



Obstetrics & Gynaecology
UNIVERSITY OF TORONTO

Newsletter published by the University of Toronto's ObGyn Department in association with AMPATH



Left to right: Dr. John Ogot (resident), Dr. Elly Odongo (gynaecology oncology fellow and KOGS president), Dr. Yamal Patel (KESES president) conducting a hysteroscopy

Welcome once again to the AMPATH-RH newsletter, an update on the extraordinary contributions that our department and university are making alongside our Kenyan Moi University and Moi Teaching and Referral Hospital colleagues and our North American AMPATH colleagues to better the lives and reproductive outcomes of women in western Kenya. As we enter the holiday season and the new year 2019, we can look back and celebrate with pride our continuing involvement in AMPATH, now well surpassing a decade! Without a doubt, it feels as if AMPATH-Reproductive Health has become entrenched in the fabric of our department – whether it be novel programming such as our fellowship in Global Women's Health and Equity, regular bidirectional exchanges of faculty and trainees, provision of Kenyan-made lanyards for our research day or a section on AMPATH in the new book detailing our department's 175 year history. 2018 has seen the tenure of our department's graduate Dr. Julie Thorne in the Team Leader position in Kenya, where her own interests focus on deeper development of family planning and adolescent health programming and opportunities. Former global health graduate, Dr. Heather Millar has taken on the responsibility of Academic Coordinator of our program, providing local leadership in research and trainee exchanges. *Message continued on page 2...*

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Message from the Vice-Chair

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Heather joined Julie in Eldoret in October, 2018 to take part in a Human Centred Design workshop to develop an adolescent pregnancy program as part of a Sick Kids innovation granting process. Our local MFM Division Head has also spearheaded the launch in Kenya of our second fellowship at Moi University in Maternal Fetal Medicine, which has seen the recruitment of Kenya's own first 2 MFM fellows – we will share more on this exciting new program in the spring newsletter!

My most sincere thanks go to all those who support our work and contribute to it day in and day out, especially my colleagues on the ground in Eldoret from Moi University and representing the University of Toronto. My many thanks as well to those who have taken the time to write for this issue and to all of you who are taking the time to read about our work. 2019 promises to be a wonderful year.

In the way of AMPATH, we forge ahead with a tripartite mission of clinical care, research and education, always “leading with care” on the ground. We wish you all the very best of the holiday season and health and happiness to you and yours in 2019.

As 2018 comes to an end, please consider supporting the work that the University of Toronto Department of Obstetrics and Gynaecology does in Kenya through AMPATH. [Click here to access our donation page](#). Many thanks in advance for your support to the women of western Kenya. We could not do it without you!

Sincerely,
Rachel Spitzer
Vice-Chair Global Health and Advocacy
Department of Obstetrics and Gynaecology, UofT

Reflection from AMPATH Volunteer

Emily Kingdom, Business/Finance Summer Volunteer

This past summer, I volunteered for six weeks in Eldoret with AMPATH. I was hoping to put my business skills to work in a global health setting – and what I found was so much more. With the support and open nature of those based in Eldoret and abroad, I had a truly life-changing experience with AMPATH and am certainly looking forward to continued involvement.

While in Eldoret, I focused on three main projects: the IMANI Workshop marketing project; volunteering at the AMPATH shelter; and assisting with research and writing in the research department at Moi University Hospital, at the Mother and Baby Hospital. My work helped to rejuvenate the marketing campaign for national sales for IMANI, streamline budgeting for the shelter, and assist in grant writing and research efforts on an ad hoc basis. I was thrilled to put my problem-solving skills to work in a medical environment – my personal passion.

With each project, I learned as much as I educated with my partners. I opened my eyes to the opportunities that we create for each other when we Lead with Care.

I also had the incredible opportunity to travel during my weekends and explored much of Kenya. Highlights included seeing the great migration in Maasai Mara, watching an eagle fish in Lake Baringo, and seeing the sunrise while climbing Mt. Longmont.

I can't say enough good things about the staff and friends I made in Eldoret. Big thank you to everyone who made me feel welcome and helped me make the most of my time.

Rafiki Adolescent Pregnancy Program (RAPP)



Heather Millar, Ryan Doyle (Idea Couture) and Julie Thorne with the RAPP Design Team in September 2018

We are on an exciting new chapter to improve the care of adolescents in and around Eldoret, Kenya. Currently, about 47% of adolescents will have given birth by the time they turn 20 years old. Besides being associated with pre-term birth and NICU admissions, teen pregnancy comes with significant social stigma. Girls have to drop out of school and they are more likely to become trapped in a cycle of poverty.

We hope RAPP will change that.

Heather Millar, our collaborators at Idea Couture and our team here in Eldoret are using human-centred design to develop an adolescent pregnancy and parenting program. We hope this will be an entry-way to engage teens in their care during pregnancy, reduce stigma in the communities meant to support them, and eventually help build up their vocational skills and abilities to return and finish school. This will be our start to a bigger conversation around healthy sex and sexuality education in schools and at home, and to empower youth to make choices about their bodies and their lives.

In September, Heather and Ryan Doyle from Idea Couture met our group of designers for two weeks to

get creating. We taught a fabulous group of pregnant and parenting teens, parents, CHVs, and healthcare providers the fundamentals of qualitative research and how to prototype. We came up with ten future projects, with four of those designated as priority projects to launch in the next year. Some of our work is going to include some building renovations—readers stay tuned for the Go Fund Me campaign!



Ryan Doyle (Idea Couture) leading the RAPP Design Team through a Journey Map exercise

Reflections from Kenya

Julie Thorne, AMPATH Team Leader

My first day covering the labour floor a woman died.

This was her fourth pregnancy, her fourth labour, and everything seemed normal when I first met her. And yet within an hour I was being called for an emergency as her heart had stopped. We will never know exactly what happened. With a nursing to patient ratio of 1 to 3-5 on the labour ward, no central monitoring, no AED and a constantly occupied ICU, we were in a poor position to save her.

I don't want to tell sad stories. I want to elevate and celebrate how hard my colleagues work, how amazing the patients are that I care for, and how beautiful life can be here in Eldoret. Every day I can eat the sweetest mangos and walk past the jacarandas in full bloom. Every day women's lives are saved because of how hard everyone is working.

But that first labour ward shift was a hard way to start. I'd never had a woman die who, for all intents and purposes, had been perfectly healthy and in labour just 30 minutes earlier. While she was my first, she unfortunately has not been the last.

My time here started in January 2018. It has been amazing and trying and sad and interesting and stimulating. My clinical work includes serving as a consultant for the labour ward, which sees about 40 deliveries per day, doing gynaecology (including inpatient care, clinic and surgeons), and complex antenatal inpatient care. We work against poor nursing to patient ratios, stock outages and extremes of illness. MTRH is a teaching hospital where I get to teach and be pushed to grow alongside residents. Between March and July there was a university lecturer's strike that left much of the hospital without doctors and residents.



Teachers and participants, including consultants, residents, OR nursing staff and biomedical technicians, at the inaugural KESES (Kenya Society of Endoscopic Specialties) Workshop

This was a reminder how much the teaching structure is an integral factor to how care is provided at an academic centre.

Laparoscopy is done in the big cities like Nairobi and Mombasa, but seldom done at MTRH. Just this month we ran a workshop alongside the Kenya Society of Endoscopic Specialties to do both laparoscopy and hysteroscopy at MTRH. We hope this is just the beginning of providing this teaching for registrars and service for patients.

Another big part of my job is coordinating visiting students and faculty to the Reproductive Health Department. We hosted Dr. John Kingdom, Chair of the University of Toronto's ObGyn Department, for his inaugural visit in September. I have supervised six medical students and three residents from North America, with many more scheduled in the new year.

Finally, I am working alongside our research innovations team improving access to care and delivery. My focus areas include improving the care and outcomes for pregnant adolescents; advancing early referrals to care through community provision of urine pregnancy tests; and understanding women's choice of contraception and antiretrovirals when balancing risks of vertical transmission of HIV with potential adverse effects of antiretrovirals themselves on a growing embryo.

My perspective as a physician has certainly changed since that first labour shift. There are delays to care. There are systemic and social inequities, especially for women. There is a long-standing partnership in advancing reproductive health care in Western Kenya between UofT and Moi University. This allows me the privilege to teach, advocate, research and provide care. I am just so thrilled I have several months left to keep at it.



Making a site visit in Port Victoria with elective trainees. Left to right: Julie Thorne, medical students (now graduated), Lakshmi Nemani (Indiana University), Adam Rosen (University of Toronto), Tim Kipkoech and Mercy (Jerono Chamas project members), medical student (now graduated), Nathana Griffiths (University of Toronto) and ObGyn resident Shambe Mutungi



Left to right: Dr. Elkanah Omenge (Moi University Head of Department, Reproductive Health), Dr. Peter Itsura (Administrator for the Reproductive Health Postgraduate Program), Dr. Elly Odongo (KOGS President) and Dr. John Kingdom (Chair for University of Toronto's ObGyn Department)

AMPATH-UofT Research Update

Heather Millar, AMPATH Team Leader

We continue to build and grow our research program in Western Kenya, with our overall focus on “leading with care”. In our research endeavours, this means that projects must always have the over-arching goal of improving the health and well-being of local women and children, and research questions must come out of identified local needs.

We are fortunate to now work with a team of over 20 young, motivated Kenyan research coordinators, assistants and interns on projects with this goal. This team is supported through grants from the Medical Research Council (UK); Saving Lives at Birth and Saving Brains; the AbbVie Foundation; the SickKids Centre for Global Child Health; Mount Sinai Hospital; and the Indiana University Clinical and Translation Sciences Institute. Our areas of focus include adolescent pregnancy; contraception; HIV in pregnancy; gestational diabetes; cardiac disease in pregnancy; early diagnosis of pregnancy and linkage to care; community-based interventions to improve maternal and early child health; and gynaecologic cancer screening and treatment.

Specific highlights currently include our upcoming Cluster Randomized Control Trial of Chama MamaToto, a project started as a pilot in 2012 by Drs. Astrid Christoffersen-Deb, Laura Ruhl and Julia Songok and managed by Justus Elung’at Ikemer. This project uses community-based women’s groups who meet in pregnancy to learn about various health topics, support each other and participate in small microfinance programs. See the article in this newsletter about Justus Elung’at Ikemer for more about the successes of this exciting and innovative program, that has grown exponentially since 2012.

Our expertise and interest in Adolescent Sexual and Reproductive Health, and Contraception/Family Planning has grown with the involvement of Julie Thorne, Caitlin Parks and myself as our recent Reproductive Health Team Leaders. We have partnered with Idea Couture, a Toronto-based design firm, to design, implement and evaluate an adolescent pregnancy program in Eldoret that will aim to improve adolescent pregnancy outcomes, decrease rates of subsequent pregnancy and enable adolescents to obtain education and sustainable employment. In October, we held a successful design-team training and are now beginning the process of implementing key identified interventions and collecting data on current adolescent pregnancy outcomes to inform our prospective cohort comparison.

As we begin 2019, we are excited by the launch of our newest clinical program, a fellowship in Maternal-Fetal Medicine. As we have seen with the growth of the Gynaecologic Oncology program, we expect that this will lead to new and important research spear-headed by fellows, that leads to improved care for women in pregnancy.

As we continue to grow in terms of our research, we are now focusing on how to grow the statistical, programmatic and administrative support for this program. This will enable us to be more productive with publications and to be increasingly competitive for the large grants that will enable us to support larger-scale research with larger impact.

As always, we do research with the ultimate goal of improve the health of girls and women in Kenya and we feel proud of what we and our Kenyan partners have achieved so far.

People of AMPATH: Justus E. Ikemer

Debbie Ungar, AMPATH Communications Manager

Justus E. Ikemer has a degree in medical microbiology, but he found his passion in listening to mothers tell stories about their children and the challenges they face.

Justus is the project manager of Chama cha Mamatoto (mother-child groups). He joined AMPATH in 2012 as a research assistant and now oversees a staff of 17 people who work on the Chamas program. This growing initiative within AMPATH's maternal and child health work now includes more than 1,800 women and their infants in nearly 100 groups in six sub-counties in Busia and Uasin Gishu counties. Training to begin groups in five additional sub-counties is in the works.

"My journey to maternal and child health has been interesting," said Justus. Part of his motivation came from his own experience as a newborn who survived a life-threatening encounter with army ants shortly after being born at home. He now shares his story to help encourage mothers to deliver in a facility.

Justus loves working with mothers and seeing them benefit from various aspects of the Chamas program. "I love interacting and sitting with women when they start and then they will tell you a story four or five years later about where they have come from. It gives you satisfaction in what you do," he said. "If you are making a difference, then you will always feel proud of what you are doing," he continued.



Each Chamas meeting includes 30 minutes for health education, 30 minutes for social education and 30 or more minutes for group microfinance activities. Each group consists of approximately 20-25 women who meet twice per month. The groups provide long-term peer support and friendship to the members who all have children of similar ages. During the first year, the topics include prenatal care, facility delivery, family planning and exclusive breastfeeding. In the second year the groups discuss topics such as immunization, family planning and complimentary feeding. In the third year, the topics turn to parenting challenges. Social topics are selected with input from the members and could include relationships with their mother-in-law, relationships with husbands or kitchen gardening.

"We try as much as possible to make this a discussion," said Justus. He recalled the recent implementation of a new parenting curriculum that advocates for time-out in lieu of corporal punishment. He admits to not being confident that the change would be

successful, but then heard from group members that the new form of discipline really worked. "I'm so surprised," Justus said. He said another change advocated by the curriculum was spending special time just talking with your children in order to build a stronger relationship, especially for fathers. "It will definitely change the way I parent," he added.

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Justus also counts the relationships within his team as one of the most rewarding parts of his job. “We have developed a network that is very nice. We are very respectful of everyone’s ideas. People feel that they are part of a team. We do things together and our retention rate is very high,” he said. “I have a very good relationship with everyone in the office. That is one of the most important things. I like the fact that I have the trust of my bosses. If I have to make a decision, I know they will back it up. They appreciate the kind of work that I do,” he continued.

Justus’ primary responsibility is making sure every program runs well and serves the needs of the women and communities. Tasks include administration, human resources, implementation and everything in between. Building relationships with volunteer community health workers is one area in which Justus feels he excels. He is honest with them and emphasizes the way in which they are each helping their community.

“I get satisfaction from the women I am trying to deliver services to and the stories they talk about. I’m making a difference. At the end of the day all of us would want to make a difference,” he concluded.

It Can Get Better: Equality in Access to Healthcare



Winnie Rotich (left), Observing Kenyan Medical Student with the Department of ObGyn at the University of Toronto

A few days into my elective period in Toronto – 7:00AM Saturday morning. Bag on my shoulder and a coffee to go in hand (the Canadian coffee culture was catching up fast), ready for my 24-hour call at labor and

delivery. I was excited, a-kid-on-Christmas-morning excited!

I got to the nursing station ten minutes earlier before the start of the shift. I had a few minutes to kill by checking emails and texts. As expected, my mum back home had texted me several messages. “How are you doing?” “Are you eating okay?” “What time is it there?” “I hope you are working hard.” Of course, my friends were asking things like, “Has ugali withdrawal kicked in yet?” Soon the whole team arrived and the shift started.

This patient was handed over to us by the night team. Thirty-something year old female, second pregnancy with a history of previous caesarean section and a myomectomy. She was at term and presenting some lower abdominal pain. She was about one centimetre dilated. Plan was to get her in for a repeat caesarean section before she went into full labor because that would be a recipe for disaster given her past surgical

history. She was a pleasant, but now obviously apprehensive, woman with her husband by her side giving words of affirmation and encouragement; basically, being husband of the year. She worked in finance at a company in the city. She seemed well informed of her medical condition, judging from the questions she asked the team. On face value, I would say she belonged to the upper middle class. The staff and resident reassured the patient, and plans for an emergency caesarean were rolling. In 30 minutes or so, a bouncing baby boy was delivered.

Two days later, I was attending the high-risk antenatal clinic. Eager to learn, we met this patient referred from ultrasound who had come for the routine 20-week anatomy scan, only to find that she had a short cervix – less than a centimeter. For purposes of getting the gravity of the situation, a normal cervix should be at least 2.5 centimeters. The Maternal Fetal Medicine fellow took a history from which we gathered the following – she was a refugee from Somalia, single, unemployed and this was her sixth pregnancy. She had one 13-year-old daughter who had just started high school and, she added voluntarily, “always had earphones on nowadays”. Her eyes lit up as she talked about her daughter – she was a proud momma. She had had four previous terminations here in Canada with DnCs. She smoked about five cigarettes per day during this pregnancy (regrettably so, she added). The fellow then broke the news to her. You could see that “my heart sank” feeling through her eyes. Then, in an almost-crying-this-sucks voice, she asked, “What do I do now?” The fellow and staff did a repeat ultrasound to confirm the cervical length and discussed, at great length, options of management with the patient. At the end of the visit, you could see a stronger, more hopeful woman.

As I thought of the two different cases later, I saw how

efficient the health system was here in Ontario. Two women with two different socioeconomic backgrounds given same level of health care, with the same urgency and importance. I was reminded of the situation back home in Kenya where healthcare is based on socioeconomic stratifications. The basic division of healthcare facilities into government/public and private. Patients in the public hospitals being mostly the uninsured, lower social class members who cannot afford to pay out of pocket for the high charges at the much better private hospitals. Doctor/nurse to patient ratios are too big at these public facilities (one doctor to every 16,000 patients and 83:10,000 for nurse-patient ratio). Basic amenities and facilities are wanting; not to mention attitude of caregivers to these patients that have no option but to attend public hospitals. Private hospitals, where conditions are better and these ratios are lower, are mainly accessed by patients with good insurance and drug plans due to the high charges.

It was refreshing to see how healthcare, especially for women, is accessible to all patients in Toronto. I’m a seeker of signs. I believe my coming here to Toronto for my elective is a sign. I could have been anywhere, but I got to come here. I believe this was for me to get perspective. To see that things can get better, that they must get better. In the words of one of my role models, Shonda Rhimes – instead of wallowing in the problem, you can figure out what it’s Yes would be. I may not have a grand solution to the problem that is my country’s healthcare system, but I can certainly be inspired by the two scenarios above. I can do better. Treat all my patients with dignity and take all of my patient’s situations seriously. That’s how the system changes – if we each change it in our small way. Who knows; maybe one day a woman in the marginalized communities of Turkana in northern Kenya will have access to the same healthcare as a woman in the leafy suburbs of the capital Nairobi.

Delivery of Service to Canadian Patients



Tabitha Maisiba (left), Observing Kenyan Medical Student with the Department of ObGyn at the University of Toronto

If I would use one word to describe Canada, then it would be efficiency and one word to reflect my stay here, then it would be growth. What has stood out most for me is the efficiency of the health system and service delivery to the patients. The universal health system in Canada has made healthcare very accessible to all Canadians. The spirit of team work, proper communication, research-based practice, confidence, time keeping and being up to task is what stood out for me.

All the doctors here, I've noticed, are all goal-oriented and their goal is to provide the best healthcare for the patient. I have seen the team work of staff, fellows, residents, nurses, anesthetists, medical students and family in achieving this goal. The coordination of all these people is just amazing.

There was one time a staff member was doing a repeat C-section. There was some bladder damage and a fellow staff member was called to assist. She was readily available to help repair the small bladder mucosal damage. On a different occasion with a fifth

repeat C-section, they discovered that the bladder was completely adhered to the anterior uterine wall and called the urology team which responded promptly and helped to sort out the situation. I've also seen staff members seeing patient on behalf of another when they're unavailable and this team work is something I really admired, I would definitely take back home.

Proper communication is vital in patient care. I loved how consent would be sought from the patient, and how they would explain the benefits and the risks to patients in detail. How everyone in a team – for example, in the birthing unit – would introduce themselves to all patients when starting their shift, and all procedures would be explained to the patients before and during the procedure. Also, how the staff members whom you'd be scheduled to be working with would have received a heads-up concerning your presence at their clinics, as well as their coordination with staff of different specialties by making referrals if the patients needed it.

Canadians are also up to task and confident in what they do. I wasn't in a position to get too hands on because of the observership program, but I loved the confidence of everyone who was taking care of patients. Everyone would be up to their task and do what they're supposed to do confidently. I have realized now, even more than in medical school, one has to be aggressive and willing to learn, and if given opportunity to do something they should be up-to-task. The learners i.e. the medical students, the residents and fellows were willing to learn and try something new and they'd get the confidence to do it next time. The fear of trying something new is gone. I'll be more confident too in doing what I already know and learn how to do what I don't know from more senior colleagues.

Something else that I found very outstanding was that the medical practice is research-based. All the staff, fellows and residents that I interacted with were quoting research done and the exact details when asked by the patient. It was not a matter of “I like doing this in this particular way just for the sake of it”, but that there’s a research done that shows that this is the best way of doing things. So I believe this was important because all the doctors would be speaking one language, as well as giving the patient the best care based on the latest guidelines. Patients would therefore benefit from various things like the Tdap vaccine because Health Canada had recommended its use in pregnancy and also the use of aspirin for patients with a high risk of preeclampsia.

Something else that I really liked was the support patients receive from their family members. I liked how husbands would attend antenatal clinics with their wives and being available for the delivery of their children. This is something we rarely see back home, but I believe is very vital.

Sincerely, I have grown. I feel like my eyes have been opened to the ideals of how healthcare should be

provided to patients. I’m more than ever determined to integrate what I’ve learned here in management of patients back home, and share it with others when giving my feedback back home. Being alone in a hospital has also helped me learn how to communicate with others, especially when I was getting lost during the first few days. But I learned how to communicate and, in case of change in the days schedule, how to sort it out with the various administrators on time.

I want to scale greater heights in my medical career, so I hope you wouldn’t be surprised to see me few years down the line doing my residency here. I believe this was an eye-opening opportunity and it hasn’t left me the same. I will miss Canada, but the memories and the growth will remain etched in my heart.

I would like to take this chance to thank everyone who was involved in making this a success i.e. Dr. Spitzer and her family, Alexandra Aaviku, Joe George, Dr. Heather, Dr. Marie, Dennis, Dr. Julie from Kenya, Sarah Ellen who organized this elective, and all the people who were involved. May God richly bless you. Ahsante.

