Chapter 8

Certification and Accreditation of OBGYNs

Speakers:
Lauri Romanzi, Gabriel Ganyaglo, Uro-Gynecology Sub-Specialization Group
Vanessa Dalton, Emmanuel Morhe; the University of Michigan – KNUST
Kobina Nkyekyer; Korle Bu Teaching Hospital, Ghana

Frank Anderson: Good morning! We have two sessions scheduled into late breakers that have been added. We're going to hear about a uro-gynecology program and we are also going to hear about the Lancet Commission on Global Surgery and an invitation to be a part of that. Before we get started with our session today, I have one announcement, too. We made a change on our agenda, and you can see that on the PowerPoint presentation. Originally, after this session, we were going to work in our small groups. That is going to be shifted to 11:00, so at 11:00 you all have two hours to work in your country groups.

Immediately, after this session, you will go to your professional group. There'll be three professional groups, the American OBGYNs, the African OBGYNs, and representatives from various African ministries of health and education. The African minister people will be meeting in the boardroom and Madeleine knows where the rest of us will meet. We will remind you that at the end of the session. Before we start the technical components of the session, I would like to invite Ray de Vries to the microphone to give some impressions.

Sociologist Comments

Ray de Vries: Good morning! I am beginning to feel a little conspicuous traveling around between groups. People say, "Oh no, here he comes. Let's stop what we are talking about." I only have a very few things to comment on today. I did spend some time going between the country groups, and I the heard in some exchange, which I thought was quite interesting, and also quite indicative of the level of cooperation that we have here. It was between an African partner and in American partner, and the African partners said, "We need to go to USAID." The American partner responded, "Who's Hussein?"

What is interesting about that is that we have gotten to the level of trusting each other. I think if you are in a group and you don't have trust in each other, you just let that go of your head and think, "I have no idea what he was saying, but let's just move on." So we have reached a level of working with each other. I thought it was quite funny.

I have to say yesterday it was very encouraging to me to see partners working together in this kind of way, but is also a bit overwhelming to be sitting in groups and hearing all of the obstacles between our dreams and the realities we are seeking. This is encouraging and discouraging at the same time, because people were drilling down and realizing that we have to think about budgets; we have to think about the way tuition dollars flow back to residency programs; or we have to get that funding because we have to get more faculty. On the other hand, we know that the dean isn't so willing to give. Seeing that level of detail is really critical for success, but on some levels it is a little discouraging as well.

Also, there are things that you would not expect to affect the work that we want to do: government

policies on pensions, which affect the way caregivers decide, "Should I stay in the country or should I leave the country?" Things like hiring freezes that really put pressure on caregivers, and those sorts of things. We heard a lot both in the plenaries but also in the country groups about how histories of displacement ripple through and affect what we want to do. But in the end, I have to say, it seems to me that the worksheets are actually working. For some of you, it may seem a little too heavy-handed or little too patriarchal, but listening to people it seemed as if people are getting into the important, detailed questions.

Just a final word, and this is more of a general word, because I'm not saying that I saw this at all. An insight from sociology is that when people work together in organizations, they often have what we call goal displacement. That is your original goal gets displaced by immediate goals. That is often reflected in misplaced metrics. I'll give you a couple from my own university. We often at the University of Michigan make public where we stand in getting NIH dollars. Are we fifth? Are we second? Oh we move moved from seventh to fifth. This is how many billions of an NIH dollars we got. That is goal displacement, because we get the money to do good work in the world, but now at an administrative level, the goal is, we want to move out to third. There's no question of what we are using that money for. Are we doing the good work that this money is intended to do? Let's talk about, "That's the real goal, but we displaced that goal." I think that is the danger working in any type of interdisciplinary cooperative activity.

I have a graduate student who did some work looking at interdisciplinary collaborations, and she distinguishes what she called artificial collaborations from natural collaborations. The basic difference gets to this displaced goals, that in artificial collaborations the secondary goal becomes primary. That is, my Dean needs to see me bringing in grant dollars; I am going to join this project. I do have something to contribute to it, but my real goal is to garner something for myself that I can then use to display my productivity. Compared to interdisciplinary collaborations where people say, "We really care about this, and our primary goal stays our primary goal." Secondary goals are required but the focus isn't lost. It tends to be true that the artificial collaborations don't get really far, and that natural collaborations do. So far, although we all struggle with this balance between the two kinds of goals, it seems that we're keeping our eye on the goals here. At this point, I am a little tired, but I'm also encouraged. Thanks, everybody.

Frank Anderson: Thanks, Ray. It's been great to have Ray here, hasn't it? To have that perspective and have some reflection? Thank you, Ray - it is great having you here. And, Dr. Danso, can you make a comment?

Kwabena Danso: Good morning once again. I think that so far the enthusiasm has been kept up and going around the African group in the Zero Room yesterday. I had a lot of positive feedback and it is encouraging. I think the enthusiasm is there. What we request is that we do continue that enthusiasm, carry it back home, and do whatever it takes to see this initiative and objective realized. So far, I would say we are doing well. I would thank you all for that.

Uro-Gynecology Sub-Specialization Presentation

Frank Anderson: In our first session today, we are going to be talking about certification in general and talk about some models of sub-certification and sub-specialization. This morning we have Anyetei Lassey and Lauri Romanzi, who will talk about an effort in uro-gynecology. Dr. Lassey is a member of the West Africa College of Surgeons and also a member of this uro-gynecology group.

Lauri Romanzi: Good morning! I'd like to thank all of our colleagues at the Kwame Nkrumah University, the Gates Foundation, and the University of Michigan for making this possible and giving FPMRS to be presented here, because it is a bit of a challenge. We are presenting today with Africa's

first formal uro-gynecology fellow, Dr. Gabriel Ganyaglo, with regard to this issue. How do you build FPMRS capacity in Sub-Saharan Africa? It is a bit of a challenge. Most of the funding comes from government organizations and NGOs that are focused solely on obstetric fistula. Obstetric fistula is a compelling issue. It is a morbidity that is related to a common maternal mortality, which is obstructed labor.

Obstructed labor either kills the woman, or if she survives, we all in this room know that she will suffer any number of horrific morbidities, with one of them being fistula. Fistula women traditionally did not get any attention. They had no money; they were the poorest of the poor. In 1996, thereabouts, when the WHO and the UNFPA began to focus on fistula as a silo-funding project, it was necessary, it was time. It has been very successful.

As a system has matured, what we find is that if you listen to the doctors that you are training, and if you look at the women in those communities, what the doctors want and with the community needs is full service female pelvic medicine and reconstructive surgery. This unfortunate pneumonic is the new term for uro-gynecology. It comes from the American Board of Obstetrics and Gynecology; I apologize for it, but we will refer to everything uro-gynecologic as FPMRS moving forward.

I had the opportunity to work with this fabulous general surgeon in Togo, Dr. Edwe Sewah. We did fistula repair for a few weeks on mercy ships, and then did a site visit to his hospital, a regional hospital way up-country that serves 600,000 people where the gynecologist had died the year before and all of the gynecologic issues fell onto him. The third thing his regional director said to me after, "Thank you for making the ten-hour journey; can I get you a cup of tea." We are so glad that Dr. Sewah has fistula skills now; we are sure they will be of use to the community. But really we have a much bigger problem with prolapse. "Is there anything you can do to help us with that? We know we are not doing a good job." This has been a challenge, because the answer typically has been no.

The traditional or the common wisdom for fistula was that there were approximately 2,000,000 women with fistula roaming the globe, most of them in sub-Saharan Africa and Southeast Asia. We now have some very recent data coming out of the London School of Public Health, more realistic, data-based numbers that show it is probably a little over one million with an annual incidence of 6000 per year. Keep this number in mind as you look at the data coming out of Pakistan. We have new data showing an annual incidence of fistula around 6000 per year and the entire fistula funding has matured to the point that it now has its own map founded and funded and maintained by three very powerful funders in the world of fistula care, who are still focused on the silo-funded model. Silo-funded model means you are only funding one clinical entity. For instance, cleft palate, and all you will pay for is cleft palate. Fistula; all you will pay for is fistula. Does everybody in this room understand what I mean when I say silo funding?

We have necessary care being rendered in all of these areas where fistula is a very big problem. On the flip side of all of this funding is that we see almost comical demonstrations of the misfiring of this concept of silo funding. Depending on which official document you read, the alleged incidents of fistula in Pakistan is anywhere from 5000-8000 new cases per year. The latest data tells us that we have 6000 worldwide. The Pakistani numbers in retrospect are interesting. In response to this, the UNFPA built seven fistula-dedicated centers, where only fistula care can be rendered. My colleague, Dr. Samya Hussein, who is a medical student looking for a project at the time, took three days to figure out that after seven years of the first fistula center opening, five years from the last center opening, all told, with over 200 full-time clinician employees, these fistula-focused centers that won't do anything else were doing a whopping five cases per center per month.

Why aren't these centers full of fistula patients? It is not the focus of this talk, so I'll move through this quickly. But either our numbers are wrong, and/or remaining barriers to care need to be

addressed. I think the most disturbing thing is that nobody knew of this. A medical student brought it to everybody's attention at an appropriate forum, and according to her, two years later nothing has changed. The easiest thing to do with these centers is to open the doors and expand the focus to other female pelvic medicine issues of which there is a great need. We have several published studies out of Pakistan in outpatient literature showing that they do in need have significant issues of unmet need for women with urinary incontinence and pelvic organ prolapse, and yet, the marketing focus, we will call it, remains on fistula and only on the tragedy of fistula to the exclusion of other female pelvic conditions. Symptomatic fecal and urinary incontinence and pelvic organ prolapse in low-income and middle-income nations is also a significant issue for women. Many of the low-income nations are known only for their fistula issue. Ghana has since graduated into the middle-income category, but be that as it may.

Some of it is prevalence; a lot of it was hospital based. This was a very loose meta-analysis with a lot of difficulty comparing data sets as you can imagine. We will take it for what it is. Which I think since they took the time to do these papers in these resource-challenged settings, the methodology we can say wasn't the most rigorous, but the fact that it was done speaks to an unmet need. They would not have done it if they were not trying to demonstrate something they know their community needs. I think perhaps, we might look at it that way.

I would like to point out a bit of an apartheid issue going on. For the big funders – the WHO, the UNFPA, the USAID – if a woman has prolapse and she is in Asia, then they are ready to pay for it. In Nepal, it is recognized that pelvic organ prolapse is a big issue in the western region of the country. UNFPA has not hesitated to fund it in full. In addition to their ongoing funding, which has always been present, for fistula care. In the same office, you have one desk and one officer for prolapse funding, and another desk and another officer for fistula funding, existing side by side, without any conflict and without any reticence or hesitation.

I conducted a regional needs assessment for UNFPA Afghanistan that took several months. They wanted to streamline access to fistula care. What we found in each of these regions is that they have an issue with fistula, which has been difficult to document between the geography and the ongoing conflict; it is not an easy recipe for prevalence studies. But there are some fistula patients in Afghanistan.

However, to a doctor, at every single site, what came back to us on this assessment was that they are looking for full-scale FPMRS services. That is what we took back to the UNFPA office, and they said, "Fantastic! Let's do it." They couldn't embrace it fast enough, and yet in Sub-Saharan Africa, the exact opposite is true. There is a lot of resistance to expanding fistula funding to include FPMRS, despite the fact that there is a prevalence and need. It is illustrated very well in the Democratic Republic of Congo, where Dennis McQuage, the founder of Panzi Hospital, has had no problem getting funding for fistula patients and women who are victims of gender-based violence, but has been fighting constantly for the prolapse patients who show up at a ratio of 3:1 compared to fistula patients. In their fistula outreach centers, they will routinely do 30 fistula cases and turn away 80-100 prolapse patients for lack of funding. Lack of funding. And these women leave in tears.

So what can we do? Well, you can take the silo model and tweak it a bit and say, "We are finishing at four but we might take some cases after four on our own time. Are you okay with that?" And they typically say, "Sure, go ahead. Just don't put it in your report." The sustainability of that is completely dependent on your trainees. These are my two trainees in Somaliland who are very devoted. When you do that, you can double your caseload, which is excellent for training and sustainability for the community. This is just a synopsis of six months of work.

Dr. Ganyaglo, will you please come up? We have other sustainable models which are emerging and

we are very proud the announce the initiation of a fellowship here in the Ghana College of Physicians and Surgeons. Dr. Ganyaglo is the very first fellow. This is a highly sustainable model started by the Ghanaians who have invited the International Uro-Gynecology Association to facilitate the development of the program.

Gabriel Ganyaglo: Thank you very much Dr. Romanzi for this opportunity. At the inception of the Ghana College, the concept of subspecialty training as a fellowship program was born. Professor Lassey who was introduced earlier and Professor Okariado who was also in the audience were tasked to develop a curriculum for this program. It took a lot of work and eventually the product was based on the Royal College module. So far, we have trainees up to module three of the program. We only have modules four, five, and six to complete. Hopefully, by the end of this year or early next year should have our first products completing all the modules for the training. The key thing for this curriculum is that the focus is on the fellow also providing general gynecological services. You can see our needs, the Mampong needs in the country are not at the level where you sit in your small corner just doing female pelvic medicine reconstructive surgery. So it is important for us and it is part of the curriculum. The key also is that it is based on what we need not on what has been proposed by either ACOG or the Royale College. It has adapted to suit in-country needs. Dr. Romanzi has been very instrumental in insisting that it should be a Ghana-based program and so far, that is where we are. Professor Nkyekyer will be talking about certification so you get to see it has all been adapted to suit the Ghanaian needs.

How did we get it all started? After the first visit by Dr. Romanzi and another colleague from the International Urogynecological Association, last year we started the program. So far we have had six faculty come in. I wish they could come more often but they are very strict recruitment criteria. Dr. Romanzi is particularly very strict on that to be sure that we get the best of the best coming to teach us this course. You don't get opportunity to come and tour the country in the name of coming to teach in the program.

So far, I believe we are around the quality assurance bit. Her presence here makes her the sixth faculty to come and from next week, she will be working with us in Korle-Bu Teaching Hospital. Do we need cystoscopy? Yes, yes, yes. After we have learned all of the surgical anatomy of the utero-sacral ligament, then you want to begin to start looking into the void but without cystoscopy, that is a big limitation. Multi-channel uro-dynamics has been discussed. That hopefully may come towards the end of next year.

What about the other countries on the West African sub-region? There is a talk of collaborating with the West African College of Surgeons to follow the Ghana example of subspecialty training. We seek to make Ghana the hub of training in female pelvic medicine and reconstructive surgery, within the sub-region at least and then later on the entire continent. But how much do people know about female pelvic floor issues? Even at the Ministry level, knowledge is a bit doubtful, and talk about the rest of the larger community. We need to get into a drive of sensitizing people about the need to talk about female pelvic floor issues and encourage them to report for treatment.

Do we want to go abroad? Yes, but when? There is a lot of talk about that. Fortunately, we are still getting a lot of offers but at the International Uro-Gynecological Association together with Professor Lassey and Professor Okoriado will be the two to determine that. By and large, this has been the collaborative effort between the Ghana College of Physicians and Surgeons and the International Urogynecological Association. Coincidentally the co-chair for this meeting is also a uro-gyn, so we seem to have a lot of blessings in the confidences of faculties that are helping to start this program. I'll hand this over back to Dr. Romanzi.

Lauri Romanzi: Thank you, Gabriel. Another sustainable model is what we are doing with

Rwanda's Human Resources for Health, where there is funding for an embedded female pelvic medicine faculty specialist on site. Over the next year and a half we are borrowing from the silo-funded model and are doing an intensive train-the-trainers model in a small group in the first phase, and in the second phase using the trainers to expand to a system of FPMRS access to care throughout the country. This is a small group, which is in so small. This is a key group of senior advisors and support. We have included a lot of nurses; I won't belabor the issue, but it is crucial when you're going to develop an FPMRS morbidities-based, high surgical volume service into a general OBGYN referral center, through the doors of the which roll by a never-ending cascade of mortalities: women hemorrhaging, women in sepsis, women with prolapsed cords, women with status epilepticus.

How do you get the FPMRS system up and rolling? If you don't invest in your nurses, it won't happen. Everyone on the team is also doing program development. Our two junior attendings are busy making amendments to guideline advisements through the Rwandan Society of Obstetrics and Gynecology for consideration by the Ministry of Health. Here are just a few of the guidelines that we have considered. We are monitoring this FPMRS system through a simple registry, the first part of it served as the facsimile of prevalence, the second part of which serves as a facsimile of quality assurance. We borrowed from the FIGO fistula manual to do an amended surgical skills assessment of fistula prolapse and incontinence over time. We are also doing private-public partnership. We are not too proud to go back to our silo funders and ask if we can have some supplies and some money and if we can do a little bit of don't ask don't tell. So far in the process, the answer has been yes.

Our three models are to use the existing silo funding and do don't ask don't tell FPMRS on the side. That's one method. The other method has been illustrated with the Ghana model. And another sustainable method is through the Rwandan HRH model. The underpinning to all of these approaches is to create a vision that is shared to get people to stop worrying about problems and thinking about what is possible. That allows your opportunities to come to the fore and I have to say, I got this from my source of all wisdom these days, Twitter! I've had great fun tweeting this meeting, and I hope you have, too. This is one of the most beautiful tweet avatars that think I've ever seen, so congratulations to you. Just last night – you know you get 140 characters so you have to be succinct – here comes Robert Gates, US tips on the business of medicine: no money no mission. I think we all understand that. And I think I'll leave you with some words of wisdom from one of the great thinkers of our time. For those of you who are not American, Will Farrell is one of our favorite comedians, who tells us, in case we don't already know, "every sixty seconds in Africa, yet another minute passes."

Family Planning Sub-Specialty Fellowship Program

Kwabena Danso: Thank you very much. Now we will move to the next presentation given by and that is going to be given by a pair; Dr. Emmanuel Morhe and Dr. Vanessa Dalton. Dr. Emmanuel Morhe is from Ghana and Dr. Dalton is from the USA at the University of Michigan.

Vanessa Dalton: I think I'm going to do some introductions. I'm going to talk about another subspecialty fellowship program that started in Ghana. I was part of the University of Michigan team that helped facilitate this but I really just wanted to introduce a few people that have been the founders of this. One is Professor Danso, and this is Emmanuel Morhe, who is part of the first cohort of fellows who went through the family planning fellowship program here. Also, the other person we were really wanted to recognize for this is Tim Johnson, because, of course, his vision and his Ghanaian counterparts are really the reason why this all happened. Unfortunately, I'm disappointed that he did not make it. I just wanted to introduce Emmanuel Morhe and let him talk a little bit about what the program is and the process of both the curriculum and also how it has gotten integrated into medical education in Ghana.

Emmanuel Morhe: Thank you very much. The objective of this panel this morning is to discuss certification and accreditation. These are very important aspects of establishing a pre-service training program. I'm going to use the family planning fellowship program that was established in Ghana as an example. Like anyone seeking employment, there are basic questions that you need to ask before you get the employment. First, what institution where you trained in? Is that institution being accredited? Who has accredited that institution?

Then the next set of questions is: Has the person seeking the job completed training? If he has completed his training, has he been given any certificate? And who did so?

The third set of questions is, do you have the requisite license to practice?

Using the family planning program, I will present it and Professor Nkyekyer will follow and give details about accreditation. I'm just going to focus on our family planning program. With regard to the pre-service training, we all knew that it is the best way of addressing the inadequate human resource challenges that we face in sub- Saharan Africa. We know that pre-service training plays an important role in preparing new professionals and also strengthening the continuous medical education, and accreditation is very important. With regard to the family planning fellowship program, it was the first sub-specialist program of the Ghana College. It was started as an international family planning fellowship program, which was a collaboration between the University of Ghana and Kwame Nkrumah University, both in Ghana.

The goal is to reduce maternal mortality. The objective of the program is to build human resource capacity and to train highly skilled experts in the provision of family planning and reproductive health in Ghana. We know that accreditation is very important and therefore in order to get accreditation and certification, we need to get major stakeholders involved. There was early involvement of major stakeholders such as the Ghana College of Physicians and Surgeons, the Medical and Dental Council, the Ministry of Health, the Ghana Health Service, and local NGOs. Other people that were involved in the early development of this program included the training institutions at universities and then the teaching hospitals. There is also the involvement of trainers. Then we should not forget the potential fellows and residents who have been recruited in this sub-fellowship training program.

To begin with, there was a need to develop curriculum. As often said, we don't need to reinvent the wheel. Therefore, the planners went to the University of Michigan where there was an evidence-based fellowship program. That program has been very successful and has spread across the US. When we went to the University of Michigan and started studying their curriculum, there was an inter-disciplinary group of people who were from Ghana and went to team up with US experts, and they developed curriculum that was suitable for the country.

Then, the next thing was faculty training, because we need to put in a strong faculty in order to develop a very strong pre-service training program. These faculty are trained in two places in the US, and it involved clinicians, researchers, and public health officials who were selected from the two universities and various institutions in Ghana and were then sent to the US to have this training.

The training focused on leadership, clinical skills, teaching, mentorship, research methodology, and evaluation and documentation. Then they came back to Ghana and started the program. It was a two-year program and it began in 2008. And it began with two obstetricians and gynecologists who had the fellowship at the West African College. They were recruited into the program; two from the University of Ghana and two from Kwame Nkrumah University. They underwent training and the training was basically competency-based and it involved clinical skills training and development,

research training and result development, with an award of an MPH degree, and leadership and advocacy skills and development.

After two years of training, the first cohort of trainees graduated from the program in 2010 and was then certified by the Ghana College of Physicians and Surgeons in 2011. Currently, we have eight fellows in the program who are being trained under the Ghana College of Physicians and Surgeons, because the Ghana College of Physicians and Surgeons took ownership of the program. Graduated fellows are already established in the medical council and offer services in various institutions in Ghana. Currently, five fellows are out of the program.

The first four inaugural fellows are all faculty members. One in KNUST, one in the University of Ghana, the other one is in the University of Ghana School of Public Health, and then fourth one is the founding head of the Department of the Tamale Teaching Hospital. The first fellow that has been produced under the Ghana College of Physicians and Surgeons is currently at one of the original hospitals.

Currently the graduated fellows are involved with so many activities. They provide the direct mentorship to current fellows, residents, medical students, and public health students. They also provide pre-service clinical and research training for medical students, residents, midwives, and nurses. They are involved in continued medical education, particularly serving as consultants for NGOs in family planning and reproductive health. They play a leading role in the conduct of research in the country.

One of the big achievements of the program was the development of the Public Health and Family Planning book. This book was written by some of the mentors of the program and some of the graduated fellows of the program. It was an attempt to put together various aspects of reproductive health. I must indicate here that it was one of the first texts in the Africa sub-region that tries to put together reproductive health issues in one text.

In conclusion, establishment of an in-country, pre-service training program is feasible in sub-Saharan Africa. However, it involves careful planning. It also needs committed leadership. Ownership of the program is good, but we must also remember that cost-sharing approach is important for sustainability. Long-standing collaborations as well as mentorship are very important for continuation of the program. I would like to give a special acknowledgement of several people who contributed to the successful establishment of this program. Thank you.

Ghana College of Physicians and Surgeons–Certification of OBGYNs

Kwabena Danso: Thank you, and I think you agree with me when I say that we continue to re-echo one of the key messages that we gave at the Rome meeting. Collectively both American and African participants said, "Yes we can." There are evolving messages and evolving stimulation that, indeed, "Yes we can."

Let us have the other aspect of this panel: certification and accreditation from Professor Kobinah Nkyekyer. Professor Nkyekyer works primarily with the University of Ghana Medical School and he is the Faculty Chairman for the Ghana College of Physicians and Surgeons.

Kobina Nkyekyer: Thank you, Professor Danso. Good morning. I'm going to talk mainly on certification. My outline will be to give you some historical perspectives and look at the current certification mechanisms and also with the licensing involves. The training of specialists in Ghana before independence – just in case you don't know, we became independent in 1957 – and in immediate post-independence students were sent abroad, mostly to the UK, and then later to

Germany, and much later to the then Soviet Union, where they had their medical training.

On completion, some came back, worked for some time, and then returned to the countries they trained in for specialist training. Others continued with specialist training in the countries where they did the primary medical education. In 1962, the University of Ghana Medical School was established. This medical school graduated its first batch in 1969. In 1975, the KNUST was established. The specialist training in Ghana started around 1983 and we expected to graduate at least ten people.

What happened was that after the end of the first year of training, you took the part one membership of the Royal College of Obstetricians and Gynecologists. After another year or two, you were granted a scholarship to an institution in the UK where after another two to three years you were expected to have completed the full membership and then return home to provide service.

However, for various reasons, there was a problem of inadequate numbers of specialists and obstetricians and gynecologists, and then we had the Carnegie-sponsored OBGYN training program in 1989. This resulted in the full training of OBGYNs taking place in Ghana as opposed to the previous arrangement in which you have to go abroad to complete your training. That full training led to the attainment of the Fellowship of the West African College of Surgeons. Even though we have the West African College of Surgeons, it was felt that we also needed our own college. After some years of preliminary work, in 2003, the Ghana College of Physicians and Surgeons was established. That is currently the body that oversees all postgraduate medical training in the clinical areas. Candidates have the option to undertake the training in both systems or in either of them. In the meantime, two more medical schools have been established. The School of Medicine and Health Sciences at the University of Development Studies, Tamale was established in 1996, and the University of Cape Coast Medical Sciences was established in 2008. Indeed, it was only in August last year that the University of Cape Coast School of Medical Sciences graduated their first batch.

As far as the current certification mechanisms are dealt, I'll first talk about the situation with the Ghana College of Physicians and Surgeons. For entry into the program, you must have passed the primary examination of the college or any examination that is considered to be equivalent. And then you will go through an interview before entry into the program. Let me mention that when the whole thing started, we used to use the old system in which you pass an entry exam and interview, but we realized that it would be better if the candidates passed the primary exam before they entered, because in the previous arrangement, you came in and were supposed to take the primary exam at the end of the year. We thought that was a bit of a distraction.

Now you have to pass the primary examination, and after an interview you are admitted into the training program. After completing satisfactorily all rotations during the three-year training program, including the six-month rotation outside the teaching hospital, you take an exam. Of course there are other mechanisms for assessing progress through the training program. There is an exam, on the successful completion of which one is awarded a member of the College. The ministry appointed such a person as specialist obstetrician gynecologist.

The member is supposed to work a year outside of the teaching hospital and then can return if you or she so desires for the fellowship training. There is a two-year program in family planning and reproductive health, as we had mentioned which has been in collaboration with the University of Michigan, a program in uro-gynecology in collaboration with the International Uro-gynecology Association, the gyn-oncology in collaboration with the University of Michigan, and we have recently started what we refer to as a general OBGYN fellowship. For these fellowships, one has to write a dissertation, and an exam involves a viva in which there is a dissertation defense and then a viva over

general areas in that particular specialty.

Oral exam - upon completion one is a rewarded the fellowship of the College and becomes eligible to be appointed as a senior specialist. The fellow is appointed as a senior specialist by the Ministry of Health, and so is eligible for an appointment to the faculty positions in the medical schools. As far as the West African College of surgeons is concerned, entry requirements are the same as for the Ghana College. In the West African College, after the three-year training, you take in part one examination, which is made up of written and clinical examinations. For that you continue straight into the fellowship program. This is also a two-year training program, and you have a dissertation and a viva in which there is a defense of the dissertation and issues on general OBGYN. Again, the fellow is appointed a senior specialist and is eligible for faculty positions in the country.

If you qualify from outside, of course, there is the issue of validation in the education being recognized. If necessary you'll take an exam, which is made up of a written and oral components, and then you are given the registration to practice. I'll talk more about the Medical and Dental Council issues later.

If somebody has a qualification outside of the sub-region, then there is the place for the person becoming a fellow of the College by election. The qualifications the person has must be equivalent or considered equivalent to that of the College. He must have been qualified for at least three years, and he must have had one publication in a peer-reviewed journal. They must have contributed to the practice of the specialty in Ghana. This means that there are some people who come around and provide service in the community or are giving help with the affairs of the specialty in the college. Then the college requires two referees of good standing. I am insisting to add that this applies to Ghanaians. But if you are a foreigner, then you would have to be working in this country before you can apply for a fellowship to become a fellow by election. The same more or less applies to the West African college. For them, whether you are from the sub-region or not, you should have been practicing here for three years before you qualify for fellowship by election.

Let me quickly deal with the license to practice. The Ghana Medical and Dental Council has three types of registration: the provisional, which is for house offices or interns for that matter. For our purpose, especially since we get visitors, there is what is called short-term temporary registration. If it is up to three months, then you will be given a temporary registration without having to take an exam. But if it is going to be longer, then you have to take the exam that all who qualify out that this country would have to take. Of course, there is a full registration which you get after you have taken the exam. But I must say, in some situations if you come on the invitation of the medical school or a dental school, there is a provision for exemption for taking the exam for full registration. Thank you.

Kwabena Danso: Thank you, thank you Dr. Nkyekyer, this was quite insightful.

Frank Anderson: We also heard about the MMED program is the more prominent East Africa. I think we heard details about that, but we don't have a presentation on it now. This model takes a lot of people in the country to actually need certification and to have that ability. There are different models, but I think you can see this model also offers a country the opportunity to make decisions about how they proceed with specialists in this quite rigorous process that ensures that your specialists have achieved a certain goal. I personally think that helps with attention. From the outside it seems that that really helps with retention a lot, when you have worked very hard to stay in your country to become a leader in this life. So, thank you, Dr. Nkyekyer.

Frank Anderson: Blair Wylie had an announcement to make.

Blair Wylie: I am very inspired by the two presentations on subspecialty training. I am wanting to

get the act together for those of us who are in high-risk obstetrics and maternal and fetal medicine. Just an announcement that at lunch MFMs who are here, let's all meet together. Those of you who are trying to start programs in Africa, come tell us what we can do to help. Those of you who are pre-contemplative come together so we can replicate what has been done. Can I ask a question? Am I allowed to ask a question?

Those who are the established subspecialty training programs in Ghana, are those available to individuals outside the country? For example, could a Ugandan come to Ghana for FPMRS training? Could Africans from other countries come for subspecialty training with the knowledge that subspecialty training hasn't been established everywhere?

Kwabena Danso: Yes I think so. Well yes, provided that the person has the requisite qualifications and meets the conditions set out by the Ghana Medical and Dental Council. We had some trainees from the Gambia who did the membership and went back. One of them has applied to come back and do the uro-gynecology program. Obviously, it would be easier for people who have already done our training, but certainly in particular cases it should certainly possible to look at the situation and deal with it as it should be dealt with. That possibility is there.

John Mulbah: Thank you for that presentation from Ghana. My name is Dr. John Mulbah. I am also the Chairman for the Liberia Medical and Dental Council. I would like to learn from Ghana in the case where a student is returned from a country after an undergraduate training and you found out that the curriculum of that country does not meet the standard of the Ghanaian curriculum. The student has returned with the diploma of MD. How have you tried to handle this situation?
Kwabena Danso: This is a difficult issue. In fact, there have been a couple of instances. In that instance, the recommendation that came from the Medical and Dental Council was that those individual have to be attached to the training centers and work under supervision, just like trainees, for some time and take exams. In fact, even currently sometimes, those who are trained outside, mainly from countries like Russia, when they come, they do take an attachment. They do some sort of two to three week attachment in the major disciplines before they take their exam for final registration. So what I'll say is that it will be an issue where the Ghana Council should make a decision on. The Council should have the capacity to verify exactly what kind of certificate the person has brought and what actually goes into training for that certificate. That is the job for the Medical and Dental Council.

Kobina Nkyekyer: Let me add that if you come to Ghana with a specialist qualification from outside, especially if your basic medical qualification is not from Ghana, then no matter where you have come from, if you are going to practice in this country, you will have to take an exam. I have been on the examiners board, so we sometimes have people who have come from other parts of Africa – South Africa – wanting to practice here for various reasons. They have to take the exam. For most cases – it is a fair exam – the person who has been well trained usually does not have any difficulty with the exam. Particularly if your primary medical qualification is not from Ghana, then even if you come as a specialist, then you have to be examined in your area of specialization. But a general rule is that if your primary medical qualification is not from this country, even if you trained in Nigeria for your basic medical degree and you come here with that degree to work, you must take an exam with the Medical and Dental Council before you are granted full registration.

Frank Anderson: Okay, so two more questions.

Jack Ludmir: I just have a question for my colleagues from Ghana. First of all, congratulations. I think one of the most frustrating things in working in different countries is who is responsible for writing the examination and creating the questions? I congratulate you that you have your system, but I would like to know who is responsible, on a yearly basis, to write those questions, in particular

in our specialty, in OBGYN?

Kobina Nkyekyer: The faculty has fellows who provide questions for the examination. The questions are submitted. We screen the questions and decide which ones to use. They are also involved in the clinical exam. I don't know if that answers your question.

First of all, we encourage people to bring us questions and we set up question banks. I still don't know if I am answering your question or don't understand what you are saying. It is the fellows in the faculty who provide questions, especially those who are from the academic centers who provide the questions; we vet the questions and then decide which ones we want to use.

Jack Ludmir: Would you be willing to share that exam with other countries who still don't have a model and don't have enough people to write questions?

Kobina Nkyekyer: I don't think it would be a problem. We probably need permission from the College before we can do that.

Kwabena Danso: Let me add here that in any particular examination, even those who submitted questions do not know if their questions are appearing. You are asked to submit questions to the College. The questions are screened and may be modified, they may be merged with other questions. So in any particular examination, it is the chief examiner, and that is the faculty chairman who knows which questions are appearing for that examination. I think this is important. It happens in the Ghana College and also happens in the West African College. We submit questions all the time. If you submit questions today, your question might appear two or three years later. You will not know until one day, maybe when you are called to be an examiner and say, 'Oh, this question probably came from me.' That's how it is.

Frank Anderson: You know there are thousands of questions that exist out there that we could mobilize questions from everyone. Jeff?

Jeff Wilkinson: Can I change the topic to the fellowship training programs for a second? I think the fellowship training is a critical part of expanding expertise of care in any region, including sub-Saharan Africa. Certain centers will be critical to establish fellowships. One thing that I would encourage you to do is to not repeat the same mistakes that have been happening in the US or Europe just because they have been happening. Number one example being urodynamics that was brought up. But even more seriously, I think it emphasizes the need to get excellence in the residency training programs in the subspecialties so that when they finish most of the graduates can do 80% of the prolapse cases and do a radical hysterectomy. For the foreseeable future, fellowship programs are not going to be the norm, so excellence in training in the residency is the critical part.

The last point is that, most fistula surgeons who are trained in Sub-Saharan Africa also are not trained in pelvic organ prolapse so I don't think you can expect to go into current fistula centers and expect them to immediately take up the pelvic organ prolapse and stress urinary incontinence training, mostly the prolapse. But it is a laudable goal. Of course, everyone with pelvic organ prolapse and stress urinary incontinence needs attention as well. The morbidity and suffering with fistula patients can't be denied in relation to that, but I applaud Lauri for her efforts, because she is really leading the way along with her Ghanaian colleagues and others.

Gloria Asare: I have a follow up question to the foreign graduates taking exams. Have you had a situation where after affiliation, the examination candidates fail a couple of time? If yes, what do you do in that situation? And then sometimes, countries that are doing this training have a bilateral agreement with the host country. So there is also the politics around that. Have you experienced

that and how did you handle it?

Kobina Nkyekyer: Let me answer the second question first. Where there is bilateral government-to-government agreement, candidates that are sent for training may be given an exemption by the medical and dental consoles so that they can have their training. And that has happened before. When somebody comes and is to take their exam, the councils usually advises that they spend some time in one of the major hospitals so that they will get to know how things are done here. Obviously, if you train in a completely different environment, you may not be familiar with the peculiar problems that we have here. So the Council advises that before anyone takes an exam, they have an attachment with one of the big hospitals.

Regarding your question about somebody who takes exam once, twice, or thrice, what may happen is that the candidate may be advised or asked to have a special attachment and training again and then take the exam. If you don't pass the exam, and you want to practice here, than that would be a difficult situation. As I said, on the governmental level, there is always the possibility that the Ghana Medical and Dental Council for the purposes of somebody coming in to train, may grant them temporary registration.

Kwabena Danso: A little addition is that in those bilateral agreements we always require the provision that if one country is training for us because of lack or needs, the person they train should be qualified to practice in that country in the first instance. If, for instance, we're training somebody for Liberia, at the end of the training if we do not accept that person to practice in our country, then Liberia should not do the same. That provision must build that after qualification that person is otherwise qualified to practice in that country. That solves a lot of problems.

Frank Anderson: Thanks, we are going to need to move on, because, of course, we are behind a little bit. One thing that we haven't done either is take a group picture. Group picture, Donatus, can we do that? I think we should do that before lunch. Of course, Madeline has this taken care of. Before you get your plate for lunch, we will have our picture taken on the front stairs downstairs. Before we do that, we will be moving into our thematic working groups. And Madeline is going to explain where those are going to be. Our technical material is up now. Now is the time to process. I have got some discussion guides for each of the group, for the American group to discuss what we are going to do next, the African to describe what they are going to do next, and the governmental groups to get together and describe what they are going to do next. We can hear about that this afternoon and talk about our process this afternoon. But we are going to have our thematic working groups now, then we will have a coffee break, then we will have group work for two hours, and then we will have lunch.

Madeline Taskier: So, as you guys can see up here, for the thematic working groups, the American OBGYNs will be in the zero room on the ground floor and Frank is going to moderate. With each group, we set up the tables the same way so break yourselves out as you are most comfortable, but we will have discussion questions at each table. You are going to work together at those tables for fifteen, twenty minutes to warm up, break the ice, start discussions. Then Frank is going to moderate a general discussion in those rooms that we can all sort of share. As I said, the American OBGYNs will be in the zero room on the ground floor with Frank. The African OBGYNs will be in the seminar room on the third floor with Professor Danso moderating with the same format – little breakout work groups and then a larger discussion – and Gaurang will also be in that room, and the Ministry of Health professional society representatives will be in the Board Room, also on the third floor. Ray de Vries is going to help moderate that and I'll be in that room as well. Does anyone have any questions?

Kwabena Danso: In the African groups, we will not be going into country groups. We're going to mix up, so it is not like the groups that we are used to. We're going to use maybe two or three tables and we want a mixture, so that what comes out is a blend of ideas. We don't want the same country groups.

Madeline Taskier: Just a quick reminder, as Frank said, you have a coffee break, then we will move back to the original breakout rooms that you guys have been in the last two days just to finalize your group work and your team plans, and then we will have lunch. But before we start lunch, we will have a picture on the front steps of the Ghana College, right where you got dropped off at the bus. We will meet there at 1:15 for the group picture and then have some lunch. Then from 2:15 to 4:30 we will have each country team present and have an open mic following up. Then we will have closing and finish at 5:00. Also, if you have to go to shuttle for your flight, just find Andrew or me. The shuttle has been on call from basically 3:00 pm on to get you back to your hotel you can get to the airport on time. Remember that you need to be there more than two hours in advance because they close check-in at an hour and a half before. Also regarding flash drives and worksheets, we will announce this a little later, but make sure you're saving everything on your desktop as well as your flash drives because I know there are multiple versions. Of course we want to collect that later, but please make sure you are saving that in both places, that would be helpful. There have been some updates to the Dropbox as well so go ahead and check that.

Frank Anderson: We are not having a separate professional society group. So the American OBGYNs would be with the professional group. It is not professional societies. It is just the governmental people in the boardroom. Does that make sense?

Kwabena Danso: There is an ACOG representative here. There is a Royal College representative here. We have also a FIGO representative. We have AFOG too. They can also form a little group so that we have their input. A lot of technical support will be needed from these associations and we need to hear from them. Do you want to stay here? Fine.

Frank Anderson: If there are some professional societies that would like to stay, I do not have a discussion guide for you but feel free to come up with your own process. Now is not break time, but you go straight to the rooms now – board room, zero room, or seminar room.

Madeline Taskier: Thanks, everyone