The Royal College of Obstetricians and Gynaecologists

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 2013, it placed 39 doctors 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. MTI applications will open again in November 2014.

In February each year, 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
E: MTI@rcog.org.uk

To find out if you are eligible, visit the RCOG website:

www.rcog.org.uk/medical-training-initiative
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In writing this editorial for a South Asia edition of RCOG International News, we are left in awe of the tremendous ongoing work and enthusiasm to improve women’s health in the region, especially in hard to reach, rural locations.

Equality of access and high quality care for all women remains a dream for many living in poverty today. Let this be a call to continued action for all of us involved in women’s health to strive towards a world where every woman, mother, daughter, infant and family counts.
Welcome to International News

This edition particularly focuses on progress towards the Millennium Development Goals (MDGs) 4 and 5, which are: MDG 4 - to reduce by two thirds, between 1990 and 2015, the under-five mortality rate and MDG 5 - to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio and achieve universal access to reproductive health care.

In addition, we also look at education and training in obstetrics and gynaecology and efforts being made to address the increasing burden of cervical cancer, which is only second to maternal mortality as the commonest cause of death of young women globally. As maternal mortality continues to fall, cervical cancer may overtake it as the number one killer of women worldwide.

The challenges of overcoming the problem of access to health care and providing safe, high quality care in low resource settings with few staff are many, but our contributors demonstrate what can be done with skill, imagination and innovation.

Advocacy has a crucial role to play in improving women’s health and is one that can be fulfilled by all those working in the field as demonstrated by so many of the articles in this edition. It means challenging the current inadequate levels of maternal health in low resourced countries and addressing high maternal mortality rates. It also involves empowering women and women’s groups to feel confident enough to demand better healthcare of their leaders; so called ‘bottom-up’ advocacy. This edition of International News coincides with the RCOG World Congress 2014 in Hyderabad, India where these vitally important areas for women’s rights and health will be further highlighted.

In this edition, we hear about the strategy and work of The All India Coordinating Committee (AICC) and the International Federation of Gynecology and Obstetrics (FIGO) in the region; progress towards the MDGs 4 and 5 in India, Nepal, Sri Lanka and Bangladesh; the work of RCOG Fellows and Members in teaching and training initiatives including the provision of emergency obstetric care and safe surgery; ‘appropriate technology’ solutions for major killers of women such as the condom balloon tamponade and cervical screening using Visual Inspection with Acetic Acid (VIA).

We read of personal experiences volunteering with Médecins Sans Frontières (MSF) in remote settings and at the LAMB hospital, Bangladesh.

Whilst celebrating hard work and achievement in this edition, Dr Summia Zaher reminds us that there also remains much to do in reforming attitudes to achieve gender equality, following the horrific attack, rape and murder of a 23-year-old physiotherapy student in New Delhi in December 2012. As we write this editorial there is news of a further brutal attack on a 20-year-old woman in West Bengal, ordered by village elders as ‘punishment’ for her having a relationship with a man from a different community. It seems that discrimination and violence against women is entrenched in some parts of society and as health care professionals we have a part to play in advocating for this to stop.

We sincerely hope you are as inspired by this edition of International News as we were when editing it. A sincere thank you to all our contributors.

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

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

We would like to hear from you!
Globalheathinfo@rcog.org.uk
Paul Fogarty MD FRCOG
Senior Vice President, Global Health

After four years of planning, the RCOG World Congress is finally here in Hyderabad and all indications are that this will be one of our biggest and most successful conferences ever. This should come as no surprise given the support for the RCOG from this amazing nation.

I trust that this South Asia edition of International News will both provide some memories of the continent on your return and perhaps stimulate you to get involved in the many different Asian projects available.

In this edition, we concentrate on women's health matters and in particular areas where the RCOG and its partners such as the Federation of Obstetric and Gynaecological Societies of India (FOGSI) and the South Asia Federation of Obstetrics and Gynaecology (SAFOG) are making a real difference.

With a population of over 1.27 billion, India is the second most populous country in the world and its population currently exceeds the entire continent of Africa by 200 million people. India’s population continues to grow with 51 babies being born every minute, which equates to 26 million per year (more than the population of Australia) and hence by 2025, it will be the world’s most populous country.

Contraceptive rates are hovering below 50% and governments are struggling to improve their contraceptive targets. The pace has been slow and falls short of the Millennium Development Goals (MDGs) 4 and 5 and that will be discussed further in this edition.

Women in Asia face a multitude of health problems and addressing gender, class and ethnic disparities and improving healthcare outcomes is a major challenge given the size of the countries and their ever increasing populations but these should not discourage us, but indeed, drive us harder.

India is one of the few countries in the world where women and men have nearly the same life expectancy at birth. The fact that the female advantage is not seen in India suggests that there are systemic problems with women’s health with particularly high mortality rates during childhood and reproductive years. Despite being one of the leading members of the BRIC countries (Brazil, Russia, India and China), India has one of the highest maternal mortality rates in the world. At present the maternal mortality rate (MMR) of India is 212 per 1 lakh live births (100,000) and the target is to reduce it to 100 per 1 lakh by 2015.

The maternal mortality target of 100 should be achievable because main causes are haemorrhage (37%), sepsis (11%), hypertensive disorders (5%) and complications of abortion (8%), all of which are preventable.

One in five maternal deaths relates to easily treatable problems such as anaemia and postpartum haemorrhage and I am sure you will find inspiration from some of the initiatives highlighted in this edition. Early age of marriage and of pregnancy, high birth rates and less spacing are some risk factors but still most of the conditions are preventable.

The World Health Organization (WHO) estimates that Non Communicative Diseases (NCDs) account for over 50% of deaths and 43% of Disability-Adjusted Life Years (DALYs) lost in India and predict that by 2030, they will account for almost 75% of all deaths.

These factors include: tobacco use (smoking and eating), alcohol use, low fruit and vegetable intake, physical inactivity, high blood pressure, high blood glucose and high cholesterol which account for an estimated 61% of the cardiovascular disease deaths in low and middle income countries.

In addition, we also have the extremes of rural malnutrition facing urban obesity, all of these leading to significant cardiovascular disease and problems with blood pressure, hypertension and stroke.

Gender discrimination unfortunately begins even before birth; the problem of female feticide remains a significant problem but the RCOG supports FOGSI and the rest of the Indian movement to Save the Girl Child.

The RCOG has a duty to advocate for the promotion of the rights and health of women and in time, and if we work together, we will make a difference.

Lastly, I would like to place on record my gratitude to all of my friends and colleagues in India who have contributed to this edition of International News; to everyone who has worked tirelessly for the RCOG both at this year’s World Congress but also at the multiple College events and examinations every year.
Please explore and enjoy the experience of India and let us work together to make things better in the future for the women of Asia.
New Dimensions
The work of the RCOG All India Coordinating Committee (AICC)

Mr Pramathes Das Mahapatra, FRCOG
Chairman

Amidst the frenzied preparations for the imminent World Congress, I look back at May 2009 when I assumed the chairmanship of the AICC. The AICC, comprising the four zonal committees of India, is no longer solely devoted to the Membership examination but has expanded its activities keeping the RCOG Global Health Strategy in mind.

In our quest for inclusive progress, we have, since 2009, worked closely with local and national societies of the South Asia Federation of Obstetrics and Gynaecology (SAFOG) countries, and have succeeded in reaching an audience far beyond our illuminated Fellows and Members.

During my tenure, I have had the opportunity to work with three RCOG Presidents: Sir Prof. Arulkumaran, Dr Tony Falconer; and presently, Dr David Richmond and under their leadership, I have witnessed the RCOG achieve new heights.

In addition to the AICC collaboration with SAFOG, FOGSI (Federation of Obstetric and Gynaecological Societies of India) and NARCHI (the National Association for Reproductive and Child Health of India) to promote women’s health, RCOG Fellows and Members have been rendering voluntary services to rural women in need, through non-government organisations such as Janchetna Manch – a women’s health centre providing education and self-help in Jharkland, India.

A team of gynaecologists regularly visits these far flung areas to dispense medical advice. The RCOG India Liaison Group from the UK has also extended its help.

Although we are lagging in reaching MDGs 4 and 5, the contribution from the AICC has been an important factor in improving the situation. The Maternal Mortality Ratio (MMR) in India has reduced from 230 in 2008 to approximately 200 in 2010.

In addition, the RCOG, AICC and FOGSI are jointly reprinting essential RCOG books for low cost retail in India. An MOU, initiated by Dr Tony Falconer and Dr Paul Fogarty, was also agreed to hold the MRCOG examination in India jointly with the Indian College of Obstetricians and Gynaecologists.

During my tenure as Chairman, I have actively participated in a range of activities to further the work of the AICC and to strengthen collaborations between India and the UK. This includes: a ‘Survey of International Fellows and Members 2009’ which I presented in Abu Dhabi during the 8th International Scientific Meeting and “From Pledges to Action, A Partners’ Forum on Women’s and Child Health”, which was jointly organised by the Government of India and the WHO under the banner of the Partnership for Maternal, Newborn and Child Health (PMNCH) on 13 November 2010 in New Delhi.

In addition, ‘The India launch of Healthcare UK’ was held in Chennai on 5 September 2013. This was organised jointly by the Ministries of Health in India and the UK. The existing partnership of the RCOG and AICC was highlighted in the panel discussion on “The future of the UK-India Health Partnerships -opportunities and challenges”. 
Over the last five years, I have seen our organisation grow into a driven community of doctors with a mission – ‘Bringing to life the best in women’s health’.

The AICC has been regularly organising practical training in endoscopic and general gynaecological surgery. “Only Myomectomy”, “Only Hysterectomy” and “Only Vaginal Surgery” were hugely appreciated by 1040 participants. Elective attachments were arranged for medical students from the UK to gain exposure in India.

My time as Chairman now comes to a close but I look forward with optimism to the developments that will take hold as the AICC begins its next chapter.

The RCOG World Congress 2014 will be held in Hyderabad from 28 – 30 March. It is an honour and a daunting task, but I am sure it will be an unprecedented success.

To read the references for this article, please visit the RCOG website to read the online version of International News.
Improving health outcomes for women

Lifebox Foundation
Safe surgery in South Asia: no one left behind

Sarah Kessler, Head of Outreach
Angela Enright, Lifebox Trustee, Head of Anaesthesia for Vancouver Island, past President of the World Federation of Societies of Anaesthesiologists and the Canadian Anesthesiologists’ Society

Unsafe surgery is one of the fastest-growing global health crises of the decade. Unevenly distributed and rarely discussed, it must be addressed if we are to see long-term improvement in maternal and child health worldwide. Lifebox Foundation is a global health charity working to make surgery safer. For more information visit www.lifebox.org or contact info@lifebox.org

In cities across South Asia, medical technology is booming – but it’s not just the bumpy roads that make hospitals in rural areas feel like worlds away. Lack of access to resources and training means that for an expectant mother struggling with obstructed labour in a remote village, a safe emergency caesarean section is a challenge to access – and often desperately unsafe.

Lifebox Foundation, a new global health charity that works to make surgery safer, has seen firsthand the scale of this rural/urban divide and the risks at stake...
Access to safe surgery is an essential component of healthcare. The risk is up to a thousand times greater in low-resource settings than in higher ones.

**Saving Mothers’ lives in the operating theatre and beyond**

*Iain Wilson*, Lifebox Trustee, consultant anaesthetist at the Royal Devon and Exeter NHS Hospital and past President of the Association of Anaesthetists of Great Britain and Ireland

For theatre teams in low-resource settings, a pulse oximeter is more than just another monitor – it’s a second pair of eyes and ears, saving lives in situations no healthcare worker or patient should ever have to face.

Choosing between mother and baby, for instance...

“After the birth, when the patient was still anaesthetized, I was asked by the midwife to help resuscitate the newborn,” reported a Ugandan anaesthesia provider. “During the resuscitation, we all heard the beep from the Lifebox oximeter start falling and I quickly realised that the mother had stopped breathing.”

In the last three years, the organisation has distributed more than 7000 oximeters to hospitals across 90 countries worldwide, ensuring that several hundred thousand patients a year are safely monitored.

But this is just the beginning. Global surgery has failed to keep pace with global need, and in low-resource countries around the world, lack of access to surgery is compounded by a surgical safety crisis.

With more than 40 percent of all surgical procedures worldwide obstetric-related, RCOG Members know only too well the risks that women and children face.

“Significant numbers of maternal deaths could be prevented by simple medical manoeuvres,” explained Dr Kate Grady, Dean of the Faculty of Pain Medicine of the Royal College of Anaesthetists. “Hypoxia can readily present in the sick obstetric patient and can kill within seconds, yet be prevented by very basic airway opening techniques and pulse oximetry monitoring.” The oximeter is also a valuable triage tool, identifying tachycardia in sick mothers.

That is why the RCOG, with a newly-launched Global Health Strategy, is working with Lifebox. Following a successful introduction at the 1st FIGO Africa Regional Conference in Ethiopia, the upcoming conference in Hyderabad presents an exciting opportunity to let colleagues in South Asia know that oximeters, training and equipment are available.

The equipment and training is distributed through countrywide programmes and joint education initiatives such as the Association of Anaesthetists of Great Britain and Ireland’s SAFE Obstetric Anaesthesia Course – but also on an individual basis. RCOG Members working in low-resource settings are encouraged to contact Lifebox about bringing this essential monitor and education programme with them.

Each package directly supports access to safer surgery for women and children worldwide. With the impact of maternal mortality extending beyond the immediate devastation of the family to long-term childhood mortality and the wider economy, it’s clear that we need a wide range of solutions now.

*To read the references for this article, please visit the RCOG website to read the online version of International News.*
The condom tamponade is inexpensive, easily available in all parts of the world and simple and safe to use.

The Condom Balloon Tamponade for post partum haemorrhage – a simple lifesaving intervention

Professor Sayeba Akhter, FCPS, FICMCH, DRH, FRCOG
Obstetrics and Gynaecology Department of Dhaka Medical College and Hospital, Bangladesh

Haemorrhage, mostly post-partum haemorrhage (PPH), is responsible for 30-50% of direct maternal deaths worldwide.

I first introduced the Condom Balloon Tamponade method for control of massive PPH due to uterine atony or placenta accreta when conservative methods failed. The idea of using condom tamponade came from the use of the Rush catheter for control of PPH.

Using this method a condom is attached to a urinary catheter/drain tubing, inserted into the uterus and then inflated with 300 - 500ml saline solution until bleeding is under control. When bleeding stops, the outer end of the catheter is tied to maintain pressure and kept for 24 hours. A vaginal pack is inserted to prevent slippage of the condom. An oxytocin drip is continued for 6 hours and antibiotics used routinely.

A study was conducted in 23 patients, in Dhaka Medical College Hospital, from January 2001 to Dec 2002 to evaluate the effectiveness of low cost balloon tamponade in controlling massive PPH. In all 23 cases bleeding stopped within 15 minutes. No patient needed further intervention. Patient characteristics are shown in the table below:

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of PPH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>19</td>
<td>82.60</td>
</tr>
<tr>
<td>Secondary</td>
<td>4</td>
<td>17.40</td>
</tr>
<tr>
<td>Mode of delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spontaneous vaginal delivery</td>
<td>14</td>
<td>61</td>
</tr>
<tr>
<td>Instrumental delivery</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Cesarean section</td>
<td>6</td>
<td>26</td>
</tr>
<tr>
<td>Cause of PPH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atony</td>
<td>20</td>
<td>87.30</td>
</tr>
<tr>
<td>Placenta praevia and morbid adhesion</td>
<td>3</td>
<td>12.70</td>
</tr>
<tr>
<td>Time required to control PPH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-15 min</td>
<td>23</td>
<td>100</td>
</tr>
<tr>
<td>Duration of retention of catheter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 h</td>
<td>7</td>
<td>30.40</td>
</tr>
<tr>
<td>36 h</td>
<td>8</td>
<td>34.78</td>
</tr>
<tr>
<td>48 h</td>
<td>8</td>
<td>34.78</td>
</tr>
</tbody>
</table>

A balloon tamponade is effective at controlling PPH but all types, with the exception of the condom tamponade, are expensive and unavailable in low resource countries. The condom tamponade is inexpensive (roughly 10 pence UK Stirling), it is easily available in all parts of the world and simple and safe to use, even by primary health workers prior to referral. It also reduces the need of surgery, including emergency hysterectomy, for control of PPH in low resource settings.

In Bangladesh, the condom tamponade is used in primary, secondary and tertiary level facilities and included in the national protocol for management of PPH. Further studies have shown similar results. Death due to PPH has declined from 31% in 2001 to 25% in 2007 and the condom tamponade may be one of the contributing reasons. The role of hysterectomy for PPH control also declined.

Benefits of this simple measure have extended to many countries including Indonesia, Nepal, India, Timor Leste and Pakistan.

To read the references for this article, please visit the RCOG website to read the online version of International News.

Obstetrics in remote settings: a year with Médecins Sans Frontières (MSF)

Dr Marianne Stephen
ST5 trainee in Obstetrics and Gynaecology, UK

Médecins Sans Frontières (MSF) is a privately funded international humanitarian organisation founded in 1971 by a group of French doctors and journalists. Their aim was to alleviate the suffering of victims of manmade conflict and natural disaster, abiding by the principles of impartiality, independence and neutrality.

Today MSF is present in 79 countries throughout the world and continues to deliver medical aid to resource poor areas, as well as conducting ‘témoignage’, the act of speaking out and advocating for those in need.

Consistently, one of the most poignant ‘health-gaps’ globally is in maternal and child health. Targets for sexual and reproductive health are outlined in Millennium Development Goal 5, and more recently in the RCOG Global Health Strategy; however there were still an estimated 287,000 maternal deaths in 2010 worldwide. Last year, MSF assisted in 185,000 births and conducted 785,000 antenatal consultations. Sadly, maternal deaths continue to burden us.
I found myself working alongside and learning from the most dedicated and talented group of people I have ever met, both expatriate and national staff.

began volunteering for MSF in 2011 as a junior registrar on a year out of specialist training. Admittedly, I had no idea what to expect, other than that it was likely to be the biggest challenge of my life. I had previously volunteered for several small NGOs (non-government organisations) but nothing as large scale as MSF.

During my year out, I undertook two field placements. The first was for six months running an obstetric unit in rural Balochistan, west Pakistan and the second for two months running a unit in Nagaland, north east India on the border with Myanmar. Both projects were equally challenging but in different ways.

In Pakistan I experienced complicated obstetric presentations and the misuse of intrapartum oxytocin and in Nagaland, the focus was more towards sexual health and preventing unsafe abortion.

By definition, a humanitarian organisation will always be present in areas of need and the team faced many medical, logistical and personal challenges. However basic training of Pakistani and Naga national staff at grassroots level was extremely effective in reducing maternal morbidity and mortality. Antenatal care and access to skilled birth attendants were of paramount importance perinatally and simple measures to identify conditions such as pre-eclampsia and causes of antepartum haemorrhage enabled prompt treatment and expedition of delivery where necessary. Likewise, with basic training and equipment, national staff were able to save lives by recognising cases of obstructed labour and managing post-partum haemorrhage.

Working with MSF was an enormous privilege. Although the work was exhausting and at times overwhelming it was, without doubt, my proudest achievement. Far from the concept of ‘educating the third world’ I found myself working alongside and learning from the most dedicated and talented group of people I have ever met, both expatriate and national staff. Our aim was to put in place simple and robust medical systems that would be effective in remote settings, to improve sexual health education and to better understand the lives of the women in the communities in which we worked. I soon realised that my purpose there was not to perform as many caesarean sections as I could, but rather, to help build a legacy of continuing care amongst the indigenous population which would prevail to save maternal lives.

To find out more about the work of MSF, visit their website: www.msf.org.uk
To read the references for this article, please visit the RCOG website to read the online version of International News.
I first volunteered at LAMB Hospital in rural north west Bangladesh in the summer of 1989 as a 4th year medical student. It was largely this exposure to maternal health in a developing country that convinced me to specialise in obstetrics and gynaecology. I remember well my first newborn resuscitation and witnessing my first ruptured uterus and first eclamptic seizure (LAMB hospital was in fact a major contributor of data for the MAGPIE trial). The climate was challenging (understatement!) and coping with the incredible heat and humidity of the summer months, largely without electricity, was not easy (lots of fainting in theatre!). But most memorable were the people I lived and worked with (both Bengali and expatriates); the fun and laughter and sense of being part of a bigger family.

Last July, I was told of an urgent need at LAMB for a senior obstetrician/gynaecologist as a short-term volunteer. My husband, three year old daughter and I decided to respond and spend our annual leave at the hospital. It turned out to be an immensely rewarding experience for us all. 24 years on, the climate, sad to say, has not changed! It is equally challenging (although helped with better electricity supply and an air-conditioned theatre!). The hospital and surrounding community have, however, changed dramatically.

They have both grown physically and the hospital, in reputation. LAMB is now a 150 bed hospital with 10,000 inpatient admissions, 6,000 outpatient visits and 4,000 deliveries per year. They have an inspiring community health project covering around 2 million people as well as a growing obstetric fistula and research program. My role was to teach, mentor and provide training for the juniors as well as support and advice for the seniors. The current head of the O&G department is Swiss and alongside the Bengali obstetricians were volunteers from Holland and Australia. In the medical team there were volunteers from Korea, New Zealand, Holland and the UK. There were American nurses, physiotherapists and teachers. Being part of such a multi-national team was great fun and there was always someone around to visit or to help entertain our daughter!

24 years on, that sense of being part of a bigger family remains.
The challenge now is to sustain all that has been achieved. Staff retention in rural hospitals is a major problem and LAMB is no exception. It has confronted this by providing a wonderful (English-medium) school on the compound primarily for the children of hospital staff but extending to those in the surrounding community.

What are now needed are skilled expatriate staff, particularly obstetricians and gynaecologists, willing to volunteer (ideally for 3-6 months at a time) in this challenging but rewarding environment, working alongside their Bengali counterparts, to mentor and support them as they train and sit their professional exams.

If you are interested, the website is www.lhcf.org.uk

Time spent at LAMB will not be regretted!

Developing Quality Standards in obstetric care and taking appropriate steps to avoid maternal deaths in Kerala

V P Paily, State coordinator, Confidential review of maternal deaths, Kerala.
Beena Mahadevan, State Mission Director, National Rural Health Mission (NRHM), Kerala
V Rajasekharan Nair, Liaison Officer, Kerala Federation of Obstetrics and Gynaecology (KFOG)
Francoise Cluzeau, Associate Director, NICE International
K Sandeep, Senior consultant M&E, NRHM, Kerala
C Nirmala, Professor and Head of dept of Obstetrics & Gynaecology, Medical College, Trivandrum, Kerala
Vasanthi Jayaraj, Consultant Obstetrician and KFOG representative to Quality Standards
V L Arathy, Consultant Obstetrician and KFOG representative to Quality Standards

The Maternal Mortality Ratio (MMR) is widely perceived as the best indicator of the standard of health care of a community. The Confidential Review of Maternal Deaths (CRMD) in Kerala, which was started in 2004, revealed that haemorrhage (20%) and hypertension (12%) were the leading causes of maternal deaths. This was in spite of almost 98% of deliveries occurring in hospitals.

With help from NICE International (UK) we defined simple, practical steps to reduce maternal deaths by developing Quality Standards (QS). Derived from evidence-based guidelines, these QS were formulated through interactive workshops with a range of stakeholders.

To avoid deaths due to post partum haemorrhage (PPH):
1. Follow active management of third stage of labour
2. Observe fourth stage of labour (two hours) systematically.
3. If hypotension occurred in spite of intravenous fluid administration, use blood and blood products as appropriate.
4. Those needing blood transfusion to be observed for at least 24 hours in intensive care/ high dependency units.
5. Identify placenta previa/accreta by routine scan at 32 weeks for all previous caesareans and refer to higher centres.

To avoid deaths due to hypertensive disorders:
1. Identify hypertension early by checking BP at every antenatal visit and urine albumin once each in first and second trimesters and every visit after 32 wks.
2. Start oral antihypertensives if BP is above 140/90.
3. In cases of severe hypertension (BP above 160/100) use parenteral antihypertensives. (We decided on a lower threshold of BP to start treatment as complications were observed in this range of BP).
4. If there are signs of Haemolysis, Elevated Liver enzymes and Low Platelets (HELLP), in addition to step 3 above, consider termination of pregnancy.
5. Use magnesium sulphate as the first line anticonvulsant.
In January 2013, the Chief Minister of Kerala and the UK Secretary of Health (Minister of Health) launched the QS document and agreed to continue support and cooperation in implementing the QS. Implementation was officially rolled out in April 2013 as a pilot project in eight hospitals – six government and two in the private sector. The initial impressions of the project have been very positive.

Further steps are required to reduce MMR substantially. QS have to be developed for other leading causes of maternal deaths such as sepsis, amniotic fluid embolism and heart disease complicating pregnancy and scaled up to include more hospitals. Improvements in staffing, facilities and training are crucial. Therefore, a multifaceted approach is required. However, QS in obstetric care will remain the key step complementing all other efforts in achieving MDG 5.

**Training in Basic Life Support**

The Quality Standards team acknowledges the role of Sri Rajeev Sadanandan, the then Principal Secretary of Health, who was instrumental in involving NICE International in this project, and thank the Department of Health, Government of Kerala and all the health workers in the various pilot hospitals for their hard work.

The work from NICE International is funded by the Health Partnership Scheme of the UK Department for International Development (DFID).

**Maternal mortality reduction strategy in India: volunteering efforts of RCOG Fellows and Members**

Himansu Basu, FRCOG
Programme Director, CALMED (Collaborative Action Reducing Maternity Encountered Deaths)

Following the launch of the RCOG Global Health Strategy (2013-17), new opportunities have been created to tap into the huge potential of Fellows’ and Members’ volunteering ability, especially in the area of reduction of maternal mortality in countries that will miss the MDG 5 target. India as a country will not achieve MDG 5 (target MMR per 100/100,000 births), although several southern states have already exceeded this.

An effective model in low-resourced countries with a high incidence of deliveries outside of the relative safety of health facilities, could incorporate incentives to promote institutional deliveries and support unmet needs for family planning. Additional actions should include; increasing the number of trained professionals in emergency obstetrics and newborn care, raising awareness of women’s health issues in the community, infrastructure (ambulance, communications) development with ready availability of life saving drugs, blood and equipment.

**CALMED is a comprehensive multi-intervention strategy, protecting women’s health and lives during childbirth, in low-resourced countries.**
One such CALMED programme has been developed by a group of Fellows and Members, in collaboration with and support from the Government of India (Ministry of Health and Family Welfare – MoHFW, National Rural Health Mission - NRHM), FIGO, FOGSI, GLOWM (Global Library of Women’s Medicine), MATI (Maternity Training International), MAF (Medical Aid Films) and Rotary International – a worldwide charitable organisation.

CALMED is a comprehensive multi-intervention strategy, protecting women’s health and lives during childbirth, in low-resourced countries, to reduce the burden of maternal mortality affected by the three-delay model, a model which identifies three types of factors which can prevent women from being able to access maternal health care.

It consists of:

- Hands-on training of health professionals (doctors, senior nurses and midwives) by a visiting group of volunteer obstetricians. The curriculum is based on the WHO programme for Emergency Obstetric and Newborn Care (EmONC), and uses a ‘training the trainer’ model, a cascading effect increasing the number trained in emergency care of mothers and newborns.

- Establishing village women’s groups, who are taught by Accredited Social Health Activists – (ASHAs), for raising awareness of women’s health, ante- and post-partum care and childcare, details of family planning initiatives and related issues, through pictorial charts, DVDs etc.

- Advocacy lead by Rotarians in collaboration with local government, professional leaders and community groups in ensuring availability of resources at all times in health facilities at all levels.

- Monitoring and evaluating the programme using agreed parameters. The programme lasts for three years and is designed to ensure sustainability.

The CALMED Programme in Sikkim, North East India

Six RCOG Fellows and Members (Drs Himansu Basu, Ippokratis Sarris, Haider Jan, Vinita Nair, Radhika Viswanatha and Sangeetha Devarajan) and a Rotarian administrative leader (Denise Collins) visited Sikkim from the UK in Spring 2013 to train 13 local professionals who became Master Trainers. Together they then trained 19 medical officers and 39 other health care professionals. An assessment of their knowledge and skills showed substantial improvement following training.

The parameters used to monitor this were: incidence of major complications, such as PPH, eclampsia/severe pre-eclampsia, sepsis, partograph use, active management of labour, Maternal Death Reviews (MDR) and verbal autopsies.

Training materials have been left enabling the Master Trainers to train 15 others within seven months with an ongoing cascading effect. Return visits (at 18 and 36 months) by visiting obstetricians will ensure quality control and sustainability.

We are delighted to announce that a second CALMED Programme is being introduced in Gujarat, India early in 2014 thanks to support by Rotary International and RCOG Fellows and Members, including the RCOG India Liaison Group.
Improving health care for women in South Asia

Our Members’ stories

On 24 October 2013, the RCOG launched its Global Health Strategy 2013-2017. To mark this launch, the Global Health Unit asked Fellows and Members to take part in a photography competition. They were asked to submit a photograph with a maximum of 250 words, which demonstrated how they were helping to improve women’s health care globally. The response was fantastic. We are delighted and proud to showcase some of the stories from our Members working and volunteering in South Asia.

To see all of the entries and to view the winning photograph, visit the International section of the RCOG website.

Bangladesh
Dr Sikhar Sircar, FRCOG

The Liverpool School of Tropical Medicine runs the Essential Obstetric and Newborn care course in eleven developing countries. One of the countries where it has had a significant effect in educating doctors and midwives is in Bangladesh. There have been courses organised in many parts of Bangladesh, including the rural districts, cities and towns.

The picture shows a course held in March 2013, hosted with the help of the Bangladesh College of Physicians and Surgeons in Dhaka. The course was attended by many young and dynamic doctors from Bangladesh and was facilitated by a combined international and national faculty.

Nepal
Florian Drews
MD MRCOG DFSRH
RCOG Trainee Representative for Wales
Nepalmed, Germany

At the foothills of the snowy mountains of the Himalayas, between India and China, lies the landlocked country of Nepal. According to a recent census, it has a population of 28.4 million and is predominantly rural with only 14% living in urban areas. Delivering medical care in these less developed regions means overcoming considerable difficulties, in particular due to lack of infrastructure. Despite the recent civil war between Maoist rebels and the democratic government having depleted the country’s resources and causing the overall health situation to deteriorate, Nepali activists and foreign NGOs, such as “Nepalmed”, continue tirelessly to provide invaluable health care services in the form of medical camps or sustenance and improvement of hospital equipment.

Amppipal is a village at an altitude of 1100 m in the hilly region in the south western part of the Gorkha district and features breathtaking views of the snowy mountain tops of the Annapurna range. The local hospital, together with three other hospitals, seven primary health care centres and 30 health posts in the bordering districts of Lamjung and Tanahu serve a population of 939,000. With the majority of women birthing at home, just over 500 women attend these hospitals to deliver, sometimes walking more than 12 hours to get there. Apart from maternity care and family planning, Amppipal hospital offers free vaccinations, dental treatment and eye care. Health education plays a major role in tackling discrimination and marginalisation women still have to face in Nepal’s families, society and state.

To find out more about Nepalmed, visit their website: www.nepalmed.de

Pakistan
Shahnaz Nawaz, FRCOG

Pakistan has one of the highest maternal mortality rates in the world, reported as 260 per 100,000 live births. Evidence for the effectiveness of simulated training is gradually emerging, enhancing transfer of knowledge, improving clinical skills and teamwork resulting in improved clinical outcomes. With this in mind a team of three obstetricians and one anaesthetist from the UK, Dr Shahnaz Nawaz, Dr Yasmin Sajjad, Dr Muhammad Akhtar and Dr Jehanzeb Malik, went to Peshawar to run a course on emergency skills and drills in obstetrics on 18 September, 2013. Peshawar is the capital city of Khyber Pakhtunkhwa province. In recent years the city has been marred by a wave of terrorist activities.

The Dean of the Postgraduate Medical Institute in Peshawar, Dr Akhtar, received the visiting team and treated them with traditional hospitality. The local organisers were Professor Sadaqat Jabeen and her team of obstetricians. The course included training on PPH, eclampsia, maternal collapse and sepsis. Furthermore, workshops were held on neonatal resuscitation, Interactive sessions were held on anaphylaxis and electronic fetal monitoring. 28 doctors from local hospitals attended the course, which started off with hands-on training on basic life support. The course was very well received and the delegates provided excellent feedback.

The picture shows a course held in March 2013, hosted with the help of the Bangladesh College of Physicians and Surgeons in Dhaka. The course was attended by many young and dynamic doctors from Bangladesh and was facilitated by a combined international and national faculty.
Nepal

Mr Richard Henry
FRCS FRANZCOG FRCOG

This photo shows our arrival in Bajura, North West Nepal on an International Nepal Fellowship surgical camp. We reached the camp after a flight from Katmandu, an eight-hour, four-wheel drive journey and then one hour in a helicopter.

The camp was in a converted barn on the side of a hill at 4000 feet overlooking a beautiful valley, eight hours walk from the nearest tarmac road. We spent 10 days operating 12-14 hours a day in basic conditions on patients who had walked for days to be treated. There was no local hospital alternative and most walked home again after complex PFR/Vaginal hysterectomy/Sacrospinous hitch procedures. All surgery was under spinal anaesthesia with occasional Ketamine.

It was an exhausting and often challenging experience but also very fulfilling and rewarding compared to a lot of current UK practice. I would recommend it to anyone who feels they need a reminder about why they embarked on a medical career in the first place. I have been back again!

To find out more about the International Nepal Fellowship, please visit: www.inf.org

Bangladesh

Dr Helen Bintley
ST4 registrar

In May 2013, I spent two weeks learning about the challenges faced by health professionals working in women’s health in Bangladesh. LAMB is a non-government hospital in northern Bangladesh that welcomes everyone and tries to treat every illness wherever possible.

My antenatal clinic and labour ward experience made this very clear. No one comes to LAMB complaining of ‘a bit of stomach ache’ or ‘a small amount of bleeding’. Women arrive fitting, exsanguinating and in full-blown labour. The midwives at the hospital are highly-skilled practitioners. They understand and act on the needs of Bangladeshi women and as a consequence, they save a considerable number of lives.

I spent the first few days at the hospital alternating between antenatal, gynaecological and family planning clinics. Highly organised and efficient, these clinics are perfectly suited to the environment in which they work. These clinics taught me a lot about the different trials and tribulations facing women and the importance of encouraging the use of contraception in the most densely populated country in the world.

This photograph shows a group of expectant ‘mothers to be’ waiting for their turn for assessment in the clinic. Thronges of women and children would be pulling at your salwar kameez demanding attention. I was overcome with a desire to help as many of them as I could. However, I realised the size of the task when, twenty patients in, there were still queues around the block waiting to be seen!

India

Dr Mohini Vachhani
Cervical cancer, which can be prevented with timely screening and appropriate treatment, is the most common form of cancer among women in India. Unfortunately, there is no organised screening programme in India.

Barriers to cancer screening include: poor understanding of cancer, even in the literate group, lack of access to services, a lack of community and family support and low socioeconomic status. Also the concept of “preventive care” is foreign to most women. PAP smear programs have proved to be too difficult to implement and costly to run in India, a country with more than 1 billion people. As a result of these difficulties, many Indian women seek care only when the cancer is advanced and difficult to treat.

There is an immense need for a massive awareness program to motivate women to get screened. The key message for this program is that cervical cancer is completely preventable and that a woman’s family benefits when she is screened.

Similarly, breast cancer screening awareness was found to be poor in women. Only a small percentage of women receive information about breast cancer from health professionals and most women are ignorant of breast self examination.

These facts constantly motivate me to spread awareness of cancer screening among women. I take every opportunity to educate patients and groups of working women, the key messages being: vaccinate early, regular cervical screening and self breast examination.

Myanmar

Professor Mya Thida,
Department of Obstetrics & Gynaecology University of Medicine 1, Yangon, MYANMAR

On October 13 2013, about 300 women from Kungyangon Township gathered at a local hospital to receive a free cervical cancer screening and treatment. This mobile “screen and treat” program, offered through collaboration between Seoul National University Hospital and the Central Women’s Hospital of University of Medicine, Yangon, utilises visual inspection after application of acetic acid (VIA) as a screening method and employs cryotherapy for VIA-positive women at one sitting, in a screen and treat approach.

Working alongside the central mobile team of trained midwives, nurses and non-specialist doctors are a local team of basic health staff and community health workers, who reach out to women in remote villages for screening and trace them for follow-up visits.

Five percent of the recruits at Kungyangon Township tested positive for VIA and received cryotherapy immediately. One percent had suspicious lesions, but they were not the only people who benefited from the programme that day. About 40 local basic health staff received both theoretical and practical training on VIA so that they could screen more women once the central mobile team moved onto a different township.

Myanmar has 17.92 million women aged 15 years and above who are at risk of cervical cancer (CC). Only opportunistic screening exists with an estimated coverage of 0.9% of women in Myanmar (WHO, 2003). Limited resources to provide PAP tests or vaccines have been major barriers to CC prevention.

With this new simple, practical and cost-effective CC screening and treatment program, Myanmar women now have a better chance to survive cervical cancer.
The Millennium Development Goals 4 and 5: are we on target for 2015?

In the next section, some of the Chairs of our International Representative Committees in South Asia highlight the situation regarding infant and maternal mortality rates in their countries.

Women’s health in Nepal
Dr Dibya Malla, FRCOG,
Chair, RCOG International Representative Committee, Nepal

Improving the health of women and children has been a main focus for health development in Nepal. Having a clear policy, strategy and action plan has definitely contributed towards achieving the Millennium Development Goals (MDGs).

The National Safe Motherhood and Newborn Health - Second Long Term Plan 2006-17 (a UNFPA initiative in Nepal), serves as the basis for implementation of the ‘Safe Motherhood’ intervention. As you can see in the following graph, child mortality has been reduced effectively, although neonatal mortality has sadly remained same.

Achievement MDG 5

The Maternal Mortality Ratio in Nepal is falling and contraceptive use is going up. Significant maternal morbidity remains high and includes anaemia and prolapse.

Selected demographic indicators for Nepal, 1991-2011

<table>
<thead>
<tr>
<th>Indicator</th>
<th>1991 census</th>
<th>2001 census</th>
<th>2011 (preliminary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population (millions)</td>
<td>18.5</td>
<td>23.2</td>
<td>26.6</td>
</tr>
<tr>
<td>Life Expectancy (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>55</td>
<td>60.1</td>
<td>u</td>
</tr>
<tr>
<td>Female</td>
<td>53.5</td>
<td>60.7</td>
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</tr>
<tr>
<td>Literacy Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>65.5</td>
<td>75.1</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>42.8</td>
<td>57.4</td>
<td></td>
</tr>
<tr>
<td>Sex Ratio</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Male per Hundred Female )</td>
<td>99.8</td>
<td>94.2</td>
<td></td>
</tr>
</tbody>
</table>

In many parts of the world, women’s lives from childhood to old age are curtailed by preventable illness and premature death. While addressing the health challenges facing women, our attention is drawn to the varied circumstances in which they live. Maternal mortality and morbidity is related to services being readily available to women. Nepal has achieved valuable gains in MDG 5 (to reduce by three quarters the maternal mortality ratio and achieve universal access to reproductive health care), but this remains off-track in different parts of the country because of difficult terrains and living conditions.
Having a clear policy, strategy and action plan has contributed towards achieving the Millennium Development Goals.

The International Representative Committee of Nepal wants to contribute to quality service and education. In five years, two Sims Black Travelling Professors from the RCOG have visited Nepal and our President, Dr David Richmond, was the first to organise a urogynaecology service in the country. In addition, we have had two Basic Practical Skills courses organised by the College that were well received.

We are delighted that plans have been made for the MRCOG examination to take place in Nepal in 2014. This will support existing post graduate education in the country towards improved women’s health.

To read the references for this article, please visit the RCOG website to read the online version of International News.

Striving towards MDGs 4 and 5: the Sri Lankan situation

Professor P S Wijesinghe, FRCOG,
Chair, RCOG International Representative Committee,
Sri Lanka

By 1990, Sri Lanka enjoyed relatively good health indices in relation to maternal, reproductive, and child health compared to its South Asian neighbours. Near universal access to free health care services, free education leading to a high literacy rate, empowerment of women, health educational programmes leading to improved health-seeking behaviour of the public, a wide road network with a public transport system, poverty alleviation programmes and many other social, economic and political measures have all contributed to this situation.

The civil war which continued for nearly three decades ended in 2009. When the Millennium Development Goals (MDGs) were set to be achieved by 2015, they posed a new challenge for Sri Lanka to improve further. Medical professionals have a major role to play in achieving MDGs 4 and 5 which deal with maternal and child health.

The under-five mortality rate which was 22.2/1000 live births in 1991, gradually came down to 12.2/1000 live births by 2010. Neonatal deaths contribute towards two thirds of the overall under-five mortalities in Sri Lanka. A worrying feature is that the neonatal mortality rate has been static around 8/1000 live births for the last 10 years. The successful national immunisation programme has significantly reduced childhood deaths due to infections such as measles. However deaths from dengue haemorrhagic fever continue to be a problem.

The maternal mortality rate has also fallen since 1990 and was 35/100,000 live births in 2010. While haemorrhage, hypertensive diseases, and sepsis still contribute to this, indirect deaths due to cardiac diseases and liver diseases appear to be a new challenge. Around 90% of pregnant women register for antenatal care and over 99% deliver at a health care institution with skilled attendants.

The rural-urban gap which is evident in the provision of these facilities and deficiencies in certain sectors like the plantations needs addressing.
Medical professionals have a major role to play in achieving MDGs 4 and 5 which deal with maternal and child health.

Continued commitment towards training medical specialists in which the RCOG Medical Training Initiative (MTI) scheme of the United Kingdom has played a significant role, and other medical and paramedical personnel have helped in expanding health care services making them easily accessible to the community. With the availability of more facilities for maternity and neonatal intensive care it is expected that the country could strive towards the desired targets.

The stagnant contraceptive prevalence rate and unmet need for contraception are two areas that need action and this is addressed with new strategies such as opening family planning clinics within curative health care facilities and introducing a wider variety of contraceptive methods. These strategies should help in reducing unsafe abortions and the total fertility rate to desired levels.

The issue of data quality where there are discrepancies between information from the Office of the Registrar General and the Ministry of Health needs serious attention. Given the strengths and weaknesses, Sri Lanka should be able to strive towards achieving MDGs 4 and 5 by addressing the identified threats and making the most of fresh opportunities.

Women’s healthcare in Bangladesh and the MDG targets of 2015

Professor Syeda Nurjahan Bhuiya, FRCOG
Chair, RCOG International Representative Committee, Bangladesh

The fifth MDG is to reduce maternal mortality by 75% between 1990 and 2015 and the OGSB (Obstetrical and Gynaecological Society of Bangladesh) is working with the government of Bangladesh, development partners and NGOs to strive to achieve this.

The OGSB was established in 1972 and its members are involved in: EmOC (Emergency Obstetric Care) training, CSBA (Community-based Skill Birth Attendant) training, training for AMTSL (Active Management of Third Stage of Labour), adolescent health programmes, programmes on violence against women (VAW), RTI/STDs, a post natal care (PNC) study and training in Life Saving Skills (LSS) and neonatal care.

Between 1990 and 2005 the maternal mortality ratio declined by 5% and it went down to 194 per 100,000 by the year 2010 due to increased access to EmOC, antenatal care, assistance at delivery, a better referral system to higher centres, post natal care, family planning services and child care.

To achieve the MDG 5, Bangladesh is committed to bring down the MMR to 143 per 100,000 by the year 2015. In order to do this, the government of Bangladesh wishes to increase the availability of community female skilled birth attendants (SBAs) and it was hoped 15,000 would be trained by 2010. By 2011, 6,563 had been trained.

Over the 15 year cycle (2000-2015) the Government wanted to increase antenatal care visits to at least four per pregnancy to 100% of women rather than only 11% of women having four visits during their pregnancies. By 2010, 23.4% were having four visits. In addition, the aim was to increase the number of women delivering with a skilled birth attendant from 9% to 50%. By 2010, this had reached 27%. The caesarean section rate rose from 0.1% in 1990 to 6.4% in 2009 – indicating improved access to life saving obstetric care. Another important strategy was the adoption of a Menstrual Regulation (MR) Policy in 1972, which ensured access to legal and safe pregnancy termination. This, in turn, led to a reduction in induced septic abortion.

The MMR of a country is considered an indicator of the overall status of women. Although maternal death occurs during...
Cervical cancer is still the most common cancer in women in India and also the leading cause of cancer deaths in Indian women.

pregnancy, delivery or the post delivery period, there are numerous socio-economic, cultural and demographic factors that contribute to it. In that sense, maternal mortality is a multifaceted and broad-based issue to be considered.

Total fertility rate, age at marriage, violence against women and malnutrition also reflect this complex reality of maternal mortality. Maternal mortality can be reduced by effective antenatal care including birth planning, comprehensive EmOC facilities within reach, appropriate referral to higher centres and facilities for obstetric ICU at the tertiary level hospital. By taking appropriate measures it is possible for Bangladesh to achieve the targets of the MDGs.

In this context, there is an immense need for regular screening and early detection facilities. MASUM’s screening programme in 33 villages (more than 30,000 population) is an effort to help rural women to manage their health problems through awareness, screening, early detection and timely medical help at low cost.

Women from the villages in the district have been trained as health care workers. They visit homes in the village regularly and educate women on various aspects of health. Once a month, women in two or three villages are informed that they should congregate in a particular place, usually a school building or a primary health centre. Women have their weight and blood pressure recorded; a haemoglobin estimation and Visual Inspection with Acetic Acid (VIA) performed by the health care workers. Since most women do not have access to cervical smears, this is the screening modality adopted.

Small steps towards better health in rural India

Dr Jyothi Unni, FRCOG
Chair, RCOG International Representative Committee, India West Zone

The All India Co-ordinating Committee of the RCOG (AICC RCOG) Western Zone is associated with an NGO called MASUM, a charity focused on women’s rights within and outside the home, which is working in the drought-prone and poverty stricken villages of the Purander Block in Pune District.

Many rural women are unable to seek treatment due to the non-availability and inaccessibility of public health care services, the high cost of private care, heavy workload in their homes or farms and lack of support from the family.

Cervical cancer is still the most common cancer in women in India and also the leading cause of cancer deaths in Indian women. In the absence of a systematic cervical cancer screening program, routine screening of asymptomatic women is almost non-existent in this region.
Women who are VIA positive are identified and once a fortnight, transport is provided for them to be taken to a government facility close by where they undergo colposcopy and further treatment if required.

Their medical and gynaecological problems are addressed by the AICC RCOG volunteers. An educational talk is given and iron, calcium and vitamin supplements distributed. Low cost medicines are made available for those needing treatment for vaginal infections or backache and joint pains, which are common problems.

Nutritional advice is given and they are told the value of inexpensive foods which are locally grown, as it has been found that traditional crops which are high in vitamins and minerals are being replaced by crops which are low in vital nutrients.

Genital prolapse is another frequent problem. For those who are unable to leave their families and undergo surgery in the near future, ring pessaries are inserted. Preventative aspects are discussed and surgery facilitated for those requiring it and able to travel.

Though training takes place on the job at each of these gatherings, once every three months, formal re-training is done for the health care workers. They are trained on recognition of various common gynaecological problems and taught when to refer women to higher centres.
Attitudes towards women: education and reform

What is required is a social revolution for empowering women which must seek to reform the mind-set and old thoughts of our society.

After the Storm
Summia Zaher, MD MRCOG, Clinical Lecturer in Obstetrics & Gynaecology, University of Wales

On the 16 December 2012, a 23-year-old medical student and her friend had just finished watching ‘The Life of Pi’ in an upmarket mall, where young girls in skinny jeans hang out at Starbucks, shop at Zara and eat sushi. What happened as they made their way home was to become one of the most horrific and brutal events resulting in an international uproar.

Was this the first of such cases? Was this the most brutal? Would this have attracted the same attention had it happened in rural India? The answer is no. The reason why it resonated with so many and caused mass demonstrations in India, which are rare, is that this young academic girl represented the aspirations of so many young modern Indian women, studying hard and daring to dream big. Jyoti Singh Pandey lost her life as a result of the severity of the injuries she had sustained in this brutal sexual assault.

Tens of thousands of protestors marched in several cities and signed online petitions, responding not only to this incident but also to express their anger at the way women in India are treated more generally, criticising in particular State indifference to reports of rape, and the severe deficiencies in law and order.

Ten months later, a Delhi court sentenced to death four of the six men accused of the gang-rape and murder of Pandey and while this verdict may have appeased her family and many sympathisers around the country, many have described it as a short-cut way to quiet public anger without dealing with the complex socio-political factors that drive violence against women.

The heightened awareness of the public regarding sexual crimes, has led to intense debates. Many have argued that the problem is caused by men’s underlying attitudes towards women. Others comment however, that by placing blame upon men is to miss the point. Their opinion is that there is not a distinct oppressor rather it’s the wall of a deeply held set of beliefs and values held by men and often by women that needs to be dismantled. These include deep-rooted ideas about the ‘honour’ of women and that any deviation by women from social norms brings shame upon the women’s family and community who respond by defaming and punishing the deviant, often employing violence as a means of social control.

Others argue the problem is the unhealthy sexual culture, sex is permanently on display, in Bollywood films, songs and TV and whilst at the same time, there remains a very conservative morality in Indian society, which results in sexual repression.

So what can be done to change things? On 29 August 2013 Sonia Ghandi said that what is required is a ‘social revolution’ for empowering women, which must seek to reform “the mind-set and old thoughts of our society.” Such change will not be achieved by death sentences or mass protest, but rather by doing the groundwork of instilling and teaching values of respect to others and gender equality to young boys and girls, in homes and schools, so that slowly but surely the ideals held regarding what is masculinity and femininity are readjusted.

It may be that these generalisations are simplistic as there is no doubt that there is plenty within the rich and historical culture of India that not only affirms the value and dignity of women but portrays them as leaders and warriors. Women can be found at the highest levels of almost every area of public life in India, from politics to academia to cinema. Now that those accused of the rape and murder of Jyoti Singh Pandey have been tried, and the protestors and their placards have left the streets, the difficult journey towards identifying and changing the inherited prejudices of a collective conscience must start. As ambassadors for women’s healthcare, we have a significant role to play in this re-education.
Cervical cancer and its prevention

Professor R. Sankaranarayanan, MD,
Head of the Screening Group (SCR), International
Agency for Research on Cancer (IARC)

A quarter of the global burden of new cervical cancer cases, deaths and prevalent cases are experienced in the Indian sub-continent; of the estimated 528,000 new cases and 278,000 cervical cancer deaths in the world in 2012, India alone accounted for 123,000 cases and 67,000 deaths. More than three quarters of cases present in locally advanced clinical stages with 5-year survival of less than 50%.

Currently, cervical cancer deaths exceed that of maternal mortality in the sub-continent. Prevalence of human papillomavirus (HPV) infection among the general populations in the Indian sub-continent varies from 7-14% and the age-specific prevalence across age groups is constant with no clear peak in young women. This observation may be the result of a low clearance rate of infections, frequent re-infection or reactivation of the infection and sexual behavioural patterns in the population.

High-risk HPV types were found in 97% of cervical cancers, and HPV-16 and 18 were found in 80% of cancers in India. A number of research studies in India have established the value of alternative screening tests such as visual inspection with acetic acid (VIA), visual inspection with Lugol’s iodine (VILI) and HPV testing, and alternative paradigms such as a single life time screening and “see and treat” approaches in the early detection and prevention of cervical cancer both in HPV infected and non-infected women. A single life time VIA screening provided by nurses has shown reduced cervical cancer incidence and mortality by 25% and 35%.
respectively in a large cluster randomized trial in southern India. A single life time screening with HPV testing was followed by a 50% reduction in advanced stages and a 48% reduction in mortality in a large clinical trial in western India. The safety, acceptability and efficacy of field based loop excision and cryotherapy treatments have been widely studied in the Indian sub-continent.

The effectiveness of fewer than 3 doses of HPV vaccination in preventing HPV infection and cervical neoplasia is currently being addressed in a large study in India. Bhutan was the first Asian country to introduce the HPV vaccination into its national immunisation programme in 2010; HPV vaccination was introduced following a pilot study involving 3167 girls in 2009 with 94% participation for the 3rd dose in 2009. National scale up involving 47,888 girls aged 12-18 years was completed in 2010 with 96% 3rd dose coverage. In subsequent years, 12-year-old girls (around 7000 annually) are targeted with 3rd dose coverage exceeding 95%.

Bangladesh has introduced a national VIA screening programme through the primary care services and more than 540,000 women have been screened with VIA during 2005-2012. There have also been pilot initiatives in HPV vaccination in Nepal. Tamil Nadu and Sikkim states in India have also introduced VIA screening through their primary health care services, although large scale national coverage for screening is yet to evolve in the Indian sub-continent.

Despite these important research and public health initiatives in certain countries and regions, the overreaching importance of cervical cancer as a major threat to women’s health is sadly not yet adequately recognised in the Indian sub-continent.
Cervical and breast cancer screening: a ray of hope in Bangladesh

Dr Fawzia Hossain, FRCOG, Honorary Secretary, RCOG International Representative Committee of Bangladesh and Associate Professor of Obstetrics and Gynaecology, BSMMU.

Globally, cervical cancer comprises approximately 12% of cancers with 273,505 deaths reported worldwide. Population based cervical cancer screening was launched in Bangladesh in 2004 with a view to implement it in a phased manner. Bangladesh is among the few countries in the world that have introduced Visual Inspection with Acetic Acid (VIA) as the primary screening test.

Bangladesh is a middle income country with a total population of 160 million divided into 64 districts. The services are currently available as opportunistic screening at 252 facilities including BSMMU. Bangabandhu Seikh Mujib Medical University (BSMMU) in Dhaka is the national centre for cervical and breast cancer screening and the central coordinating body. The UNFPA, Bangladesh is the major funding agency.

Cervical cancer in Bangladesh constitutes 25% of all cancer cases in women and accounts for around 17,686 new cases and 10,364 deaths each year (Ferlay et al., 2008). The PAP test has been the standard screening test in the Western world for the last five decades. VIA is currently a more popular screening test. The incidence and mortality of cervical cancer have been reduced dramatically as a result of successful screening in developed countries. Clinical breast examination is also performed as a primary tool for breast cancer screening. As per the country guidelines, screening is offered to women aged 30 years and above at three-year intervals. The screening test is free of charge. Screen positive women are then asked to attend the referral centres.

The VIA screen-positive women are referred to fourteen designated medical colleges for colposcopy and treatment. Every VIA positive woman is asked to provide a contact telephone number. However, a ‘see and treat’ approach is preferred due to non-compliance of patients.

Approximately 300,000 women have been screened in the last five years. Treatment by cryotherapy and LLETZ/LEEP is available. Histology is undertaken in the Department of Pathology of the referral centres.

The VIA is being performed by nurses and female health volunteers after they undergo a certified training course of 15 days at BSMMU, with a reorientation course within 6-12 months. It is the practice of most providers to get their findings cross-checked by a clinician, when they detect a positive case.

The GAVI Alliance indicates that Bangladesh stands 11th in the world for cervical cancer fatalities with 179 per 100,000 women dying due to the sexually transmitted HPV virus each year.

Immunising girls with three doses of the vaccine before initiation of sexual activity and before exposure to HPV infection holds the key to cervical cancer prevention. Bangladesh is trying to get the vaccination at a low cost through GAVI and the government.

Awareness programs are also being carried out by the Master Trainers of this centre to remote areas and villages of the country. Therefore, earlier cases of cervical cancer and preinvasive disease are being detected through this program and we are hopeful that a decrease in the incidence of cervical and breast cancer will be achieved in our country.
Developing a sustainable cervical cancer service in Nepal

Mr David Nunns, FRCOG

Cervical cancer is a major cause of death in young women in Nepal. In 2002 the Nepal Network for Cancer Treatment and Research (NNCTR) started the task of introducing mass screening for cervical cancer in collaboration with the WHO (World Health Organization) and the IARC (International Agency of Research on Cancer). To date, over 20,000 women have been screened. The management of screen positive patients was problematic as colposcopy services were poorly developed and many patients were subjected to overtreatment with hysterectomy. To tackle this problem, a partnership between PHASE (a UK/Nepal NGO working mainly in primary healthcare in rural Nepal), NNCTR and Nepali gynaecologists was formed.

The PHASE colposcopy group is a collaboration of UK colposcopists working voluntarily to assist the partnership. The purpose of this partnership is to:

• develop a sustainable, high quality colposcopy service to the women of the Katmandu valley referred following screening from camps organised by the NNCTR and the local clinicians
• strengthen existing services through training and education
• develop a pool of high quality, well-trained colposcopists in Nepal
• advocate for fighting cervical cancer at a local and national governmental level
• help develop the vision of a population-based cervical screening programme with the aim of reducing cervical cancer death rates.

We aim to achieve this by colposcopy workshops with lectures, hands-on training for Nepalese gynaecologists in Nepal and exchange visits to the UK of six senior Nepalese doctors and two Nepali nurses to train in colposcopy. Recently, to address the overall process of the programme, we have run workshops for pathologists and training for biomedical scientists to improve the accuracy of histology interpretation.

Our training programme has recognised the role of nurse colposcopists in the screening and diagnostic process. To date, the service is functional with women screened in rural communities by empowered and trained staff who follow the patient through the whole clinical pathway.

To find out more about the PHASE project, please visit: www.phaseworldwide.org

All photographs for this article courtesy of PHASE Nepal
Looking to the future: training and development

Healthcare UK – a British Government initiative to contribute to improving healthcare outside the UK

Rory Shaw, Medical Director Healthcare UK

The NHS has developed sophisticated health services for women. New medical technologies have been introduced. Teaching special skills has been given high priority and clinical subspecialisation within obstetrics and gynaecology has developed. The growing importance of multidisciplinary teams and ever stronger clinical governance has ensured that all patients receive the best available care, and that the quality of outcomes and of patient experience is assured. Ensuring safe childbirth has been a major focus. Openness and public participation has been a guiding principle. Thus, technologies to increase fertility are under the governance of the Human Fertilisation and Embryology Authority which is open to public scrutiny and criticism.

Many parts of the world are in a different place on their journey to improve health services. Some countries will feel that they wish to take advantage of some of the lessons learnt by the NHS, and others will have important lessons to teach the UK.

The British Government is keen that the NHS looks outside the UK and works with other countries. Many of these have plans to increase spend on healthcare, with, for example, China planning to at least double healthcare provision.

Increased health expenditure requires investments in facilities, systems, processes and large programmes of training for a wide variety of staff. This must integrate with existing local arrangements and culture. In the UK we already have great experience in integrating services and in embracing multiculturalism. Many British staff have already contributed individually on a philanthropic basis in delivery of services overseas. There is now an opportunity for NHS organisations, Royal Colleges, British universities and UK training establishments to play a more formal commercial role in setting up services, training staff and handing over proven high quality services.

The first step is to build inter-governmental and commercial links with specific countries. Healthcare UK currently has a specific focus on China and India. We hope over the next five years to see many partnerships between centres in these countries and the UK.

During the recent visit by the British Prime Minister to China, very substantial progress on building these partnerships was made. Memoranda of Understanding between the Governments were signed and a number of British groups entered into commercial arrangements. These included Sinophi Healthcare starting a joint venture with Huai’an First People’s Hospital, one of the biggest hospitals in Jiangsu Province in east China. British companies also made progress in discussions to build a range of mixed-use healthcare facilities, a 1000 bed oncology hospital, and to work in high priority areas for the Chinese as they respond to their growing elderly populations.

In India under the leadership of Lord Kakkar, the Jawaharlal Institute of Postgraduate Medical Education & Research (JIPMER), based in Pondicherry, signed a partnership agreement spanning healthcare training and research.

These links pave the way for in-depth commercial and clinical relationships and the transfer of “know how” from the NHS to China and India. As more British institutions become involved, it will provide a wonderful opportunity for those UK staff who want to contribute to improving healthcare in these countries.
Many parts of the world are in a different place on their journey to improve health services. Some countries will feel that they wish to take advantage of some of the lessons learnt by the NHS, and others will have important lessons to teach the UK.

The Making it Happen Programme: improving the availability and quality of Emergency Obstetric and Newborn Care (EmONC) in South Asia

Bettina Utz and Terry Kana,
CMNH (Centre for Maternal and Newborn Health)

The Centre for Maternal and Newborn Health (CMNH) at Liverpool School of Tropical Medicine (LSTM) works closely with the Ministry of Health and partner organisations in three Asian countries under the framework of the DFID-funded Making It Happen (MiH) Programme. MiH aims to reduce maternal and newborn mortality and morbidity by increasing availability and improving the quality of Emergency Obstetric and Newborn Care (EmONC) through the delivery of a country-adapted, competency-based training package, (re)introduction of Quality of Care methodology and improving data collection and use. Experienced volunteers from the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) deliver the EmONC training package alongside national trainers from sister professional associations.

MiH has been implemented in 11 countries including India, Pakistan and Bangladesh. In India, MiH has supported the development of a new training curriculum in Reproductive, Maternal, Newborn and Child Health and will support the setting up of skills laboratories. A Skills Lab Core Group meeting took place in Aurangabad, Maharashtra in August 2013 to assist in finalising the Master Training manual, course programme, skills checklists, and equipment required for approximately 160 planned skills laboratories across India. CMNH will be involved in equipping the first laboratories and assisting in training Master Trainers.

In Pakistan, MiH is being implemented in four districts of the Punjab: Gujranwala, Attock, Rahim Yar Khan and Khanewal. Since the start of the programme in 2012, 238 health care providers have attended training in EmONC in two districts; 48 participants have become Master Trainers and 34 attended a workshop to improve their ability to collect and use Maternal and Newborn Health (MNH) data. MiH in Pakistan will train 750 health service providers and 75 master trainers in EmONC by the end of 2015.

In Bangladesh, a total of 438 providers working in maternal and newborn health (including doctors, nurses and family welfare visitors) were trained between 2009 and 2011 as well as 49 national Master Trainers. Qualitative and quantitative data were collected to assess the impact of the training on knowledge and skills of health care providers, change in clinical practice, availability of signal functions of EmONC and maternal and neonatal health outcomes. In Phase 2, the MiH programme will be expanded to six new districts. By 2015, we expect to have trained 1000 health care providers working in MNH in 49 facilities and an additional 100 new Master Trainers.

Postgraduate medical doctors are trained at the Bangladesh College of Physicians and Surgeons in Dhaka, where a new skills laboratory has been established, since early 2012. To date, 248 trainee obstetricians have been trained in EmONC.

If you are a midwife, gynaecologist, obstetrician or anaesthetist and you would like to volunteer to deliver our training in the UK and countries across sub-Saharan Africa and Asia, please visit our website to find details of the opportunities available as well as an application form at www.mnhu.org/about-cmnh/get-involved/

To find out more, please visit: www.mnhu.org
As we move forward, strategies are being considered so that the futures of women affected by fistula change from one of shame to one of hope.

FIGO’s initiatives to improve women’s health in Asia and Oceania

Dr Upeka de Silva and Professor S. Arulkumaran, President of FIGO

The FIGO (International Federation of Gynecology and Obstetrics) commitment to the provision of comprehensive sexual and reproductive health services and the current funding environment has resulted in valuable partnerships with a range of stakeholders such as the International Confederation of Midwives (ICM), International Pediatric Association (IPA), Jhpiego and the Global Library of Women’s Medicine (GLOWM – www.glowm.com).

FIGO will continue to strengthen the capacities of obstetricians and gynecologists to adopt the latest evidence-based clinical practices to improve women’s health. However, as we move forward, innovative strategies for systematically institutionalising best practices and for creating demand for the improved services among underserved communities need to be developed to ensure that a real difference is made to the lives of the women we seek to serve.

Misoprostol for the management of PPH

This project, funded by a grant to Gynuity Health Projects from the Bill & Melinda Gates Foundation, aims to advocate for the use of misoprostol for post-partum haemorrhage (PPH) prevention and treatment and to disseminate related evidence-based information to a global community of health professionals and clinical policy makers. In order to do so, expert panel sessions have been held at international and regional conferences including Women Deliver in Malaysia in May 2013 and the FIGO Africa Regional Conference in Ethiopia in October 2013.

These sessions consistently generate active audience participation and as new evidence starts to emerge, particularly on the use of misoprostol at the community level, securing key opportunities for dissemination will remain a priority.

Additionally, as part of an on-going effort to ensure the safe and effective use of misoprostol, user-friendly guidelines on the recommended dosages of misoprostol based on current evidence were produced and are available online in English, French, Portuguese and Spanish. The guidelines are available on the FIGO website here: www.figo.org/projects/figo-misoprostol-post-partum-haemorrhage-low-resource-settings-initiative

Post Partum Intrauterine Device (PPIUD)

In July 2013 FIGO initiated a project on Institutionalising Post-Partum IUD Services in Sri Lanka. The project aims to address the post-partum contraceptive needs of women by institutionalising the practice of offering immediate post-partum Intra-Uterine Device services (IUD) in six teaching hospitals in Sri Lanka.

Training the delivery team on immediate post-partum IUD insertion, strengthening the capacity of community level midwives to counsel women on the benefits of Long Acting Reversible Contraceptives (LARCS) with the use of IUDs and supporting relevant healthcare providers and managers to regularly review and improve their performance on post-partum IUD services are important components of this initiative which is set to expand to other countries including Kenya, India and Ethiopia in the near future.

Training workshop for insertion of PPIUD in Sri Lanka

The project also aims to improve the quality, scope and reliability of information available to health care professionals worldwide on all aspects related to family planning and safe abortion care through The Global Library of Women’s Medicine (GLOWM) website; a global platform for knowledge transfer.

Partnership for Maternal, Newborn and Child Health (PMNCH)

The Health Care Professionals Associations (HCPAs), including FIGO, ICM and IPA, consider it a professional responsibility to work with their member associations at country level to accelerate the dissemination mechanisms for 17 Essential Interventions (from the WHO/PMNCH Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health). They launched a new project in Indonesia and Uganda which is expected to institutionalise quality implementation of the Essential Interventions.
through close collaborative work between the three HCPAs, Ministries of Health, WHO, civil society, academia and the private sector.

**Maternal and Child Health Integrated Program (MCHIP)**

FIGO is promoting advocacy for better practices in post-partum haemorrhage and pre-eclampsia and eclampsia through a project funded by Jhpiego in six selected countries – Ethiopia, Mozambique, Nigeria and Uganda in Africa and India and Nepal in Asia. National consultants are collaborating with health facilities to scale up evidence-based high impact maternal, newborn and child health interventions and are providing inputs to sustain this advocacy process in the future.

**Fistula initiative**

The Fistula Training Initiative aims to build the capacities of fistula surgeons in accredited training centres, using the FIGO Global Competency-Based Fistula Surgery Training Manual. It helps dedicated physicians to acquire the knowledge, skills and professionalism needed to prevent obstetric fistula and provide high quality surgical, medical and psychosocial care to women who have incurred fistula, whether during childbirth or because of inflicted trauma. Over the last few years, FIGO has successfully accredited centres such as the Babbar Ruga National Fistula Hospital in Nigeria and the Hamlin Fistula Hospital in Ethiopia where doctors from countries including Bangladesh, Madagascar, Nepal and Nigeria have gained competence in fistula surgery. As we move forward, strategies for motivating training centres to take on an increased number of trainees, and for supporting the newly trained providers to create demand for their services, are being considered so that the futures of women affected by fistula change from one of shame to one of hope.

**Prevention of unsafe abortion**

The overall goal of this project is to reduce the rates of maternal mortality and morbidity associated with unsafe abortion. Now in phase two of its implementation plan, the Prevention of Unsafe Abortion Initiative works across 44 countries to ensure that FIGO member societies work with key partners to prepare and implement national plans of action for meeting the needs of women faced with unwanted pregnancies.

18 priority countries with high rates of unsafe abortion and related maternal mortality have been selected to receive focused attention whereby activities for reducing unintended pregnancies, improving access to safe abortion services and increasing the quality of and access to post-abortion care (including post-abortion contraception) are supported. National societies in these countries, which include Bangladesh, Nepal, Pakistan and Sri Lanka, will seek to introduce new services such as Manual Vacuum Aspiration (MVA) and misoprostol for the treatment of incomplete abortion, mifepristone for legal termination of pregnancy, and improved access to a full range of post-partum and post-abortion contraception including long acting reversible methods, such as IUDs and implants.

**The RCOG Enhanced Revision Programme**

Rakhi Shah,
Senior Marketing Development Manager, RCOG

Over the past few years we’ve been working hard to give more doctors outside the UK the chance to sit our exams. Within India we have been working in partnerships with the Federation of Obstetric and Gynaecological Societies of India (FOGSI), and the RCOG’s All India Co-ordinating Committee (AICC) to develop resources for doctors undertaking the MRCOG.

We know that candidates outside the UK are disadvantaged when they sit the MRCOG. They are not as familiar with the institutions or clinical practices of the NHS and are often less acquainted with the exam techniques they need to do themselves justice.
Therefore, in 2012 we developed the Enhanced Revision Programme (ERP); a 15 week course that takes place over the Internet. Candidates had weekly hour-long sessions with a UK-based specialist who taught them how to apply their clinical knowledge to practical situations. The programme ended with a final, three-day course held locally and in exam conditions.

This pilot was very popular with candidates and in September 2013 we launched the new and improved programme in four centres around the world – India (Delhi and Kolkata), Pakistan and Sudan.

Pakhee Aggarwal is Assistant Professor at Lady Hardinge Medical College in New Delhi and was one of the first people to take part in the College’s Enhanced Revision Programme. She passed her Part 2 MRCOG exam in September 2012.

The programme will be useful for people who have never worked in the UK because it tells you about things that are routine practice there, like clinical governance and risk management – things which wouldn’t be done elsewhere. That’s useful, especially for non-UK candidates.

We also had examiners from the UK, so if we had any queries regarding what is the best practice, or what is done in the UK, you could get an immediate answer – ‘we do this’, or ‘this isn’t done any more’ and things like that, so having a live examiner in the sessions helped us to get answers straight away.

The first time I took the Part 2 exam I passed the theory; it was the OSCE (oral exam) that let me down. Although the programme didn’t help much with my knowledge, my technique improved a whole lot – the examiner pointed out the key words we needed to look for. That was a big help and boosted my confidence the second time around.

The final part of the programme was a three-day course that took place in India, and that helped. The books alone aren’t enough: either you need to work in the UK or use this programme to be in touch with examiners who can tell you where you’re going wrong, otherwise it’s difficult.

The personal view of the Medical Training Initiative (MTI) Scheme

Dr Mukta Chattopadhyay, MRCOG

My main objective of coming to work in UK was to gain international work experience and pass the MRCOG examination. I was a little anxious as this was my first experience of moving overseas. I found the whole process to be very well-documented online. The GMC registration process was not complicated and went through without a hitch.

We have a different work culture in India so initially I faced difficulties such as team-working with midwives. It is not easy at first being questioned about each and every decision you make, but then you start realising that those questions help you learn to justify your actions, ensuring safe practice. You also realise the immense patience and role that midwives play in delivering women.

I also faced language problems at first. It is difficult to understand the accents and so phone conversations are especially difficult. But soon I got used to it and life became easier. Staying away from home all alone in a new country can be very stressful, especially with the weather being dull grey most of winter, and then some of summer; it can get depressing. But again, one gets used to it and starts to get into the ‘Keep Calm and Carry On’ mode.

Work per se was initially stressful as there are strict protocols and policies to follow. But you soon learn that everything is there on the RCOG website for you to see and learn. Colleagues and seniors are helpful and once you get used to following the protocols work becomes easier.

Studying for MRCOG exams helped me understand the work and vice versa; work helped me visualise what I was reading for the exam. The National Guidelines are followed everywhere in UK, so it doesn’t matter where in UK you are posted, the NHS has the same policies and protocols.

Coming here through the MTI scheme has helped me improve my communication/counselling of patients, manage high risk obstetrics, gain more experience in instrumental deliveries and improve my documentation, which I am sure will help me when I go back and I’ll be sure to implement what I have learnt here to provide safe, evidence-based obstetrics and gynaecology for women back home.

I suggest that you come to the UK with a clear idea as to what you want to achieve in the two years; work hard and you can achieve a lot.

ERP combines the best of technology and the interpersonal skills of UK and local members to mentor doctors in preparing for the MRCOG examinations. We are even more excited to be able to expand the programme beyond India and look forward to developing further resources for our Members.

To find out more, email rshah@rcog.org.uk
CONGRESS SNAPSHOT
• Participation from over 65 countries
• Abstracts published in BJOG
• Interactive congress workshops
• Organised with global partnership
• Supports UK revalidation

KEYNOTE SPEAKERS
• Prof Diana Bianchi USA
• Dr Camran Nezhat USA
• Prof Pedro Ramirez USA
• Prof Roberto Romero USA
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Have you read the RCOG Global Health Strategy 2013-17?

Learn about the global health focus for the RCOG
Visit www.rcog.org.uk/globalhealthstrategy