indeed no surgery is undertaken – this results in the loss of countless mothers who could easily have been saved.
Prior to the involvement of Mothers of Africa, nurse anaesthetists reported unnecessary deaths of otherwise fit and healthy women often from airway complications. Simulation training to include, for example, failed intubation management and the introduction of environment-appropriate pulse oximeters and training from the charity Lifebox has meant there have been no reported airway-related deaths during 2011 – 2012 at the hospital.

**Links with other charities**

Mothers of Africa is currently working with two other charities in Liberia – Maternal and Childhealth Advocacy International (MCAI) and the Advanced Life Support Group (ALSG). An innovative project is currently under way between these three organisations and the Liberian Ministry of Health to train midwives to perform emergency obstetric surgery safely and nurse anaesthetists to provide anaesthesia, emergency neonatal care and high-dependency care. The aim of the project is that, once trained, these highly skilled healthcare professionals can be relocated to work in new centres providing comprehensive emergency obstetric and neonatal care in the less well-served areas of the country, which will allow more women and their babies more timely access to emergency care. As access increases, a separate collaboration with the surgical safety charity Lifebox will help support the safe delivery of this care in Liberia. A donation of 58 pulse oximeters, specially designed for use in low-resource settings, will ensure that all anaesthesia providers have access to this essential monitoring equipment. The additional training in pulse oximetry and the World Health Organization’s Surgical Safety Checklist will ensure that this equipment, and the broader surgical safety aims that it supports, are more fully-integrated into patient care.

**Valuable lessons that have been learnt along the way**

- The best results are achieved by collaborative efforts with local authorities and healthcare providers. A team approach enables local people to become empowered and thus helps to make projects more sustainable.
- Communication – as with all areas of healthcare, good communication is vital. Often things can be lost in translation or misunderstood, so patience, persistence and regularly checking everybody is working towards the same goal is vital.
- Patience! Things won’t change overnight – it takes time to train people, to establish links and mutual trust and to raise the required funds to allow changes to take place.
- It is vital to liaise with other medical charities that are working in the country as it is important to have a unified approach when teaching skills and clinical practices: for example, it would simply complicate matters if one organisation was to teach neonatal life support in a different way from another (even if both could be deemed correct).
- There is little point in reinventing the wheel; many of the processes that occur here in the UK, including clinical and educational ones, can be applied in the healthcare systems of developing countries with just some modifications.
- Hierarchical systems are very much in place – it is relatively easy for anaesthetists in the UK to approach a surgical colleague to clarify the details of a case, the reasons for surgery, the intended surgical plan or indeed check things are going well during the procedure. In a country where anaesthetists are nurses and surgeons are medically qualified, this type of interaction is more difficult to instigate. However, with time and encouragement this communication barrier should be able to be resolved.
- Frustration is inevitable – because of the above reasons and others. However, achieving one’s objectives despite setbacks is even more rewarding.
- Build and strengthen what is already there. The enthusiasm of the nurse anaesthetists, midwives and doctors to learn is inspiring. We feel very privileged to be working with them.
- Improving emergency obstetric care, which is 70% of the emergency workload, strengthens all emergency care in a hospital and is very cost effective.

**Future goals**

Mothers of Africa will continue to work alongside MCAI, ALSG and the Ministries of Health to address the problems that sub-Saharan African countries have in providing suitable facilities and appropriately trained healthcare workers in the poorly resourced rural areas of these countries. Ultimately, allowing women greater access to emergency and elective obstetric care will help to reduce greatly maternal and neonatal mortality and morbidity.

Furthermore, Mothers of Africa also aims to fund the upgrade of facilities in Phebe hospitals’ theatres and high-dependency area to improve the care given to obstetric patients, neonates and others as they initially present to hospital. From March 2013 the first long-term volunteer – Dr Alison Carling, Consultant Anaesthetist in Aneurin Bevan Health Board in South Wales – will be resident in the country. One of her main aims is to establish a critical care outreach service in the hospital. As yet, the facilities in the high-dependency area are extremely basic but with time and funding it is hoped these will be improved on. In the meantime, the outreach service will aim to identify the hospital’s sickest patients so that early and appropriate treatments can be commenced in order to prevent further deterioration in health. The charity is actively seeking volunteers and funding to allow these projects to be a success.

**Dr Cerys Richards**

**Advanced Trainee Obstetric Anaesthesia**

**Royal Gwent Hospital, Newport**

**Dr Tei Sheraton**

**Consultant Anaesthetist, Chair of Trustees, Mothers of Africa**

**Royal Gwent Hospital, Newport**

For further information on the charity, its projects, becoming a volunteer or helping with fundraising please contact Dr Tei Sheraton: Tea.Sheraton@wales.nhs.uk
Strengthening emergency obstetric and neonatal care in Liberia

The work of Maternal & Child Health Advocacy International (MCAI), the Advanced Life Support Group (ALSG), Mothers of Africa, The Liberian Ministry of Health and WHO Liberia.

Dr Brigid Hayden
FRCOG

Professor David Southall
OBE MD FRCPCH

The medical charities Maternal & Child Health Advocacy International (MCAI) and the Advanced Life Support Group (ALSG) have been working together for many years in poorly-resourced countries, equipping local health professionals with the skills to provide emergency care to mothers and babies.

As documented in the RCOG International News of March 2009, the Emergency Maternal & Neonatal Health (EMNH) course (which was developed by MCAI/ALSG) is now well-established in Pakistan and The Gambia, with local instructors now undertaking the majority of the teaching.

Following on from this venture, which is already bearing fruit in terms of a significant reduction in maternal mortality in the Gambia, MCAI and ALSG have now branched out into another West African country, namely Liberia.

Historical background

Founded by former slaves and freeborn people from America and the Caribbean, Liberia was the first ex-colony in Africa to gain independence, becoming a republic based on the United States model in 1847.

Liberia now has the first democratically-elected female president in Africa: Ellen Johnson Sirleaf, who came to power in 2005.

Ms Sirleaf was awarded the Nobel Peace Prize in 2011, and is one of 27 members of the UN System Task Team, which is to deliver its report later this year. This team was brought together to advise on the global development framework following the Millennium Development Goals target date of 2015.

The country has had a turbulent past, and is now only 10 years on from a brutal conflict which lasted for most of the time between 1989 and 2003. The role of diamonds in fuelling hostilities brought the situation in Liberia, Sierra Leone and Côte D’Ivoire to wider international attention. 250,000 people, one in fourteen of the entire population, were killed in the conflict. A third of the remaining population fled to neighbouring countries.

The conflict in Liberia brought the country to the verge of collapse; the economy was left in ruins, with non-existent basic infrastructure and services. Parts of the capital Monrovia are still without electricity. The most urgent priorities in Liberia are to improve its health and education systems, as well as to confront the challenges of a post-conflict society, including the reintegration of thousands of ex-combatants back into society.

The needs of the population are massive, and the resources are severely constrained, despite major international development projects, including those funded by DFID/UKAID and USAID. As is always the case in such situations, maternal and child health are in extremely poor shape. The maternal mortality rate is 990/100,000; the neonatal mortality is 34/1,000. Large numbers of children are orphans and 40% of under-fives are malnourished.

The vast majority of the population in Liberia live below the international poverty line of US $1.25 per day.

Our project in Liberia

Understandably in a poorly-resourced post-conflict country, there is an extreme shortage of trained healthcare workers, especially in rural areas, as well as severely restricted access to continuing professional development.

Against this background, and in partnership with Mothers of Africa, the Ministry of Health of Liberia and the World Health Organization (WHO), we introduced a programme to strengthen the emergency obstetric and neonatal healthcare system through a combination of training, provision of essential equipment and hospital renovation. The programme also aims to train selected midwives to perform emergency obstetric surgery, a component of the programme that is particularly relevant to rural areas where there are few if any doctors.

The first set of courses took place in Phebe Hospital, Bong County, Liberia, from 19 - 27 November 2012 and the second from 18 - 23 February 2013. Four EESS-EMNH (Essential Emergency Surgical Skills-Emergency Maternal and Neonatal Healthcare) courses took place, followed by a Generic Instructors’ Course (GIC), at which, selected successful candidates were taught the principles of medical education, as their first step towards becoming Instructors in their own right.

Funding for this venture has come through a grant awarded by DFID/UKAID via the Tropical Health Education Trust (THET) as a twinning arrangement between the Aneurin Bevan Health Board in South Wales and Bong County Regional Health Department in Liberia.
In total, 83 candidates (two doctors and 81 midwives and nurses) were taught during the four EESS-EMNH courses, which were each of three days’ duration. They were all provided with a manual in advance of the course (see www.mcai.org.uk to download the manual).

Three midwives have been identified as suitable for training as obstetric clinicians to undertake emergency obstetric surgery. The necessary trainers from both the UK and Liberia have been identified to undertake this training which is projected to start in July 2013.

Internationally accredited ALSG instructors from the UK and The Gambia, all experienced in teaching obstetric and/or neonatal emergency skills, were engaged in these courses, providing a ratio of around three candidates to each instructor.

The instructors brought with them the equipment for the courses: neonatal, adult and pelvic manikins, as well as the audio-visual aids and emergency supplies (such as bag valve masks) needed to undertake the skill stations, scenarios and workshops. This equipment has been left at Phebe Hospital for future courses, and some items are to be used by local staff for training in obstetric and neonatal emergencies. All 83 candidates passed the course, having received their training with enthusiasm and commitment.

The instructors selected seven candidates (two doctors and five midwives) to participate in the first GIC (Generic Instructor Course) which occurred on the 26 - 27 November 2012 and was conducted by three instructors including an ALSG Educator (Dr Barbara Phillips).

On completion of each course, a presentation ceremony took place, at which the candidates were given the following items: a bag and two masks for lung inflations, a pocketbook of the essential components of emergency care for pregnant women newborn infants and children (see www.mcai.org.uk for download) and a CD ROM of EMNH, including around 120 videos of examples of emergency care for mothers and babies.

The candidates were also given a logbook, in which they are to enter details of every emergency intervention which they perform using skills learnt on the course.

These data will be used by WHO Liberia, who are providing the monitoring and evaluation for this project.

Of the seven candidates who attended the first GIC course, three (two doctors and one midwife) were successful in achieving Instructor Candidate status, and have started to teach on EMNH courses under the mentoring and support of international ALSG Instructors. The aim is for the course to become self-sustaining within Liberia, taught by Liberian instructors, and rolled out across the country.

MCAI/ALSG has provided so far US $8,000 to renovate and equip the Emergency Room at Phebe Hospital and equipment for the neonatal wards at Phebe and CB Dunbar Hospitals has also been acquired. The first course training midwives and nurse anaesthetists to care for ill and low birth-weight newborn infants will be undertaken in June 2013.
Reflections on the EMNH courses

The faculty members were all impressed by the candidates’ enthusiasm and willingness to engage with the training provided.

At the examination at the end of each course, all the candidates were found to be proficient in the vital skills required for maternal and neonatal emergency care. Other important skills, such as assisted vaginal delivery and venous cutdown, were assessed at the teaching stations during the courses.

In the light of observations and comments made by candidates and instructors, various modifications are being made, which will make the course applicable to local needs, such as incorporating a skill station on twin delivery.

It was noted that major trauma, which is highly prevalent in Liberia, largely from road traffic accidents, is too important a subject to be addressed in one lecture. Consequently, there is a plan to set up a separate 1-2 day course on major trauma in the future.
The introduction of the well-received Emergency Maternal and Neonatal Health course to Liberia is an important step towards improving healthcare provision to women and babies.

Professor David Southall FRCPCH (Project Leader)

Dr Brigid Hayden FRCOG (Director of all courses)

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If anyone would like to work with us on this programme and/or contribute to the capacity building integral to this programme, please contact David Southall on: +44 7710 674003 or at director@mcai.org.uk
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Medical Training Initiative (MTI) Scheme

What is the MTI scheme?
- MTI facilitates a two year post-graduate training programme called the International Doctors’ Training Programme (IDTP) for International Medical Graduates (IMGs) supported by the Academy of Medical Royal Colleges (AoMRC).
- It has been developed to allow non-UK/EU doctors to come to train in the UK under the NHS system on a Tier 5 visa.
- Trainees on the scheme are sponsored by a Medical Royal College to obtain GMC medical registration therefore exempting them from the GMC’s PLAB test.

MTI for trainees in Obstetrics and Gynaecology
The RCOG has offered a very successful MTI scheme since 2008. In 2012, it placed 37 doctors from nine countries in NHS hospital posts around the UK (ST2 – ST5) for the two-year training programme.

Doctors on the scheme are expected to sit for their Part 2 MRCOG within the two-year period. After the two years have passed, doctors must return to their home country.

Am I eligible to apply?
Before considering the MTI scheme, it is important that you discuss your plans to apply with your current supervising consultant or head of department. Their support is vital as the application process will require two references from those who supervise your training.

The application process
Hospital placements traditionally start in August each year. We will accept applications from trainees for August 2014 placements from November 2013.

In February 2014, the RCOG Selection Panel shall meet to review and assess all applications. Those who are successfully chosen will be allocated a post at a hospital that has informed the RCOG that they would like a trainee from the scheme.

Providing a placement for an MTI trainee – what is in it for your hospital?
We encourage UK consultants to offer training placements for MTI trainees. Not only does the experience have an enormous positive impact upon the trainee it also provides a great opportunity for units in the UK to learn from their overseas colleagues and share experiences and surgical knowledge.

Educational guidance and support is available from the RCOG and trainees have full access to the RCOG’s e-portfolio for training and monitoring purposes.

Please contact the Global Health Unit of the RCOG for more information about the process of providing a Deanery-approved placement for an MTI trainee.

For more information
RCOG Global Health Unit
T: 00 44 (0)207 772 6285
E: globalhealthinfo@rcog.org.uk

To find out if you are eligible and to make an application, visit the RCOG website:
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What are the benefits of volunteering?

• Adds value to healthcare in developing countries
• Enhances your leadership and professional skills
• Gives education and research opportunities which can benefit patients in both communities
• Provides greater understanding of social and ethnic diversity
• Allows volunteers to develop a greater understanding and sensitivity to the needs of individual patients
• Allows you to gain a public health perspective
• Gives opportunities for further learning such as Diploma and Masters in International Health
• Develops a greater understanding of global health issues

Who can volunteer?
Anyone can volunteer from medical students, specialist trainees to consultants.

How long do I have to commit for?
• Depending on an individual’s availability, volunteering can be available for a minimum of three months to a maximum of two years.

For further information, visit the RCOG website:
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