Department of Obstetrics & Gynaecology

Global Health Unit Newsletter

Dec 2017

Announcements!

Call for Resident Global Health Electives:

The New Year is quickly approaching, which means a new year to take part in a Global Health Elective abroad!

The Global Health Unit is looking for OBGYN residents who are interested in taking part in a Global Health Elective in an under-resourced settings, and who have or have not completed a Global Health Elective before. All interested residents are welcomed and encouraged to participate, however space is limited so enquire now!

Join Our Global Health Interest Group:

Our next Global Health Interest Group (GHIG) meeting will be held on **December 11th** at **6:30PM** at the **BMO Community Room** in the **Halifax Central Public Library**. During this meeting we will be discussing Refugee/Newcomer Women's Health and the role our GHIG members play. All interested residents and staff members are welcomed and encouraged to attend.

Mobile Outreach Street Health (MOSH) Clinic:

The Global Health Unit is happy to announce that our OBGYN residents and staff members will be partnering with the Mobile Outreach Street Health (MOSH) Clinic at the North End Community Health Centre (NECHC).

The MOSH Clinic provides accessible primary health care services for people who are homeless, insecurely housed or street involved. By joining MOSH, our residents and staff will be able to provide health care services to underserved women in the North End community. The clinic is scheduled to be begin on **December 11th**.

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For more information about any or all of the above mentioned announcements, including how to participate and become involved, please contact Samira Thomeh at samira.thomeh@iwk.nshealth.ca or 902-470-7175.

Global Health Events

The following is a list of other global health events that may interest our OBGYN staff, residents and personnel, as collated by the Dalhousie Global Health Office.

- **Dec 15, 2017**. Halifax Convention Centre: Call for Abstracts: 2018 Healthy Living Healthy Life Conference
- **Jan 10, 2018**. Dalhousie University: Call for Abstracts: Crossroads Interdisciplinary Health Research Conference
- **Jan 10 - 13, 2018**. University of Toronto: Global Health, Equity and Primary Care Course
- **March 16 - 18, 2018**. New York City: CUGH Global Health Conference 2018
- **March 25 - 27, 2018**. Toronto, Canada: Bethune Round Table in Global Surgery
- **April 27 - 28, 2018**. Toronto, Canada: PEGASUS Conference
- **June 22 - 25, 2018**. University of Saskatchewan: 5th International One Health Congress in Saskatoon

Global Health Research in Ghana Lauren Adolph

One would think going to Africa for a week was insane and way too short to get anything done. I thought so too, but man was I wrong.

I am a PGY-2 in OBGYN and had the opportunity to travel to Cape Coast, Ghana for a week of research in Global Health. I started this adventure after learning about the unique relationship Dr. Heather Scott and the NGO Kybele had with the Cape Coast Teaching Hospital (CCTH). This partnership was born out of their mutual desire to improve maternal and newborn health, and continues out of great respect for the expertise each party contributes to this goal. I learned in a discussion with Dr. Scott that one of the unaddressed priorities identified by CCTH at the outset of this collaboration was obstetric triage. She learned of my interest in triage in different areas of medicine and thus my joint resident research project evaluating the implementation of systematic obstetric triage at CCTH was born. To be invited to join this collaborative and intensely productive team was a privilege.

A proposal was complete, submitted and accepted to ethics. The only thing left to do was get on a plane to Ghana, identify resident and staff OBGYN partners for my project and get to work collecting data. A big task for 5 days? Yes. But amazingly, we got it done.

We arrived through customs and the officer looked at my immigration card and asked, “Are you a doctor?” When I confirmed this, he looked into my eyes and quietly commented, “Your patients are very lucky to have you. Thank you for coming.” After a quick overnight in Accra, we boarded a bus for the 2-hour drive to Cape Coast. Jet leg cannot be a factor when you have such limited time to get to such big goals. So, it’s up the next morning and straight to the hospital for morning rounds, then meetings, small group breakout sessions, furious manuscript writing, data gathering, re-writing quality improvement indicators and testing these in real time. All the while ensuring the local champions of each endeavour were right alongside us and taking the reins with both hands by the time the week was up. These were our days at CCTH: long, full of new learning, productive and immensely fulfilling.

The goal of this collaboration is to make change for the mothers and babies of CCTH and the surrounding communities. We wanted to support change at the heart of the hospital, and that meant not only implementing policy and practice improvements but also developing a system of collecting and analysing institutional data on quality of care indicators that will inform the next round of self-sustaining change and improved care at CCTH.

But perhaps you are wondering if I was deterred by the overwhelming poverty and suffering. This is, after all, West Africa. I’m not saying these didn’t exist. I am not suggesting we can ignore the prevalent lack of resources. And it would be hypocritical to say I was fully prepared to face the stark contrast I experienced at CCTH with health care we take for granted in North America. For me, what was most impactful was the dedicated and talented staff at CCTH who function in a system overrun and severely under resourced. Despite these constraints, the staff resolve to function at the highest clinical standards. Their training is steadfast and resolute. These individuals are working for the true vision of Global Health—equity in our delivery of health care across the globe.

Above L-R: Heather Scott & Lauren Adolph in Cape Coast, Ghana.

Leaving No One Behind (Part 1) Samira Thomeh

The 23rd Annual Canadian Conference on Global Health (CCGH) was held from October 29-31 in Ottawa, and I was thrilled to be a part of it. With the UN third Sustainable Development Goal being "reproductive, maternal, and newborn and child health", I was happy to see that the agenda for the conference had many sessions focused on this. There was at least one maternal and child health (MCH) lecture per block. Needless to say, I made an effort to attend each of those sessions.

The opening plenary at the conference included a remarkable group:

- **Dr. Paul Farmer**: Co-founder of Partners in Health from Harvard Medical School
- **Dr. James Orbinski**: Humanitarian/Leading Scholar in Global Health from York University
- **Dr. Shakira Choonara**: Regional Advocacy Officer from Southern Africa AIDS Trust
- **Basimenye Nhlema**: Director of Community Health at Partners in Health in Malawi
- **Julia Sanchez**: President and CEO of the Canadian Council of International Co-operation

Dr. Farmer was the keynote speaker and discussed colonialism, global health equity and the "socialization of scarcity on behalf of others". Dr. Farmer's presentation raised many important points such as how we need to shift our thinking from what we can't do to what we can do in global health equity, how we must not create competition between public health actions and causes if we want equity in health – we must work together, and how health systems strengthening is important but not happening. This presentation really set the tone for what I anticipated for the rest of the conference – thought-provoking and motivational.

Blind-Folded CCGH Panelists.

After Dr. Farmer presented, we moved onto the panelists. Dr. Choonara, the panelist representing young leaders in global health, impressed the audience as she walked us through a simulation of what visually impaired individuals have to experience when taking their own medication. This involved blind-folding the rest of the panelists and getting them to "read" the prescription. The theme of the 2017 CCGH was "leaving no one behind" and this demonstration really brought this to light. The panelists clearly could not read the prescriptions while blind-folded, which shows that even in our western society, we are leaving people behind.

An overview of the sessions I attended on the first day (October 29):

"Allyship: Exploring the Role of Privilege and What to do With/About it in Global Health."

The first session I chose to attend on the first day was on "allyship" – a fairly new concept to me but one worth exploring. This was a 3 part workshop, beginning with "practicing allyship", then "applying principles of practicing allyship to cases" and finally "consolidating ideas".

The workshop began with a video titled *The Monkey Business Illusion*. While the video was playing we were asked to count how many times the team dressed in white passed the ball (side note: there was a team dressed in black also passing the ball). At the end of the video most people counted correctly; however, very few noticed a man dressed in a gorilla suit who danced on and off the stage. The gorilla in this experiment was a metaphor for privilege and how we can be oblivious to our own privileges.

Privilege means you have a benefit others don't, you didn't earn it, you have it because of who you happen to be. Oppression means you have a disadvantage others don't, you didn't earn it, you have it because of who you happen to be (e.g., marginalized populations, disadvantaged communities, high-risk groups). Privilege and oppression was demonstrated with a diagram of a coin. The coin represented the system (e.g., racism), the privileged person (e.g., white person) was above the coin, and the oppressed person (e.g., black person) was below the coin.

A key message or learning I took away from this workshop is that health equity work is for oppressed groups, but in order to really help those oppressed groups, we need to learn about the coin (aka the system) and the privileged people above the coin so that we can help those below the coin – the oppressed. I learned that health equity work is typically equated with marginalized groups, without attention to systems of privilege. I also learned that "allyship is an active, consistent, and arduous practice of unlearning and

re-evaluating in which a person of privilege seeks to operate in solidarity with a marginalized group of people" (The Anti-Oppression Network, 2017). Practicing "allyship" requires that people on the privilege side of the coin:

- Stops trying to 'help' (i.e., acknowledge that it is not one's intent that matters, it is the impact of one's actions)
- Step back (when with people on other side of the coin)
- Shift both symbolic and material power
- Be alert to how practicing "allyship" can backfire by strengthening vs. dismantling the coin

Session on "Allyship".

"Maternal and Child Health (MCH) Handbook Initiative: A Continuum of MNCH Care Tool to Ensure Better Health for the Most Vulnerable Mothers and Children in the World."

The next session I attended was a wonderful opportunity to learn about some initiatives taking place around the world to ensure better health for vulnerable mothers and children, with key focus on lack of education and finances (i.e., some of the key social determinants of health).

The session began with a bit of background information to really put the issue into context. A study released by the United Nations Population Fund, estimates that 70% of the world's maternal deaths – almost 400,000 lives – could be prevented if an additional $13 billion was spent annually on health care and family-planning services ($4.50 per person per year).

Unsafe abortion and lack of contraceptives are also key factors. More than 15% of maternal deaths in South Asia are a result of unsafe abortions. More than half of women in developing countries want to delay or prevent pregnancy, yet a quarter of them are not using modern contraceptives, usually because of poverty, lack of education and services.

In 1948, the Maternal and Child Health (MCH) Handbook was published for the first time. The MCH Handbook are home-based records that provide mothers and their children with vital health education, facilitate two-way communication between families and health workers, and serve as a tool to record health information. MCH Handbooks are a critical starting point and a basic tool for promoting maternal, neonatal and child health. Since it was developed in Japan, the MCH Handbook has expanded to 39 countries. This handbook can facilitate the continuum of care needed to improve maternal, neonatal and child health.

Obstetricians, pediatricians, public health nurses and midwives may write down medical records in MCH Handbooks and parents can bring it with them to clinics for health examinations, immunizations or treatments. Studies show that the MCH Handbook can enable people to develop the capacity to cope with difficult and complex conditions. It is also a low-cost tool, translated into local languages, and thus can be implemented in developing or resource-constrained settings.

Stay tuned for part 2 of my learnings from the 2017 CCGH!