Introducing our keynote speaker:

**DR. BRIAN GOLDMAN**

Join us in Calgary to hear from this physician and author, host of CBC Radio One's *White Coat, Black Art*. Dr. Goldman works in the emergency room of Mount Sinai Hospital in Toronto and is an award-winning medical reporter.

A sneak peak at some of our symposia presenters

- **Dr. Vincent Covello**, founder and director of the Center for Risk Communication, will speak on the improvement of quality of care through health networks.

- **Dr. Catherine Allaire**, medical director of the BC Women’s Centre for Pelvic Pain and Endometriosis, will speak on endometriosis.

- **Dr. David Grimes**, clinical professor of obstetrics and gynaecology and a fellow at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina, will speak on long-acting reversible contraception.

- **Dr. Jon Barrett**, head of maternal fetal medicine at the Sunnybrook Health Sciences Centre, will speak about the findings of the Twin Birth Trial.

- **Dr. Philippe Bouchard**, professor emeritus at the Pierre et Marie Curie University in Paris, will speak on the future drug class of selective progesterone receptor modulators (SPRM) for the treatment of uterine fibroids and their mode of action.

- **Dr. Alex Ferenczy**, professor of pathology and obstetrics and gynaecology at McGill University and the Jewish General Hospital Montreal, will speak on progesterone receptor modulators associated with endometrial changes, as well as safety considerations.

- **Ms. Leslie Beck**, registered dietician and best-selling author, will speak on the role of nutrition and other lifestyle considerations in menopausal women's health.

Visit [www.sogc.org](http://www.sogc.org) for the most up-to-date information:

- The International Women’s Health Symposium
- Our full scientific program, including over 45 postgraduate and best practice sessions
- Social events and networking opportunities
- Conjoint meetings and programs
- What to see and do in Calgary
- More chances to view and hear abstracts

Take note: Syllabus available online

An electronic syllabus will be available in advance of the Annual Clinical Meeting. As a registered delegate, you can access this document from our event website. Free WiFi will be available at the conference.

Please note that this is the only way to access the syllabus. The SOGC will no longer provide a USB key on-site.

The full abstract program will also be available from our event website; we will no longer print paper copies, though the titles of all abstracts will be published in the final program.
ALL ABOUT NUTRITION
By Dr. Jennifer Blake, chief executive officer

What did you have for breakfast this morning? Maybe it was fruit, whole grains and a very healthful protein; however, as an overworked professional, spouse, parent, etc., chances are it was whatever was closest at hand as you dashed out the door, something you could eat with one hand in the car.

March is Nutrition Month in Canada; a great reminder for us all to reflect on the small decisions we make every day which can have a big impact on our health. If you haven’t done so recently, I encourage you to take stock: revisit Canada’s Food Guide — are you more or less following the advice you would give to patients? Many aspects of our lives can be difficult to control — babies and gynaecologic health issues don’t wait — but we can help ourselves by giving our bodies the resources to get through tough days and long on-call hours.

And, of course, please use this awareness month as an opportunity to be proactive in talking about nutrition with patients. Many of us are the health-care providers that our female patients see most often: we are in strong positions to make a difference in their nutrition, reminding them of appropriate supplementation and of how nutrition can play an important role in their sexual and reproductive health, as well as their general wellbeing. These messages are essential to women of all ages.

Coming soon …

At the SOGC, this month marks the first face-to-face meeting of a working group which will be writing a new clinical practice guideline, tentatively titled the Canadian consensus on female nutrition: The needs of a woman through her lifespan. This will be an excellent resource for clinicians, patients and the public, helping to guide eating and supplementation at every stage of a woman’s life.

In addition to the upcoming guideline, the SOGC already has several great resources to help you, all available at www.sogc.org: our brochure on healthy eating, exercise and weight gain before and during pregnancy, and our clinical practice guideline and brochure on folic acid supplementation.

Do you have a talent to share? This year — in addition to dinner and a night of dazzling entertainment — the premier social event of the Annual Clinical Meeting will feature some healthy competition from you. We already have a few acts lined up — from an opera-singing midwife to a musically-inclined industry representative — but we’re still accepting participants.

Contact csarkisian@cfwh.org for more information.

Just want to watch? Join our host, Canadian comedic entertainer Jessica Holmes, and support your colleagues who will be competing their way to the top! Also hear a special performance from violinist Sophie Serafino. Visit www.cfwh.org to purchase tickets or tables.

Regional chairs, alternate chairs and other representatives

• Western region: Stephen Kaye, MD, North Vancouver
  Radha Chari, MD, Edmonton
• Central region: George D. Carson, MD, Regina
  Hussam M. Azzam, MD, Thompson
• Ontario region: Wendy Lynn Wolfman, MD, Toronto
  William Mundie, MD, Windsor
• Quebec region: Isabelle Girard, MD, Montréal
  Robert Sabbah, MD, Montréal
• Atlantic region: Joan Crane, MD, St-John’s
  Krista Cassell, MD, Charlottetown
• Junior member representative: Stéphane Foulem, MD, St. John’s
• Public representative: Micheline Bouchard, Montréal
• Associate member (FP): Andrée Gagnon, MD, Blainville
• Associate member (RN-NP): Janet Walker, RN, Vancouver
• Associate member (RM): Kimberley Campbell, RM, Abbotsford
• APOG representative: Lucie Morin, MD, Montréal
**NEW RESOURCES: Sexual function or dysfunction? Two new tools**

To help celebrate Sexual and Reproductive Health Awareness Day on February 12, the SOGC launched a new *Female Sexual Health* online learning module for the assessment and treatment of female sexual dysfunction.

The module contains a section on the physician’s role in addressing the sexual function of primary care patients, the classification and etiologies of sexual health, tips for inquiring about sexuality issues, general and specific screening questions, meeting patient concerns with information and practical suggestions, as well as treatment strategies.

This application is based on the first-ever clinical practice guideline on female sexual health, which appeared in the August 2012 issue of the *Journal of Obstetrics and Gynaecology Canada*. This guideline was designed to help health-care professionals address the complexity of female sexual function and dysfunction and provide advice about how to engage women on sexual issues in order to ensure they get the help they need.

In addition to the launch of the new online application for health-care professionals, the SOGC has also produced a public education brochure on the topic of female sexual health – this document discusses changes in sexual desire and frequency throughout the lifespan, what patients should or shouldn’t be concerned about, and how to broach the subject with a doctor, nurse or midwife.

**Did you know?**

Between one quarter and one half of all women in Canada have sexual concerns but, due to embarrassment or unease about bringing up the subject, remain silent. They often hope that their health-care professional will begin the conversation.

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**Upcoming meetings**

**SOGC meetings**

- **West/Central CME Update in Obstetrics and Gynaecology**
  - March 21–23
  - Banff, AB

- **69th Annual Clinical Meeting**
  - June 11–14
  - Calgary, AB

- **Quebec CME Update in Obstetrics and Gynaecology**
  - September 19–21
  - Mont Tremblant, QC

- **Quebec CME in Obstetrics**
  - For family physicians, nurses and midwives
  - November 14–15
  - Montréal, QC

- **Ontario CME Update in Obstetrics and Gynaecology**
  - November 28–30
  - Toronto, ON

**ALARM Program schedule**

<table>
<thead>
<tr>
<th>Location</th>
<th>Date</th>
<th>Notes</th>
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<tr>
<td>Scarborough, ON</td>
<td>May 3–4</td>
<td>Offered in English, waiting list for residents</td>
</tr>
<tr>
<td>Calgary, AB</td>
<td>June 9–10</td>
<td>(in conjunction with the ACM) Offered in English, waiting list for residents</td>
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<tr>
<td>Halifax, NS</td>
<td>September 27–28</td>
<td>Offered in English</td>
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<tr>
<td>Québec, QC</td>
<td>November 16–17</td>
<td>Offered in French</td>
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**Other meetings**

- **ALARM International Program Instructor Course**
  - April 26 – 28, Montréal, QC (This course will be offered in English and French)
  - Email to intl@sogc.com

**Upcoming clinical practice guidelines**

Below is a tentative schedule for upcoming guidelines to be published by the SOGC. Please note that the publication dates listed are subject to change. All guidelines are published in the *Journal of Obstetrics and Gynaecology Canada (JOGC)* and are available on the Society’s website, www.sogc.org.

**March**

- Cancer chemotherapy and pregnancy

**April**

- Epidemiology and investigations for suspected endometrial cancer
- The role of adjuvant therapy in endometrial cancer
- The role of surgery in endometrial cancer
Recent studies authored by SOGC members


SOGC POSITION STATEMENT:
Recommendations on screening for cervical cancer

The following is a joint response from the SOGC, the Society of Gynecologic Oncology of Canada and the Society of Canadian Colposcopists to the guidelines produced by the Canadian Task Force on Preventive Health Care (CTFPHC) which were published in the January 2013 edition of the CMAJ.

How do the existing guidelines compare to the new 2013 CTFPHC guidelines?

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<th>Existing provincial guidelines</th>
<th>New CTFPHC guidelines</th>
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<tr>
<td><strong>Initiation</strong></td>
<td>(When to begin obtaining Pap tests)</td>
<td>Age 21</td>
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<tr>
<td><strong>Interval</strong></td>
<td>(Frequency of Pap tests)</td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td><strong>Cessation</strong></td>
<td>(When to stop obtaining Pap tests)</td>
<td>Age 65-70</td>
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The CTFPHC guidelines agree with provincial guidelines that cervical cancer screening with the Pap test is an effective method to prevent cervical cancer. We encourage Canadian women to obtain a Pap smear regularly.

We have reviewed the guidelines carefully, as well as the evidence used to articulate the recommendations. Although the CTFPHC focused on the most important topic (i.e. decreasing mortality), we find it unfortunate that articles focusing on other important aspects of health were not given full consideration.

As subject matter experts responsible for health issues related to female sexual and reproductive health as well as gynaecologic cancers such as cervical cancer, increased consultation with professional/provincial organisations could have been beneficial to the development process and could help harmonize guidelines, as was done in the United States.

Our conclusions

1. Until better data exists to support the safety of delaying the initiation of screening, we are of the opinion that screening be initiated at the age of 21.

2. The role of HPV testing in a screening programme should have been addressed. As a result, the recommendations seem out of step with a number of provincial programs, including Ontario which has already recommended the incorporation of HPV testing, and British Columbia that is considering such changes to its guidelines. Until there is clarity and initiation of co-testing (Pap test combined with HPV testing), it is recommended that provinces maintain the frequency of testing currently identified in their respective guidelines.

3. While we agree with decreasing harms from screening (e.g. overtreatment), the guidelines should also address strategies to increase benefits (e.g. decrease in incidence and mortality from cervical cancer).

4. We hope that, as HPV vaccination is implemented and young women are protected against HPV-related disease, these recommendations will be adjusted in a timely manner.

The new recommendations are very similar to the existing national guidelines. Most provinces and territories have been making comparable recommendations for some time now. (Refer to bullet 5 of the key considerations for a breakdown of provincial/territorial guidelines.) However, there are some important ongoing debates in terms of initiation and frequency of screening that give rise to some concerns.

Key considerations regarding the new CTFPHC national guidelines on screening for cervical cancer

1. These updated national guidelines do not apply to all Canadian women.

As indicated in the new guidelines, the recommendations are intended for "healthy" women; not those with a history of abnormal Pap smears, or women at increased risk.

2. Cervical cancer is a disease of young women as well as older women. The age of initiation remains controversial, and there is no consensus to support raising the age when women begin to be screened for cervical cancer in Canada to 25.

Cervical cancer is the second most common cancer in Canadian women between the ages of 20 and 44, and the mortality rate is approximately 25%. Because of the impact of cancer treatment on fertility and sexual function in young women, our goal should be to find and treat cancer precursors at an early stage, when treatments are less invasive. We should remember that screening 21-25 year old women for precursors has the potential to prevent cancer in women in their 30s, when cervical cancer rates start to rise.

As stated in the CTFPHC guidelines, the evidence to support the recommendation to begin Pap tests at the age of 25 is weak. Some studies that show it is safe to defer screening until the age of 25 were conducted in countries where individuals (on average) become sexually active at a later age. Some studies also looked at the age when women were invited for screening, and failed to take into account that in many cases, Pap testing had already been taken place.

As a result, we believe that the decision to begin screening for cervical cancer should be taken after discussion with a health-care professional, and that for many women, 21 may be the appropriate age to start.

3. While we agree that a delicate balance must be reached between benefits (reducing incidence and mortality) and harms (overtreatment), we disagree with the CTFPHC that the best way to reach this balance is by withholding screening in women 21-25.

In general, we support the goal of implementing initiatives to reduce the volume and frequency of unnecessary medical procedures and their associated risks. It is also desirable to reduce the time and financial burden on the health system, but we must ensure that doing so will not negatively affect women and the health-care system in the medium to long-term.
We support recommendations not to conduct any cervical cancer screening for women before the age of 21 because we find the evidence against this practice is strong enough.

For women between 21-25, we believe that new colposcopy guidelines that specifically seek to address the issue of over-treatment, will enable women in this age group to benefit from screening, while keeping harm to a minimum.

Moreover, changes in pathologic understanding of the disease are helping to further reduce unnecessary interventions. The use of molecular biomarkers helps more accurately define the true “high grades” of abnormal cells that need to be treated. The better definition of “high grade disease” by the histopathologist, paired with the more conservative colposcopy guidelines (Colposcopic Management of Abnormal Cervical Cytology and Histology) published in the December 2012 edition of the Journal of Obstetrics and Gynaecology Canada, present a different situation from those studied in the past. Under these new management guidelines, women with abnormal smears will be provided with careful follow-up and monitoring to enable treatment should their disease progress. It is inappropriate to reduce screening when the problem has been addressed by adopting a more conservative response to abnormal findings.

4. The greatest factor resulting in the development of cervical cancer and mortality from this disease remains under-screening or no screening. This is where efforts must be directed. It would have been useful for the CTFPHC to inform us on the best ways to reduce under screening, as this is what will likely decrease incidence and mortality. 50% of all cancers develop in women who were never screened, or who lapsed in their Pap tests. Attention needs to be focused on reaching out to the under-screened women in our society and addressing barriers to screening.

The CTFPHC recommendations are based on systems in which women are screened every three years. As we know, this is not an interval that can be easily remembered by most patients. An effective screening program requires a system of tracking and recalling women for Pap smears at three-year intervals. Currently, such systems are only in place in a limited number of Canadian provinces.

5. Provincial and territorial guidelines are very similar to one another and to the new national guidelines.

Health is a provincial jurisdiction. As a result, provinces and territories have adopted guidelines which sometimes differ slightly from one another and from the national guidelines. Age of initiation is where the main differences appear. Having said this, we believe each province/territory, with appropriate expert consultation, knows how best to screen and provide surveillance of the population for which it is responsible.

Closing remarks

The recommendations around cervical cancer screening will require ongoing evaluation as the knowledge around this disease and HPV increases, as the uptake of immunization increases, as the vaccines themselves change, as screening procedures (Pap test screening versus HPV testing) continue to be analyzed and improved, and as the behaviour of the population changes.
The SOGC is pleased to welcome some of the newest members to our society:

Ob/gyn member: Dr. Ray-Wen Melissa Tai
International member: Dr. Abdulrahim Rouzi; Dr. Khalid Sait; Dr. Emmanuel Ugwa
Junior member: Dr. Sritarani Kandasamy; Dr. Cheryl Lee; Dr. Jacob Ruiter
Associate member (family practice): Dr. Kofi Amu-Darko; Dr. Elwyn Joanne Brown; Dr. Seamus Donaghy; Dr. Di Naidu; Dr. Riaan Nieman; Dr. Mary O’Dea-Donaghy; Dr. Meha Patel; Dr. Suzanne Roberts; Dr. Nadine Sauve; Dr. Nathalie Staney; Dr. Kelly Tackaberry; Dr. Michael Alan Thompson
Associate member (registered midwife): Ms. Marie Nadege Aladin, RM; Dr. Cathy Carlson-Rink; Mrs. Diane Michelle Entwistle
Associate member (registered nurse/nurse practitioner): Ms. Jenny Briscoe; Ms. Jessika Pelletier-Boucher; Mrs. Michelle Stolz; Mrs. Stephanie Whiston
Associate member (students in health-care training): Miss Noor Amily; Ms. Ronke O. Babatunde; Ms. Jeanne Bouteaud; Mr. Wilson Ventura Chan; Ms. Maria Christine Cusimano; Ms. Megan Delisle; Miss Kelli Flemming; Miss Megan Gao; Miss Alexandria Legge; Miss Alicia Long; Ms. Corinne McDonald; Ms. Michelle Erin Miller; Mr. Justin Mui; Ms. Neha Sarna; Mr. Christopher D. Skappak
Associate member (Research): Dr. Kristi Bree Adamo; Ms. Hilary Fast; Dr. Beate C. Sydora
Associate member (allied health-care professional): Ms. Annette Batey; Mr. Aneel Singh Brar; Dr. Laura Fye Moore

Diane-35 and the risk of VTE
Visit www.sogc.org to read the SOGC’s position statement on Diane-35 and the risk of venous thromboembolism (VTE).

News from the University of Ottawa
By Dr. Aisling Clancy

The 2012-2013 academic year has been a busy and successful year in obstetrics and gynaecology in Ottawa. We said farewell to our PGY-5s after they passed their Royal College exams, and we welcomed our new PGY-1s: Dr. Nika Alavi-Tabari, Dr. Aeysha Butt, Dr. Brienne Bodkin, Dr. Kathryn Cossar, Dr. George Gray, Dr. Noha Kadhom, Dr. Miguel Russo and Dr. Patricia Toomey.

Our Northern Ontario School of Medicine resident group continues to be an integral part of our program. Dr. Frank Potestio was recently welcomed as the new regional program director of the Ottawa Obstetrics and Gynaecology Northern Stream Residency Program.

Our holiday season was busy with parties and some very entertaining and unforgettable video clips at our annual Christmas rounds. Our social calendars were also filled with baby showers as we welcomed a number of new family additions over the fall and New Year. We are expecting a few more on the way — congratulations to all!

Our resident retreat, also in October, was focused on advocacy. Our speaker, Dr. Jeff Tumbull, gave an informative and enlightening talk on the role of physicians in patient advocacy, with many personal experiences to share. This only added to our enthusiasm for our own advocacy project as part of Cervical Cancer Awareness Week.

In our second annual participation in the National Pap Test Campaign, our residents provided on-the-spot testing without referral or appointment. Overall, we provided testing to 84 women over two days of clinics. Our junior residents provided educational information and pamphlets to raise awareness about the human papillomavirus and cervical cancer prevention. Many thanks to Julie Hakim and Stéphanie Paquette for keeping us all organized!

We also had some new academic developments. This year, our pediatric gynaecology faculty introduced a new pediatric and adolescent gynaecology workshop to our academic half-day, the first of its kind in Canada. As usual, we have regular simulation sessions incorporated into our academic half-day for minimally invasive surgery and hysteroscopy. Nevertheless, our program director, Dr. Glenn Posner, continues to surprise residents on the labour and delivery ward with interdisciplinary simulation scenarios in addition to these regularly scheduled high-fidelity simulation sessions.

A new gynaecologic surgery journal club was initiated to review articles with a surgical focus as well as review related teaching topics. Thanks to Dr. Sony Singh for spearheading this teaching effort. This is in addition to our regular journal club where we continue to develop our critical appraisal skills under the guidance of Dr. Amanda Black and Dr. Tien Le (over delicious food, of course). We are looking forward to our upcoming annual research day in May. In 2012, this was expanded to a full-day event with an added poster session to make room for our active and productive resident research projects. We look forward to showcasing some of this research again at the SOGC’s annual clinical meeting in Calgary in June!

March is Endometriosis Awareness Month
For information on endometriosis, access the SOGC’s clinical practice guideline, “Endometriosis” at www.sogc.org/guidelines or the SOGC’s public education website, www.endometriosisinfo.ca.
CALL FOR NOMINATIONS

Chair-elect of the SOGC Junior Member Committee
The objective of the SOGC Junior Member Committee is to provide a forum in which ob/gyns in training can express opinions and recommendations pertaining to issues directly impacting ob/gyn residents. The committee develops programs for residents and facilitates communication among the resident communities of each university. The committee enables a national voice for residents.

If you are interested in this position, please visit the Junior Members’ section of the SOGC website, www.sogc.org, to find out what this position entails. The deadline for submissions is May 1, 2013.

Medical Student on the SOGC Junior Member Committee
The SOGC Junior Member Committee is looking for a medical student representative for the term from July 1, 2013, to June 30, 2014. The Junior Members Committee consists of residents from across the country who are involved with various SOGC events and activities, including the Annual Clinical Meeting and the Resident Professional Development Program. The committee also works in collaboration with various organizations and other committees, including the SOGC Council, APOG and the SOGC Promotion of the Specialty Committee.

The medical student representative who sits on the committee will represent medical student members from across the country and be their active voice within the Junior Member Committee.

If you are interested in this position, please visit the Junior Members’ section of the SOGC website, www.sogc.org, to find out what this position entails. The deadline for submissions is May 1, 2013.

Can you “Stump the Professor” in 2013?

Since its inception, this event has become one of the most popular at the Society’s Annual Clinical Meeting. All residents are invited to submit a detailed summary of an interesting case, and the winning entries will be selected by a committee. The individuals whose entries are selected will be invited to present their case in the hopes of stump our panel of ob/gyn experts at the meeting in June. A $1,000 prize is awarded to both the best obstetrical case and best gynaecological case.

Cases should include:
1. Patient profile
2. Reason for admission
3. Symptoms/problem list
4. Past medical history
5. Family and social history
6. History of present illness/prognosis
7. Lab work
8. Medications
9. Follow up

Deadline for submissions: April 1, 2013
Please send your draft power point presentation to Janie Poirier at jpoirier@sogc.com.

Invitation to attend the 2013 SOGC Medical Student Program

The Medical Student Program (MSP) is a unique one-day program that will take place on June 10 in conjunction with the SOGC’s Annual Clinical Meeting (ACM) to be held in Calgary from June 11 to 14.

Program objective
The program is designed to benefit medical students by exposing them to scientific programs, hands-on workshops and seminars that enhance their awareness and understanding of the profession of obstetrics and gynaecology. In addition, students are able to meet with ob/gyn residents and staff physicians from across the country. The SOGC Medical Student Program will select 30 applicants from sixteen Canadian universities to attend our program and the Annual Clinical Meeting.

The deadline to apply for the 2013 Medical Student Program is Friday, March 29, 2013. Visit our 2013 ACM website at www.sogc.org and look for ‘Conjoint meetings’ for information concerning the MSP and the application process.

If you have any further questions about this program, please do not hesitate to contact Janie Poirier at jpoirier@sogc.com.

REMEMBER: All members to receive SOGC News by email in April
The majority of SOGC members already choose to receive our monthly membership newsletter by email in PDF format. As of April 2013, we will produce only an electronic version of this product – all members will receive the SOGC News by email. Members who choose a print subscription to the JGOG will continue to receive that publication in the mail. If you would like to update your email address on file with the Society, please contact Linda Kollesh at lkollesh@sogc.com or 1-800-561-2416 ext. 233.
Comparing obstetric practice in Zimbabwe to that in Canada: Reflections from a member’s volunteer experience abroad

SOGC member Dr. Alison Tennent was the 2012 recipient of the SOGC International Development Grant for Volunteers, which aims to assist SOGC obstetrician/gynaecologist members who wish to pursue volunteer clinical work in developing countries. The grant allowed Dr. Tennent to travel to rural Zimbabwe from April 13 to July 2, 2012, to volunteer at Howard Hospital. Below is Dr. Tennent’s description of her experience.

During my time at Howard Hospital, my primary place of work was the maternity ward, which performs 2,500 to 3,000 deliveries per year. Dr. Thistle, the Canadian chief medical officer at Howard and the person who usually runs this ward, was quite relieved to hand this over. An obstetrician/gynaecologist by training, Dr. Thistle is clinically engaged in all specialties at Howard and my presence gave him a chance to focus elsewhere and reduce his excessive working hours. This was one of my stated objectives of the volunteer position, to provide physician relief to a resource-poor hospital with a severe physician shortage.

As the only physician covering the maternity ward, I was expected to perform a wide range of daily duties which included doing rounds on the 20 to 30 plus antepartum and postpartum patients, performing antenatal consultations sent from midwives, doing up to 15 obstetrical ultrasounds per day, attending to obstetrical intrapartum issues and emergencies at the request of the midwives, performing Caesarean sections and operative vaginal deliveries, and doing rounds on all the neonates in a special care unit. This made for a very grueling daily schedule starting at 7:30 a.m. and not finishing until nearly twelve hours later, often working at a frantic pace. Night call was shared with two Zimbabwean general medical officers. Incredibly, Dr. Thistle has performed the above role on the maternity ward for 17 years, in addition to seeing at least one hundred general outpatients per day, performing daily minor and major general surgery and gynaecological procedures, running other wards, and doing the bulk of the hospital medical administration.

Differences in practice

At Howard Hospital, midwives perform all deliveries. The World Health Organization’s partograph is consistently used by the midwives to identify at-risk labours. Midwives consult a physician regarding suspected fetal distress, failure to progress despite oxytocin or failure to progress in the second stage, antepartum and postpartum hemorrhage, preeclampsia, preterm labour, chorioamnionitis, and management of inductions. The midwives at Howard are generally competent in multiparous term vaginal breech delivery and most twin deliveries. Nulliparous term breech deliveries are encouraged and usually performed by Dr. Thistle. Intermittent auscultation is the method used by the midwives for intrapartum fetal surveillance.

The vast majority of labors are low-risk and this is appropriate, but unfortunately there is no reliable continuous electronic fetal monitoring available for the high-risk pregnancies. There is an old donated electronic fetal monitor on the labour ward, but there is no supply of paper for it. Cytotec (misoprostol) is used routinely for induction of labour, due to its low cost in comparison to prostaglandin gels. This is not yet approved for induction of labour in Canada. The use of analgesia in labour is rare except for the occasional injection of Demerol for the nulliparous patient who is progressing slowly. The Demerol stock has been depleted several times on my previous visits. The Caesarean section rate is much lower than in Canada, running at approximately 10 per cent. A trial of VBAC is always promoted, along with appropriate augmentation as needed. At Howard, everything possible is done to allow for a vaginal delivery, as the one operating theatre must accommodate for both Caesarean sections and general procedures. Also, performing Caesarean sections uses up vital hospital resources, which must, in reality, be rationed.

There are other major differences. All antenatal care is provided by the midwives at the family child health centre. This care is of a basic nature (the only tests done in the pregnancy being HIV, CBC and RPR at booking); routine ultrasound is not performed. The midwives are taught to identify high-risk pregnancies and to have these pregnancies reviewed by Dr. Thistle at least once during the pregnancy. Also, management of HIV in pregnancy is a huge issue at Howard as Zimbabwe was hit hard by the southern African HIV/AIDS pandemic. Fortunately, the adult prevalence rates have plummeted in recent years but HIV is still a pervasive disease in pregnancy at Howard, encountered daily. All HIV positive pregnant women now receive either zidovudine (with nevirapine in labour) or triple therapy antiretrovirals (if CD4 count is less than 350 or HIV is stage 3/4) during pregnancy as part of a national program. All HIV positive patients...
undergo vaginal deliveries, except if there is an obstetrical reason to do a C-section. For a multitude of reasons, breastfeeding is the best and only option for these women.

The learning curve for western physicians is very steep at Howard. Dr. Thistle would always remind me of that. Fortunately, Dr. Thistle was usually only a ward away if I needed his expert help, when I ran into problems not usually encountered in Canada: difficult vaginal breech deliveries, late stage management of severe fetal hydrocephalus, or delivery issues around eclampsia. I will emphasize that this dedicated obstetrical program at Howard Hospital, although resource poor, has saved the lives of countless women and babies in the region over the years. Sadly, not all women make it to the hospital to avail of these services due to multiple barriers to accessing health care.

**A population, and a hospital, in need**

However, this small mission hospital has been increasingly overwhelmed by patients from out of its district over the past few years. Many patients can no longer afford medical care in Harare, the capital city, and decide to make the 80 km trek to Howard. This often led to chaotic and disorganized conditions on the labour ward. In the 2.5 months I was at Howard, there were three perinatal deaths (one at 34 weeks, one at 35 weeks, and one term) and one case of probable perinatal asphyxia at term that I can say were almost definitely due to an excessive workload on the labour ward resulting in lack of both appropriate maternal assessment and appropriate fetal monitoring during labour. These were unfortunately preventable deaths, resulting from a hospital situation that was stretched beyond its capacity.

The lack of essential drugs in stock for obstetric emergencies was also a real concern. Although broad spectrum IV antibiotics, oxytocin, and IV fluids were readily available this time, IV antihypertensives (hydralazine or labetalol), magnesium sulphate, and misoprostol were not. Preeclampsia/eclampsia is one of the leading causes of maternal mortality in Africa. It is therefore unacceptable that a district hospital like Howard is often not stocked with magnesium sulphate and antihypertensive drugs for severe preeclampsia.

The lack of nurse and physician manpower and the lack of vital medical equipment and medications does speak to a lack of political will when it comes to the health of the people of Zimbabwe. No matter how many foreign medical volunteer workers come to Zimbabwe, or how many clinical programs are funded by foreign donors, or how much money is donated, there will be only limited improvements in health care in the country as a whole until the government of Zimbabwe chooses to make it a priority. This will have to be within the framework of an improved medical infrastructure, as the current one is outdated. Existing health-care workers are burned out, underpaid, and demoralized. Medical equipment and hospitals are dilapidated. Impoverished patients are expected to shoulder the cost of health care with prohibitive user fees. The current system is clearly unsustainable.

The highly publicized removal of Dr. Thistle from the Howard Hospital in August 2012 has since left an even greater strain on the hospital’s human resources. The 270,000 people in the district were suddenly left without an obstetrician or a surgeon, with no plan in place for an obstetrician/surgeon replacement. The hospital is now functioning at only about 20 per cent of the workload it used to. Regrettably, this does not reflect the true medical needs in the district.

Finally, although this was a medical volunteer stint, it was much larger than that for me. Over my last four visits to Howard in the past 10 years, I have developed lasting connections to various people in the Howard community: health-care professionals and community members. I have continued to keep in contact with them while in Canada. Their stories of resilience and struggle are unforgettable. It is for this reason that this time I leave Howard with more than the usual unease, knowing that the future of the hospital and community are now uncertain, without the strong Thistle presence to make the health care of rural impoverished Zimbabweans a priority.
In the summer of 2013, the SOGC will be publishing the Health Professionals working with First Nations, Inuit and Métis Consensus Guideline. This guideline is the result of a partnership between the SOGC’s Aboriginal Health Initiative and the National Aboriginal Health Organization (NAHO), as well as the dedication of a pan-Canadian, multidisciplinary group of principal authors, committee members and special contributors. As the acting chief executive officer of the NAHO and a principal author, Mr. Simon Brascoupé has been a key contributor to this guideline.

Simon Brascoupé was born and raised on the Tuscarora Indian Nation and is a member of Kitigan Zibi Anishinabeg, Maniwaki, Quebec. He is a member of the Aboriginal Health Initiative Committee of the SOGC. Simon’s artistic vision is to pass on traditional values and teachings through his artwork and its narrative. Simon’s work has been exhibited in Canada, the United States, Europe, China and Cuba. He is represented in the collections at the Canadian Museum of Civilization and the Smithsonian Institution, Washington, D.C. His work is also in major corporate and private collections. Simon Brascoupé is an adjunct research professor at Carleton University and adjunct professor at Trent University. He has a B.A. and M.A. from State University of New York at Buffalo, where he is also completing his Ph.D. He has a strong interest in traditional knowledge and medicine and sustainable development.

In addition to his contributions to the writing and execution of the guideline, Mr. Brascoupé also honoured the SOGC by creating a painting for publication as the cover image of the guideline. This image represents the creation story told to him by his grandmother:

Skywoman. 2013. Simon Brascoupé, Haudenosaunee/Anishinabeg

Sekon, Peace. The Skywoman was pregnant when she created the world. She lived in the spirit world above the sky dome. In the middle of her village was a tree covered in bright lights; it was a beautiful thing to behold. She wanted to learn what made it so wonderful, so she had the tree lifted out of the sacred ground to look at its roots. When she gazed at what she saw, she fell through the hole in the ground into this world. As she reached out to stop her fall, she grasped strawberries in one hand and the sacred medicine tobacco in the other hand. The world back then was dark, with water and animals. As she fell into the world she brought light. The animals and birds saw her falling and decided that some birds would fly up, catch her on their backs and bring her safely onto the back of the turtle. A muskrat swam to the bottom of the water and brought up some earth in its paws so the Skywoman had something soft to stand on. The Skywoman began to walk in a counter clockwise spiral creating Mother Earth. This is the story my grandmother Sarah Patterson told me, Onen.

In this image created for the Society of Obstetricians and Gynaecologists of Canada, the Skywoman is falling from the sky world at the moment of creation. In her hair are a flower and birds signifying our sacred relationship with the natural world. If you turn the image “upside down” you will see the Three Sisters; corn, beans and squash. The corn signifies that the Skywoman is pregnant and women’s ability to create life. On her dress is a branch of the Tree of Life with seven lights symbolizing human’s life course; song, dance, art, gift, family, community and spirituality. There are two Turtles with a spiral on their back to let us know that birth is still happening and that the Skywoman is still with us.

In June 2012, the NAHO was forced to close its doors in the wake of the Federal government’s budget cuts. The SOGC is deeply grateful to the NAHO for their partnership in the production of this guideline. The SOGC is also grateful for Mr. Brascoupé’s continued dedication to the guideline and to the Aboriginal Health Initiative. We are honoured to share his Skywoman with our members as the cover image for the upcoming Health Professionals working with First Nations, Inuit and Métis Consensus Guideline.