

African OBGYN Perspectives

Kwabena Danso: What are the major lessons learned from this meeting that pertain to academic African OBGYNs?

African Participant 1: Thank you. Actually, I am not an OBGYN but as Vice Chancellor that North-South partnership collaboration is well-developed. Regarding the South-South partnership, I don't know what to do about this. I think we should think about the strategy for South-South partnership.

Kwabena Danso: We are starting with the one for African OBGYNs.

AP Koroma: Yes, on this: What are the major lessons learned from this meeting? I am Phillip Koroma from Sierra Leone and I think that I did not have the opportunity to present but I would like to first of all express my sincere thanks to the Ghana College of Physicians and Surgeons for assisting us in Sierra Leone, having our boys in your country training to become OBGYNs. Sierra Leone as it is, we are definitely in a shortage of OBGYNs. I am, as I am speaking to you, the most senior one in the country. Then I was Senior Registrar. I have learned a lot, that partnership and collaboration will definitely be important in my own country.

I will also want to know if you Ghanaians will please open up our school. Looking at our program for these three days, I have learned a lot. If we do not partner or collaborate with most of you, then we will definitely not succeed. We are short of staff. -I have been in the provinces for ten years and for nine years in the city as the only OBGYN. I am a Fellow and Senior Registrar. We started our program in 2008 according to my predecessors and up until this year, we have produced none. That is why I want to use this opportunity to plead with you Ghanaians once more, to please come to our country and assist us in this particular program. We are now partnering with Johns Hopkins. We have done a lot in these few days. Even the certification and deployment process is not so much ready. Everyone is stationed in the country. The old ones are 70 years and above. So, there is a big problem in our country. I have definitely learned that collaboration and partnership are very important for our country.

Kwabena Danso: So, partnership is important. Those who are a little bit higher up should assist those who are beginning to also come up. This is what we have captured. We will build a consensus and then will move on. Any response? We are still on the first question. What are the major lessons learned that pertain to Academic OBGYNs?

Stephen Rulisa: The lesson I learned is that what we are told to share what we are doing in order for the Academic OBGYN program to be successful. The agenda needs to be lead by the local nationals and then the partners can help to achieve the objective - not that the partners come with their own objectives. What I want to say is that local partners of the African Academic Institutions should first define exactly what they want and how they want it, so that whenever the partners come, they cannot deviate you from where you want to go. They can only help you to speed up the process.

Kwabena Danso: This is clear, right? Yes.

Bellington Vwalika: I am Bellington Vwalika from Zambia. What I have learned is that with the partnership that we have with northern partners, if there are programs such as the fellowships that you have introduced, then there is no need to reinvent the wheel. We can just adapt and make them suitable to our environment.

Kwabena Danso: In other words, there are resources and material around, but we need to adapt it to suit our local conditions in solving our problems.

Hillary Mabeya: My name is Mabeya from Kenya. I think what I picked up from this conference is that we need to increase inter-African organized exchange programs because the training of uro-gynecology here. I should come from Kenya or I should send a colleague from Kenya to have training in cost reduction and there is synergy in what we are doing. From nothing, you can actually do something. My take home message from here is that maybe we need to interconnect more than we are doing.

Kwabena Danso: Yes, South-South connection. It boils down to that. The first point upon which we have regularly agreed.

John Mulbah: My name is Dr. John Mulbah from Liberia. What I have learned and enjoyed from this meeting about partnership is encouraging. But I want to admonish every one of us to take ownership of our program and to be focused and perseverant. If you take the newly-born program in Liberia, it is just last year that we visited Ghana. And when we came to Ghana - right in this room - we were advised by the professors here that no matter how many constraints you have ahead of you, you must be persistent. Today we see our program established and we will partner with the western countries. But I think we need to take ownership of our own program and make sure that nothing can stop the establishment and progress of these programs. Thank you.

Kwabena Danso: On my part, what I would like to add is that African or sub-Saharan problems and challenges are best solved by sub-Saharan Africans. Whatever we need from elsewhere is a means for us to get to the end - we should not leave the pathway to them. We welcome the support, but we have to lead the support. I remember way back in primary school when we learned history; there was a textbook of history, makers of civilization. There was one part that was talking about Mango Pa, who was the one who discovered the river, I think it was Kongo or So. But at the end of it all it was an African who lead him to the river, isn't it? Yes. He came from somewhere and went to the river, but it was an African that showed him that there is a river here. So, Africans should solve their own problems. We need help, yes, but we have to solve our own problems.

Yirgu Gebrehiwot: I think one important thing to remember is that most countries are at various development levels and we cannot talk about one solution that addresses everyone. The solution has to be context-specific. Probably the most important take home message is that countries have to define their own needs, they have to identify their own priorities, and they have to identify their own challenges. Their partners can help in solving those already identified problems. If we expect that every solution will come from out of Africa and every partner will save us from whatever difficulty we are in, then I think the misery is going to continue. So we need to make sure that we have concrete actions, action plans, identified priorities, and identified challenges so that our partners can chip in on the process and galvanize the change that is occurring in the continent.

Kwabena Danso: On this note, we can close this all. African problems are to be solved by Africans. Partners can help, but we should lead the way based on our own priorities and the kind of solutions that we want.

Now we can move to the second question: How do you envision this group of African OBGYNs continuing to work together? And, for that matter, under what auspices?

I think this question is very important. There is no doubt that every country is doing something. But we also know that the sum of various parts is not necessarily the same as when the various parts are geared towards the same direction. Whatever activities we are doing, how can we continue to work together in this respect? Comments?

Stephen Rulisa: I think we Africans know exactly what we want and we know exactly where we want to go. So I think the best way is to forge our own partnership of African institutions first and then solve the problems. Then the partners will come at different levels because we are at different levels of this program. What may work in Ghana may not work in Ethiopia or Rwanda. Even if we solve the same problem of maternal mortality, we need different tools to solve it. I think if we first forge our own relationships and make ~~it~~ them stronger, I actually think it should be much stronger than the relationship we have with the other partners across the ocean.

So, I think we should first forge our partnerships to be very strong. We have an example in Rwanda where we use our Human Resources for Health. We told all American institutions that, 'Before you come, first get together in the US and come as one group'. We put together 27 institutions in the US, like Yale, Harvard, and others, and we don't see them as Harvard, but as partners from the US. They come as one group now to solve one problem in our country. We know exactly where we want to go and they can chip in at different levels. So I would look at it this way: In Africa, we should first forge our own partnership and make it much stronger so that whenever a partner comes, we say, 'You know what? That solution can work in Ghana but that solution cannot work in Rwanda. We need it this way.'

Kwabena Danso: Okay, first let me give a follow-up question directly to you. How do we do that? Do we remain in our individual countries? How do we communicate? How do we know that you know that Kenya is doing ~~that~~ this and Liberia is doing that and Ethiopia is doing something else and the Democratic Republic is doing that? How do we do that?

Stephen Rulisa: I think this should be the first step. I would propose we draft a tool that would go to each of us to capture different questions that we would want to hear. For example: Who are you? Do you have a running program? What are your maternal mortalities? What are your challenges? What are your biases? And then we have a database from each of us, and then we know who is at which level. Then among this, we would elect some kind of coordinating mechanism. Who is coordinating where? Who is the chair? Who was the secretary? Who takes leadership? Then we form a partnership that is driven by certain bodies that we can forge now.

Kwabena Danso: I think certain words have emerged from his discussion: Coordination, leadership, and so on.

Yirgu Gebrehiwat: I think I can see opportunities here. The opportunity is the newly formed African Federation of Obstetrics and Gynecology. AFOG has 28 member societies from Africa. The rest are not members because they do not have societies or they have too few obstetricians in country. In fact, I had it a discussion with two of my colleagues, one from Sierra Leone here and I also had a discussion from a colleague in Botswana. We have got a meeting between the 21st to the 23rd in Khartoum next week; I am going to bring up these issues. Members of AFOG have to be societies. Where there are no societies, an individual OB/GYN in the respective country can serve as a focal point. So that would be a good platform for streamlining whatever activity. One of the goals of AFOG is to improve the quality of Obstetrics and Gynecology training in the continent. That will give us one very important platform.

The second issue is universities. I mean, African university should also learn to work together. For example, we can suggest the formation of a consortium of African universities. All of the 13 institutions can come together, can have their own charter or code of conduct, what they want, how they want to deal with the respective medical universities. American universities should also come as one group. You have both a professional body (AFOG) and you have a consortium of African academic universities, because the very natures of academic institutions and societies are entirely different. Then we have a third group, which is a consortium of US universities. As an accessory group, they can sit down and discuss on what base to move. We are talking about the etiquette of change. We heard talk about things that are happening until 2015 and then beyond 2015. We know that we are not going to make MDG 5 by 2015. For most sub-Saharan African countries, it is quite obvious. It does not mean that we're going to sit, defeated. We have to plan, we have to learn from our mistakes, and we have to move forward so that we make some substantial change in the history of 2015. This is what I think should be the way forward to move this agenda of training more obstetricians in the continent. If you look at it, 1000+ is like having 90 or 100 obstetricians in the next ten years or so. Is that enough? I don't think that is enough.

Kwabena Danso: 1,000 new.

Yirgu Gebrehiwat: Yes, new. In ten years, I tell you, I have got like now 77 residents in my program. In the next four years, I am going to go beyond that. So what I am talking about, is that for the next ten years, it is not 1000+ new, but that we need more. Okay? Sierra Leone needs more than 100. Botswana needs more. This is an opportunity that we need to seize, but we need to work more and we need to work hard. The mechanism as it is, is a tri-part relationship: university consortium of African universities, US universities, and African Federations.

Kwabena Danso: Okay, thank you. Two suggestions have been put on the floor. One is the African Federation of Obstetricians and Gynecologists and ~~then~~ the other one is a consortium of African academic institutions in the training of OBGYNs. I think we should be directing our discussion in that direction. Yirgu, I think this idea of 1,000+ is ... we need to know what would have been produced under this condition. So the 1,000 is the 1,000 we would have produced on top. Certainly in two to three years time, it should change, because the demand will be higher.

Gregory Halle Ekane: I am Dr. Halle – Ekane from Cameroon. The aim of making this comment is not to bring up controversy, but I think it is important to highlight ...

Kwabena Danso: Controversies are welcome!

Gregory Halle – Ekane: Okay! It is important to emphasize that value should be given to values. I was a little bit surprised that because of our discussion I did not hear any participant talking from Nigeria. This is a country that has a world-solid postgraduate program. I just brought in the country to make an example of how South-South collaboration is important, and I think we have every interest to protect values. There is no doubt about it. I also heard somebody make a comment about accreditation in the postgraduate programs and Ghana, and they mentioned South Africa. In South Africa, somebody from the University of Cape Town has to write an exam again for a university that is renowned in the world. Some of these things have to be looked at so people do not feel marginalized. There are certain values that already there, which we have to maintain. I don't think we should give the impression that we are falling back. A university that may be in Cameroon should not try to evaluate somebody from the University of Cape Town. There is something that already poses a problem, so values should be retained, and I think that the way forward is to continue. We don't have the impression that we are trying to pull on certain groups of people. That is the comment that I wanted to make.

Kwabena Danso: Thank you. Let me respond to the one about the exams. I think a country asking foreign trainees to write an exam is not something that we can control. This is on a national level. If that country thinks that trainees are coming from elsewhere and that they are okay, then I think it is a local issue. If a country thinks that even if you are in the same country and if you want to practice in one region of the country, then they will let you take some interview, then that is one issue at this meeting that maybe we cannot discuss.

Gabriel Yao-Kumah Ganyaglo: I think his point is about the complementarity of certificates.

Kwabena Danso: Well the complementarity of certificates would come at a certain level. It still becomes a question of national policies. I don't think that we want to go into that. Even in the United States, if you want to move from one place to another, you take exams, isn't it?

Stephen Rulisa: Different states

Kwabena Danso: Even if you take an exam this year after some time you still have to come back and take exams. But the other point about Nigeria, we are still in the formative stage. I think at the appropriate time we will get them involved.

African Participant: I also wanted to make a little comment about the exams and the universities. The fact that the candidates are being examined does not mean that their certificates are not recognized, otherwise they would not be examined at all. We have examined people with MSUG and found that we could not completely and immediately let them go out and practice in the country. That does not mean that we do not accept their message. We accept their message but the particular individual; we do not completely feel that we could let him out immediately. He accepted and he went to a hospital, brushed up, came back six months later and is now practicing. The certificates are acceptable but the individual must be evaluated.

Kwabena Danso: In Ghana now, if you come out of medical school, there is a time window, within which you are supposed to start your hard jobs. If within that window you don't start your hard jobs, you go ~~se~~ somewhere, you come again and you take your exams again. Let's move on.

Josephat Byamugisha: Thank you very much. I just want to go back and look at the 'how' of the way forward. Two suggestions are on the floor: A consortium of African Universities and then also all the professional bodies.

Kwabena Danso: AFOG

Male African Participant: Yes, that is right. I want to also bring in the issue that we are aware that in some countries - especially in Ghana and I know Nigeria, for instance - whose graduate medical education is under the auspicious of the postgraduate medical college, which is entirely independent of the University. Therefore, if you are looking at the umbrella body, we should not forget about these well-recognized institutions that have the national mandates to run the programs. I know in some countries it is under the universities, so that would have probably been difficult. But we also need to recognize the third component, which is where the national colleges are, the ones mandated to do things.

Kwabena Danso: So maybe in that respect, we are aspiring to be named African Academic Departments and Colleges.

Mr. Chairman: We are supporting you from behind.

Josephat Byamugisha: Thank you Mr. Chairman. The first one is some point of information. What is a recommended OBGYN to population ratio? We don't seem to have the figure, but if there is a recommendation from the WHO, it would help us a lot in terms of the numbers that we require.

Yirgu Gebrehiwat: I don't think there is such a fixed number. For physician to population, the WHO number is 1:10,000 for developing countries.

Josephat Byamugisha: For OBGYNs?

Yirgu Gebrehiwat: Per Population you mean?

Josephat Byamugisha: Per population, yes. We should have some estimates.

Stephen Rulisa: The ratio measurements of physician to population is an idea that they don't go into specialty.

Josephat Byamugisha: The second one is that there are groups that are existing that we need to use. SAMS – sub-Saharan African Medical Schools. I think there is an association like that because they assess various medical schools. Some of these should be utilized. The other one that I see that has a lot of work; the president of AFOG now, there are lots of things that you need stats, yes they are looking at. You have very many small blocks. We have the West African College of Surgeons, East Africa, East, Central, and Southern Africa, Eastern College of Surgeons. I think there are extra organizations and we may have to start thinking seriously about the ... and we also have things like the American College of OBs and GYNs ... so we don't we have African College of ... If all of these can unite. So then the countries are almost splitting the others. You want to come, do exams. We could look at it from a big perspective... and AFOG should head up in this aspect.

Kwabena Danso: Okay but let me ask this question. The medical schools, so far - don't they all come under universities? When we capture the university department...

Yirgu Gebrehiwat: I think the issue here is very relevant. What we need to do is probably pick the bodies that are responsible for postgraduate training. It could be a university, it could be a college, or a council, whichever. The second issue that was raised about the regional blocs, we are all quite aware of all the regional blocs. For Maghreb Countries, for West Africa, for East Africa, and South Africa – that is one of reasons that so far with us there is no European college, the American College, for Asia and Oceania; we never had one big umbrella organization for Africa. Now we have it, but that is not going to be the end point. We need to move forward and bring in all these sub-regional groups. We need to look into training. We need to look into establishing an African College of OBGYNs and when we address those issues in years to come, then all the issues of not recognizing certificate X or certificate Y will be sorted out. We will have a similar standard in those countries.

Kwabena Danso: Let me take a last comment and I think we can move on. The idea is emerging that we need to form some sort of consortium. A consortium of institutions responsible for – let's make it generic – responsible for training OBGYNs. Then also for professional bodies – the Association of African OBGYNs, which is now in place under the auspices of FIGO. Those are the two platforms. Any other that we bring into that? So you conclude this thing for us! [to Stephen Rulisa]

Stephen Rulisa: I'm not concluding, please. [Laughter]

Kwabena Danso: After this comment we go on to the next question.

Thomas Egbe: I am Thomas Egbe from Cameroon. What I wanted to say is that some universities don't yet have postgraduate training. It is a good thing we are here. Those universities can learn from those who already have a program. So what should we do, in that as we are here, we should have an internal group where the universities that do not have a postgraduate training program can easily contact other people and seek advice. How can we go about this? And, it is easy for us to move that way. It is not all that easy for everybody to have a meeting where everybody will be there. You can communicate from time to time as the consultancy advices.

Then, secondly, I wanted to make a comment concerning the exams that recognize the certificates. Generally it is very difficult for a country to take a decision and have exceptions. For example, in Ghana they say they have to examine people who come from outside. They cannot give an exception for other countries. They have to examine everybody. So it is a national level - you cannot say, 'America is a well-developed country'. You need to examine them. Because not everybody that comes from the USA has the same competency.

Kwabena Danso: It is competency for the place you are going to. If we are understanding that if you are a doctor, that does not mean that you can function effectively in all parts of the world. It depends on where you are going to work. That is the bottom line. With your permission, I think the first part of this presentation should go to the first question. Some countries are beginning or don't have a program at all. Those countries that have should help them. I think that goes to the first part.

So, now we move on to the third one. How would you as a group like to work with other organizations? How could partnerships form? Do we agree that we have addressed this? Agreed? [Murmurs of affirmation]

The last two questions. What other major issues need to be discussed? And then, what would you like to see happen next? Let's take the first question, which is, 'What other major issues need to be discussed?'

Stephen Rulisa: I can say that the other issue I want to talk about here is the issue of quality of training or accreditation. As much as we would like to harmonize our program, we should also emphasize that as much as we want quantity, we should not forget about quality in training. I would want us as a group to not lose track on the quality of education that we to promote. I visited one medical school that I won't name, which is training post-medical education, undergraduates, doctors... The whole medical school has three doctors who are generalists. They teach physiology, anatomy, gynecology, surgery, pediatrics - everything. And these people graduate as doctors. This is why I am surprised when you say, 'Don't examine someone?' It is too much. So these people are doctors. But can you imagine a little bit of the quality of education that they would give? So, much as we need numbers in Africa, we have to look at quality as well.

Kwabena Danso: Yes, person at the back?

African Participant: Yes, I do not know whether it is the appropriate forum for this issue to be addressed. There are linguistic problems. You realize that most of us assembled here are speaking English. But I wonder whether when you go north of Ghana, just across the border, east of Ghana, west of Ghana - I don't even know, I think they speak French. But here we are. How many of us are comfortable with the language? I think that just from this beginning, we should begin to understand that we should have brought in the francophone colleagues. Yes, we should have brought them in - some of them are conversant with English language - at least to begin with, so

that they don't appear to have been intentionally left behind in the formation of such an august body. I don't know why this has yet to be addressed.

Kwabena Danso: In fact, in Cameroon there are two languages; English and French. Maybe is it too much to suggest that medical schools should think of learning the other language. This is a little controversial. Okay Prof. Klufio.

C.A. Klufio: Klufio from Ghana. I think in Africa we will all agree that obstetrician gynecologists are the leaders of the obstetric team. I am sure we will also agree that in Africa and in most developed countries, we cannot operate effectively without a strong midwifery service. It so happens that as leaders of the team we have more clout than the midwifery service has with our government. I think while we are trying to increase our numbers, we should think about how we can strengthen and broaden the midwifery services. In some countries, midwives can compete with obstetricians in the delivery of normal cases. Not so with us. We need them. We desperately need them. I think we should spend a little time on that. Thank you.

Kwabena Danso: Thank you. I think in the first meeting in Rome we recognized that the American College of Nurse Midwives was present at that meeting. I think is good that we make this a point. In fact, we have to be concerned about anesthesia. We have to be concerned about child health because when you bring out the baby, who is going to take care? These are peripherals that we need to ...

C.A. Klufio: We need midwifery. It is very central. [laughter]

Kwabena Danso: Okay these are other centrals.

C.A. Klufio: No, no, no. Midwifery is central. Anesthesia may be peripheral. Even neonatologists ... many obstetric trainees are made to go through the neonatal division. But for obstetric practice in Africa and for many years to come, obstetricians will be the leaders. The practitioners will be the midwives. For many years to come. And if we don't carry them along, so they know when to either call or refer to us, our effort will be in vain.

Kwabena Danso: I think we should avoid the word 'peripheral'.

Yirgu Gebrehiwat: You know in fact, that reminded me of one thing. When you try to expand postgraduate training, if you don't have a strong undergraduate service that can feed into the postgraduate program, then there will be a problem. You will like to do like 100 obstetricians and don't produce any medical doctor in country. Then from where will you bring that candidate? I think we need to go from a proper mix, training a proper mix of professionals, so when they go out they can properly practice.

African Participant: One major issue I consider which did not seem to come up so far is the advocacy role of the obstetrician as the leader of the obstetric care team. We need to form a strong team to address advocacy.

Kwabena Danso: I think we can add this one to it. Any others?

African Participant: I think history has shown that we are very good at developing documents, as an example, Maputo Protocol. When you release a very beautiful document, if we have followed it we would have made a lot of progress by now. I want to suggest that in our discussion we should pay particular attention to timelines and identify clear prime movers of specific actions that we are going to take.

Kwabena Danso: So in the time line implementation and steps, and we need to identify champions to move this forward. Everyone here should be a champion. If we take the football team, we say that we have strikers, but everybody else is in the team. The last question is, 'What would you like to see happen next?' Next steps.

African Participant: Next steps – one should be that we should find a time to meet again as a group to move things forward.

Samuel Obed: We should have periodic reviews of what we are going to embark on. When we say two or three years, where have we reached? If we are falling behind, we should double up, so that we can catch up finally.

Kwabena Danso: We met first in 2012; it was October. And now it is 2014 February. I was tempted to call it Rome +2 but I was reminded that it was not exactly two. Using the figures, it is still Rome +2, if we keep adding Rome +, it will remind us whether we are behind or not. Accra is now Rome +2. Okay next steps.

African Participant: I think the next step should be applying what we have learned so far for those who have preexisting programs. To make an appraisal of what they are already doing and what corrections they can do for their existing programs to make them sound better.

African Participant: I think the next step should be creating the database that Dr. Stephen has spoken about and then working along with the African Organization of OBGYN to see how everybody can be carried along. We know what everyone is doing, we have the database, we have the contact for anything that will strengthen our collaboration and corporation.

Kwabena Danso: Building the database and starting measurements so that we can know what we are doing.

Stephen Rulisa: What I would want to see from here is most countries or programs revising their way of doing things. I would want to see more training. If you don't have a program in your country, start looking internally. Why should you send someone to the US or Europe or China when there is an immediate neighbor where you can take even a bus and have OBGYN training with the local context. I think that is more applicable if you study in a local context. You can do it if you are African. The existing schools are enough to train our Africans and cheaper than sending people to study abroad and come back without local context.

Kwabena Danso: Using African resources and training institutions.

Stephen Rulisa: Yes, exchange programs, rather than...

Kwabena Danso: Only in the extreme instances maybe ... [in reference to overseas exchange]

Joseph Ngonzi: I just wanted to make a comment on the logistics and the funding. For some with future engagements, do we still have to look to our partners to make this happen? Even as we develop some of the future documents or whatever they may be, we also need to look at the funding. How do we make this sustainably African?

Kwabena Danso: I can just react a little bit to this. What we are doing does not prevent you from continuing with your partners. What we are doing, eventually we hope to put it into a collective effort and look for big funding with all the various components. Even within the big funding, a donor might decide to pick particular partnerships based on the statistics that are available. So this one does not prevent anybody from continuing to do what you are doing. What are we saying? We

are saying that let us all note that we are all moving in the same direction.

African Participant: Maybe next we should get other neighboring African countries involved, especially the francophone countries so that at the next forum, we will have representations from a bigger number.

Kwabena Danso: Next step should be the involvement of other francophone countries and all other sub-Saharan African countries, which have not participated so far. Yes?

Josephat Byamugisha: One of them is encouraging visibility. Most of these activities are not easily accessible on the net. So I think we need to have a lot more. If we are searching, it could be a website, it could be AFOG, but we need more information that we can access from the continent. The other one is the issue of the report. These deliberations, I think it would be good if all of us could be able to look and say, 'Where are we?' 'What are we doing?' Especially the action points that would be helpful.

African Participant: Being a polygamous collaboration, I would want to see more involvement of Europe collaborations rather than American collaborations only. Thank you.

Kwabena Danso: Involvement of Europe and other continents.

African Participant: Chair, I think what I would really want to see next is this team moving to develop its own team of trainers. I really go with the idea of us having a database of trainers to say who is going to train and what type of company do you go for. I think there is a lot you need to learn from the College of Surgeons of East, Central, and Southern Africa. I think they have done quite a lot of trying to set up a system of training. Just relating to them I am sure the College of Obstetricians is going to learn quite a lot. Depending on universities to raise these trainers for you, I think, is something we have to think about twice. I am a dean of a medical school. The universities have problems employing lecturers. I think now it is for the obstetricians to let Ministries of Health see how best you can actually train under the auspices of the universities. It is a ball game that I think we need to learn how to play in Africa, because things are just not going our way. I am talking to my colleagues everywhere and everyone complains. 'Why do we have a lot of obstetricians under the Ministry of Health and none under the University?' I don't think that is something we can solve tomorrow, but you as an association are able to dictate, saying we need to train obstetricians and that we will persuade consultants who are there to train. And you are going to train them to be trainers? Because not every practitioner is a trainer. So I think we need to work on that and that is something you can work on quickly. As I said, the College of Surgeons has done it. As I was saying, there is a consultant somewhere who says, 'Well, I think I can take one resident this year who wants to send me one?' And so people are shuffling these trainers amongst themselves and if they are competent, then they are certified. I think you have to work at that, if the obstetricians are going to increase numbers in the near future.

Kwabena Danso: Thank you, but I think you can talk with other colleagues around to share their experiences. I am a former dean, so we can talk and I can give you the experience of Ghana. It is not only OBGYNs who are employed by the university who should be involved in teaching. The country must look towards making it possible for every OBGYN to be a teacher.

Yirgu Gebrehiwat: I think this lesson is something that we will seriously look into. What happens with AFOG and the West African College should be like a platform from which we start when we look into the African College issue. When it comes to what should happen next, I see it at two levels.

The first level is that the activity is here. I think of what Frank has started and what Michigan has started. They have already identified partner-led institutions, they have identified collaborators from our side. So, what should happen next?

We need to have a concrete set of actions. I wish we could have the consortium established. I wish we had some sort of planning or logical framework of where we want to reach by what time. Because what has been raised is that there are too many places going on in this part of the world. I mean the Abuja Declaration in 2001 - nothing is happening. The Maputo Plan of Action 2005-2006 about SRH - nothing much is happening, which is why most are not reaching MDG 5 by 2015. If we want to go beyond talk, then we have to put in a concrete set of actions. So a consortium, a clear logical framework for our activities, and a need assessment, each of the institutions doing a particular need assessment of where they want their the partners to chip in. I think these are very essential issues.

I think the last point is how we can streamline it with national goals. If universities plan for themselves, I am sure they are likely to fail, because in the end, your trainees are going to be employed by the Ministry of Health. So, what is the need of the particular Ministry of Health in each particular country? Can they chip into this process while utilizing whatever foreign assistance that is there? Doing realignment and harmonization with national plans and priorities should be some of the things we need to do in the coming two years.

Kwabena Danso: Thank you. What I would add is that previous declarations, if you look at it carefully, they were lead by political will. I think this one is being mooted by academics and professional groups, so maybe the next step should be that academics and professionals must now come to the forefront and move on the path of addressing maternal mortality and morbidity as well as neonatal mortality and morbidity.

So, on this note, I would like to thank you all for your involvement, cooperation, and the enthusiasm you have given to this. There is a wealth of information. The secretaries will pair their write ups and I think we will still appoint them to present when it comes to the presentation. Thank you.