Proceedings from the 32nd Annual Conference of the Ethiopian Society of Obstetricians and Gynecologists (ESOG)

LEADERSHIP IN WOMEN'S HEALTH
TOWARDS REDUCING MATERNAL AND NEONATAL MORBIDITY AND MORTALITY:
THE ROLE OF OBSTETRICIANS AND GYNECOLOGISTS AS LEADERS

FEBRUARY 19-20, 2024

Inter Luxury Hotel
Addis Ababa, Ethiopia

Content Page

ACRONYMS

AMREF	African Medical and Research Foundation
BMI	Body Mass Index
ANC	Antenatal Care
CME	Continuing Medical Education
CS	Cesarean delivery (C-section)
CT	Computer Technology
CSO	Civil Society Organization
EDD	Expected Date of Delivery
ESOG	Ethiopian Society of Obstetricians and Gynecologists
ETB	Ethiopian Birr
FIGO	The International Federation of Gynecology and Obstetrics
GBV	Gender Based Violence
IDP	Internally Displaced People
MCH	Mother and Child Health
MRI-	Magnetic resonance imaging
MSIE	Marie Stopes International-Ethiopia
MOH	Ministry of Health
NGO	Non-Governmental Organization
OB-GYN	Obstetrician-Gynecologist
PPS	Postpartum Sterilization
PTD	Pre-Term Delivery
RCD	Randomized Controlled Trial
RHS	Reproductive Health Service
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SGBV	Sexual and Gender Based violence.
SRHR	Sexual and Reproductive Health Right
SRH	Sexual and Reproductive Health
UNHCR	United Nations High Commissioner for Refugees
UNICEF	The United Nations International Children's Emergency Fund
WHO	World Health Organization

Introduction

32nd annual conference of ESOG was organized and conducted under the theme — Leadership in Women's Health towards reducing maternal and neonatal morbidity and mortality: the role of obstetricians and gynecologists as leaders. The theme brought different sub themes that mainly discussed how to improve maternal and newborn health outcomes by removing barriers to effective utilization of priority evidence-based interventions through leadership development, gender equity, advocacy, and communication. To discuss perspectives, success stories, challenges, lesson learned and the way forward about the role of OBGYNS and ESOG. Moreover, in- person and virtual scientific sessions were conducted on maternal and reproductive health services and related issues.

Acknowledgement

ESOG acknowledges Engender Health, Mega We care, Ethio Tebib General Hospital, The David and Lucile Packard Foundation, Ipas Ethiopia, Dosha MCH Center, MSIE, MartIn-Luther-University of Hallen-WITTENBERG, Clinton Health Access Initiative, Mindray, FIGO LDI REACH Project, JSI-L10K, Etab Inter Medica, Wholemedicare Healthcare Information Center, St. Paul Institute for Reproductive Health and Rights, Grace MCH Center and Betsegah MCH Center and pharmaceutical firms/Exhibitors for their support, and participants of the event also expressed their gratitude in applause.

Welcoming Address

Dr. Kidist Lemma, Master of Ceremony

Honorable Dr. Ayele Teshome,
Former Minister of Health Dr. Lia Tadesse,
Distinguished Guests, Panelists, Ladies, and Gentlemen,

Good morning. I am Dr. Kidist Lemma, an obstetrician and gynecologist from SPHMMC, and I will be your host this morning. On behalf of the various committees established to organize this conference, I would like to welcome you to the 32nd annual ESOG conference, themed "Leadership in Women's Health: Reducing Maternal and Neonatal Morbidity and Mortality – The Role of Obstetricians and Gynecologists as Leaders."

Over the past year, ESOG has undertaken various endeavors to improve maternal and reproductive health. This includes running multiple projects, conducting numerous training sessions, and engaging in extensive advocacy work. Further details of these activities will be shared in the afternoon session.

We are thrilled to announce that our valued member and former ESOG president, Dr. Mekdes Daba, has been appointed as the new Minister of Health of Ethiopia, continuing the legacy of obstetricians and gynecologists in this significant role. Additionally, ESOG would like to recognize Prof. Demisew Amenu, who has been awarded full professorship by Jimma University.

Ladies and gentlemen, thank you for joining us for the various deliberations scheduled over these two days. Today, we will have remarks from esteemed guests, recognize new graduates, and honor individuals and institutions for their contributions to the profession. This will be followed by a panel discussion. In the afternoon, we will hold a business meeting for members only. The conference will continue tomorrow with scientific sessions and the continuation of world-class CMEs that have been provided over the past three days.

Before proceeding to the next session, ESOG would like to honor the memory of three of our beloved members: Dr. Zewge Tegegne, Dr. Fisseha Tiku, and Dr. Fitsum Araya. Please rise for a moment of silence and prayer in their memory.

Thank you all! For those unable to join us in person, virtual attendance is available.

Now, I would like to invite His Excellency Dr. Ayele Teshome to deliver the opening remarks.

Opening Address by

Dr. Ayele Teshome, State Minister of Health

Dr. Lia Tadesse, Former Minister of Health
Dear Dr. Abdulfetah Abdulkadir, President of ESOG
Dear Dr. Anne Kihara, President of The International Federation of Gynecology and Obstetrics (FIGO)
Country Directors and Representatives of our Development Partners
Esteemed Colleagues, Members of ESOG,
Distinguished Guests, and Fellow Advocates for Women's Health

Ladies and Gentlemen,

I am profoundly honored to stand at this annual conference today as we gather to address the critical theme of "Leadership in Women's Health."

As we reflect on our journey, it is with great pride that we acknowledge the remarkable successes in maternal health that Ethiopia has achieved. Our nation has made tremendous strides in reducing maternal mortality rates, expanding access to prenatal and postnatal care, and improving overall reproductive health outcomes for women across the country.

These successes are a testament to the dedicated efforts of many—from healthcare professionals to community leaders, from policymakers to international partners—who have worked tirelessly to create a brighter, healthier future for Ethiopian women.

At the heart of this success is the unwavering commitment of leaders at all levels of our health system. It is the tireless dedication of our clinical leaders, who provide compassionate and skilled care to women during childbirth and beyond. It is also the strategic foresight of our administrative leaders, who have implemented policies and programs to expand access and improve the quality of care.

In this regard, the recent trend of appointing three obstetricians and gynecologists out of the last four health ministers underscores the pivotal role of ESOG in shaping the nation's healthcare leadership. Their significant impact on shaping crucial decisions, policies, and initiatives within the healthcare sector underscores the importance of expertise in women's health at the highest levels of leadership.

This also emphasizes the value of diverse and inclusive leadership within the healthcare sector, setting a clear precedent for the continued influence and participation of obstetricians and gynecologists, especially women, in guiding the country's health agenda towards improved outcomes for women nationwide. It is fantastic to see that these individuals are part of this conference, and their invaluable leadership contribution in addressing maternal neonatal morbidity and mortality is truly commendable. I'd like to take this opportunity to express my gratitude and admiration for Dr. Lia, who has been an exceptional leader and mentor. Her contributions as the Minister of Health for her country have been invaluable.

In addition, we should also underline the fundamental role that community leaders play in empowering women to take charge of their health and well-being. Their advocacy and commitment create an environment where women are not only informed about their healthcare rights but are also encouraged to actively participate in decision-making processes concerning their own well-being. The advocacy and commitment of these community leaders serve to create a culture of empowerment, where women are encouraged to prioritize their health and well-being, leading to healthier and stronger communities. Their work is a testament to the transformative power of grassroots leadership in advancing women's health at the local level.

Dear Colleagues, Ladies, and Gentlemen,

Apart from our achievements, however, as we stand here today, we also recognize that our work is far from over. We must continue to embrace strong leadership at every level of our health system and engage in all types of partnerships, from local communities to international collaborations.

We must build upon our success and tackle the remaining challenges with the same spirit of determination and collaboration that has brought us this far.

Together, we must strive to ensure that every member of our society, from the most remote villages to the bustling urban centers, has access to comprehensive and high-quality reproductive healthcare. We must forge new partnerships and strengthen existing ones, working hand in hand with communities, civil society, and international allies to build a truly inclusive and responsive healthcare system that leaves no woman behind.

More importantly, as we embark on the discussions in the upcoming days, it is crucial for us to deeply contemplate the intricate and diverse elements that shape women's health in our nation. The landscape is complex, involving various elements such as access to care, quality of services, cultural intricacies, and the broader socio-economic determinants that impact the well-being of our mothers, sisters, and daughters.

And, as we gather here, we shoulder a distinct responsibility in navigating these intricacies. Your leadership goes beyond the boundaries of clinical practice; it extends to advocacy, shaping policies, and engaging with communities. Each of you holds the power to bring about change, with the potential to influence not only the healthcare system but the very essence of our society.

Dear Colleagues, Ladies, and Gentlemen,
The challenges we confront are interlinked, necessitating a comprehensive and cooperative approach. I urge each of you to actively engage in discussions, share your experiences, and contribute to the formulation of strategies that can be put into practice at both grassroots and policy levels.

We rely on your expertise, perspectives, and unwavering commitment to pave the way for sustainable advancements in women's health.

Beyond the domain of this conference hall, I urge you to deliberate on the broader influence of your leadership. Advocate for increased investments in maternal health, collaborate with non-governmental organizations, and champion initiatives that bridge the gaps in healthcare quality and accessibility. Your leadership should extend far beyond the confines of your institutions and reach into the very heart of the communities you serve.

On another note, sustainability hinges on local ownership and strengthening the capabilities of professional associations and societies, including ESOG, regional health bureaus, and local champions, as well as ensuring the perpetuation of institutional knowledge among all healthcare practitioners.

Also, consistent and dedicated funding, whether from national or local resources, is paramount. In this regard, the Ministry of Health is steadfast in providing all feasible resources and welcomes members, partners, and donors to join hands in this endeavor.

Lastly, I extend my heartfelt gratitude to ESOG. The contribution to improving women's health in Ethiopia is truly commendable. Through your steadfast dedication and tireless efforts, you have made significant strides in addressing the healthcare needs of women across the country. Platforms like these serve as cornerstones for advancing the understanding and support of women's health issues; they allow for the dissemination of cutting-edge knowledge, development of impactful strategies, and the establishment of enduring partnerships.

ESOG's ongoing contributions are pivotal in promoting meaningful change and working towards a future where women's health in Ethiopia continues to be a top priority, supported by collaborative efforts and a strong foundation of shared knowledge and expertise.

May this assembly serve as a wellspring of inspiration, innovation, and renewed commitment to the cause of enhancing women's health in Ethiopia.

In closing, I call upon each and every one of you to embrace your role as a leader in women's health. Let us continue to inspire, innovate, and advocate for the health and rights of every woman in Ethiopia. Together, let us lead the way towards a future where every woman has the opportunity to thrive and lead a healthy, fulfilling life.

Thank you.

Keynote Address

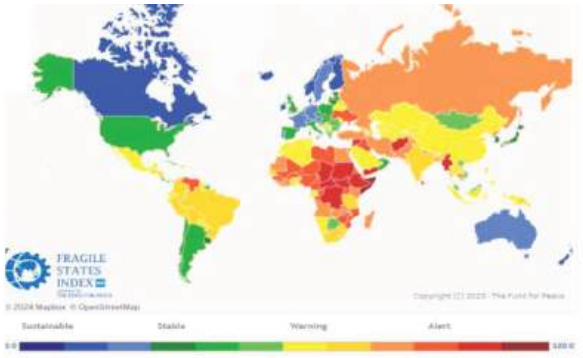
Professor Kihara Anne- Beatrice President, FIGO

A changing global context necessitating Mastery leadership to optimize SRHR outcomes

- Outline of presentation
- The Changing global context
- Re- imagine our technical assistance
- Accountability
- Mastery leadership
- Conclusion

A changing global context

- Geo-political turmoil
- Terrorism
- Humanitarian crisis
- Fragile state index
- Unplanned population migration(PHED)
- Heterogeneity of socio- economics, culture and
- social protection
- Global, regional to local trade directions



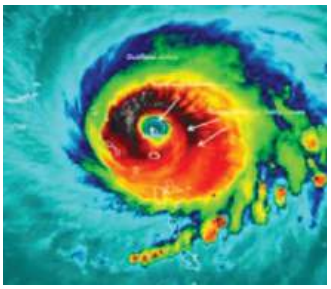
Climate change and environmental pollutants and toxins

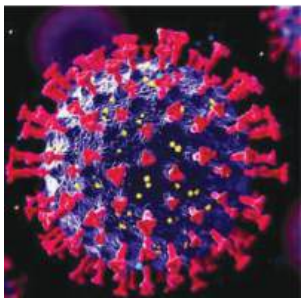
Climate change and environmental damage direct and indirect effects

- Unmet basic needs: clean air, food, shelter, water and sanitation and MHH management
- Malnutrition and food security;
- zoonotic diseases and antimicrobial resistance
- Water borne diseases
- Vector borne diseases

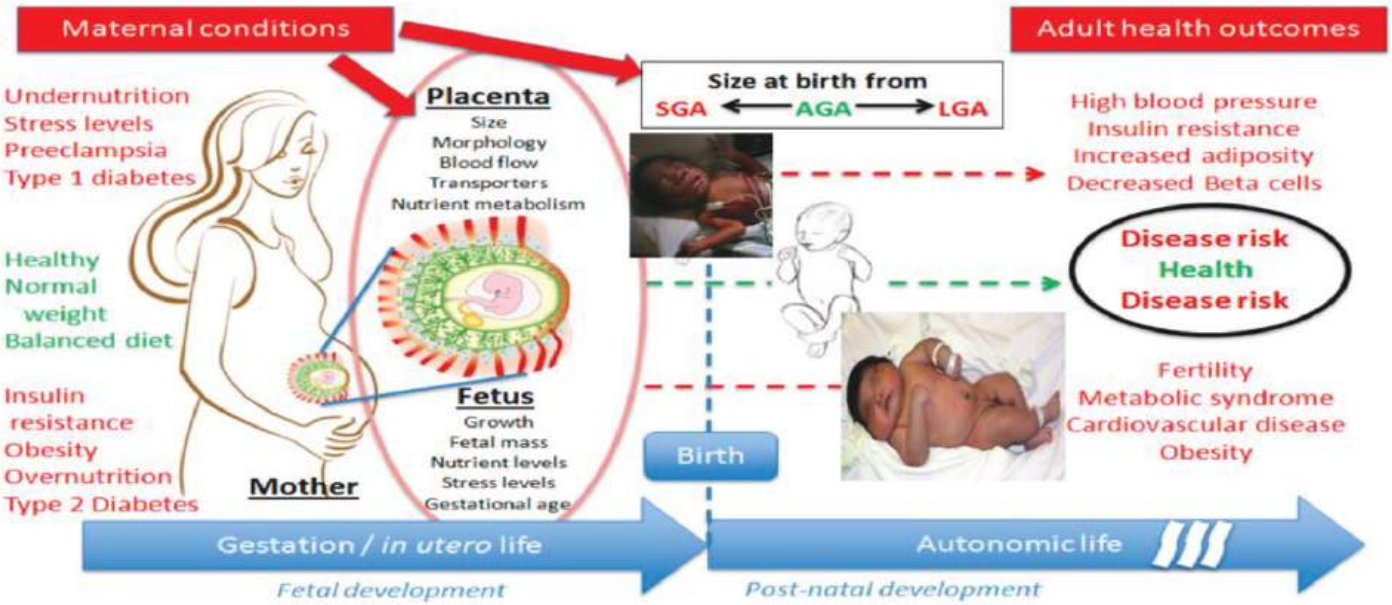
Communicable and non –communicable diseases

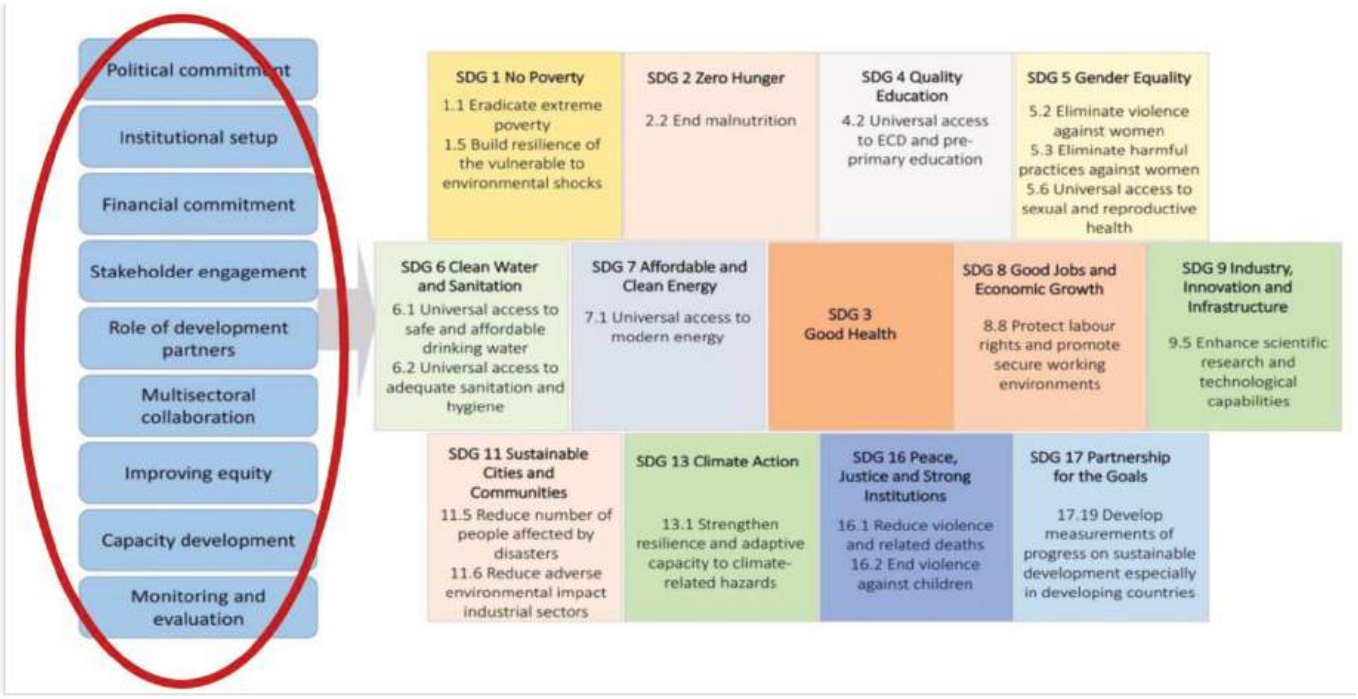
- Disruption with reduced access and effective coverage in healthcare
- Changes in -omics, immunology, emerging diseases,
- Endocrine disruptor chemicals
- pregnancy wastage and /or fetal complications
- Direct injuries and fatalities





Malnutrition and effects in pregnancy





Women and children are disproportionately affected

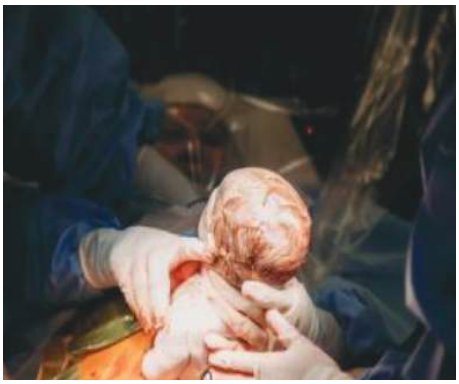
- Displacement
- Malnutrition and food insecurity
- GBV and reduced social protection
- Reduced performance indicators in SRHR and in some cases death
- Socioeconomic catastrophe
- Reduced social livelihoods for mother and babies
- Mental ill- health
- Breaking down of the family fabric

Our technical assistance in SRHR

- Is our training, programs and research agenda fit for the changing global environment?
- Should we revisit our normative environment?
- Are we conducting implementation barrier assessments?
- What is the role of our professional societies?

ARE WE PROVIDING LEADERSHIP

- Contextualized for driving quality and safe SRHR
- PHC/UHC
- The normative environment: international treaties and covenants ratified, constitution, policy, strategic direction, guidelines
- Resilience of the health system, access and coverage
- Health equity
- Technology: digitalization, LMS, data repositories and dashboards; Fem – Tech
- commodity procurement and supply logistics



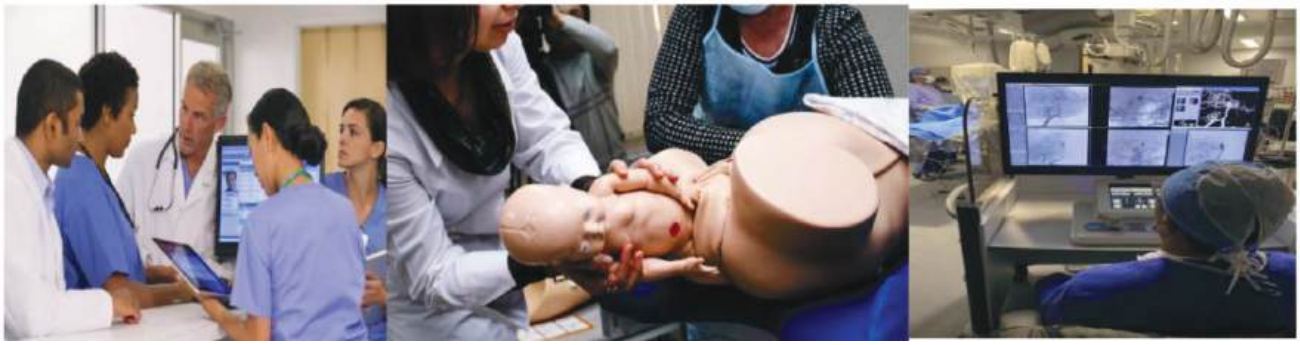
Curriculum-HRH competencies, patient centric, professionalism and ethics, addressing brain drain

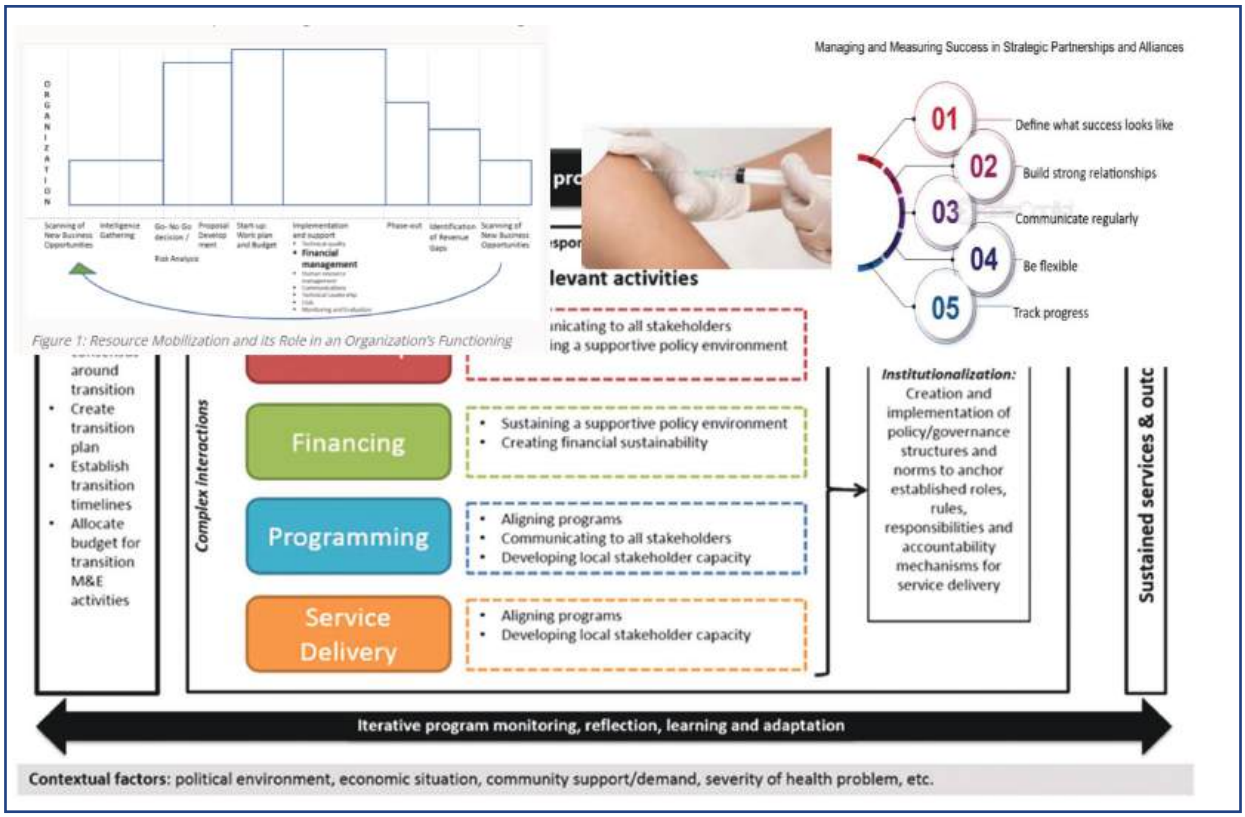
- public education
- Resource mobilization
- Strategic partnerships
- Advocacy and call to action
- Social accountability

Re-imagining our technical assistance put in context

- Global to localized agenda: political goodwill, shifting power and relationships
- Domesticated resourcing
- Technology: big data, AI, ML
- Collaborative partnerships: N-S, S-S, PPP, multidisciplinary , multisector with systemic thinking beyond health
- Gender mainstreaming– global alliance of women's health
- Life course approach with focus on intersectionality
- Health equity (DEIB)

Re- imagine technical assistance as professional societies





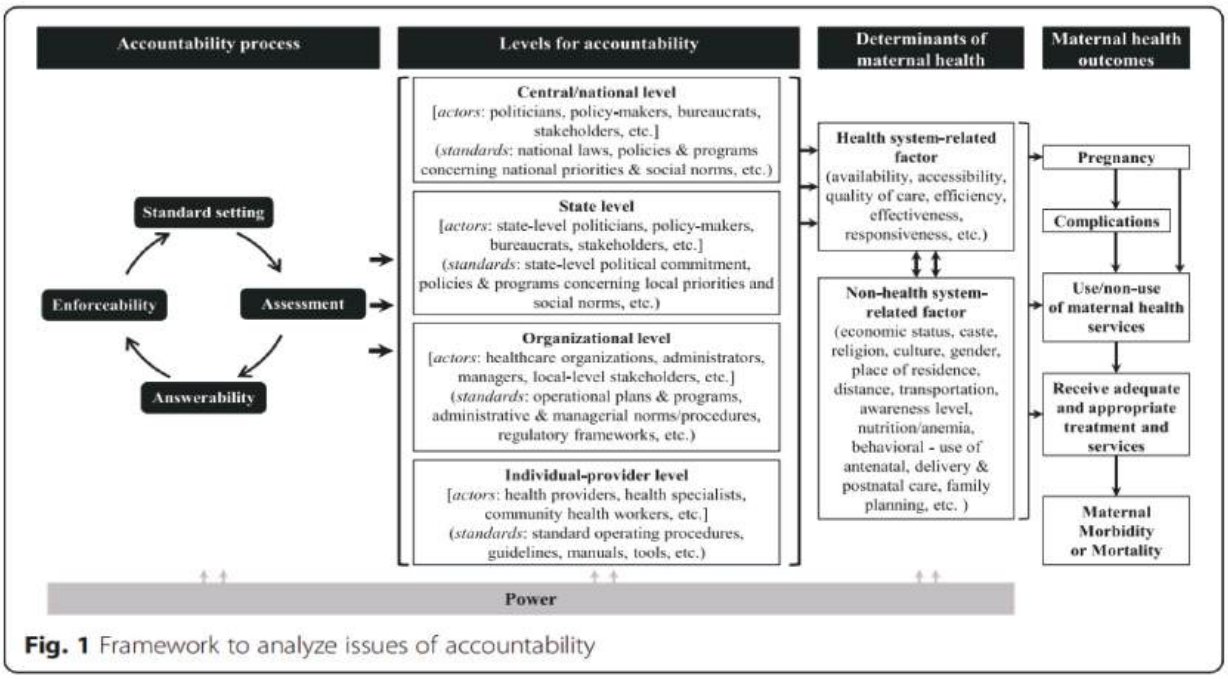
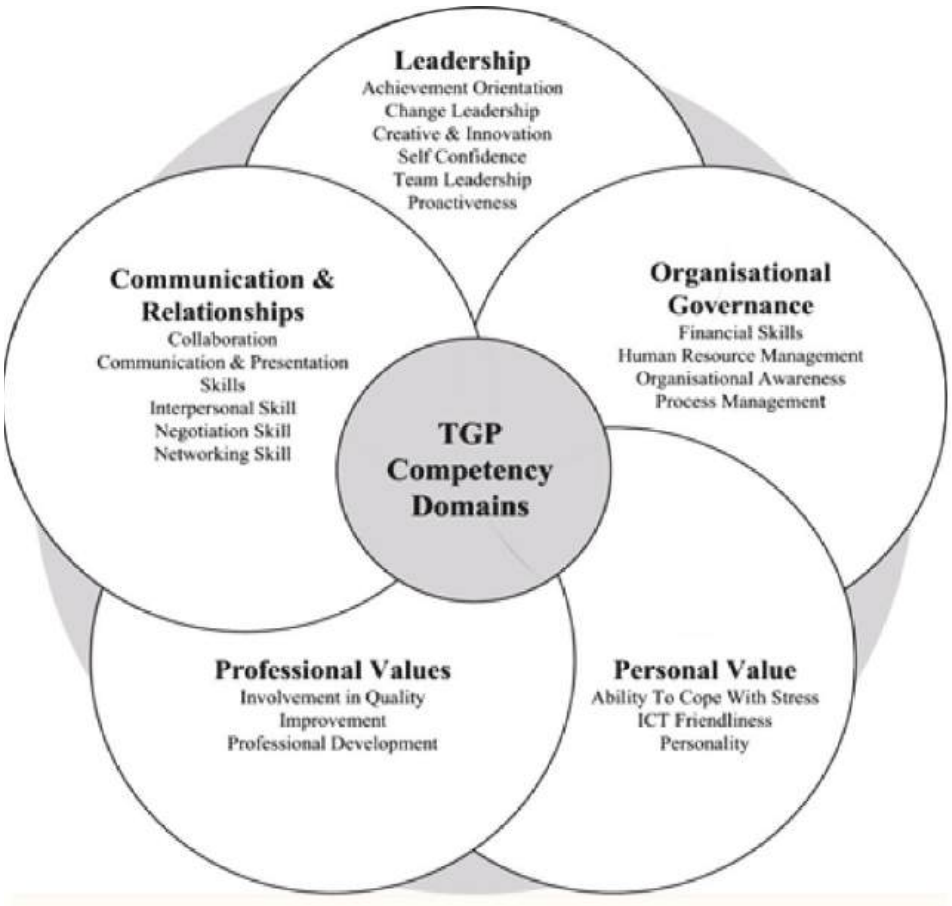


Fig. 1 Framework to analyze issues of accountability

Types of leadership from Ethiopia and Malaysia



Goal is improving maternal and newborn health outcomes through: increased coverage of key clinical interventions, rapidly implemented at scale, through the leadership of resilient national societies, all conducted through the lens of gender diversity and equality. This programme of collaborative work aims to deliver quality improvement in clinical practice and ultimately a reduction in adverse maternal and newborn morbidity and mortality.

Mastery leadership

Mastery of the skill to be a dynamic influencer; mastery of strategic planning and visioning; mastery of consistent achievements and results. Instead of being an ongoing, internal growth process, mastery is usually seen as mastery of something outside of ourselves.

Mastery leadership is influenced by PESTELE and needs to take into account capacities, culture, needs and preferences of the patient / client. It is interchangeable based on the context, to access and effective coverage of clinical interventions; the health building blocks and quality framework to provide quality, safe, equitable outcomes.
Different types of leadership may be needed such as positional, situational, result orientated, strategic, system wide, transformational based on the context, circumstance and desired outcome in and beyond health

Soar like an eagle

Mastery leadership can be sustained and scaled with 360° evaluation, empowering others, cross learning

- Retain your focus
- Stay away from narrow minded persons
- Do not rely on past success always look for new frontiers
- Face challenges head on knowing you shall overcome
- Leave your comfort zone there is no growth there
- Shed off old habit that can be a burden and add no value

Presidential Address

Dr Abdulfetah Abdulkadir, ESOG President

Good morning!

Your Excellency Dr. Ayele Teshome,
State Minister of Health

Professor Anne Kihara, President of The International Federation of Gynecology and Obstetrics (FIGO)

Esteemed country directors and representatives of partner organizations

Distinguished guests

Esteemed members of ESOG, seniors, colleagues, and friends

Ladies and Gentlemen

On behalf of the Executive Board of ESOG, the chairs and members of the conference organizing committees (CME committee, Fundraising committee, Scientific committee), and myself, it is with great honor that I welcome you all to the 32nd annual conference of ESOG. This year's conference takes place against a backdrop of significant challenges posed by internal conflicts and related issues across our country, resulting in loss of life and displacement. These challenges have profoundly impacted our health sector, particularly affecting women and perinatal health. We remain hopeful for peace and stability across the nation.

In 2023, the Executive Board convened 12 regular meetings, 3 extraordinary meetings, and two project appraisal sessions. ESOG actively participated in numerous international, regional, and national workshops. Additionally, we published four issues of the Ethiopian Journal of Reproductive Health, four newsletters, and conducted weekly community education through print and electronic media. ESOG also proudly serves on the National Task Force of Reproductive Health and Technical Working Groups at the Ministry of Health, and has expanded its partnerships.

With over 850 members nationwide and six chapter offices, ESOG leverages its extensive network to advance the health and well-being of women, girls, and newborns across Ethiopia.

Throughout 2023, ESOG engaged in diverse activities involving members, partners, and donors. These initiatives included:

- Enhancing reproductive health quality through stigma reduction and advocacy
- Establishing a business and revenue plan project for financial sustainability
- Conducting nationwide studies on CPD and preeclampsia risk assessment tools
- Introducing heat-stable Carbitocin and Tranexamic acid into health facilities
- Participating in the FIGO Leadership Development Initiative program

- Incorporating simulation-assisted training in OBGYN residency programs
- Supporting the National Self-care Network and advocating for safe abortion

ESOG has played a pivotal role in expanding access to MOH priority emergency surgical interventions, including enhancing C-section services and developing training manuals. During Safe Motherhood Month, ESOG donated medical equipment to facilities in Mekelle and South OMO ZONE.

Key donors supporting these projects include the David and Packard Lucile Foundation, USAID, the US National Institute of Health, the Bill and Melinda Gates Foundation through FIGO-ESOG Collaboration, and partners such as PSI, the Concept Foundation, Laerdal Global Health, and MSI.

The pre-conference CMEs featured a three-day program on Obstetric ultrasound, Hysteroscopy, Colposcopy, LEEP, and management of deep implants. Thirty-eight presentations were delivered during these sessions, with recordings available online for further learning and CEU credits.

Our hybrid plenary event, both in-person and virtual, gathers national and international experts. I extend sincere gratitude to the CME, scientific, and fundraising committees, and ESOG's dedicated team for their efforts in making this conference a success.

The theme of the 32nd annual conference, "Leadership in Women's Health: The Role of Obstetricians and Gynecologists as Leaders," underscores ESOG's commitment to strengthening member capacity and influencing healthcare policies. Through the FIGO Leadership Development Initiative program, ESOG will continue advocating for maternal and newborn health, improving outcomes through evidence-based interventions and leadership development.

I urge ESOG members and professional associations like EMwA and EESSA to implement the National PPH Guidelines and utilize care bundles to reduce maternal morbidity and mortality. Let us collaborate with clinical, political, and managerial partners to advance ESOG's leadership in women's health and improve national health systems.

Join us in exploring the challenges, achievements, and opportunities in women's health leadership during our panel discussions. Your participation is crucial for shaping policy recommendations and fostering collaboration among stakeholders.

On behalf of the Executive Board and myself, I extend heartfelt thanks to all donors, partners, and stakeholders supporting this annual conference. I wish you all a productive and enriching experience during our deliberations.

Thank you very much!

Welcoming New Graduates of Obstetrics and Gynecology

As ESOG's tradition dictates, new graduates who joined the Ob-Gyn community were welcomed at the Conference.

Awarding Great Contributions:

Dr. Lia Tadesse, outgoing minister of Health received an Award of Honor

Dr. Fekade Deneke, recipient of ESOG 2024 Lifetime Achievement Award

DR. Tadesse Kitila Sanyii Recipient of ESOG 2024 Distinguished Service Award

DR. Ashebir Getachew Recipient of ESOG 2024 National Service Award

DR. Kokeb Mohammed Abdule Recipient of ESOG 2024 Community Service Award

Professor Delayehu Bekele Recipient of ESOG 2024 Especial Contribution Award

Plenary Session:

Theme

Leadership in Women's Health towards Reducing Maternal and Neonatal Morbidity and Mortality: The Role of Obstetricians and Gynecologists as Leaders
Dr. Malede, chair of the panel invited Dr. Gelane Lelissa to make the first presentation before the panel.

Dr. Gelane:
Leadership Development Initiatives of ESOG

Dr. Gelane Lelissa, Vice president of ESOG

Objective of Presentation

- To discuss the initiatives of ESOG in the arena of leadership in health particularly in development on this art & skill in OBGYNS
- To site the FIGO LDI: Reach programme

Introduction

- ESOG was established in 1992.
- Recognition of maternal health & SRH status in our country
- Need for marshalling efforts at the society & more significantly in the health system starting from facility RMNCH units to FMoH clear from the outset
- One of objectives of ESOG from inception is "To influence policy, strategy and plan development & training & research in SRHR and MNH"

ESOG works with FMoH & international partners & all works have an element of enhancing leadership roles

- It had worked in the enhancement of leadership capacity of especially members involved as faculty in training of OB GYNS in collaboration with ACOG
- Gender diversity & equality is always considered of paramount importance ESOG has so far contributed to legislative process in SRH issues & will continue to do so.
- ESOG has worked with FMoH on all aspects of RMNCH & SRH being part of TWG. • ESOG has worked through its members to implement projects
- As part of its strategic plan it aims to strengthen chapter offices to take on the tasks of impacting MNCH at regional levels by working with health institutions & partners

Background

It mainly revolves around two pillars

- **LEADERSHIP development**
  Tailored leadership training which enables the development of capacity to identify the inherent steps in effecting change in health care systems

- **Clinical best practice**
  Two targeted Key intervention, Barrier identification, Planning, implementing, barrier, tracking, Planning

- **Design of the project**
  The two pillars are interdependent

Key clinical interventions

1. E-MOTIVE for PPH
2. Use of Antenatal Corticosteroids for preterm birth

Leadership development at level

- National & Societal level
- Regional & CEO of facility
- At level of department & individual health care providers

Tailored leadership training

- After basic discussion on leadership in the context of maternal health services, participants are guided to reflect on leadership & other systemic barriers to implementation of E-MOTIVE & ACS at their service areas
- Then they will be guided through prioritization & planning exercise
- This team continues to engage in implementation through continuing barrier tracking
- They will involve in not only introducing the implementation plan to their colleagues but they will also champion these interventions in their institutions
- This learning & capacity is expected to be rapidly expanded within institutions to other interventions & to other institutions

Who have been involved so far?

- FMoH MNCH directorate
- EPSA
- Regional health institutions

Selected facilities

1. SPHMMC
2. MSI
3. WUSH
4. Adare hospital

Summary

ESOG has taken ownership of the initiative.

- We will disseminate learning generated by sharing of success stories.
- We are forming national level partnerships, situation analyses, mentorship of champions, follow-up workshops, and study visits.
- The initiative is more than a training-based approach, focusing on coherent national strategies including health systems strengthening, network integration and local data collection for problem solving.

Dr. Malede:
Thank you, Dr. Gelane. I will now forward the first question to Dr. Ayele. Dr. Ayele, how do you see the impact and contribution of OBGYNs as a profession and society in improving maternal health in Ethiopia? Additionally, what are the challenges, traits, and opportunities regarding greater involvement of obstetricians in the region? While I understand you are an obstetrician, I am referring to the broader obstetrician community.

Dr. Ayele:
Thank you very much. I'm honored to be here, and it's good to see our colleagues. We are indeed aging! The impact of our society and its members on the national health system, particularly women's health, is significant. This is not only in terms of service delivery but also in strengthening the system across various components such as workforce development, evidence generation, and collaboration with other societies and colleagues. The level of engagement from our society and members, beyond clinical service delivery, is considerable. This is something I have witnessed in my career and during my time as a leader in the ministry.

We must acknowledge our successes. For example, the recent transition from Dr. Lia to Dr. Mekides, as seen in social media posts and comments, clearly demonstrates the impact of obstetricians in the Ethiopian health system. Although I don't have specific data, the influence at various institutional levels, including the roles of medical directors, is substantial.

One major challenge is the mindset. As Professor mentioned earlier, the mindset of weak clinicians is a significant problem. Are we ambitious enough to be leaders? Do we view leadership as a skill, similar to a sub-specialty in the clinical field? Leadership involves envisioning the desired changes in the health system and designing a path to achieve those goals, which requires dedication and balancing personal needs with long-term objectives.

To be impactful, we must consider leadership a skill and work on the foundational elements necessary to become leaders. As obstetricians or doctors, we are trained as subject matter experts, but not necessarily as leaders who manage resources, data, and human capital effectively. Therefore, our education system needs to incorporate system thinking not only in the curriculum but also in evaluation mechanisms.

Currently, more students are focusing on leadership, and our orientation increasingly includes public health components. By integrating more systemic components into our curriculum, we can cultivate more leaders within the healthcare system. Additionally, leadership should not be seen as a favor granted by politicians but as a responsibility we all share to create better outcomes.
Effective leadership is about managing resources efficiently and innovating solutions to problems, even in resource-constrained environments. As discussed earlier, leadership is a skill, not a position. Therefore, we need to emphasize its importance.

Furthermore, we need to work towards attractive payment incentives and balance them with sacrifice and devotion. While these factors present challenges, there is ample room for us to engage and bring positive changes to the system, particularly in women's health. Investing in capacity-building programs, including leadership development, is crucial. If we view leadership as a specialized skill and commit to it, we can pursue this path successfully.

Dr. Malede:
Thank you, Dr. Ayele. You have highlighted important points such as the lack of skills and motivation among professionals. Leadership is not just about holding high-level positions; it must be practiced at every level. My next question is for Professor Anne. As the President of FIGO, you have considerable experience in institutionalizing leadership within professional societies. Could you share international experiences where professional societies have assumed leadership roles in influencing decision-making in national programs, beyond setting clinical guidelines and activities, specifically in resource allocation and planning? What has been FIGO's experience in this regard? Could you provide some evidence and examples?

Professor Anne:
Thank you very much. I would like to acknowledge the leadership of ESOG. At FIGO, we have WATOG, which focuses on grooming young leaders. Recognizing the importance of involving young gynecologists is crucial because they bring energy and new perspectives, even though we often rely on the wisdom of older generations. It's essential to cultivate leadership skills in the younger generation, as Dr. Ayele emphasized.

The most critical aspect of leadership is building networks. For instance, the recent AU summit - how

many of us were actively engaged there? Opportunities won't come to us; we must seek them out. As I mentioned earlier, "You can walk fast alone, but you can go far together." An interdisciplinary and multi-sector approach is also vital. Events like COP28, the Davos Economic Forum, and the African Union meetings are significant. Gynecologists must actively seek partnerships that can bring funding and support. For example, understanding the link between fetal programming and the risk of non-communicable diseases due to malnutrition should prompt immediate action.

We must step out of our comfort zones and think creatively. Recognize the pillars within your society. FIGO provides strategic direction, which permeates all member societies. Key areas include capacity building, public education, advocacy, and implementation research. Contextualize evidence for your country and region. For instance, I learned that Ethiopia has seven regions, each with unique contexts. Conducting implementation research can inform local strategies and attract partnerships and resources.

Aligning with the global agenda is crucial. We are currently focusing on primary healthcare and universal health coverage, which are fundamental rights. However, many people face financial hardships accessing these services. Where is our voice in this? We must be at the decision-making table.

Communication with communities is also essential. They understand their needs and challenges. How often do we engage with them and articulate their concerns to higher authorities? Effective communication and trust-building are key to successful leadership.

Lastly, consider a leadership model centered on community involvement. It starts with individual health-seeking behavior and addresses the "three delays" in healthcare access, plus a fourth delay related to community communication. Understand where the community fits within your institution and how you, as a leader, can influence cultural change, health system strengthening, innovation, and policy adaptation.

Reflecting on the structural context, consider the legislative framework for maternal and newborn health. How does it translate into policy? How often is it reviewed and updated to provide strategic direction? This, in turn, informs guidelines and job aids. By thinking within this structure, you can become an effective leader. This is the approach we promote at FIGO.

Dr. Malede:
Thank you, Professor. My next question is for Dr. Serkalem. As the leader of one of the largest reproductive health research projects supported by USAID, how do you perceive the role of ESOG in enhancing the quality of such projects? Additionally, how is ESOG engaged at the national level?

Dr. Serkalem:
Thank you so much for having me. I feel honored to be part of this panel session alongside our honorable minister and other influential leaders who are shaping healthcare leadership both nationally and internationally. Addressing your question, it's important to recognize that women's access to quality reproductive healthcare is currently very low. To drive the necessary changes within our health system, it is crucial to involve and engage professional associations and local civil society organizations. ESOG, as one such organization, works closely with the Ethiopian government to support initiatives aimed at improving maternal and reproductive health for women, girls, children, and society at large.
ESOG played a significant role in designing and creating our project, the USAID Quality Healthcare Activity. To provide some background, this is a five-year project funded by USAID, focusing on improving the health and status of women, adolescent girls, and children. In line with USAID's shift towards locally led programming, we involved civil society organizations and professional associations from the onset of the project's design and co-creation phase.

ESOG and its members actively participated in this phase by proposing and developing evidence-based initiatives to improve maternal and adolescent health. Moving forward, as we implement the project, we are in the process of signing a Memorandum of Understanding (MOU) with civil society organizations, including ESOG. Additionally, the Network of Ethiopian Women Associations (NEWA) is a key partner in this project. They will be involved in the implementation phase, particularly in mentorship and coaching related to maternal health.

ESOG is also participating in revising and developing national guidelines to improve maternal health, family planning, and outreach services. They will lead capacity-

building programs at primary healthcare units, designing and providing in-service training, and supporting initiatives related to task shifting and task sharing.
In summary, within the USAID Quality Healthcare Activity, ESOG, as a professional association, plays a leading role in setting the agenda and implementing initiatives that will enhance the health of mothers and children. Thank you

Dr. Malede:
Dr. Desset, my question to you concerns the gender disparity within professional communities and societies. For instance, in this community, the number of women who have reached leadership positions is quite limited. Given your experience with gender-transformative training in healthcare services, how do you view women's leadership, and how can we improve it?

Ms. Desset:
Thank you very much. I am truly honored to represent UN Women today. While entities like UNICEF and UNDP are widely recognized, UN Women is the United Nations entity focused on gender equality and the empowerment of women, much like UNICEF's work with children. I am proud to be here on behalf of my agency.

I am glad the moderator brought up this issue. As I observed the awardees today, I noticed that out of six recipients, only one was a woman. I discussed this with someone sitting next to me, and they confirmed it. I was waiting for more women to be recognized by the organizers, but none were. Additionally, among the 160 graduates from various universities congratulated today, only 10 were women. I am grateful to the woman who provided me with this data during the break.

When I inquired why this disparity exists, she laughed, indicating how challenging it is to break through these barriers. I spoke with more female professionals who shared their difficult journeys. They didn't need much prompting to reveal the arduous process they endured to reach their positions.

As a lawyer and human rights advocate, I feel it should be these resilient women sharing their lived experiences today. They should speak about the harassment, sleepless nights, and hardships they faced. One woman shared that she worked 36-hour shifts three times a week. She detailed her struggle, supported only by her husband, to complete her education. Her daughter once asked, "Do doctors cry?" after seeing her in tears several times. Despite the challenges, she persevered to be a role model for her daughter and other young girls.

This is the message I want to convey: as an outsider, I urge you to do better. Thank you.

Dr. Malede:
Thank you very much. Let's move quickly to the next round of questions, and then I'll open the floor to the audience. I hope you're jotting down your questions. First, I have a challenging question for Dr. Ayele regarding the role of professional associations, like ESOG, in influencing health policies. In my research on leadership in women's health, I found that in some countries, such as Canada, these associations not only contribute to clinical guidelines but also influence ministries to formulate and allocate resources for policies. In contrast, in Africa and specifically in Ethiopia, policies are dictated by the ministry and then implemented. How do you perceive ESOG's role in decision-making, and what are the current barriers and challenges? How do you envision this evolving in the future?

Dr. Ayele:
Thank you for the question. Professional associations like ESOG indeed play a significant role in shaping health policies in Ethiopia. However, it's important to recognize that policy formulation here depends heavily on available priorities and resources. Not all recommendations from associations may be accepted verbatim; there could be modifications. Nonetheless, input from associations and stakeholders is integral to every policy and strategy proposed to the ministry. It's true that engagement with stakeholders sometimes falls short of expectations. We acknowledge that higher-level decisions can overlook the necessity of involving stakeholders adequately. Bridging this gap requires concerted efforts from both sides.

One of our major challenges lies in integrating initiatives more effectively into academic institutions. Improving medical education and aligning it with the country's healthcare needs remains a daunting task. It's crucial that we start addressing these issues early, during pre-service training, to better prepare future healthcare providers. Collaboration with associations and academic institutions is key to addressing these challenges, including sharing knowledge and experiences.

Ideally, empowering associations to take on more regulatory roles, such as in licensing and re-licensing, would streamline governance and support our efforts in healthcare delivery. As a ministry, we fulfill multiple roles—providers, regulators, and purchasers—and enhancing the capacity of associations in regulatory functions would greatly facilitate our operations. We are actively advocating for policy reforms to support these initiatives, particularly in healthcare financing.

There are numerous opportunities for collaboration and mutual trust between the ministry, associations, and other stakeholders. By working together, we can overcome existing challenges and deliver better healthcare outcomes. This collaboration is pivotal as we navigate the complexities of healthcare management and policy-making in Ethiopia.

Dr. Malede:
Dr. Ayele has underscored the critical role of pre-service training. How do you perceive leadership development programs, especially within residency programs and for the next generation of leaders? What has been FIGO's experience?

Professor Anne:
I'll begin by emphasizing the centrality of our societies, alongside my esteemed colleague. Here, we have academicians, private practitioners, and public health experts gathered, highlighting the need for centrality in our efforts. Have we engaged our ministers effectively, advocating for our presence at decision-making tables? This is where our journey begins.

Regarding pre-service and in-service training, how many of us have received education in implementation research, utilizing routine data for evidence-based decision-making, and addressing gender-disaggregated data? The numbers are starkly low. For instance, when it comes to grant writing skills, only a handful have been adequately trained.

The approach to implementation research should not be an afterthought or merely a skill learned for grant applications. It should be integrated early in our professional development, becoming second nature by the time we enter the workforce.

Additionally, we need to be proactive in embracing initiatives like "With You and Women" and tools such as the Garware tool for women empowerment. These initiatives require us to think beyond traditional boundaries and explore interdisciplinary approaches. For instance, recognizing achievements like our veterinary colleague's award underscores the importance of a holistic "One Health" policy.

In medical education, where I am privileged to teach, collaborative training and interdisciplinary discussions are crucial. These platforms foster cross-learning and prepare future leaders comprehensively. However, there remains a gap in integrating such approaches into our current consultative frameworks within ministries. Bridging this gap requires a concerted effort to understand and implement integrated approaches effectively.

Ultimately, our ability to address complex health challenges hinges on our readiness to embrace a holistic, integrated approach from the outset of medical training. This proactive stance is essential for advancing our field and improving health outcomes globally.

Dr. Malede:
My next questions are for both of you. How do you recognize the unique contributions of women leaders to improving human health? And how can we narrow the gender disparity gap in leadership?

Dr. Serkalem:
Thank you. It's an intriguing question. I'd like to begin by referencing an article published by the WHO several years ago, which highlighted the global gender disparity in healthcare leadership. Despite women constituting approximately 70% of the global health workforce, they only occupy about 25% of leadership positions. This disparity is mirrored in our own nation, where women make up 52% of the health workforce but hold significantly fewer leadership roles. This gap is particularly evident in public institutions where health services are delivered. For example, our successful health extension program, led primarily by women, has significantly improved health outcomes. Yet, when it comes to higher leadership roles within institutions like health offices, zonal health departments, and hospitals, women's representation remains disproportionately low. This disconnect underscores the urgent need to empower more women professionals to assume leadership roles, not just for gender equity's sake, but for the benefit of our healthcare systems. Women bring valuable perspectives, wisdom, and expertise that are essential for enhancing our health systems.

Another crucial aspect is the need for a paradigm shift in our mindset and institutional practices. We must challenge existing gender biases, both conscious and unconscious, embedded in our systems, policies, and practices. This shift is essential to create a more inclusive environment where women can unlock their full potential and contribute more effectively to society. Thank you.

Ms. Desset:
Thank you. My colleague has eloquently covered much of what I intended to say. Looking forward, there are specific actions we must prioritize. Firstly, we need robust data and evidence-based advocacy to drive meaningful change. Secondly, political will is crucial. We've seen transformative results when political leaders prioritize gender parity, such as the significant increase in women's representation in Ethiopia's Council of Ministers in 2018. This demonstrates that change is possible with decisive political support.

Moreover, we need male champions who actively promote women's leadership. It's imperative that initiatives and awards actively include and recognize women's contributions. For instance, in research projects and prestigious leadership programs, the inclusion of women must be prioritized to ensure a balanced and comprehensive approach. This gender lens is not just about fairness; it directly impacts critical health indicators like maternal mortality, teenage pregnancy rates, and HIV vulnerability among women. Ultimately, our collective efforts towards gender parity in leadership are essential for the well-being of current and future generations. Thank you

Dr. Malede:
Thank you. We've concluded our panel discussion, and now it's time for your questions. Before we open the floor, I would like to invite Dr. Abebe, the country director of MSI, who has authored a book on women's health leadership, to speak for five minutes and provide insights on today's themes. Could we pass the microphone to him, please?

Dr. Abebe:
Thank you very much. Good afternoon, Your Excellency, distinguished participants, ladies, and gentlemen. I extend my heartfelt congratulations to ESOG for organizing this annual event. The theme, emphasizing the critical role of leadership in improving maternal health, is particularly inspiring. In Africa, where maternal and neonatal health challenges persist despite various adversities such as COVID-19, conflicts, and climate change, this discussion is timely and essential. These challenges have taught us valuable lessons and underscored the need for forward-thinking leadership.

From my experience, I would like to emphasize three key points on why leadership is crucial in our efforts. Firstly, leadership involves not only applying professional skills but also engaging our minds and hearts to better understand and serve women's needs effectively. Financial resources alone are insufficient without effective leadership guiding their allocation and utilization.

Secondly, having a clear purpose is fundamental to effective leadership. For instance, Ethiopia, once a major contributor to global maternal mortality rates, made significant strides in reducing these rates over the past three decades. This progress was driven by purposeful leadership, advocacy, and collaboration across sectors and civil societies.

Thirdly, leadership is about catalyzing change, particularly in the lives of women. True leadership isn't just about making global changes but starting with improving women's health as a pivotal entry point. By prioritizing women's health, we lay a foundation for broader societal transformations.

Additionally, effective leadership attracts followership and fosters strategic partnerships. I'm here today because of ESOG's compelling vision and strategic direction, which I proudly support and contribute to.

Lastly, leadership is a resource that, when wielded wisely, can bring about significant positive change. Despite financial constraints, strategic leadership has enabled MSI and its partners to provide essential maternal health services to thousands of women, illustrating the impact of effective leadership in action.

In closing, I want to highlight the importance of empowering women in leadership roles. I've witnessed firsthand in Zimbabwe and here at MSI how promoting women's leadership not only achieves organizational goals but also catalyzes transformative change. Therefore, if we aspire to meaningful transformation, we must actively promote and support women in leadership positions.
Thank you for this opportunity to share my thoughts.

Participant 1:
Thank you for the opportunity to speak. I have two comments and a question. Firstly, regarding leadership capacity development, back in 2016 during a collaborative project with technical support from a partner, one of our key focus areas was leadership capacity development. Professors Delayehu and Dr. Makdes attended a two-week training in the US, which they then disseminated. However, I am unsure of subsequent efforts since then. There were several training sessions at that time, indicating our recognition of the importance of leadership in OB GYN practice.

Secondly, concerning gender diversity in leadership, currently, three out of our seven executive members are women OB GYNs, representing approximately 42%. This is encouraging, and with upcoming elections, we aim to increase female representation further. It's commendable that three out of four panelists today are women, showing progress.

My question is for Dr. [Participant 2]. Given the importance of leadership capacity in obstetrics, how do you propose integrating it into pre-service training? Considering the crowded academic calendar, do you foresee this becoming feasible in the near future?

Participant 2:
Thank you. I commend all panelists for their insightful discussion on the timely topic of leadership, particularly highlighting gaps in female leadership roles. Nationally, we are seeing more women in high-level positions like Professor Annie, but there remains a gap in middle and lower tiers. As Professor suggested, focusing on the younger generation is crucial. Dr. Dereje mentioned the potential of pre-service training, aligning with a system-oriented medical education approach. Have there been any initiatives in this direction nationally, and what progress has been made?

Participant 3:
Firstly, I would like to extend my gratitude to all the panelists and participants who contributed to these discussions over the past few days. Dr. Ayele's point resonated strongly with me when he highlighted our tendency to perceive ourselves as leaders without embodying true leadership qualities. I fully agree with this sentiment. Often, professions such as medicine or obstetrics and gynecology confer upon us a level of respect that society interprets as leadership, yet true leadership demands specialized training, which is often lacking in our educational systems, not just in Ethiopia but globally.

Upon graduation, many of us are thrust into roles as medical directors or department heads without adequate preparation to lead effectively. We become experts in our fields but not necessarily leaders. As Professor Anne rightly pointed out earlier, involving diverse stakeholders, including government health officials, in these discussions is crucial. Only then can we begin to reform educational curricula to prioritize leadership development from the outset.

Moreover, the concept of leadership extends beyond simply occupying a position of authority. True leaders should engage directly with their teams and communities, demonstrating care and fostering leadership qualities in others. For instance, a medical director should empower departmental leaders within their hospital to drive initiatives and create a multiplier effect of leadership throughout the institution.

I am reminded of an inspiring example from Zeros/Good Shepard, an organization that empowered women through community activities. This initiative not only supported women but also recognized the transformative power of inclusive leadership. As a leader myself, I advocate for empowering women because of the profound influence my mother, a role model of leadership, had on me.

Furthermore, I echo the sentiment shared by Deset regarding the necessity of policies to address gender disparities and integrate leadership principles at all levels of society, starting from our homes to educational institutions and beyond. This inclusive approach ensures that leadership is not a privilege but a skill set accessible to all, starting from a young age.

Leadership is not innate; it can be cultivated through education and practice. Dr. Serkalem's leadership in managing a $50 million project exemplifies this, where effective leadership is pivotal to achieving meaningful outcomes.

In conclusion, initiatives like the Leadership Initiative underscore the importance of leadership in transforming lives and practices. By embracing and institutionalizing

leadership principles early on, we can drive positive change and address critical challenges such as maternal mortality rates due to postpartum hemorrhage in Ethiopia. Thank you all for your valuable insights and contributions to this discussion on leadership.

Participant 4
Thank you all for today. We've had many enriching experiences and inspiring insights that encourage us to reflect on our roles—both as individuals and as part of a team or program—in enhancing the quality of service we provide to mothers. One highlight was Professor Annie's speech, particularly her discussion on the challenges and opportunities of project management in sub-Saharan countries. She emphasized the pitfalls of working in silos without proper coordination, prompting us to consider how we initiate and sustain projects slated to conclude in the coming years.

Professor Annie also noted that only 77% of postgraduate specialists are female. This statistic underscores the importance of fostering more female leadership in obstetrics and gynecology. It raises critical questions about our strategies for increasing the number of female specialists through university programs and beyond.

I would like to direct a question to Dr. Ayele and representatives from the government and Deset: Do we have a roadmap in place to facilitate greater participation of female specialists in our field? This roadmap should not only focus on increasing their numbers but also on creating a supportive environment where women in medicine, particularly in obstetrics and gynecology, can thrive professionally.
Thank you.

Dr. Malede:
Thank you all very much. We have received valuable comments, which have been well received. They serve as excellent supplements to our panel discussions. We have three questions, primarily directed at Dr. Ayele, but others are welcome to contribute as well. The first question addresses the integration of leadership strength in residency programs by Dr. Ayele. The second pertains to the establishment of a national leadership development program, especially for young individuals. Lastly, how can we enhance specialty training? I invite responses from all of you.

Dr. Ayele:
Thank you for the questions. Regarding the integration of leadership into pre-service training, as mentioned earlier, effective healthcare hinges on comprehensive care, human satisfaction, and resource efficiency. While our current curriculum emphasizes evidence-based care, incorporating safety components, healthcare is fundamentally about delivering holistic care. When we send doctors trained in Addis to regions like Afar, they must adapt to local resources. Effective leadership means achieving results with available resources and options. Over the years, significant investments have been made in leadership development, infection prevention, patient safety, and other areas. These resources could have been utilized differently had they been integrated into the core curriculum. Training doctors in health system pillars alongside service delivery would address challenges such as high maternal and neonatal mortality rates. Academic institutions play a crucial role here; however, there is resistance to change. We must think innovatively and systematically, focusing on operational implementation research to complement conventional approaches.

Leadership involves influencing and motivating others, particularly the youth, to solve problems. This responsibility falls not only on the government but on all of us. We are currently revising curricula to include more system-oriented components alongside clinical expertise. For instance, an OB/GYN curriculum could allocate 70-80% to subject matter and 20-30% to systems and leadership. This balanced approach encourages comprehensive learning and prepares students for real-world challenges.

Addressing gender balance in specialties like OBGYN requires robust policy interventions. While discussions and workshops are beneficial, actionable policies are essential. We need decisive steps, such as revising civil service requirements to ensure equitable representation. This initiative requires national support and coordinated efforts from decision-makers.

Enhancing healthcare and leadership training demands collaborative efforts and a proactive stance from all stakeholders. We must challenge existing norms and integrate innovative solutions into our educational and healthcare systems. That is what I believe.

Professor Anne:
Thank you all. I'd like to share some reflections that I believe will benefit us all. Let's begin with the last question on creating an enabling environment for women. We, as women, have advocated for facilities like baby crèches. These are crucial because they allow us to work while ensuring we have a place to breastfeed or care for our young children. In Nairobi, we are pioneering centers that provide such supportive environments, enabling us to balance academic pursuits with childcare responsibilities. I pose this challenge to all of you, as leaders at the helm.

Secondly, addressing how academia can contribute, you've urged us to integrate leadership into our practices. In response, within our medical training programs, we have begun incorporating aspects of public health. This includes understanding policy, strategic direction, constitutional principles, and the healthcare system. Despite initial resistance, we have persisted, even integrating related questions into our registrar exams. This initiative has sparked interest and is fostering a deeper engagement with these critical issues.

Thirdly, I want to emphasize the role of organizations like ESOG. Beyond technical expertise, there is a need for webinars that delve into various facets and pillars of leadership. Recently, I participated in a webinar with 500 attendees from Latin America, highlighting a strong demand and interest in leadership development. This platform can serve as a gateway to providing solutions.

Lastly, during a recent session, a lady sang a song that resonated with me deeply: "What does mum mean to each of us?" It reminded me of the importance of always learning and evolving. As leaders, it's crucial to remain receptive, acknowledging that learning is continuous and there's always room for enhancing our leadership qualities. Thank you.

Ms. Desset:
As UN Women, I commit to providing technical support for your efforts to promote women's leadership. I echo His Excellency's call for a minimum quota of 20%. It is crucial that we work diligently across all platforms to achieve this goal.

Additionally, I urge the mainstreaming of gender in leadership trainings. Gender considerations should permeate all topics; for example, time management differs for men and women. We must avoid a gender-blind curriculum.

I recently reviewed one of your leadership training reports and identified areas where gender elements could be integrated. I encourage you to explore this opportunity. Lastly, during a break, I spoke with an OB-Gyn who shared her experience. She advises women to breastfeed their children until six months, yet she herself couldn't do so for her daughter, resorting to supplementary food at three months. She asked, 'Aren't I a mom, too? Aren't I a woman, too?' Let's recognize all our colleagues as mothers and women. Thank you

Dr. Malede:
Summarized the main points raised by the panelists and closed the session.

Abstracts Presented during the Conference

Preventing maternal death from postpartum bleeding and clinical trial capacity building in Ethiopia: the case of I'M WOMAN clinical trial

Clinical trial title: Tranexamic acid by the intramuscular or intravenous route for the prevention of postpartum hemorrhage in women at increased risk: a randomized placebo-controlled trial (I'M WOMAN)

Trial Sponsor: London School of Hygiene and Tropical Medicine (LSHTM)
Ethiopia trial coordinating institution: Armauer Hansen research institution (AHRI)

List of identified Ethiopia investigators: Dr. Abel Gedefaw, Dr. Betel Dereje , Dr. ketsela Lema, Dr. Nardos Aynalem, Dr. Tadese Gore, , Dr. Mekonnen Teferi, Dr. Alemseged Abdissa, et.al.

List of potential identified Ethiopia implementing hospitals: St. Paul Millennium Medical College's Hospital, Ghandi Memorial Hospital, ALERT Comprehensive Specialized Hospital, Jimma University Specialized Hospital, Hiwot Fana Comprehensive Specialized Hospital, et al.

Protocol summary
Background: Postpartum hemorrhage (PPH) causes about 70,000 maternal deaths each year, worldwide. Intravenous (IV) tranexamic acid (TXA) reduces deaths due to PPH by one third when given within 3 hours of childbirth. The WHO recommends early use of IV TXA for the treatment of PPH. However, the IV route of administration is currently a major access barrier. Consequently, the WHO Roadmap to combat PPH (2023-2030) states that research on the comparative effectiveness and safety of alternative routes of TXA administration is the top innovation research priority. IM TXA would have practical advantages as it is quicker and simpler to administer than IV TXA, with the potential to enable task shifting and expand equitable access to early TXA treatment.

AIM: To assess the effects of IM and IV TXA in women at increased risk of PPH

OBJECTIVES:
1. Assess the effect of TXA on the risk of PPH and other bleeding-related outcomes;
2. Compare the effects of IM and IV TXA on the risk of PPH;
3. Compare the effects of IM and IV TXA on the risk of adverse events.

PRIMARY OUTCOME: A clinical diagnosis of primary PPH.

SECONDARY OUTCOMES: Surgical and postpartum blood loss, interventions for bleeding, pre-specified maternal adverse events), days in ICU/HDU, length of hospital stay, death by cause, neonatal outcomes, other adverse events.

TRIAL DESIGN: A randomized, placebo-controlled, three arm trial.

POPULATION: Women having a vaginal or caesarean birth, who are at increased risk of PPH

INCLUSION/EXCLUSION CRITERIA: Women thought to be aged 18 years or older at increased risk (one or more risk factors) of PPH who are admitted to hospital to give birth vaginally or by caesarean section are eligible. Women who have a clear indication or contraindication for the trial treatment should not be recruited.

TRIAL TREATMENT, REFERENCE THERAPY, DOSE AND MODE OF ADMINISTRATION AND RESTRICTIONS:
a) 1 gram of tranexamic acid as two 5 ml IM injections (100 mg/ml) and IV placebo (10 ml 0.9% sodium chloride); b) 1 gram of tranexamic acid by IV injection and two 5 ml IM placebo injections; or c) matching placebo. The trial treatment will be given just prior to skin incision (after draping) in caesarean births and at crowning in vaginal births.

SETTING: The trial will be conducted in hospitals in Africa and Asia where maternal mortality due to PPH is high. We will recruit approximately 30,000 women from Ethiopia, Tanzania, Nigeria and Pakistan, where maternal mortality due to PPH is high. In Ethiopia, we plan to recruit nearly 2500 women from seven hospitals.
DURATION OF PARTICIPATION: Trial participation ends at discharge, death or 42 days after randomization, whichever occurs first.

CRITERIA FOR EVALUATION: Women who receive IM TXA will be compared with those who receive IV TXA in a per-protocol analysis. All those allocated

to receive TXA will be compared to those allocated to receive placebo, whether they received the allocated treatment or not (intention-to-treat analysis).

Current status: Submitted for ethical and regulatory approval

Study period: February 2024- December 2026.

KNOWLEDGE, ATTITUDE, AND PRACTICE OF POST-PARTUM CARE IN WOMEN WHO HAVE UNDERGONE CESAREAN DELIVERY IN AYDER COMPREHENSIVE SPECIALIZED HOSPITAL

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Abstract

Background: In the immediate postoperative period after cesarean delivery (CD), vital signs, uterine tone, vaginal and incision bleeding and urine output should be closely monitored. Early ambulation and oral intake should be encouraged. Breastfeeding initiation should be in the delivery room. Patients should receive consistent pre- and post-procedure counseling.

Methods: A hospital-based cross-sectional study was be applied and data collected from a sample size of 412 women. One time phone interview was also used to collect data on maternal practice after discharge. Data was analyzed using Statistical Package for Social Science (SPSS) version 27. The dependent and independent variables' frequency distributions were calculated. Results were shown in a table as percentages. Multivariate linear regression analysis was utilized on the variables with a significant P-value in simple linear regression to determine the determinants of postpartum care knowledge of mothers and their attitudes.

Result: The majority of mothers had a good level of knowledge of postpartum care and attitude towards it (74.8% and 96.4% respectively). Educational Status significantly affected total knowledge and attitude scores ($P < .001$). In addition residency, number of previous cesarean delivery and birth outcome significantly predicted total knowledge score ($P < .005$). Of mothers who responded to questions, regarding practices, 94.4% attended their first-week postpartum appointment. Meat was the most commonly avoided food by mothers (10.8%) followed by milk (6.8%) and egg 14 (3.2%).

Conclusion

The knowledge of mothers regarding postpartum care was generally high and adequate, with most women having a positive view of it. Furthermore, there was a significant correlation between the mothers' knowledge and their educational background, previous cesarean deliveries, and the outcome of their pregnancies. Therefore, it is essential to provide extra care for women with low educational levels, those from rural areas, and those who have undergone their first cesarean delivery.

Keywords: Knowledge, attitude, practice, postpartum care, Cesarean delivery, post-operative care

PREVALENCE AND ASSOCIATED FACTORS OF SEVERE DEGREE PERINEAL TEAR AT MEKELE PUBLIC HOSPITALS, TIGRAY, NORTHERN ETHIOPIA: A 7 Year Review

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Abstract

Background: Poor maternal health outcomes are linked to obstetric anal sphincter injuries (OASIS), which result from perineal trauma during vaginal delivery. The most severe perineal tear occur in low-resource settings during unattended births. Even in hospitals, where skilled personnel are present during vaginal delivery, some women still get OASIS. However, in environments with limited resources, the extent and commonly attributed risk factors are not sufficiently explored. This study looked to determine the magnitude and associated risk factors for third and fourth-degree perineal tears at Mekelle Public hospitals, Tigray, northern Ethiopia from July 2016 to June 2023.

Methodology: Institutional-based unmatched case-control study design was conducted in Mekelle public hospitals in Ethiopia from 1st July 2016 to 30th June 2023. Cases were mothers who delivered vaginally with severe perineal laceration whereas controls were mothers who had delivered vaginally without a severe perineal laceration. All available Cases that fulfilled the inclusion criteria in seven years were included and three controls who delivered vaginally on the day of severe degree perineal tear repair were selected. Data on sociodemographic, Maternal, fetal, labor and delivery and health provider characteristics were collected using piloted and structured questionnaires. Data entry and analysis were done using epi-Data Management version 4.6 and SPSS version 23 respectively. Bi-variate and multivariate logistic regression analysis was done. A p-value of <0.05 was considered significant at 95% confidence interval and the strength of association was measured using odds ratio.

Results: A total of 361 participants (88 cases and 273 controls) were included in the study and the mean maternal age of cases and controls were 26.2+_5(SD) and 26.9+_5.6(SD) respectively. The prevalence of severe degree perineal tear in the last seven years was 0.157 %(1.57/1000 vaginal deliveries). Risk factors for severe degree perineal tear were: Rural residence, prim parity, Gestational Age ≥40 weeks, Birth Weight≥3.5kg, Instrumental delivery. Episiotomy was associated with reduced risk.

Conclusions: The risk factors for severe degree perineal tear during vaginal delivery at Mekelle Public Hospitals were: prim parity, instrumental vaginal delivery, fetal weight ≥ 3.5kg, Gestational Age ≥40 weeks and rural residence with mediolateral episiotomy associated with reduced risk. Operative vaginal delivery skills of birth attendants should be regularly monitored and continuous training to update their skills is important.

Key words: Perineal Tear, risk factors; obstetric injuries, Ethiopia

MATERNAL AND NEONATAL OUTCOMES OF MOTHERS WITH A SINGLE PREVIOUS CESAREAN DELIVERY SCAR IN LOW RESOURCE SETTING: A PROSPECTIVE CROSS-SECTIONAL STUDY

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Abstract

Background: For decades, because of the concern that uterine scar may rupture during labour, previous caesarean deliveries were considered as an indication for caesarean section in subsequent pregnancies. However, the maternal and neonatal outcomes of mothers undergoing a trial of labour versus elective repeat cesarean delivery are not adequately investigated in resource-limited settings. This study sought to examine the adverse maternal and neonatal outcomes in women who underwent elective repeat cesarean delivery versus trial of labour after cesarean delivery in Ayder Comprehensive Specialized Hospital and Mekelle General Hospital, an academic setting in Tigray, Ethiopia, from February 01, 2023 – June 30, 2023.

Methods:
A prospective cross-sectional study was employed to collect maternal baseline data and variables concerning postpartum maternal and neonatal outcomes. The data analysis was done with Statistical Package for Social Sciences (SPSS) version 23. The data was summarized using frequency and proportion. Chi square test was used to compare proportions between groups with p-value < 0.05 regarded as significant. Multivariate logistic regression was done to see factors associated with successful trial of labour after cesarean delivery.

Results:
Among the 4654 mothers who gave birth at the Ayder Comprehensive Specialized Hospital and Mekelle General Hospital, 376 had a single previous cesarean delivery scar, with a prevalence of 8.1%. Seventy-six mothers were excluded because they have obstetric or medical complications which can impact maternal and neonatal outcomes. The remaining 300 mothers fulfilled the eligibility criteria and were analyzed. Among these 300 mothers, 183 (61%) opted for trial of labor, while the remaining 117 (39%) opted for elective repeat cesarean delivery. Out of those who opted for trial of labor 134 (73.2%) successful gave birth vaginally, and the remaining 49 (26.8%) required emergency Cesarean delivery.

Women in the trial of labor had significantly unfavorable maternal outcomes including uterine rupture (95% CI, 3.8[1.7, 7.4], P=0.032), perineal tear (95% CI, 35.5[28.9, 42.6], P=0.001). Women in the trial of labor had statistically significant low first-minute APGAR score (95% CI, 4.9 [2.5, 8.8], p=0.015]. Though not statistically significant, women in the trial of labor group also had increased other neonatal outcomes such as intrapartum stillbirth (95% CI, 1.1[0.2, 3.5], P=0.257) low fifth minute APGAR Score (95% CI, 2.7 [1.1, 5.9], p=0.071), and low tenth minute (95% CI, 2.2[0.7, 5.1], P=0.107). Eight neonates in the TOLAC group were resuscitated with a bag and mask (95% CI, 4.4[2.1, 8.1], p=0.082) and four of them end up with early neonatal death (95% CI, 2.2[0.7, 5.1], P=0.107). Five of the resuscitated neonates were because of perinatal asphyxia secondary to uterine rupture, admitted to NICU and four of them died. In contrast, women in the elective repeat cesarean delivery group had increased rates of surgical site infection (95% CI, 2.6 [0.7, 6.7], P=0.029) and prolonged hospital stay (95% CI, 24.0[18.3, 30.6], p=0.001)..

Conclusions: In the present study, a fair number of women attempted with nearly 3/4th of them succeeding vaginal birth. Women attempting trial of labour after cesarean delivery experienced statistically significantly increased risks of uterine rupture, perineal tear, perinatal death and low first minute APGAR Score. In contrast, women at the elective repeat Cesaren delivery group were at increased risks of surgical site infection and prolonged hospital stay. Uterine rupture should be taken as the most important indicator of the increased unfavorable maternal and neonatal outcomes.

Keywords: Cesarean Delivery, Trial of labor, elective repeat Cesarean delivery, failed trial of labor

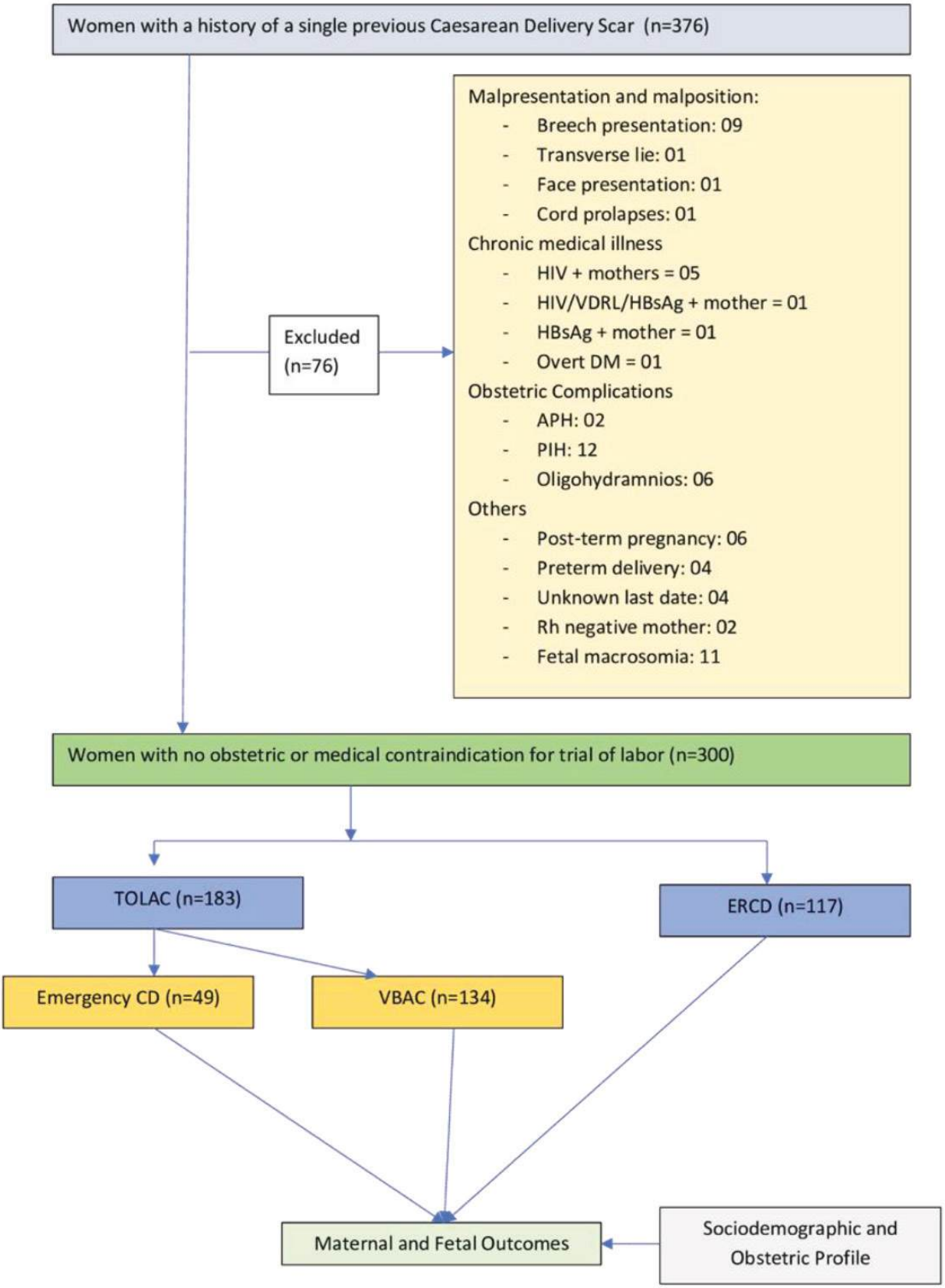

Fig 1. Conceptual framework
APH: Antepartum Hemorhage, CD: Cesarean delivery, DM: Diabetes Mellites, ERCD: elective repeat Cesarean delivery, TOLAC: Trial of Labour after Cesarean delivery, VBAC: Vaginal birth after caesarean delivery.

EXPLORING PREFERENCES TO ACCESS SEXUAL AND REPRODUCTIVE HEALTH SERVICES: A QUALITATIVE STUDY OF ADOLESCENTS' AND SERVICE PROVIDER PERSPECTIVES

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Abstract

Introduction: Access to and utilization of adolescents' sexual and reproductive health services promotes positive adolescent health outcomes. To optimally utilize sexual and reproductive health services, the healthcare system needs to be responsive to the expectations of adolescents. Understanding what adolescents want and how preferences are likely to vary among different groups is important to make the healthcare system responsive. To date, to our knowledge, there is no published evidence on preferences for sexual and reproductive health services among adolescents in Ethiopia, despite their essential role in overseeing the functioning of the healthcare delivery system.

Objective: To explore preferences to access sexual and reproductive health services in Gamo zone, south Ethiopia from adolescents' and healthcare providers' perspectives. Methods: A phenomenological qualitative study approach with a purposive sampling technique was carried out in the Gamo Zone from August to September 15, 2023. Seven focus group discussions, including 9-14 participants per group were conducted with adolescents. Ten key informants' interviews with healthcare providers were conducted. Before starting coding and analysis, audio files were transcribed verbatim and translated into English. We applied constant comparative analysis techniques was used to explore the data collected.

Results: A total of 75 discussants and 10 key informants have participated in the study. Many participants preferred male health workers. With regards to the age of healthcare providers, we observed age differences; older adolescents preferred younger health workers close to their age and younger adolescents preferred older service providers. The neighborhood health worker was not preferred for any of the adolescents, but we found that adolescents preferred receiving SRH services from unfamiliar health workers. Many participants often explain that neighborhood health workers break confidentiality and can tell for adolescents' families and relatives. The most preferred source of abortion services is traditional medical centers and prefer to access condoms and emergency pills from pharmacies and patent medicine vendor shops rather than public health facilities. Adolescents find it easier to express themselves, and their confidentiality, they trust the provision of the services, as well as the accessibility and affordability of such services in their local area as the reason for their preferences

Conclusion: We conclude that public health facilities were not the preferred source of SRH services for adolescents. Male and unfamiliar health workers preferred service providers for adolescents. Also, older adolescents preferred younger health workers and younger adolescents preferred older service providers. The study highlighted the need to consider the preferences of adolescents when designing their adolescent health programs.

Key words: Adolescents; Sexual and Reproductive Health; Preferences; Ethiopia

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FACTORS ASSOCIATED WITH HUMAN PAPILLOMAVIRUS INFECTIONS AMONG WOMEN LIVING WITH HIV IN PUBLIC HEALTH FACILITIES WESTERN OROMIA, WESTERN ETHIOPIA.

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Abstract

Background: Human Papillomavirus infection is among the most common sexually transmitted infections with the highest incidence and prevalence worldwide and has been established as the main cause of cervical cancer that remains public health problem globally. In Western Oromia, Ethiopia cervical screening remains a major issue because of limited resources, and shortage of HPV testing technology, and as a result, the prevalence of HPV and associated factors remained unknown among HIV-positive women. This study aimed to assess the magnitude of HPV and associated factors among women living with HIV attending ART services in public health facilities of East Wallaga and West Showa Zones, Ethiopia, 2022.

Method: Using a cross-sectional study design a total of 415 women ≥ 18 years old were enrolled using systematic random sampling from five public health facilities. Cervical specimens were collected by a trained nurse from April to May 30, 2022, and tested at Nekemte Public Health Research and Referral Molecular Biology, a certified/accredited Laboratory for HPV-DNA Polymerase Chain Reaction by expertise using Abbott m2000rt-PCR assays. Finally, Epi data version 4.6 for data entry, and SPSS version 24.0 were used for data cleaning and analysis, and frequencies and magnitude of HPV were computed. Variables were identified using the multivariate model and statistically significant associations of variables were determined based on the adjusted odds ratio (AOR) with its 95% CI and P-value < 0.05 to determine the strength of association.

Result: The magnitude of HPV was 30.4% [95% CI: 26.0, 34.9]. Of HPV-infected women, 11.9% were positive for HPV-16, 9.5% for HPV-18, and other hr-HPV 65.9% were positive for other high-risk-HPV. The risk of HPV was 2.85 times more likely among respondents who were in the age category of 48 years and more (AOR=2.85, 95% CI: 1.16, 5.58), 4.12 times more likely among those who had three or more sexual partners in their life (AOR=4.12, 95% CI: 2.34-8.62), 4.73 times more likely among those who didn't use condom during sexual intercourse (AOR=4.73, 95% CI: 1.98-9.33), 4.52 times more likely among those who had previous history of abortion [AOR=4.52, 95% CI: 2.04, 6.89], 3.62 times more likely among respondents who had contracted STI (AOR=3.62, 95%CI: 1.75, 5.83) and 3.31 times more likely among respondents who didn't have abnormal vaginal discharge [AOR=3.31, 95% CI: 2.87,7.35) compared to their counterparts.

Conclusion and Recommendation: The magnitude of HPV infection among HIV-infected women was high in the study area. Given the above-associated factors, we recommend the stakeholders integrate HPV prevention strategies into HIV /AIDS services. Furthermore, the study has provided essential information about the HIV link with hr-HPV infections, which may explain the high prevalence among HIV-infected women. This can contribute to policy development and planning of prevention strategies incorporating HPV infection prevention especially among youth and HIV-infected people.

Key Words: Human Papillomavirus, Women, Human Immunodeficiency Virus

GLOBAL INEQUITIES IN SURVIVAL OF EXTREMELY PRETERM INFANTS: A SYSTEMATIC REVIEW AND META-ANALYSIS

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Abstract

Introduction: Advances in medical technology in neonatal care units have improved survival rates for extremely preterm infants, despite associated major morbidities. However, the varying survival rates of extremely preterm infants within and between countries make it a challenge to prioritize policy decision around standardization of care. Therefore, this study was aimed to synthesise and compare the differences in global survival rate of extremely preterm infants at discharge over the last two decades.

Methods: We conducted a comprehensive search across PubMed, EMBASE, CINAHL, Scopus, Web of Science, and AJOL databases without language restriction. Observational studies on infants born before 29 weeks of gestation (extremely preterm) from 2000 to September 1st, 2023, were included. The Newcastle-Ottawa Scale for assessing the quality of cohort studies was applied. The existence of heterogeneity across studies was assessed and quantified using Cochrane Q statistics and inverse variance, respectively. Der Simonian-Laird random effect model was fitted to estimate the pooled weighted survival to discharge rate of extremely preterm infants by gestation age, low-middle and high income setting and during the Millenium development (2000-2014) and Sustainable Development periods (2015-2021).

Results: We included 217 studies involving 885,654 extremely preterm infants. Globally, survival to discharge rate of extremely preterm infants was 61.7% (95% CI; 58.4, 65.1), and 52.6% (95% CI; 45, 60.2) were discharged without major morbidities. Both survival and survival without major morbidity rates increased significantly from 26.5% and 14% at 22 weeks of gestation to 87.8% and 69.7% at 28 weeks, respectively. Survival rate was significantly lower ($p<0.001$) in low- and middle-income countries (44.3%) compared to high-income countries (61.7%). The survival to discharge rate was 63.5% for infants born during Millennium developmental period and 50.8% for those born in Sustainable developmental period.

Conclusion: Globally, a significant disparity exists for survival of extremely preterm infants, with less than half surviving in low- and middle-income countries. Survival rate showed no improvement during Sustainable developmental period compared to Millenium developmental period. Our results highlight the need for evaluating the quality of care and resource allocation to improve inequities in global survival rate of extremely preterm infants.

Key words: Survival; Extremely preterm birth; Global; meta-analysis.

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MAGNITUDE AND ASSOCIATED FACTORS OF PRIMARY POSTPARTUM HEMORRHAGE AMONG MOTHERS WHO DELIVERED AT SELECTED HOSPITALS IN EAST WOLLEGA ZONE, WEST OROMIA, ETHIOPIA, 2022.

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Abstract

Background: Postpartum hemorrhage is the main cause of maternal mortality globally. Most postpartum hemorrhage-related illness and death occurs' within the first 24 hours after delivery and may be complicated by shock, renal failure, acute respiratory distress syndrome, coagulopathy, and Sheehan's syndrome. Therefore, knowing its burden in the healthcare setting is crucial. The study aimed to identify the magnitude and associated factors of primary postpartum hemorrhage among mothers who delivered at selected hospitals in East Wollega Zone, West Oromia, Ethiopia, 2022.

Method: A facility-based survey was conducted among 650 mothers who gave birth at four selected public hospitals of East Wollega zone from January 15– March 15, 2022. A systematic sampling technique was used to recruit eligible mothers. Data was collected by direct interviewing the mothers and mothers' card reviews using pretested semi-structured questionnaires. The collected data was coded and entered into Epi-data version 3.1 and then exported to SPSS for analysis. A P-value was used to screen variables. Variables having (P-value< 0.25) in bivariable analyses were transferred to multivariable analysis. Multivariable logistic regression was undertaken to identify the factors associated with primary postpartum hemorrhage at 95%CI and p-value <0.05.

Results: In this study, six hundred fifty mothers participated with 100% the response rate. The mean age of the respondents was 26.06 years (SD + 4.9, Ranging 18-42) years. The finding indicated that the magnitude of primary postpartum hemorrhage was 17.1% (95% CI: 15.03 – 19.17). The finding also indicated that factors significantly associated with primary postpartum hemorrhage including twin delivery [AOR= 6.409, 95%CI (2.437, 16.857)], instrumental delivery [AOR =2.868,95% CI:(1.346, 6.112)], receiving active management of third stage of labor [AOR=0.341, 95% CI: (0.192, 0.605)] and stillbirth [AOR= 3.537, 95% CI: (1.424, 8.787)].

Conclusion and Recommendation: PPH is significantly high in the current study. Monitoring the second and third phases of labor using instrumental delivery with caution giving special attention to risk factors like twin delivery and stillbirth will avert the PPH.

Key Words: Ethiopia, Magnitude, Primary Postpartum hemorrhage, risk factors

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GENDER INEQUITABLE NORMS AND ITS ASSOCIATE AMONG UNIVERSITY STUDENTS IN SOUTHERN ETHIOPIA

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ABSTRACT

Background: Inequitable gender norms characterize women as one who should be submissive while promoting male dominance and toughness. For a society to achieve gender equality, ensuring equitable gender norms is a basis. Little is known about inequitable norms and their association in our context.

Methods: An institution-based cross-sectional study was conducted among Arba Minch and Jinka University students, in Ethiopia from October 25 to November 10, 2022. A multi-stage sampling technique was used to select 615 students. Gender Equitable Men Scale tool was used to assess gender norm attitudes. Data were checked and entered into Epi-Data Version 3.1 and analyzed using SPSS Version 25.0. Binary logistic regression analysis was used to identify associated factors with gender inequitable norms. Variables with a p-value <0.25 in bivariable logistic regression were candidates for multivariable logistic regression. A multivariable logistic regression analysis was fitted to identify factors associated with gender inequitable norms. A Hosmer–Lemeshow goodness-of-fit statistic was used to check model fitness and was satisfied. A p-value <0.05 was used to declare statistical significance.

Result: The mean score for GEM scale was 61.38 (SD 8.36), 271 (44.7%) participants scored below the mean value. Inequitable norms were endorsed in each domain, in violence domain,

45.1% male and 48.7% female student totally/partially agreed with "a woman should tolerate violence in order to keep her family together", similarly in domestic life and child care domain, 61.4% male and 56.9% female student agreed with "a woman should obey her husband in all matters" and in reproductive health and disease prevention domain; 36.4% male and 28.8% female student agreed with "it is woman's responsibility to avoid getting pregnant". Finally in sexuality domain 49.0% male and 43.9% female student agreed "men need more sex than women do". Except for violence domain statistically significant difference was observed in all other domains between male and female students. The odds of favorable attitude towards inequitable gender norm were 1.74 (CI 1.19-2.56) higher among male student, 2.09 (1.14-3.88) higher among student with broken relationship, and 3.14 (CI 2.15-4.58) higher among student with poor attitude towards gender equality.

Conclusions: Significant proportion of participants endorsed a favorable attitude toward gender inequitable norms. Being male, having romantic relationship breakup, and poor gender equality attitudes were associated with favorable attitudes toward gender inequitable norms. Hence, the finding highlights the need to work rigorously by addressing identified factors from all concerned bodies for enhancing equitable gender norms among university students.

Keywords: Gender equality, Gender norm, Factors, University students, Ethiopia.

Abstract: Group Care 1000: Improving MCH through Age Two

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Group Care 1000 is a program combining the concepts of group prenatal care [Centering Pregnancy] with Centering Parenting continued through the infant's second birthday. This concept is currently part of a finishing multisite project sponsored by a larger social infrastructure grant funded by the European Union in the countries of Ghana, South Africa, Suriname, Kosovo, and cities of London, Brussels and Amsterdam. The project focuses on in-depth understanding and a systematic development of acceptable, feasible and sustainable strategies to integrate group care into health systems for antenatal and postnatal care during the first 1000 days. Group care is evidence-based while transforming the delivery of maternal, newborn and child healthcare. This concept reduces inequities in service utilization, improves the quality of services and makes a significant positive impact on the health and wellbeing of mothers, families and children. Evidence-based guidelines are currently being developed for health systems to establish and sustain this transformative model. Care in a group changes the user[s] provider experience, encourages self-care, is empowering and enables end-users to learn to increase healthy behaviors for themselves and their children. It breaks the vicious cycle of poor-quality care and inadequate utilization of services by offering comprehensive antenatal and postnatal care as a single continuum using a consistent cadre of physician and non-physician providers. Health promotion and health information activities and integrated into each group session while building on the gradual empowerment of the women as they become more invested in their own health and that of their newborn. Country data currently being collected will assist in refining the implementation process and enable the creation of country specific blueprints for scale up. Cross-country synthesis will assist in developing a global implementation strategy toolbox for adaptation to use for the most vulnerable groups of women and children world-wide.

VULVAR CANCER AND HIV CO-INFECTION IN THE SUB-SAHARAN AFRICA: CLINICAL CHARACTERISTICS AND POST-TREATMENT SURVIVAL OUTCOMES

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Abstract

Background: There is limited information on vulvar cancer patient characteristics and survival in parts of sub-Saharan Africa, such as Ethiopia, where HIV infections is prevalent. In Ethiopia, the survival outcome of vulvar cancer with and without HIV co-infection has not been studied before.

Objective: To compare survival outcomes of vulvar cancer patients with and without HIV co infection at a gynecologic oncology treatment center in a sub-Saharan setting

Methodology: This was a 6-year review of vulvar cancers patients (with and without HIV co infection) that were managed at St. Paul's Hospital Millennium Medical College (Ethiopia) between 2017-2022. Data were extracted patient's medical records using a data extraction tool. Data was analyzed using SPSS version 26. Simple descriptive statistics and Kaplan-Meier survival analysis were carried out as appropriate. Frequencies and percentage were used to present the findings.

Results: There were a total of 106 vulvar cancer patients that were managed during the study period. After excluding 10 patients for incomplete data, a total of 96 patients were included in the final analysis, out of which 65(67.7%) patients had HIV co-infection. Surgery with or without chemo-radiation/NACT was the most common (62/96, 64.8%) treatment modality provided for the patients while the remaining 34 patients were treated with primary chemo radiation. Among those who had surgery, the majority of them (43/62, 69.4%) were managed with surgery alone, followed by another 16(25.8%) patients who were treated with neoadjuvant chemotherapy followed by surgery. There was no difference in the overall survival (mean survival of 5.4 vs 6.1 years, p value=0.481) as well as progression free survival (mean survival of 4.2 vs 3.4 years, p value=0.052) between HIV-sero-reactive vulvar cancer patients and HIV sero-negative vulvar cancer patients.

Conclusion: Two-third of vulvar cancer patients included in this study had HIV co-infection. We found no difference in overall disease survival and progression-free survival between vulvar cancer patients with HIV co-infection and without HIV infection.

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