

News and Events

9th South Asian Federation of Obstetrics and Gynaecology Conference
Federation of Obstetric and Gynaecology Societies of India
Organized by: The Agra Obstetrics and Gynaecology Society
28th February 2013 to 3rd March 2013

Prof. Rashid Latif Khan SAFOG Oration

Harshalal R Seneviratne MBBS (Ceylon) DM by Research (Colombo) FSLCOG (SL) FRCOG (UK)
Immediate Past President, SAFOG (2011-2013)

President and Council of South Asian Federation of Obstetrics and Gynaecology, Past Presidents of SAFOG, Prof. Rashid Latif Khan and the members of the family, invited guests, honored ladies and gentlemen, as the immediate past president of SAFOG it is my responsibility to deliver the Prof. Rashid Latif Khan SAFOG Oration, a responsibility that I have taken very seriously. I am deeply honored by the invitation to be the orator today and shall do my best to present meaningful suggestions for SAFOG to implement on the subject selected for this oration namely 'The Challenges for Medical Education in South Asia'.

At this moment, I cannot help but reminisce on the development of SAFOG and how far we have progressed since that original meeting in Colombo. From the very beginning over the past years, through good times and bad there was one personality who acted as the leader, the mentor, the trouble shooter and friend. He is Prof. Rashid Latif Khan the founder President of SAFOG.

Rashid Latif Khan graduated in 1961 from Nishtar Medical College in Multan. After house jobs, he went to England and obtained the membership of the Royal College of Obstetricians and Gynaecologists and the Fellowship of Royal College of Surgeons of Edinburgh. After returning to Pakistan, he was appointed as Assistant Professor of Obstetrics and Gynecology at Nishtar Medical College. He subsequently served as the Professor at Quaid-e-Azam Medical College in Bahawalpur, Nishtar Medical College at Multan and then in two institutions in Lahore—Allama Iqbal Medical College, and Postgraduate Medical Institute from where he retired in 1998 after serving as Dean for 2 years. Later he was made as Professor Emeritus of the Postgraduate Medical Institute, Lahore.

Professor Khan is recognized as the father of *in vitro* fertilization (IVF) in Pakistan. This is an undisputed status because of his pioneering work in establishing the IVF technique in Pakistan by starting the country's first Assisted Reproductive Center in 1984, just 6 years after the birth of the first test tube baby of the world. Pakistan's IVF baby was born in his center in 1989.

To me, his most valued contribution has been in the field of medical education for which he is greatly respected and revered for his role as a medical teacher, policy maker, administrator and general driving force. Having commenced his career in medical education at his *Alma mater*, he progressed in Lahore and in Pakistan to become a medical teacher of international repute. Even after retirement from the Postgraduate Medical Institute, he proceeded to establish a private medical institute and school. For his contributions including innovative medicine and medical education in Pakistan, he has been awarded with the highest honors that the country and the profession can offer. It is this unique person Prof Rashid Latif Khan who gave the leadership to commence the South Asia Federation of Obstetrics and Gynaecology. As the outgoing President of SAFOG, I am deeply honored to deliver the Prof. Rashid Latif Khan SAFOG Oration for 2013, on the subject 'The Challenges for Medical Education in South Asia'.

What is the need to provide medical education? On reflection one wonders whether:

- Is it to fulfil a professional requirement?
- Is it to 'pad-up' the CV?
- Is it to provide a means of income for the medical professional?
- Is it to be a medical insurance policy for family and friends?
- Is it to be a commercial venture for the provider?
- Is it to enhance national ego and status?
- Is it to add to the brain drain?

While all these may operate the most relevant reason to provide medical education is to ensure the health of a population.

On a personal or national basis, medical education is a continuum (Fig. 1) which commences at entry from school, followed by a basic medical course which is deemed to be strenuous and graduating as a doctor. Many doctors continue to provide basic medical services while some progress into a Postgraduate course with specialization or even sub-specialization. In addition, parallel courses leading to paramedical qualifications are much needed entity. The challenge for the South Asian countries would be to marry these two aspects of medical professional development to ensure teamwork and to provide maximum benefits to its people. SAFOG has the responsibility and the capacity to provide the leadership and the technical inputs for this purpose.

In 2010, the Lancet Commission Report¹ on medical education traced the historical development and its effect on health. The Flexner report (1910) was the first attempt² to look at medical education on a rational basis. It presents a series of studies on education of health professionals up to recent times. Subsequent developments included integration of modern science into medical curricula at University Medical Schools. Although the 20th century resulted in improved health parameters at the beginning of the 21st century many gaps and inequities remained in the provision of health care. It is stated that medical education has not kept pace with its ability to meet these challenges. Further new challenges in health needs have emerged. What are these challenges? Broadly speaking, these are of two categories; viz fresh health challenges and continuing system failures.¹

It can be noted that many of these barriers relate to staff knowledge, attitudes and skills. Human resource development is therefore a key area that needs urgent and focused attention. While the problem may be global, the third world in general and South Asia in particular has unprecedented staffing issues, where the practice of medicine is often looked upon as a materially lucrative occupation rather than the process for improved health for the millions of economically deprived people who desperately need the services.

In ensuring that the service provision occurs efficiently other logistic issues come into play. Quality assurance in medical education is an essential component where member societies have played their part by introducing continuous professional development. The process however is mostly voluntary at present. SAFOG could play a role in making this essential item for quality assurance more formal and provide it with an international flavor. In a similar manner, reviews of training institutes and processes could evolve to become responsibilities of SAFOG. In the past, this task was performed by the Royal College of Obstetricians and Gynaecologists and therefore training in South Asian countries was acceptable for trainees to sit the membership examination (MRCOG). It was discontinued with the more recent changes in the examination regulations leading to the elimination of the leverage the Profession had to persuade the authorities for improvements in service provision and training facilities.

In the provision of medical education, it is necessary that a clear direction is followed. The Lancet Commission Report¹ has highlighted the progress of medical education from a science-based process in the early 20th century via problem-based curricula of the mid-20th century to a health system based one in the 21st century. It suggests a mission statement which indicates that ‘all health professionals in all countries should be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centered health systems as members of locally responsive and globally connected teams’. This is an achievable high ideal. The ultimate goal is to assure universal coverage of the high quality comprehensive services that are essential to advance opportunity for health equity within and between countries.

The process of medical education for any professional group is initiated. The educational track that follows is recommended by the WHO for any training program. It emphasizes the need for identifying the ‘tasks’ to be performed by the professional based on which the entry criteria along with the selection process is decided. It is only then that the many components of the training program are planned which include the training of trainers and supervision of training in addition to the details of training curriculum. Following the evaluation of training certification is performed along with accreditation. The Tasks can now be used/modified to develop the job description. Further developments include continuous professional development. This process could be exploited maximally to ensure that the concepts of professionalism, such as teamwork, leadership, interpersonal relations and many others are imparted to the trainees.

Selection for Undergraduate Medical Education

Influencing the success of the training process and tracking through every stage of its implementation is whether the correct person is selected for training. The Sri Lanka experience of selection of medical undergraduates over the past decades has been

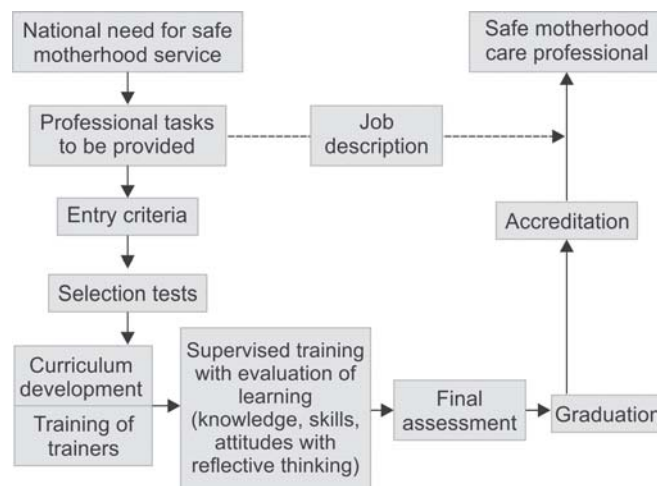


Fig. 1: The educational track for the provision of needs based medical education applicable for the training of all categories and grades of medical care providers

Table 1: New challenges in health needs

<i>Global fresh health challenges</i>	<i>Continuing system failures</i>
<ul style="list-style-type: none"> • Rapidly expanding new infections • Environmental risks • Behavioral risks • Epidemiological transitions • Rapid changes in demography, etc. 	<ul style="list-style-type: none"> • Persistent professional status gender stratification • Static curricula • Narrow technical focus than broader conceptual idea of health • Sporadic patient encounters vs continuous care • Hospital care rather than community/primary care • Mismatch of professional competencies to patient/population needs • Professions working in isolation and no integration • Lack of team work • Deficient leadership to solve management problems • Incompetency of medical professionals • Costly and complex health services • Regional inequities in provision of healthcare

one of changing priorities where that responsibility shifted from the state to the universities and finally to the University Grants Commission. It also involved the concepts of a selection interview, practical tests, aptitude tests, etc. The move toward ethnic proportions and opportunities for the economically under privileged has been brought into this process.

Envisaging the inevitable to happen Prof CR De Silva states in a document on The Politics of University Admissions ‘further problems arise, when in the context of a plural society each ethnic and religious group tends to evaluate the ratio of university admissions obtained by its members as an index of equality of opportunity or of discrimination. University admissions thus cease to be the exclusive preserve of academics and become the concern of politicians and leaders of various groups and interests’.³ Ideally, the admission criteria should be defined by the requirements for medical services and the job description of the professional.

The Undergraduate Medical Curriculum

While the selection process determines the ability and the compatibility of the professional doctor in training for the task the curriculum would direct the training process. The purpose of a medical curriculum may be interpreted differently as follows:

1. The method by which a syllabus is covered.
2. To make the medical professional a clinical database.
3. To develop a doctor who would be a good medical technician.
4. To guide the future medical professional to be educated to mobilize knowledge and to engage in critical reasoning and ethical conduct so that they are competent to participate in patient and population-centered health systems as members of locally responsive and globally connected teams.¹

The realities of the medical curriculum indicate that learning continues up to and even beyond retirement as the undergraduate period is expected to cover only approximately 15% of eventual learning. It is as an undergraduate that the foundations of learning abilities are ingrained which would then extend into postgraduate training. The professional competencies developed during postgraduate training is meant to provide a specialist with learning abilities for the next 25 years and not a mere 5 years.

Medical curricula have undergone major changes over the past decades and now a common pattern has emerged. No medical school would function today without defining the objectives of its medical course which in effect states the qualities that their medical graduates would carry at graduation. Most curricula follow the ‘SPICES’ model⁴ which shifts the emphasis toward student orientation, problem-based learning via an integrated course structure which incorporates community services through a process of elective learning and delivered by a systematic educational system. The curriculum would be stratified and sequenced according to streams, such as for basic, applied, clinical, community and behavior sciences. Establishing such a curriculum takes effort, commitment and patience. Like all good things, the curriculum needs to be established by evolution and not revolution.

In a global world, medical schools are expected to be accredited for quality. The older state medical schools based the maintenance of standards on tradition. In recent times, however, accreditation by local medical councils (SLMC 2011)⁵ as well as international organizations has become a necessity. Commercialization and competition has encompassed the normal administration of all medical schools. Vision and mission statements and corporate plans have become common components of the organizational structure. In many ways, SAFOG would be very well suited to ensure that the reproductive health component of medical training is well planned and uniformly implemented in the South Asia region.

The economic issues relate to medical education in two ways. Firstly, the cost of training a medical graduate has escalated so that many state medical schools strain to provide non-fee levying courses. The second issue is that the inability to enter state medical schools compels many students to seek admission to private fee levying medical school overseas. The eight Sri Lankan state medical schools graduate 1,175 doctors annually. In addition, 350 graduands from 191 globally located medical schools return to Sri Lanka. The cost of training overseas is a drain on the country’s foreign financial resources. The debate as to why Sri Lanka does not permit and promote private medical education is ever present. Uncertainty of the confidence on the maintenance of standards and quality assurance has been a serious barrier to such a move.

A move toward an integrated, problem-based and student-centered curriculum is a major change and fraught with many student and teacher issues. These are described in Table 2.

Table 2: Current student and teacher issues to be considered in medical education	
Student issues	Teacher/trainer issues
<ul style="list-style-type: none"> • Lack of appreciation of student-based learning concept • Shift from knowledge-based via practical to reflective learning • Lack of understanding of opportunities for ideal self-learning in the wards, clinics and community • Misunderstanding of role of electronic learning facilities • Communication barriers with human learning resources • Overcrowding of learning evaluation activities • Economic and social burdens, etc. 	<ul style="list-style-type: none"> • Past teachers were involved with planning and implementing the curricular change which are unfamiliar to the new teachers • Lack of appreciation of student-based learning concept • Shift from knowledge-based via practical to reflective learning • Lack of understanding of opportunities for guided self-learning in the wards, clinics and community • Inadequate and inappropriate use of interactive, practical teaching/learning methods, including electronic facilities • Communication barriers with students • Overcrowded/inadequate teaching facilities, etc.

These above mentioned issues in Table 2 could be addressed with the assistance from alumni, professional associations and federations. Teachers also need to appreciate some realities which affect the smooth operation of the medical course. Teaching needs commitment, planning and teamwork. Self-review and reviews by students and peers help to improve the educator ability of the teacher. Every student has some abilities which should be recognized and nurtured by the teacher. In any batch of the students, most would be of average abilities and require mainly general guidance from the teachers. A few would be at the high end of performance and need overall support while those students who are below par should be identified to be helped with special support and guidance. There would also be students with special needs whose requirements should be addressed.

Considering the challenges for medical education in South Asia, the priority is to ensure that the community needs are fulfilled. In doing so the role of doctors in the health care team should be defined. Then the question of the suitability of an individual for selection to receive medical undergraduate education arises. In the South Asian countries, another ever present issue is the availability of financial and other resources needed to conduct an effective medical course. In view of the attraction for migration by possible brain drain to high income countries the return of investment of training a doctor for the South Asian countries can be expected to be suboptimal. Strategies to maximise the local utilization of the training have to be developed. In recent times to enhance the income for medical education, establishments are required to balance community responsibility with commercialization. An indirect impact of these issues is that accreditation of institute, course, degree and graduates have become a requirement thus providing an avenue for quality enhancement.

What would then be the responsibility of SAFOG for undergraduate Medical Education? South Asia in general is a region with high maternal mortality ratios, infant mortality rates, total fertility rates with an urgent need for emergency obstetric and neonatal care, RH education, etc. If these issues in public health are to be tackled, it is necessary that the concept of starting young in acquiring knowledge, attitudes and practices (KAP) for reproductive health (RH) is implemented. SAFOG by ensuring uniform coverage of RH in the undergraduate curriculum in South Asia could direct such a move. Practical and interactive practices in the curriculum supporting basic didactic teaching which enable case analysis, problem solving and reflective thinking as inbuilt competencies would then be a reality. As a further support for such a curricular change, SAFOG could promote the development of teaching material for use even at rural settings. A most valuable and urgently needed activity by SAFOG would be to develop standardized evaluation methods for KAP of undergraduates in the South Asia region according to local needs.

Postgraduate Medical Education

While SAFOG could contribute in many ways to improve undergraduate medical education its influence on enhancing the process and quality of postgraduate medical education is multifaceted (Fig. 2). The development of a medical specialist is a

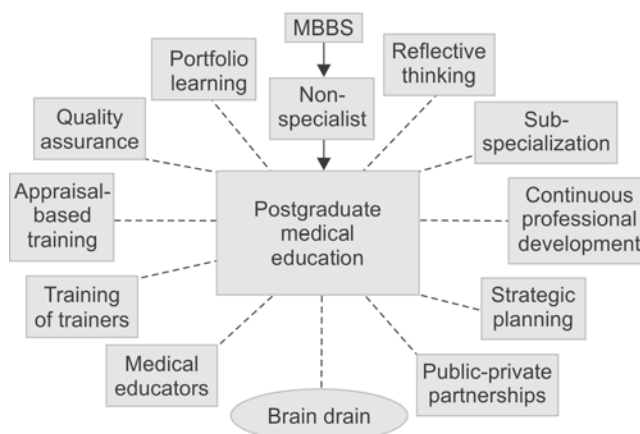


Fig. 2: The multifaceted nature of postgraduate education

continuum which is initiated at graduation from medical school. Postgraduation medical training is therefore influenced by undergraduate exposure to the different fields of medicine and direction toward RH is a serious consideration.

Since postgraduate training and evaluation in obstetrics and gynecology in South Asian countries has been adopted from that practiced during the British colonial period, some uniformity can be noted through the region. However over the past decade, many new essential areas have been added to the process of postgraduate education to make it more relevant to present needs. In many of the South Asian countries, these aspects are still in their infancy and would benefit from support within or outside the region. In an effort to achieve such a process, the First South Asian Conference on Postgraduate Medical Education was hosted by the Post Graduate Institute of Medicine of the University of Colombo in 2005 in Colombo, Sri Lanka.

During that conference, many issues were highlighted. Now eight years on it is prudent for organizations, such as SAFOG, to review these issues with a view to correcting any deficiencies. Some of these will be addressed next in this oration.

Postgraduate assessments assume a greater significance than that of the basic medical qualifications in view of the responsibilities to be shouldered by the specialist. It is therefore desirable that the assessment of training be more focused and organized. The application of the concepts stated in the Miller's pyramid on evaluation⁶ is a guide to defining what the trainee knows, knows how, shows how and is able to do. Assessment of the future professional specialist goes beyond mere practice of skills. In addition to assessment of 'what the specialist is able to do' (doing the right thing) an indicator of 'what the specialist's approach to practice is' (doing the thing right) and 'whether he is practicing as a professional' (is the right person doing it?) are components that should be incorporated into the evaluation of a postgraduate trainee. These ideals are yet to be met in the South Asia region and organizations, such as SAFOG, could do much to enhance this process.

Brain drain by reducing the number of qualified care providers and trainers is a serious barrier to the establishment of services of quality. In all South Asian countries internal and external brain drain mostly affects the specialist services. On the other hand, the ripple effect of such a problem is felt at all levels of care as the specialists both in the clinical and community areas need to participate as leaders for reproductive health care. The migration of professionals from less developed countries to better developed ones is unidirectional and detrimental to the former. However, the countries which attract these professionals are not without their own problems. While the recipient countries enjoy the benefits of knowledge, intensive services and advanced developmental activities contributed by the expatriate doctors, issues related to social adaptation, changes in demography and economic dissatisfaction are ever present.

The magnitude of the brain drain was clear from the presentations at first the South Asian Conference on Postgraduate Medical Education held in Colombo in 2005.⁷ While 2.8% of doctors trained in India serve overseas, most are attracted to USA, UK, Canada, Australia and Middle East. In the National Health Services of UK, 30% are from India. In Sri Lanka, the state spends for the entire school and medical education including overseas training. A recent wave of migration of doctors has occurred after Board Certification as Specialists by the Post Graduate Institute of the University of Colombo.

What are the solutions for South Asia to tackle the problem of brain drain? It is necessary that countries develop innovative schemes to modify the health infrastructure. They could also interact with the international agencies (UN Global Commission on International Migration) to define the country specific issues and solutions. On a stronger global note, they could initiate the moves to implement the WHO Global Code of Practice on International Recruitment of Health Personnel⁸ that recipient countries should recruit doctors only via a memorandum of understanding (MOU) with each country. Further actions would involve the activation of the WHO resolution (57.19)⁹ which discourages active and targeted recruitment of doctors from countries which are experiencing shortages. These actions involve commitment along with unwavering efforts by all concerned. As they curtail options for individual doctors and recipient countries, doubts of their successful implementation are raised.

Subspecialization

What is subspecialization? Some would say that it is to know more and more of less and less and less until one knows everything on practically nothing. However, a most appropriate definition was provided by our own former President of SAFOG Professor Farrukh Zaman at the First South Asian Conference on Postgraduate Medical Education held in Colombo in 2005 as appropriate additional intensive training, gaining of expertise and experience derived by mastering defined competencies in focused areas in the speciality recognized to be accredited as a leader and expert in that particular area of the speciality.¹⁰ This statement emphasizes the important training and individual experience gained in a focused area. It therefore follows that the process of defining tasks, stated entry criteria, training with supervision and evaluation followed by accreditation which should be implemented to ensure quality in establishing subspecialist services.

The next issue that needs to be addressed is whether South Asia needs subspecialist services. This was discussed at length at the SAFOG session conducted at the XIVth International Scientific Conference of the Society of Obstetrics and Gynaecology of Pakistan held in Islamabad, Pakistan from 14th to 15th 2012. It was shown that each country had to decide on the requirement for subspecialization based on country and professional needs. The state has a responsibility to provide basic health care to all its citizens and should therefore seriously consider the resource allocation for the different components of health care. There are however compelling reasons to promote the development of subspecialization in a country. Presently, the people of South Asia have become increasingly knowledgeable of the advances in medical technology and the demand for access to such facilities is

very real. It also becomes an issue of fundamental rights to provide these technologies for the public. On the professional front subspecialization is essential as a path toward establishing newer technologies in the country as well as for future individual professional development.

Accepting that subspecialization is an essential component of medical care, some important issues should be addressed. Firstly, the organization of the training path from defining the service needs to the eventual accreditation and registration and even subsequent professional development of the subspecialist should be agreed and clearly stated (see Fig. 1). Secondly, there must be a team concept established between a particular subspecialist facility and the more basic services so that the knowledge and experience gained from that service could filter down to improve the provision of primary care. Last but not the least the proportionate allocation of resources for development and provision of subspecialization as a part of the overall health care responsibility of the state has to be seriously considered. In view of the high cost of both training for and the provision of these facilities, personal expenditure by professionals and private sector development has been the main path for establishing subspecialist services in South Asia. In Sri Lanka over the past decade, the Post Graduate Institute of Medicine has been instrumental in arranging the training of subspecialists in selected areas, including gynecological oncology and infertility, while the Ministry of Health has absorbed those trained and accredited into the package for provision of advanced care for the public. The overall financial burden to the state is very high as the state bears the total cost which is considered to be a responsibility of the state as Sri Lanka has always provided 'free education' and 'free health care from birth to demise'. A compromise would be to develop 'special interest' training to generalists so that the service needs can be fulfilled although it should be followed by subsequent complete development of the field of subspecialization.

As stated at the XIVth International Scientific Conference of SOGP in 2012, the role of SAFOG in establishing subspecialization in the South Asia Region is one of support when it is based on recognized needs and implemented as a planned program for health care. All South Asian member countries represented in SAFOG have resources and strengths in capacity building and logistic development which can be used for mutual benefit in this regard. SAFOG could be and should be the main coordinator and the catalyst for the whole program for subspecialization in reproductive health in South Asia.

Task Shifting

In the efforts to achieve the millennium development goals (MDG), countries of South Asia are seriously hampered by the lack of human resources for basic and emergency reproductive health care. Shifting of essential tasks to subordinate staff has been a serious option. To review this issue, SAFOG along with the United Nations Fund for Population Activities — Asia Pacific Regional Office and in collaboration with the Sri Lanka College of Obstetricians and Gynaecologists organized the 'Workshop on Quality Enhancement to Achieve MDG 5' in Colombo Sri Lanka from 27th to 29th April, 2012. The meeting resulted in a very extensive report¹¹ of 46 pages and four pages of consensus statements. This report provides the base and directions for future SAFOG activities in supporting and coordinating task shifting in the region.

Paramedic Training

Provision of reproductive health care is a team concept. The team should comprise of all those who can meaningfully contribute and support the activity to be provided. The paramedical services are an essential components of RH care, and the training of paramedical personnel to fit into the service protocols is therefore mandatory. It is essential that the leadership for incorporating the paramedical services be provided by the member societies of SAFOG. The support for such a process in terms of arrangements for training and program management could be performed by SAFOG.

President of the South Asia Federation of Obstetrics and Gynaecology, a new era has dawned for the activities of the federation. The federation has matured into one which should be providing the leadership and guidance to meaningfully solve the reproductive health problems of the people of South Asia. SAFOG has now established its presence become known to the global community. The time has arrived for SAFOG to make its mark by innovative thinking and relevant actions needed to provide the much awaited relief for the people of South Asia. In doing so let us take serious note of the wisdom of that eminent regional and global leader, Pandit Jawaharlal Nehru, I quote:

'Build your own house on your own soil with your own ideas, but keep the windows of your mind open to the winds that blow from foreign shores'.

Prof. Rashid Latif Khan, Sir, in providing the leadership to establish the South Asia Federation of Obstetrics and Gynaecology you did exactly that. We respect and value your wisdom and vision.

I wish the new President and the Council the very best in guiding the federation along the path of great achievements and service to the people of South Asia for a better future.

ACKNOWLEDGMENTS

The support, assistance and guidance given by Dr Indika Karunatileke, Director and Senior Lecturer and Dr Gominda Ponnampuruma, Senior Lecturer of the Medical Education Development and Research centre (MEDARC) of the Faculty of Medicine, University of Colombo, Sri Lanka, are greatly appreciated.

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AOFOG and SAFOG News from Pakistan

The Asia and Oceania Federation of Obstetrics and Gynecology (AOFOG) Conference at Thailand from 20th to 23rd of Oct 2013 was well-attended by delegates from different areas of Pakistan, including Peshawar, Islamabad, Lahore, Karachi and Quetta. President Society of Obstetricians and Gynecologists of Pakistan (SOGP) Prof Tasneem Ashraf participated as an official delegate of the congress and was included in AOFOG Council as a member at the opening ceremony of AOFOG congress. She attended AOFOG, SAFOG council meetings in addition to AOFOG general assembly. She also participated as an invited speaker in the meet the experts nine symposium on GDM organized in SAFOG session. Prof Lubna Hassan immediate past president also attended the AOFOG council meeting and gave presentation on maternal health economics in South Asia in another SAFOG Session. Many doctors from Pakistan presented their papers at different sessions, including Dr Sikander, Dr Shaheen... . Few photographs of the conference are attached with for publication in news letter of SAFOG. Figure 1, President SOGP Prof Tasneem Ashraf, Dr Ghazala and Dr Saqib with FIGO President Dr Sabaratnam, and in Figure 2, with president of Bangladesh Prof Latifa and President elect of AOFOG Dr Kurian Josef.



Fig. 1



Fig. 2

Warm Regards
Prof Tasneem Ashraf
 Head, Department of Gynecology (Unit IV)
 BMC Hospital, Quetta, Pakistan
 President, SOGP
 Provincial Coordinator, NCMNH
 Councillor, SAFOG
 Councillor, AOFOG