

Final Country Presentations

Frank Anderson: What we thought we would do is to have each country come up, and if you have multiple partnerships in a country, you could come up and just answer the three questions: What are your lessons learned, what are your challenges, and what would you like to do next? Just in a five minute summary. We are going to start with the list as it is on your agenda, which means that Cameroon will be first. Thomas Egbe, Mike Brady - could the whole group from Cameroon come up?

Cameroon

Crista Johnson Agbakwu: My name is Crista Johnson-Agbakwu. I have had the extraordinary privilege to work with our Cameroonian partners. We actually flew to Cameroon before this meeting last weekend and had some time to get another faculty. This is Dr. Gregory Halle. Dr. Thomas Egbe was here at this meeting and Dr. Victor Mbome Njie, who represents the Ministry of Health. And we have been pleased to have Dr. Justin Konje who is representing the Royale College of OBGYN, but as a Cameroonian he offered tremendous insight for our group over the last several days in our breakout sessions.

This is a extraordinary learning opportunity for all of us and that we are just embarking on our partnership. There is not an existing residency program at the University of Buea and it is really insightful for us to learn the staggering health disparities that exist throughout Cameroon, but especially in the Southwest region where they are essentially only six OB/GYN's who are part of the University of Buea.

Here is Dr. Thomas Egbe; he has been our key collaborator with this partnership that actually began with our department chair, and then Mike Brady, who is our Residency Program Director. I will probably highlight and then have the others speak briefly. Some of the main themes that we have highlighted as both immediate and long-range plans for our continued partnership and growth is curriculum development and looking at ways that we can examine the accreditation process and really look at some of the immediate steps that we can take in terms of beginning some cross institutional collaborations in terms of didactic grand rounds, videoconferencing, and case-based discussion between both Universities.

Funding is probably the largest challenge that we identified on both sides and we will be making strategic plans to enhance our ability to garner sustainable support for ongoing partnerships. One of the immediate challenges to starting a residency program is that the faculty of the University of Buea needs to have a certain level of professorship standing within the University of Buea. It's a time-based promotion process of six years and we do not have faculty who have reached that point in time yet and we are looking if we can potentially have visiting professorships from the University of Arizona that might serve in that role and allow our program to begin right away. Some of the major points and goals that we have are to obtain buy-in, not just from the University of Buea but also from the Cameroonian government. We have immediate steps to work with the vice Chancellor and the Ministry of Health in garnering that support. We are in the process of completing our MOUs, our Memorandums of Understanding, between both Universities and we are hoping that with in the next two months, we can have it completely finalized. We are hoping to completely start our

residency program in 2015. And, of course, as with all of us, our eventual goal is to increase obstetric practice within Cameroon and really make some progress towards reducing maternal and child morbidity and mortality. I'm going to let our partners say a few words, as well as Mike Brady.

Dr. Thomas Egbe: The process we've gone today and throughout this week has been very enriching for us because it is a first of its kind or the second of its kind after Rome, where we have specialists from all over with come to give ideas for us who want to open a new OB/GYN training in Cameroon. I think with the group discussion we had to open group or something like that, we're going to learn more and more from other people from the University of Arizona. I thank Frank for inviting us here and we hope that our partnership with the University of Arizona is going to give a good final result. Thank you very much.

Dr. Gregory Halle: I don't know whether I absolutely have to say something, but if I have to say something then I hope to express our sincere gratitude for the participants and the organizers for allowing us to take part in this august ceremony. I call it an august ceremony. I think at an institution like this, it is difficult to express emotions, but I think we will go back with a positive impression about your organization. At times you don't know the capabilities that you have until you are exposed to certain situations. Before coming here I did not have a clear idea of what exactly is going to come out, but just having others around, I think this acted as a great source of motivation and I was personally surprised with the ideas that came up, just by seeing the others around. So I think we should all give a round of applause to ourselves for making these contributions.

Kenya

Frank Anderson: Okay, we have a change in the order because Kenya has to depart early. We will now hear the Kenyan Country Report. And if anyone else has a time constraint, please let me know.

Hillary Mabeya: Thank you so much. We were lucky from Kenya that we came with a team of people from the Ministry of Health and the Ministry from Education. We had a whole team and our partners from the United States. We had a bigger team that looked at the whole area. What came out clearly is that the Kenyan government has a new structure, whereby 47 counties are looking at a have a medical facility. In that order, it means that we need more specialists. The program is already in place, but what we need now is to maybe increase the number of trainees. At the moment we are training about five per year, but we need to increase in the next 10 years to maybe 10 or 15 per year, so that in 10 years we have maybe 100 or 150.

Our First Lady is very interested in maternal health so we are actually planning to maybe meet as a team from the Ministry of Education and Ministry of Health and form an agenda. The goal of the agenda is actually to increase the number of trainees in OBGYN. The Office of the First Lady is interested in maternal health so we would use that opportunity to kind of push the agenda for government buy-in. The other thing is that training for the residents has to be supported by the Ministry of Health because of the employment part. So what we came up with was when we go back home we will meet as a team from the Ministry of Health, the county representatives, and then we might be able to put up a strong team to advocate for more residents.

The needs for countries in Sub-Saharan Africa, we were able to look at what kind of support partners can give. We are lucky in Kenya that the partnership that has been there for the past twenty years can be moved. Support is especially important in the areas of exchange programs, but the fact is that this workshop has actually given us an idea on how we can support our neighboring countries in terms of exchanging, countries that have a strong experience in some areas like uro-gynecology for example. We will explore how we can use that local experience instead of starting a new program. Is there a way we can use other countries to train, rather than setting up completely new

programs. I think a lot came out from our discussions and we hope that we may be able to do monitoring and evaluations to see what new things we can add on top of that. I don't know if I have left anything out.

Frank Anderson: Now if we can have the Ghana contingent come to the front, the Ghana representatives.

Ghana

Kwabena Danso: I think we can have Dr. Edu, if he is here, to join me and Dr. Gumanga for the Ghana group. Please if you can come up; I may leave out something very important.

By and large, we are a bit fortunate. It is a project that is the center for this conference, but that notwithstanding, the country funding needs assessment came up critical both ways – in country fundraising and external sources, for equipment as a whole, particularly with the evolving sub-specialty training programs came up strongly and funding to equip faculty in research and research mentorship, recent graduate proposal writing, and indeed an establishment of a grant office. I am told Michigan has something like that; Nogouchi has something like that. It came out very strongly that if we could be supported to establish a grant office, that would go a long way to help faculty in their research efforts. That is a bit on the academic or teaching side.

When it comes to service, the need for a fetal assessment unit also came up after most of our deliberations and it has generally been agreed that it would be important to consider the establishment of a fetal assessment center to attempt to reduce the number of the perinatal mortality rates. One of the thorny issues that has come up is the difficulty of visa acquisition for the resident and student exchange programs. We have been informed that the visa requirements have changed from B1 to J1 so now we know it needs a lot of planning ahead of time.

The need to support the new medical schools to begin residency programs took the better part of the discussion. Professor Nkyekyer was the chair and he is also the faculty chair in the college. Those sentiments have been taken down for consideration so that Tamale Teaching Hospital and Cape Coast Medical School can eventually, in the long term, also start residencies in OBGYN to beef up the numbers. Communication from external faculty to local fellows had a few gaps. I think we have spoken frankly about it. Those will be smoothing out. The need to copy all academic heads in programs and not just to send mail down to the fellows also came up strongly. I don't know if Dr. Gumanga would like to add a few points to the Ghana deliberations.

Dr. Gumanga: I think that basically you have captured the main things, because here we are limited by a very high clinical load; I was checking the notes I had and have seen that the major issues have been brought up. It is very important for me to add that the most heated thing in our deliberations for the group from Ghana was how to get new medical schools to start residency programs as early as possible. In these few meetings of the faculty and of the college, those are going to be issues that are going to be brought on the agenda. Generally there is an agreement that there is a possibility to increase the current numbers by 10 if the others come on board, if not more. Thank you very much.

Kwabena Danso: I don't know if anybody wants to add anything to the Ghana group work. Professor Nkyekyer? Okay, thank you very much.

Frank Anderson: Actually, from the Michigan side, I was in and out. But we were also having this conversation, that, as you know, this Ghana group is a mature group. They are already starting to discuss supporting other residency programs in other parts of their country. They also have an opportunity now to improve the quality in their labor and development units and to provide the

example so that in the next five years, we will be hearing how the Ghana program has done quality improvement projects that can be replicated throughout the consortium. That is my challenge to you guys and I think that at this point, you have the opportunity to do that and show us how it is done in Africa. Thank you.

Liberia

Stephen Kennedy: First of all, I would like to extend thanks to the partnership from Liberia. From the Liberia College of Physicians and Surgeons, I represent them. We also have Professor John K. Mulbah who is the chair of the Faculty of OBGYN. From the Ministry of Health, we have Dr. Bernice Dahn. From the Icahn School of Medicine at Mt. Sinai, we have Dr. Ann Marie Beddoe and Dr. Lise Rehwaldt. And from the Baylor College of Medicine, we have Dr. Yvonne Butler.

There are a couple of lessons learned. What we found is this section to be quite productive, in the sense that as you know the Liberian program started about three, four, six months ago. We were less ambitious. Our focus was primarily developing curriculum, faculty development and deployment to be able to address the issues relative to the shortage of specialists within the country. Also, it was less ambitious as well because at the time, our thinking was primarily based on the World Bank. This section has provided us the impetus to begin to consider a broader perspective from a partnership standpoint. What that means is for example is that over ten years we have looked at possibly, based on our strategic plan, to train 40 OBGYNs. We did not factor into that extended partners and what additional resources they could have brought to the table. By having this forum, we realized that instead of 40 over 10 years, we can produce 75 to 80 OBGYNs.

Other issues to consider is that we developed a curriculum based on the West African Health Association model. The whole emphasis on implementation of the curriculum and less emphasis on revisiting the curriculum annually in terms of modifications based on experiences learned as you move along. From this forum, we realized that as we go back, we have to include that in our implementation plan.

Other issue that we gathered from this forum is that we were more interested in numbers in terms of faculty. We were looking at say for example, the Department of OBGYN. The first quarter of the first year was based on two residents per one faculty. That was the ratio we established. We placed less emphasis on issues like faculty development and did not consider the context of extended partners and additional faculty and sub-specialists who are brought into the picture. So, all I am saying in short is that there have been significant lessons learned from the time we spent in this small group section.

What are the challenges, basically, or the next step? As we leave from here and go back, the team is going to reorganize. Basically what we are going to do is revisit our priorities. We realized that – I don't want to use the word 'selfish' - but we have to broaden our scope and enlarge our priorities to begin to consider what our partners would bring to the table.

The next thing we have to consider is that we will have to re-engage our partners. We were one of the programs that said that we are desperate. Whatever you gave us, we accepted. This forum has given us the concept of rethinking that. We have to align our priorities with what could be provided by partners and in addition, also to be able to clearly organize and coordinate all partners to ensure we are able to meet the goals and objectives we set up in our strategic plan. Also we realized from here is that part of the next step is an aggressive effort to identify additional partners and lastly to be able to get together and begin to develop specific content-specific precursors to begin foreign agencies to submit our proposals. Those were the key issues that we picked up from this forum. Thank you very much.

Frank Anderson: Wow, that was great. Thank you. The Liberia group did a lot of work. You guys are amazing. Which country is next? Senegal.

Senegal

Khady Diouf: Hello everyone, my name is Khady Diouf and I am working with two of my colleagues representing the Senegal – Harvard Partnership. This is Dr. Mansour Niang, he is a professor at the University as well as a professor at the medical school and also Professor Magatte Mbaye who is part of the faculty at the medical school. They also participate in resident education. I am a faculty member at Brigham and Women’s Hospital as well as Harvard Medical School. Our collaboration in Senegal – I guess to use the analogy of fetal development – is at the morula stage. So we haven’t yet developed such a strong partnership, but we have been in Senegal since 2012 when I joined the faculty at Brigham and Women’s with the idea to foster a strong partnership over the years.

The Gambia

Patrick Idoko: Good afternoon my name is Patrick Idoko. I’m from the University of the Gambia. It’s been a tremendous pleasure this week to get to finally meet Owen Montgomery and Allen Waxman and we really had a nice time getting to know each other and getting to talk through some of things we’ve been hearing so. Thanks to Frank and your team for inviting us. Thank you for helping us to see that it’s possible to move along with post graduate OBGYN training in the Gambia. Two years ago I was at Rome and I remember clearly the presentations of countries like Liberia and Malawi and we’re all in the same boat. One thing I remember clearly was we all have very few faculty and it looked difficult. Personally, it’s a big source of inspiration to hear that Liberia will someday have a post graduate program and that Malawi has already started one.

So I’ve titled my presentation here as “OBGYN Training in the Gambia: Can it Happen?” The reason I gave it that title is before the Rome meeting and immediately after the Rome meeting, I tried to make those of the Ministry of Education and the Ministry of Health to see that the way forward for us in the Gambia if we’re going to have an impact on the health of women and of children was to train locally. But somehow the general impression I get when I talk with people is that that’s a big step that we cannot, we cannot go that way right now. It’s almost like it’s impossible. At the same time the politicians are getting upset because the medical school has been on for about more than ten years and we’ve had some graduates and for those graduates who are interested in becoming specialists, the government was training them but because there was no local training in the heart of the African country that makes them not available to offer services.

So since 1996 when the medical school was established, all the doctors that had trained in the Gambia were all working within the capitol in the urban area. So we have nine medical health centers and hospitals in the country apart from the teaching hospital. Each of these hospitals is equipped to offer both comprehensive and emergency obstetric care services. But only two of these hospitals have one OBGYN specialist each. So everything else has to get on to the teaching hospital if they’re able to make it and the political leaders were getting frustrated.

When our first residents finished the halfway mark of their training in Gambia and they were called back and were unable to finish. It’s been a big struggle to get them to come back to finish their fellowship in Gambia. We hope that we will be able to cross that barrier very soon. At least we have the assurance from the government that they are willing. Part of the problem is the government has not understood what it takes to train those graduates or specialization training.

So some of the things we have learnt here as we listen to all the other people who are talking was the importance of political support. I made reference to countries like Liberia and Malawi - we realize that getting that kind of support from politicians is very important to get a program started. Then we also learnt that partnerships need to be mutually beneficial. One of the strongest, one of the questions I've struggled with all this week is how can we be beneficial to Drexel and the University of New Mexico and we're still discussing all these things.

I think I've mentioned some of our challenges are the political will and commitment to get OBGYN training started in the Gambia. Part of the problem is that we have a very high turn over of policy makers. In one year we can have three Ministers of Health, for example, that makes it very difficult to get anything started.

Again, we have a very big problem with faculty. At the University of the Gambia we have two full-time faculty and four part-time people. It makes more sense to be part-time financially than to be full-time so it's kind of difficult to convince people to come on board full-time. So we know that the Gambia is one of the poorest of the poor. If I can say so there are a lot of challenges when it comes to issues of finance. Our partnership has decided as a goal that we're going to establish an OBGYN residence in the Gambia and our purpose is to improve the health of women and children in the Gambia. The near term goal should start at least a three year residency, with faculty to train residents and ultimately the next faculty should start to see a drastic reduction in the amount of maternal and child mortality.

So what are the next steps? We will discuss what the University of the Gambia will do, and what the University of New Mexico will do and what Drexel will do. So from the University of the Gambia we will lead, we will spearhead the writing of a proposal for OBGYN training. We are hoping to get a lot of input from our partners, from Drexel and University of New Mexico. Also we'll be looking at all the other programs that happen in West Africa and probably also look outside West Africa at the East African systems as well and see how we can adopt.

Then immediately after this meeting we're going to begin our focus visits to more senior members of the invested community and also people in government and we will seriously consider hiring three additional faculty. Incidentally, our University has a MOU with Drexel, so Owen is going to review that MOU and send a copy of that to me so I can look at it. This is an MOU for the whole university - not just our department - so there's some kind of partnership already going on. Owen is also going to facilitate close contact between our department and senior members of our University. We are hoping that a faculty member from Drexel will be able to visit us very soon and see how we can take it from here. So I think those are our immediate next steps that we think we can. I don't know if I left out anything.

Owen Montgomery: I was particularly impressed by Patrick and I think that had this meeting occurred two years ago the Gambia would not be here and therefore Drexel would not be here as well. But Patrick is incurably optimistic and as an obstetrician that is a very good trait to have. But at the beginning of the meeting I think Professor Donaldson said, I think the message was yes we can and Patrick keeps saying yes we can. He is not daunted by the challenges in the Gambia. I think that this has also been an eye opening partnership between Drexel and University of New Mexico because either of us as US partners alone I think we would not support Patrick in his mission in the Gambia but I think together we're a very complimentary partnership. Drexel will host Patrick as visiting faculty and we're going to pick a time that he can also be at University of New Mexico so we can continue the relationship. Over the next 18 months we've planned several meetings ultimately ending in FIGO Vancouver 2015 so we can continue the progress. So, I think leaving with just a very positive understanding of thinking that, 'Yes we can,' and we want to make sure that we continue to be a part of this partnership because there's so much that we can learn. As I said before,

I think we were put in 'Room Zero' because we were at 'Ground Zero', but there's so much we've learned from the other partners in terms of partnership and infrastructure and some of the strengths that we have will become evident. But we need to help Patrick with his vision and I think the impact factor in the Gambia will be very evident very quickly. His goal was to train twenty OBGYNs in the next ten years and I think that with our help maybe he can realize that goal.

Frank Anderson: Thank you. Congratulations, Patrick. That's fantastic. Well, we have had to change the schedule because Malawi has to take off soon, so Dr. Mataya and the Malawi group - would you guys please come up and let us know what's going on? Can the whole Malawi group come up?

Malawi

Ron Mataya: So Jeff left us already and I think he did this on purpose so he wouldn't have to come talk. I think that I can say with some certainty that we had an incredibly productive meeting here and we're really so privileged to have been a part of this crowd. I think that I'm frankly shocked at how far we've come in the past six months. It seems like we've accomplished a lot in a short amount of time but when I think back to when this all began a couple of years ago it seemed like a dream that we would be where we are to today and now we're here. So, it's pretty exciting. One of the things that I think I'm most excited about that came out of all our discussions at our table was that we actually used the words 'development exit strategy' today and I can't believe that we did that. We just started and we're already saying that we need to have a plan for five years down the road to make my presence in this group unnecessary. Though I did say that I was hoping that they would let me stay. I did ask that and they said maybe. They weren't sure.

But we came up with actually what we consider, what did we call this guys? We called it action items? Yes. We came up with action items and I think we're all pretty happy with the action items that we came up with. I think it's all a little overwhelming but a great list. Do you guys what to mention some of them? So I'm not the only one talking? Ok. We talked about things like, we actually want to work on some issues that we consider critical to the success of the training of our registrars. One of those things being the lack of support we have in both of our campuses around anesthesiology and around radiology services and our laboratory services. We think that those are real weak spots and we're going to take trying to look into providing some sort of solution to that very seriously. We also talked about things like, right now we're doing conference calls between our two campuses. We're working on boosting our IT support and we're hoping we can even move into something that involves video conferencing, Skype, something like that once we have powerful enough IT infrastructure.

We're talking about, with coordination between our campuses, that we need to go ahead and start putting on the books when are our quarterly faculty meetings going to be that are going to be joint for our two campuses. We've already got, I'm really proud to say that we have our first annual scientific meeting coming up in two weeks that's going to be attended by all of the Malawian faculty and many of the participating ex-pat faculty. I am unfortunately going to be back in the states at the APCO meeting so guys better make it fun because I'm missing it. But we want to get those regular meetings on the books and we want to be sure that we have continued funding and support to have those types of meetings because we're really excited that we're actually going to be able to get everyone together and really boost the entire profile of OBGYN in the country. I think that those are just some of the highlights of things that we got out of this meeting and talked about as a group and really appreciated that time to hear from other groups and we got some of these ideas from listening to all of you, so thank you so much.

Dr. Anderson: Ok. The next presentation, Uganda.

Uganda

Josephat Byamugisha: Ok good. Here comes Uganda. We are a big delegation but we are represented by three persons. We have privileged that have the academic institutions and the government represented by a commissioner of the Minister of Education. I am Joseph and we have Joseph here and Robert. We have three other persons right over there. Where are they? Meg, Adelene, and Blaire. Now in terms of representation you can see the various intuitions. We have three MMED programs. Two are the public institutions and one, which is in the private sector just coming up. We have got here an association of obstetricians and gynecologists of Uganda commonly known as ADGU which is affiliated with FIGO. We've 15 to 18 graduates by year that is those who are coming from the various institutions. About 150 OBGYNs. 60-80% stay all around the city that is Kampala. Our population is predicted at 36 million and the doctor to population ratio is 1 to 20,000. Maternal mortality rate is 438 per 198,000 births but it has gone up by three in the last 5 years.

We observe that about 80 percent of our faculty have either private practice or some other way of increasing their income. One of the reasons being that we have the lowest salary in the East African region compared with other countries around us. So we have sub-specialties coming up, but we don't have people who are formally trained to be sub-specialists. We have an issue also that we've got a backload of recruitment so that even if these people are fine, they may not get the chance to be included. And currently, some specialists may be promoted but they can't move to those positions because they are needed where they are.

The other is retention which is difficult because of the factors which have been highlighted and we've got infrastructure and equipment gaps. Some of the simple things that the specialists seek to do their work. Equipment - especially the increasing technology, improving technology, and scopes. We need improvements. Even improving complete sets for operations. Let's move on. My colleague Joseph will take over from here. Joseph is the chair of the OBGYN department of the Mbarara University of Medical Science and Technology commonly known as MUST.

Joseph Ngonzi: Thank you. It's been a rare privilege learning of the countries stories. As someone, actually some of the things have been picked from many of the things we've been hearing from here and we thought we would also be able to implement some of them. One thing we have come to agree on is that we need to develop a country-wide vision for OBGYN training as it is in countries like Rwanda.

And level two, to create a strategic and business plan to implement. Our interaction with Robert Odok Ocheng, our ministry representative, has been rich here than has been in country. We have been able to learn so many things here from him on behalf of government that we have no chance of learning back home. And we ask that supplement government funding to implement some of the ideas that we've already heard would be provided. We learned of government funding agencies so when we get back home we are going to work hard so we can be able to present our needs and find where we can get funding. We will start regular meetings with Minister of Health officials and also other stakeholders in this whole plan.

In our country the northern region has suffered from instability for the last 35 years. And government was just able to establish a medical school. So far they have graduated about six batches of medical students and so we have great need in the area - much more than the rest of the country to get back and support that medical school to have postgraduate training on the agenda. We also discussed adding sub-specialist training within the country or we can even use some countries around us who already have got some of these areas covered like Kenya, like south Africa, wherever we can

and where we can get it cheaper having in mind the quality we are looking for.

Also improving collaboration sharing between Mbarara University and also Makerere and other medical schools within the country. Thank you for arranging this meeting because we discovered there are things that we can do in country and it was a sure learning some of the things from here so when we get back we are going to see that joining our efforts and be able to learn from each other and Uganda. I think we will move and also improve collaboration in the east central and southern African region and leverage and also coordinate efforts from some key partners like any others that will possibly come in the future

And lastly, since hearing about the establishment of the Ghana college it's clear we need to support our society when we go back. We are going to put in effort in east central southern Africa obstetricians society first, using some of the ideas that we are able to learn from this meeting. Good enough - this year Uganda should be taking over leadership of this society. So this was a very timely meeting for us to learn very many lessons. Thank you.

Robert Odok Oceng: I just want briefly to inform you what at government level I think has been done, made possible by the government agencies an official here cost a lot. There is little discussion between ministries in every country, especially health and education because health institutions are under education and where they train from they are under ministry of health and some misunderstandings always there and we're busy trying to share our work and cooperate.

Now what I will do is to bring four ministries. For me it is very vital with the training of these health workers because Ministry of Education trains and Ministry of Health, they recruit and have the workers. Ministry of Finance finances the training and Ministry of Public Services are the ones in charge of equipment. The coordination between Ministries is very important. I know the graduate will get more technicians around him. Now when you train one doctor and you have no technician around that doctor, it will not be effective.

Therefore, as we depart we should think about how do we bring on board the midwives, the clinical officers, and the nurses so that they support these doctors because in Uganda 80% of the rural section is being helped by clinical officers, and nurses and midwives. Doctors are really almost 90% in the urban centers mostly Kampala so training at that level would not achieve what we wanted but if we train also we find a way of training up to nurses level then the people we are talking about there will be helped. So I don't know if this is a question for one of us. We take it home, think about it and get solutions maybe at the next meeting we can inform the meeting. Thank you very much.

Frank Anderson: Incredible. Every country has a different story based on where they started and where they ended up at the end of this meeting and this whole issue of communication seems to be coming up, doesn't it? Ok the next group is Rwanda. Rwanda group.

Rwanda

As Rwanda is getting ready I think it's important to make the point that other activities are moving towards reducing maternal mortality so certainly the increase of training of midwives, anestheticians, whatever we must to hand in hand with these. This will be the driving force, the pool to take along, the others if we realize that so it will be... for us to realize to present this as if this would be the only approach to solve that so we recognize that other sectors or other areas of health ...training is important. We are looking at it because it is in our domain.

Stephen Rulisa: We have one medical school in Rwanda. We have a limited number of OBGYN

of 35 or 40 for the whole country, and over 80% of them are in the capital. We have one school that is training medical doctors. We have a unique situation where by we have a partnership of many US institutions - yet all are as one partnership. The Minister of Health, our government strategy of vision, OBGYNs. The partnership is not for OBGYN only - it's for all many programs.

The partnership includes residents and midwives, nursing schools and medical schools and all medicine in general. So the US institutions come as one. We don't see them as New York or Yale or Harvard, we see them as partners from the US institutions who partner with Rwanda's health sector to achieve one common objective. Beyond that we also begin to transform our partnership. By the time when the mentor goes back he has transferred all that he has to me.

The challenges we discussed are some of challenges in the health sector – there are very few number of trainers and the number of faculty is very, very low. One of the objectives is to train at the home country for seven years. So that by the time this partnership is over we will have at least trained more who can continue learning our residence program.

The other challenge that we discussed was different in African in procedures to have essential medicines in our hospital. So one of the changes we discussed is it becomes very difficult get medications very fast and we have to go through all the procedures which sometimes makes it's difficult to have access to medicines.

The other challenge that we had was we don't have the problem of retention of doctors because we don't have them. But once we discover that have them then there will be a problem of how to retain them in these hospitals. Now we don't have them so we are talking more of having them first be trainers and then in the future once we have more trainers then they can be retained in this hospital. So finally, in our country we don't have a problem of doctors going outside Rwanda. Everyone we have outside is coming back, so that is not the problem so far. The problem is that we need more so they can go in these hospitals and help to train.

Washington Hill: Briefly, I also think that the Rwanda program had matured to the point that we're ready for some monitoring and evaluation in the form of quality assurance but also on both sides of the partnership both to figure out what currently exists already within the Rwandan Ministry of Health because there is a system. We don't seem to know much about it and how to interface with that to make it possibly a little more transparent because we don't know much about it. That speaks to the lack of transparency and also on our side to beginning to get feed back from our Rwanda partners as to how HRH is doing.

Not only for OBGYN but I also think system-wide because we're here to facilitate Rwanda's goals and we're looking for some serious feed back because we actually don't have seven years - we have five years, right? We're two years into it so that's one of the challenges we have right now. We learned a lot from other countries that are in various stages of giving birth to conception mature countries so if there's anything we can help you from Rwanda's standpoint don't hesitate to ask. Thank you very much.

Frank Anderson: The next country will be Zambia.

Zambia

New Speaker: Good afternoon, everyone. Know that we are currently anxious to go back to our bases. I'd like to thank Frank and organizers for making it possible for me to bring my strong team. I'm supported by my dean of the school and a doctor who is also an obstetrician and he's director of the ministry and in charge of support services. And representing our partners is Doctor Ben Chi. Now, like most African countries, the response to the non-return of people we sent abroad for training, the university first introduced a masters program in 1982. And during this time we have produced just close to over 40 specialists. And it has made possible that most of these have been able to stay in country. Now over the years we've got really sub-specialized and we think that is the way to go now. And this is why we've learned a lot of things from our partners that are here. How some of them plan to go out and start the sub-specializations. All this time we only have on medical school but in the last three years we've seen one public medical school come up and two private ones. So we hope we can produce 15 specialists in a year and in 10 years will have 150.

What we've learnt here are some of the things we already talked about. Some of the fellowships that are offered in our partner's universities we would like to offer in our university. It's from these we can probably start also the sub-specialization by concentrating resources and efforts to particular people who have the knowledge and the knowhow. And also what we're learned is that this cooperation between Africa universities also very possible. Because through other programs we have tried to develop as a university some clinical protocols which are very similar to other countries. I'm happy to report that we have a market share with Malawi so that what needs to there will need to be done here as well.

Some of the challenges are also again similar to other countries. The university positions are not attractive compared to government. So most people would rather work in government than come to the university to teach. We also have problems of infrastructure and equipment. But I do hope the way will be much easier because our first lady is an obstetrician and gynecologist and she's passionate to help us to drive the agenda of maternal and neonatal health. Also the minister of health is also an obstetrician gynecologist and he is the director of support services so I do hope he can help us plan our next course.

New speaker: Well, I think for us we should just be thankful that we were included in this whole arrangement because the thing has given me time to think about just what are the many programs that we are running and when I looked at the number 1,000, I think how do we get 1,000 for ourselves? But after three days something tells me, 'No'. Actually, if we did 15 that would be good enough so I said, 'Yeah, surely we can.'

Ben Chi: I want to say a few words from the partner perspective. I think like others this has been a very eye opening experience and UNC's work in Zambia has really been project focused. It's been very HIV focused until very recently when we engaged the university as well as the Ministry of Health in the Medical Education partnership. I think that the frame work that's been set out here from the Michigan and Ghana relationship as well as others helps us think about how we can engage from this kind of individual-to-individual or project-to-project relationship to something broader and institutional. I think that that's very exciting! And I think that having the department chair, the department to outline what they need and if UNC can't meet it, then how do we engage other US universities that are working at the school or some of you all? How do we fill those needs so that the institution is built up and it's not just about a single partnership but about the needs being met in-country. Thank you for sharing all your experiences and we hope to continue to hear about that cooperation and those relationships. Thanks.

Frank Anderson: That group did a lot of work as well. It's a nice perspective shift to expand that work in Zambia. Next, Ethiopia.

Ethiopia

New Speaker: Thank you very much for the opportunity to be here. We have learnt many lessons thanks to Frank and others from our attendance at this meeting. To mention some of them we are thinking we have a good supporting team to train gynecologists in our set up. We are thinking we have certain medical schools now which are producing about 3,000 undergraduates medical students, so this will be a good input for us so we are thinking that we could go even beyond 1,000 to fulfill the needs.

There is work ready to be done through a partnership so we really understand the importance of our partnership and it was a very good level opportunity. Most of our discussion was how we are going to improve our partnership so that we utilize our US different partners to the best level. We have sorted out some possible solutions. For example, we are going to set an academic consortium and the Society of Gynecology and Obstetrics will be the coordinator for this. We have planned also to adopt this Michigan chapter to use for us so that we have effective partnership.

There are many things that we have listed down- to understand the strategy plans in the country for our partners we have health sector development plan, we have educational sector development plan, so we've tried to communicate this. We were very hopeful thinking of creating an educational environment for our partners at the institutional level and skills for communication and advocacy from our university faculties.

Frank Anderson: They had quite great conversations. All the different partners working together met for the first time and used the partnership process to come up with some really new ways of working so congratulations on all. Next, Botswana.

Botswana

Doreen Ramogola: Good afternoon, everyone. We are in the home stretch. I feel completely at home. As the youngest person in an African home is said, this is usually the one who is said to run the errands, so here I am to do the errands. I really want to say thank you for hosting us, and Frank and your team, thank you for funding us to come here and it's just been phenomenal to be here with all of you and to lean from you.

So, lessons learned. I think the first lesson learned is that I need to learn French so I can communicate with some of my West African colleagues. I think that on a serious note really the message is it can be done. The resources are actually in this room and we don't need to go any farther. We don't need to recreate any wheels.

Just a brief background. Botswana is a country with 2 million people the size of Texas or France and we have a brand new medical school that started in 2009. Just to give you perspective in terms of our history. Between 2004 and 2010 the ministry of education spent close to \$200 million US dollars training doctors outside the country - about 800 or so of them. None of them are back in the country and that is why it's really imperative to be able to do the training, and again, because the county is small and the population is small we really can do this. The curriculum we can get from all of you and the expertise we can get from all of you is very valuable.

So this exercise has actually been wonderful for us to take back with us and whoever will be the chair of the department had their work plan set out for them. That actually has been the biggest challenge

is that unlike pediatrics and internal medicine where they have been able to do a residence training, obstetrics and gynecology has struggled because they have not been able to recruit the chair to the department to really have this going. So hopefully one of you in this room will be able to come and help us set up the department.

I think I've really touched on those challenges. They are a reoccurring theme in terms of what is happening in all our countries. The bottom line is that we cannot put fourth faculty because there is not enough faculty in the continent. Perhaps in the country - so that's why training 1,000 and even more is imperative. We will be coming to all of you to ask for your material, your human expertise and to help us set the program. But, thank you again. In fact, we did bring a pediatrician with us who's actually worked as a senior member in the Ministry of Health and we thought this would give perspective..

New speaker: Thank you. I think she's covered the challenges that we've had and I think for me as a pediatrician when we look at child morbidity and mortality figures we've done quite a lot in terms of preventable causes. Now the biggest chunk - around 50-60% - is related to neonatal mortality and we'll have to discuss our colleagues who are obstetricians to address this problem. So I can't let it go far from me because I have a vested interest and also we've started a MMed program in pediatrics. I'm really looking forward to a program in OBGYN. I happen to be in the University and therefore I think I can play a role to assist since I really have a vested interest. Thank you.

Jack Ludmir: Just a word of thanks to Frank and the whole team here and everyone. I consider myself very lucky. I'm very humbled to be here. I consider myself a citizen of the world facing wherever you go the issue mortality. But I think you just heard my partners here and I think I would love to work for this woman. I think she is just a source of inspiration and I mean that she's a true leader. I think she can make a difference and that's the reason I'm willing to do whatever is possible to try to do, in a humble way, something good. I think we are delighted that we were invited here. I think that is an absolutely wonderful way of putting ideas together and not only ideas but I think the process is in place to make it a reality. So I thank everyone here.

Frank Anderson: I think we're all surprised to learn of Botswana's situation of retention and not having a post graduate training program. So, we're going to put this all together and, as Chris Johnson said, this will be the Bible of Implementation of Program. All this information is going to be a great resource.