2017/2018 COUNCIL ISSUE 1

OGSM NEWSLETTER

FROM THE PRESIDENT'S DESK

Obstetrical & Gynaecological Society of Malaysia

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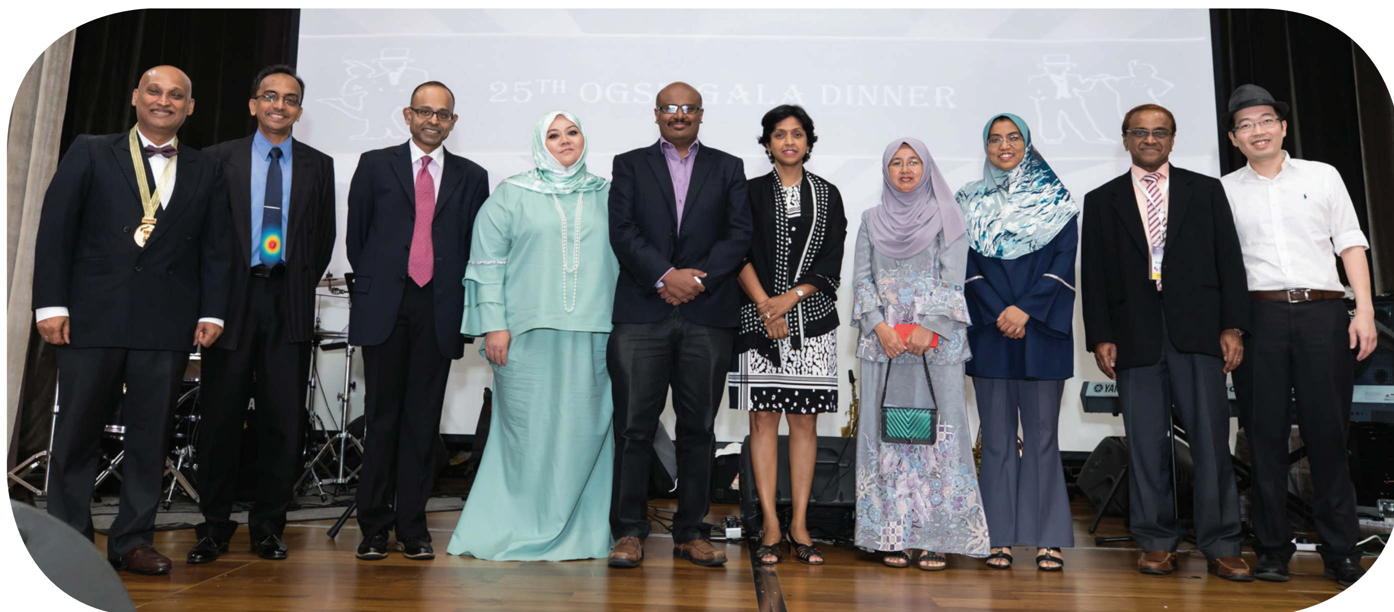
It is a great honour to become President of the Obstetrical and Gynaecological Society of Malaysia.

Thank you for all the support and encouragement from the members of this esteemed society. Many of you attended the OGSM President's installation ceremony during the gala dinner at Hotel Shangri-La.

I have a new team to manage the OGSM office and new council members to work with me. This council will not appoint any new state chairmen or subcommittee chairmen because their tenure are for two years and these positions have been nominated at the beginning of 2017.

The 25th OGSM Congress was successfully held at Hotel Shangri-La, Kuala Lumpur from 27th-30th July 2017. In this congress, there were many international delegates from Australia, Bangladesh, India and Pakistan. In total, there were more than eight hundred and fifty delegates. The scientific chairman introduced the new OGSM Challenge, an inter universities quiz challenge, which was both enlightening and entertaining to watch. Congratulations to team members from University Malaya who were the winners of the challenge. Other participating teams were from UKM, UIIM, USM and Ministry of Health. Good luck for next year. The winning team was awarded three free congress registrations for the 26th OGSM Congress 2018. As organizing chairman, I would like to thank the team for organizing the question bank, quiz master and others who worked tirelessly behind the scenes to conduct this challenge. My wishes for the future OGSM Council is to continue this inter university quiz competition in future OGSM Congresses.

INTRODUCING THE OGSM COUNCIL 2017/2018



President	Dr. Thaneemalai Jeganathan
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FROM THE PRESIDENT'S DESK

OGSM will be working with the College of O&G and the Medicolegal Society to produce addendums to consent forms for various Obstetrical and Gynaecological procedures. Once completed, OGSM members will be able to download these forms from the OGSM website. This set of forms will enable members to explain various risks, complications and communicate with patients; indirectly reducing risks of medical litigation in the future. OGSM will be conducting medico legal training workshops, which will include expert witness, effective communication, alternative dispute resolution training and standardised guidelines. These are activities from OGSM to decrease medical litigations.

OGSM members often face challenging situations such as medico legal issues, social media defamation, patient disputes and other ethical issues. To enable OGSM members to access help and information, the society will revive the Ethical and Advisory Committee. New senior members will be appointed and a guideline process will be put in place to assist this committee.

OGSM is a large body looking into the needs of its many members but small sub specialities should not feel that their issues are not addressed. Various sub specialities interest group meetings were held on 30th July 2017 during the 25th Congress.

OGSM will continue conducting Masterclasses that will enable trainees who are sitting for Part 1

SUBCOMMITTEE CHAIRPERSONS AND STATE COORDINATORS

SUBCOMMITTEE CHAIRPERSONS

Fertility & Sterility	Dr. Kannappan Palaniappan
Maternal Fetal Medicine	Dato' Dr. Bavanandan Naidu
Gynaecological Endoscopy	Dr. S. Sevellaraja
Gynaecological Oncology	Dr. Suresh Kumarasamy
Office Gynaecology	Prof Jamiyah Hassan
Urogynaecology	Dr. Aruku Naidu
OGSM Newsletter	Dr. Sharmina Kamal Shamsul Kamal
OGSM Website	Dr. Tan Chong Seong
Corporate Social Responsibility	Dr. Goh Huay-Yee
Sexual & Reproductive Health & Rights	Dr. Mohamad Farouk Abdullah
Medicolegal Matters	Dr. Tang Boon Nee

STATE COORDINATORS

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Kedah	Dr. Murizah Mohd Zain
Penang	Dr. Suresh Kumarasamy
Perak	Dr. Jayabalan Valliappan
Kuala Lumpur / Selangor	Dr. Ng Beng Kwang
Negeri Sembilan	Dr. Faridah Hanim Zam Zam
Melaka	Dr. S Sevellaraja
Johor	Dr. Sureshkumar Subramaniam
Pahang	Dr. Roziah Husin
Terengganu	Dr. Mailini Mat Napes
Kelantan	Dr. Sukri Hj Ahmad
Sabah	Assoc. Prof. Helen Benedict Lasimbang
Sarawak	Dr. Tan Yiap Loong

and Part 2 examinations. Work for the I Love Me 2018 public forum has started with the previous chairperson at the helm. For members who have not received a copy of the book "50 Years History of Obstetrics and Gynaecology", the OGSM office will devise a mechanism to distribute our award winning book. Kindly update your details on the membership database to facilitate the distribution of the book.

Congratulations to Dr Ravi Chandran, OGSM past president, on his installaton as President of the Asia Oceania Federation of Obstetrics and Gynaecology at the recent Asia Oceania Congress of Obstetrics & Gynaecology 2017, Hong Kong. The inaugral "Malaysia Lecture" was held at this congress and Prof Mats Brannstrom from the University of Gothenburg, Sweden presented on Uterus Transplantation with Live births and the Future. I would like to thank Dr Ravi Chandran who has been instrumental in arranging the Malaysia Lecture to be held in the next few AOFOG congresses. OGSM will be working with AOFOG to run the Intensive Course in Obstetrics Emergencies in the regional countries like Mongolia, Bangladesh, Pakistan, Cambodia and Laos.

These are my plans for this year. I hope I succeed in my task. Looking forward for your support.

Best wishes!

DR THANEEMALAI JEGANATHAN

Private HealthCare Fee meeting MOH

Dear OGSM Members,

On 9/8/2017, the Ministry of Health under the chairmanship of YBhg Deputy DG Datuk Dr Jeyaindran Tan Sri Sinnadurai had convened a committee meeting on the Private Healthcare Practitioner's fees. I had represented OGSM.

I would like to summarise the important points raised and the matter that will require your input into the following points:

1. Amongst the matters, the issue of unbundling/multicoding was discussed. The MOH strongly discouraged unbundling of codes/multicoding.

   Example of Unbundling & multicoding: appendicectomy: charged for appendicectomy+adhesiolysis+drainage of abscess.
   Ovarian cystectomy: Laparotomy, ovarian cystectomy, cathetherisation, subcutaneous injection of local Analgesia

2. Another matter of importance: MOH requires every specialty to present to the MOH list of procedures from each specialty which require another assistant from the same specialty. The insurance companies may use these procedures as a guideline to enable payment for the second assistant (second assistant is paid maximum of 50% of original fee according to the guideline)

3. Looking into the future the MOH is working towards adding new procedures to the present list. The tabulated list is with the MPC (Malaysian Productivity Commission) for review. The timing when new procedures will be included into the present list may take months.

4. Request from the Insurance Industry:

   1. The standard LIAM forms: please fill every column; this will reduce waiting time for approval.
   2. For elective procedures: please try to send request as early as you can, preferably 3-4 days before the proposed procedure.

Please write to me at tangboonnee@gmail.com with any comments and your suggested list for O&G procedures (point no 2) that will more likely require the assistance of another O&G Specialist for the safety of the patient; to be tabulated by MOH.

I look forward to your reply; and if within reason the list shall be compiled for the MOH's information.

Thank you.
Dr Tang Boon Nee

25TH OGSM CONGRESS REPORT

OGSM Annual Congresses are usually held during the 1st weekend of June but this congress was postponed to a later date due to Hari Raya Puasa. The 25th Obstetrical & Gynaecological Society of Malaysia Congress was held at Shangri-La Hotel, Kuala Lumpur from 27th to 30th July 2017. This congress was organizined by an able committee of key members, who were part of many other international congresses. This Congress' website was launched in December 2016.

Pre Congress Workshops was held on 26th July at the same venue.

"Masterclass in Coloposcopy" was conducted by Dr Quek Swee Chong from Singapore. This workshop covered basic topics and interactive cases. Workshop 2 was Cardiovascular Disease in Pregnancy attended by many primary care physicians and obstetricians. Dr Geetha Kandavello from IJN was the convenor of this workshop which covered areas of cardiovascular disease in pregnancy leading to maternal mortality. Workshop 3, Prof Sir Arulkumaran was the convenor of "The Essence of Labour and Delivery". Nearly 110 participants attended this workshop. This workshop covered the essence of care in the labour room for practicing obstetricians from obstetric emergencies to non technical skills. Workshop 4 was Ultrasound in Obstetric Emergencies. Dr Japaraj Robert Peter was the convenor. Workshop 5 was Massive Obstetric Haemorrahge and Shoulder Dystocia which was conducted by ICOE Midwives. This hands-on technical skills training had more than 50 midwives participating

The **Scientific Programme** consisted of five Plenary Lectures, seven titled & themed lectures, Obstetric Grand Ward Rounds with eleven concurrent symposiums, two Hands-On Skills training, two surgical workshops and free communication sessions. The **Plenary lectures** covered areas in maternal sepsis, general obstetrics & gynaecology, postpartum haemorrhage, urogynaecology and reproductive and sexual health. The President's Lecture titled Second Victim spoke about issues faced by doctors after an untoward incident.The I.S. Puvan Memorial Lecture was given by Professor CN Purandare, President of FIGO. A special lecture during the opening ceremony was delivered by Datin Paduka Marina Mahathir entitled Women's Reproductive Health Issues in SEA.The Enrichment Lecture was about Child Adoption Laws in Malaysia and was delivered by Mr Nizam Bashir. **Hands-On skills** training covered Four Chamber View of Fetal Heart, POP-Q Examination, Safe Port Entry, Fetal Dopplers, Diagnostic Hysteroscopy & Urodynamic Study interpretation. Fifty Speakers around the world participated in this congress.

For first time, the **25th Congress Web App** was Launched on the first day. This was useful for all delegates with information about the Congress available with mere touch of a button. Many delegates were happy about use of less paper and notably traditional abstract was not printed. This app had an access to all abstracts, exhibitors' information, speakers' information, social programmes, daily congress highlights and congress photographs. All the lectures are available on video through this app. Delegates who missed important topics will be able to watch the lectures on video.

The OGSM Challenge Inter University Quiz Competition was held instead of the traditional debate. Five universities with three participants in each team took part in this event. Dr Goh Huay Yee was the quiz master. 25 questions were given to all five teams in the first round. After that two teams were eliminated. In the second round there were another twenty five questions of rapid fire was given between three university teams from University Malaya, University Kebangsan Malaysia and University Sains Malaysia. Finally the OGSM Challenge winner was University Malaya. A team of young O&G specialists from Sarawak GH prepared the question bank. This is available for future OGSM Challenges competition.

Meet the experts were sessions where five leading international experts sat down with delegates for a round table discussion and these sessions were held every morning of the congress. Specific topics were given for each expert for 30 minutes from 8 to 8.30 am. These sessions were pre booked by delegates and was well attended even though they were held early morning.

A forum entitled Empowering Women & Children: Unfinished Agenda was held on the last day of the Congress, this was hosted by Professor Jamiyah Hassan. This session covered issues affecting transgender, Human trafficking, child abuse and termination of Pregnancies.

Congress Gala Dinner was held on 29th July 2017, with a theme of Hats and Bows. The fun evening started with dance performances and a music band.

There were 856 registered delegates attending this Congress. They were from the following countries Australia, Canada, Bangladesh, Pakistan and India.

DR THANEEMALAI JEGANATHAN

25TH OGSM CONGRESS REPORT

WOMEN AND REPRODUCTIVE HEALTH AND RIGHTS IN SOUTHEAST ASIA: THE ROLE OF THE OBSTETRICIAN AND GYNAECOLOGIST IN THEIR PROMOTION

**This speech as given by Datin Paduka Marina Mahathir as a special lecture at the 25th OGSM Congress 2017 at Shangri-la Hotel, Kuala Lumpur*

Professor Chittaranjan Narahari Purandare,
President of the International Federation of Gynecology and Obstetrics.

Dr J. Ravichandran R. Jeganathan,
President, the Obstetrical and Gynaecological Society of Malaysia.

Members of the Obstetrical and Gynaecological Society of Malaysia, Good afternoon and to those coming from abroad, welcome to Malaysia.

Let me begin by thanking the Obstetrical and Gynaecological Society of Malaysia for inviting me today to speak to you. It's actually a rare opportunity for one of your patients to be able to address all of you with some authority so I will be sure to make the most of it.

Ladies and gentlemen,

My own gynae is in the audience I know but I would like to begin with a story of my own experience with him. I would like to preface it however by saying that he was a wonderful and caring gynae to a late-age mother and he helped shepherd the delivery of a beautiful baby girl by caesarian section almost exactly 18 years ago.

But my story is really about the pre-natal experience. In the twelve years since I had my first baby, and very excited about my second, I had read a lot about all sorts of birthing methods. My first had been an emergency c-section and I was convinced that I wasn't a real mother unless I had a natural delivery. And not just a natural delivery in a regular delivery room but in a room I fantasised as being the ultimate in comfort and luxury. I floated the idea of all sorts of 'natural' deliveries, mostly thought up by Western women eager to 'return to nature' including an underwater birth sitting in a bathtub of warm water. My husband was horrified but my gynae smiled and took it all in calmly, nodded his head in agreement and as my due date approached, steered me gently towards what he really wanted which was a c-section, quick and easy, first thing in the morning.

I knew what he was doing of course but he was my doctor and despite my so-called fierce reputation, I couldn't really stand up against someone who was in charge of delivering a much-wanted baby so I eventually went along with it. Much to my husband's relief. I'm telling you this story, ladies and gentlemen, to provide a gentle entry point to an issue which affects many women of reproductive age today in our country and around the developing world. As an educated middle-class woman, I actually saw a gynaecologist for both my pregnancies and had access to all the information, medicines and technologies I needed to deliver healthy babies safely.

As you probably know, many women in the developing world do not have the advantages that I had, to sometimes fatal consequences. Maternal mortality is a significant indicator of the progress made by countries towards the development and recognition of women's health and rights, and the attention paid towards mitigating preventable maternal deaths. From 1990 to 2015, the global maternal mortality rate declined by 44% - from 385 deaths to 216 per 100,000 live births, according to UN estimates. This translates into an annual reduction rate of 2.3% which, while impressive, is still short of the 5.5% reduction target needed to

achieve MDG Goal 5 in 2015. Malaysia has shown good improvement in reducing maternal mortality rates from 79 deaths per 100,000 live births in 1990 to 40 deaths per 100,000 live births in 2015 and much of that reduction can be attributed to the work of our Ministry of Health in educating women on the need for antenatal care, as well as the provision of the necessary services all over the country. But 40 deaths of women in childbirth is, I am sure you would agree, still too many. It is rare to hear of women dying while delivering their babies or soon after but in this day and age, I can tell you that I personally know of some.

The definition of maternal mortality rates mentions that they are important indicators of the recognition of women's health and rights. I don't know how often the word 'rights' comes into your usual discussions but allow me to elaborate here.

If women are to be recognised as full human beings, then their rights to be treated equally as men in all aspects must be respected. The right to life and the right to health are two important rights for all human beings. By and large, there are more threats to these two rights for women because of their gender than there are for men. As an example, when women earn less than men, they are unable to access healthcare to equal levels as men. When a society deems that women need permission from men to access certain treatments including lifesaving ones, then their health may be severely threatened should the men in their lives withhold permission. Women face all forms of violence, sometimes even from their intimate partners, and this has a significant adverse effect on their wellbeing, both physically and mentally. And finally in exercising the function that society most often exalts in women, that is, motherhood, the lack of proper pre- and post-natal care can result in highly preventable threats to the mother's health and even life.

When any particular country experiences high mortality rates, it is an indicator often of how well women are treated in that country. It is no coincidence that where the status of women are at par with men, maternal mortality rates are also low, and the lifetime risk of dying from complications of childbirth are also low. For instance, in high-income countries, the lifetime risk of a 15 year old girl dying from childbirth-related problems is 1 in 3300. Those are also countries where she is likely to be educated, to be protected under the law from childhood, to marry later and to have less babies later in life.

On the other hand, her equal in a low-income country has a lifetime risk of maternal mortality of 1 in 41. But this girl is also likely to be poorer, less educated, married and a mother earlier and less able to make her own decisions in life. Why should it therefore be surprising that 99% of global maternal deaths in 2015 occurred in developing regions, with Sub-Saharan Africa suffering the worst rates followed by South Asia.

The Sustainable Development Goals which followed the MDGs however has set, as part of its goal of achieving gender equality, a target to 'ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.' At the very core of such goals is the notion that sustainable development cannot be achieved without gender equality, that it is both desirable, necessary and achievable.And sexual and reproductive health and rights are at the heart of achieving that.

But how do we get there? There are of course legal ways to achieve many of these objectives and indeed when we as a country sign up to international conventions such as the SDG, we do have some legal obligations to comply. For example, the Convention for the Elimination of Discrimination Against Women (CEDAW) is the premier human rights document for gender equality. When we signed and ratified CEDAW in 1995, we agreed to introduce laws and other instruments that are recommended in the Convention, with the objective of eventually giving women the rights that they should expect in order to be recognized as full human beings.

But even though we signed it, Malaysia also put in reservations on some of the clauses in CEDAW, some of which were lifted in 1998. However there are still reservations on some key clauses. For example, we still have a reservation on Article 5 (a) which asks us 'To modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women'.

It might seem incredible that we have a reservation

on this but all our reservations are based on the proviso that none of these clauses contradict with 'the provisions of Islamic Syariah Law and the Federal Constitution of Malaysia'. Thus, for example, based on the belief that women cannot be leaders, there is a reservation on Article 7(b) that says that women should 'participate in the formulation of government policy and the implementation thereof and to hold public office and perform all public functions at all levels of government'.

Of relevance to us here is our non-compliance of a recommendation by the CEDAW Committee that we raise the age of marriage for both men and women to 18. Currently the minimum age of marriage under our civil laws is 18 for men and women but women may marry if they are younger with the consent of the Chief Minister. Not only is there a disparity between the genders in the permissible age of marriage, but there is further inconsistency between the civil law and the Muslim Family Laws where men may marry from age 18 and women at 16, but that even younger Muslims may marry upon the onset of puberty with the permission of a syariah judge.

There are other inconsistencies in our laws that contradict these views of marriageable age. For example, the age of majority in Malaysia is 18; that means anyone under that age is considered a minor. Anyone who has sex with a child aged 15 is considered to be committing statutory rape. Yet we have loopholes in our laws which allow for children as young as 10 to get married.

In 2016, the Minister for Women, Family and Community Development replied to a Parliamentary question to say that the number of applications for Muslim child marriages between 2005 and 2015 was 10,240 although she did not say how many were actually approved. The annual average number of applications for child marriages recorded by the Department of Shariah Judiciary Malaysia between 2005 and 2010 was 849, and this average increased to 1029 between 2011 and 2015. So this is an increasing trend.

As for non-Muslim child marriages recorded by the National Registration Department between 2011 and September 2015, there were 2014 girls aged between 16 and 18 involved. 68% of these were married to men aged 21 and above while the rest were married to men closer in age to them, between 18-21.

When we talk about marriage, we also have to talk about the corollary to this that is divorce and widowhood. Children are not only marrying young, they are also becoming divorced and widowed young. According to the 2000 census, there were 10,267 children aged between 10 and 14 who were married, while 229 out of this age group were widowed and 75, divorced or permanently separated. Married girls outnumbered boys in this age group at 58% to 42%.

When broken down according to gender, 4,334 boys aged 10-14 were married as of 2000, while 71 were widowed and 17 were divorced or separated. As for the girls, 5,933 in this age group were married, while 158 and 58 were respectively widowed and divorced or separated.

As our overall population grew, there has been an increase in the numbers of these child marriages although there no longer seems to be any record of those married children aged 10-14. However there has been an increase in marriages between children aged 15-19, most of them overwhelmingly female at the beginning of the 21st century, but then almost evening out a decade later at 82,382 females and 73,428 males.

We can debate the causes of this surprising phenomenon in our modern developing country, but for our purposes here, our main concern is the sexual and reproductive health and rights of all these children, especially girls, who get married at these tender ages. I don't have to reiterate here the physical consequences of too early pregnancies and childbirth, nor the emotional and psychological ones of children bearing and rearing children. The social and intellectual consequences are also obvious: children who get married tend to stop schooling, especially if they are girls and very often they do not have the opportunity to work either. They become isolated and cut off from their friends and their own personal development becomes stunted. And as you know, healthy babies depend on the level of education of their mothers.

And as disastrous as early marriage and motherhood are to these children, imagine being widowed or divorced as well. Given that often parents allow their daughters to marry because of poverty, returning to their families may not always be a viable option.

We should all be alarmed by this trend. Teen and child mothers face a greater risk of dying in pregnancy and childbirth. The State of the World's Mothers 2015 report by international children's rights group Save the Children showed that one in 1,600 women in Malaysia are at risk of maternal death, nine times higher than Singapore's at one in 13,900.

The report also showed that a child born in Malaysia is three times more likely to die before turning five compared to Singapore, with the child mortality rate here at 8.5 per 1,000 births, while Singapore's is 2.8 per 1,000 births.

To add to all this is the danger of HIV/AIDS in Malaysia. Although new infections seem to be declining, there has been a sharp rise of heterosexual transmissions of HIV from 15.6% of all new infections in 2010 to 34.6% in 2015. This was a trend that we could have foreseen two decades ago when we were first dealing with the epidemic in Malaysia. At the time, our surveillance showed that injecting drug users were the primary group becoming infected with the virus. But we forgot that these groups do not live in isolation from the rest of society. Today we are seeing the results of that shortsightedness because it is the partners of those early people with HIV who are getting infected, with far worse consequences.

Women living with HIV who are pregnant can be treated early because they would be tested in maternity clinics and provided with anti-retrovirals if found positive. This Prevention of Mother-to-Child-Transmission programme has proven very successful in Malaysia in preventing HIV among babies and in keeping both mothers and babies alive. But we are not actually doing anything much to prevent infection to the women in the first place, only being concerned that their children will be protected. And yet the cheaper way to prevent babies from becoming infected is to prevent their mothers from becoming infected. Such prevention is not just a matter of giving people leaflets with information about HIV or even a talk or two. It involves dealing with the way women are seen in society, without their own bodily integrity, without the right to say no, without the ability to demand that they are protected by and from their own husbands. This entails far more than clinical advice to individual women. It involves comprehensive changes in the mindset about women, less about protectionist approaches to women and more about empowering women to make their own choices about their bodies and health, as well as promoting men's responsibility to protect themselves and their families.

What does this mean for all of us? Some of you, especially those in private practice may say that you don't see any child brides and teen pregnancies in your practice so this doesn't concern you. Those of you in the public hospitals are more likely to see them. But what are you to do, and how should you do it?

First, I think we need to have proper documentation of the cases that we do see. It is important to note the age of the mother, and especially if the mother is a child under the age of 18, the circumstances under which she came to have a child. She may be married or she may not be. The baby may be the result of a consensual relationship or it may not be. And if it is the latter, then any signs of violence must be recorded and reported. Just this month, the Chief Syariah Judge of Terengganu reported that many divorces were initiated by wives who complained of their sexually over-demanding ('gila seks') husbands, sometimes resulting in their own physical injury. Although it is not yet a crime under the Domestic Violence Act, these could be interpreted as acts of marital rape as obviously the wife does not consent to them.

Secondly, I think that obstericians and gynaecologists are well-placed to be advocates for the rights of women to enjoy their sexual and reproductive health to the highest level. You see the consequences, both physical and mental, of too early and too many pregnancies and childbirths. You know better than many about the unmet needs of many women for safe contraceptives, which if available, would lessen the need for abortions. I am also sure you know the consequences of making our progressive abortion laws stricter; it doesn't lessen the number of abortions by women who need them, it merely makes them more dangerous. And as we know, unsafe abortions lead to many unwanted consequences, including death.

I am also sure you know that the growing conservative attitudes towards women are not contributing to better women's health. I am sure you have read about calls for women to only go to female obstetricians and gynaecologists, to have dubious surgical garments worn by women giving birth or even in some cases, to have women deliver at home, sometimes by untrained 'midwives', rather than in hospitals. While other less developed

countries are moving towards safer deliveries for women by getting them to be attended to in hospitals or by at least trained birth attendants, some Malaysians are going backwards and putting women at risk. How can any of this be good for women, or even the nation?

These types of attitudes, as well as attitudes towards female circumcision and vaccinations, display a growing mindset towards women that is confusing to say the least. On the one hand, women's role as mothers is exalted. On the other hand, the very process of becoming a mother puts her at risk. Not only is it contradictory, it is self-defeating.

I believe these trends can be countered with authority, and that authority is based on knowledge and expertise. You are all the experts on this and you should embark on a more pro-active role in advocating for safer childbirth and motherhood. Indeed good healthcare and wellbeing for all women. Your voices must be added to the calls for better sex education for our children. There is no point in being alarmed and outraged by the numbers of abandoned babies if we simply let them happen through the lack of education about how their bodies work and how babies are conceived. It's not just about educating girls either. We also need to educate young boys about their bodies and about the emotional impact of puberty. We need to also educate both about how to respect themselves and each other. Studies from other countries such as the Netherlands have shown that good comprehensive sex education leads to later and safer sexual behaviour and low numbers of teen pregnancies. Instead we are seeing both child brides and sometimes grooms, teen mothers and abandoned babies. I truly cannot understand why we wring our hands in helplessness every time we read about these things in the papers when we know what to do. So we need all voices to speak up on what is a needless preventable issue.

Ladies and gentlemen, I told you I was going to take advantage of this opportunity. I truly urge you that in these days when we are confused about many things, when we no longer know what is true and what is fake, even what is right and what is wrong, what we can rely on is empirical evidence and facts. And the facts tell us that women in Malaysia are still suffering unnecessarily from preventable sexual and reproductive health issues. All we need to do to support them is to ensure that they enjoy their full rights to be treated as human beings, with respect, with dignity, with their wellbeing and safety as top priority. You have a very important job, ladies and gentlemen, and all of us who get to meet you are very grateful for your care and expertise. But it's not so much about us, it's about the environment we live in which treats half of humankind as lesser beings. And it's about the very many other women, some of whom you see, many of whom you don't, who suffer as a consequence. Every woman counts, regardless of their age, race, religion and circumstance in life.

Thank you.

"WHERE GREAT MINDS COME TOGETHER" - INSIGHT FROM AN MO VOLUNTEER ON OGSM CONGRESS 2017

Dr Dalila Hassan is a medical officer from Hospital Kajang and was one of the MO volunteers during the 25th OGSM Congress.

I remembered vividly how swift I was to say "yes" when Dr. Sharmina eloquently asked me to be a volunteer for what was going to be the most proactive and thought provoking four days of my life. Nothing could have ever prepared me for this...

Day 1 : Pre congress
From CTG's to the latest updates in labour management, my team and I were on our toes to make sure everything went smoothly. The day started off with an array of lectures on topics which I found very useful for an O&G trainee like myself. Despite feeling dwarfish in a place filled with heroic giants in the field, not once did anyone make us feel marginal.

The highlight of the day was to be able to meet the founding father of CTG himself - Prof Sir Arulkumaran. He is definitely a man of vast knowledge and experience. In spite of the weathering thoughts playing through my mind, I knew that the day would not be complete without a fan based picture. So, I gathered what little nerve I had in me and audaciously asked for a "selfie".
Thus, the day ended with a calm and smooth transition, not knowing what the next day had in store for us.
Day 2 : Congress
We started very early in the morning. The Meet the Experts session was a like a sold out Michael Jackson concert, at this point we were like Hercules trying to control the swarm of participants.

From plenaries to symposiums, from time keeper to a door custodian, everyone had a role to play in making sure the day went on smoothly for the delegates and the speakers.

The day ended with a special lecture from Datin Paduka Marina Mahathir and ultimately officiating the 25th OGSM congress.

Day 3 : Congress
The day started out smoothly with the Meet the Experts session followed by plenaries and symposiums. The Hands On Training was an amazing session where many of us had a chance at the laprascopic simulators. Despite allocating a 20 minute session of POP Q, Prof Lim Pei Shan successfully managed to impart a wealth of knowledge into my cerebral cortex.

The Gala dinner was a way for us to unwind and have fun after a rigorous 3 days. During the dinner, winners of the poster and oral presentation were announced. With this year's theme, "Hats & Bows", many arrived with their elegant and chic ensemble. Without a doubt everyone looked stunning.

Day 4 : The finale
Sunday morning- the last day of the congress. With on going plenaries and symposiums, we still made time for booth visits for last minute goodies. The highlight of the day was the forum where issues pertaining to women and children were addressed.

Four days went by swiftly and it was time to bid farewell to the Maroon team. Truth be told, as a delegate we never really appreciate what goes on behind the scenes and the enormous preparation involved. Being a part of the Maroon team made me realise that such events require months of planning, dedication and sleepless nights in making sure every crucial detail is not missed. We were fortunate to be given such an experience.

Like the famous quote from Dr Seuss, "Don't cry because its over, smile because it happened".

Maroon team out.

DR DALILA HASSAN

SRI LANKA COLLEGE OF OBSTETRICIANS & GYNAECOLOGISTS GOLDEN JUBILEE CONGRESS 2017 ESSENTIAL SKILLS WORKSHOP IN OBSTETRIC EMERGENCIES

The Obstetrical and Gynaecological Society of Malaysia (OGSM) was invited to participate in this congress with a one day pre-congress workshop that was held at SLCOG building, 112 Model Farm Road, Colombo 8. Pre-course arrangements were done on 1st August 2017 at the venue. The course was held on 2nd August 2017, from 8:30 am till 5:15 pm. This workshop covered topics of Basic Life Support, Management of Postpartum Haemorrhage, Management of Shoulder Dystocia, Breech Delivery, Cord Prolapse, Uterine Inversion and Caesarean Delivery. The teaching methodologies used were short lectures with breakout sessions consisting of hands on training, demonstrations and interactive sessions.

The trainers who participated in this workshop were Dr Gunasegaran PT Rajan, Dr Tang Boon Nee, Dr Muniwaran, Dato Dr Zaridah Shaffie, Dr Eliza Mohd Noor, Dr Thaneemalai and Mr Baskaran (ICOE executive). The participants consisted of 16 medical students, house officers and medical officers. There were also 26 registrars and 2 senior consultants. In total there were 50 participants and observers. The training mannequins and pelvic models were brought from OGSM and disposables were supplied by SLCOG. Flight costs was covered by OGSM whereas local transportation and accommodation was provided by Sri Lanka College of Obstetrics and Gynaecology. Dr. Chandana Jayasundara was in charge of this workshop. He was kind in arranging the transportation and essential equipment in the College building.

Pre & post-test was carried out in the form of pictorial multiple choice questions which showed pre-test scores averaged around 38% with highest score of 7 out of 12 and lowest was 3 out of 12. Post test scores showed remarkable improvement with the average score of 80%, with the highest score 10 over 12 and the lowest score 6 out of 12. The course feed -back from the participants confirmed 96%t enjoyed the course, knowledge acquired was useful and it met their objectives.

The few comments:

"Priceless, wonderful and enjoyable session. The knowledge acquired was remarkable and the skills learned a lot"

"We look forward for this course in a regular manner"

"Very valuable workshop, lot of important practical points were elaborated"

"Valuable and Enjoyable course"

"Excellent workshop! It gave practical skills for participants"

"Very friendly and fun staff made this session a very knowledgeable and pleasant experience"

"The number of Participants should be limited for hands on training"

This workshop requires two full days with participants limited to twenty-four to meet the objective of structured skills training programme. OGSM is looking forward to work with SLCOG to continue this training programme and improve the clinical skills, communication and non-technical skills of members of the O&G community in Sri Lanka.

DR THANEEMALAI JEGANATHAN

BEHIND THE CURTAIN - MY EXPERIENCE AS AN ICOE TRAINER

Dr Khoo is a senior O&G Consultant in Columbia Asia Hospital Seremban and is a dedicated ICOE trainer, having trained doctors both locally and internationally.

And so I became an iCOE trainer. Why? Nobody in his right mind would want to devote his time

and effort pro bono. Why leave the comfort of the office and hospital and travel long distances and, in certain times, early flight times, airport queues, immigration and customs to teach junior doctors free of charge something that you have paid heavily to learn?

Being an obstetrician does not begin with your postgraduate degree or ends with it. Getting your postgraduate paper qualifications does not automatically confer you the skills and experience required to be a first class obstetrician. As anywhere in medicine, it is a lifelong learning experience. I remember when I first did a forceps delivery as a registrar. In those days you see one case and do the next one without supervision. It was expected of the learning experience in that era. You start at the deep end. So with trembling hands holding the forceps i popped in the blades and happily they locked. Then happily with the next contraction I pulled while telling the assisting midwife to do an episiotomy and out came the baby with little effort. Happy ending? No. To my horror I had created a third degree tear with the ends of the anal sphincter spitting reddish insult at

my incompetence. Of course the boss is not going to come at 2 am to repair a third degree tear for you. Armed with book knowledge, I proceeded to repair on my own and reported to the boss the next morning. He did not say a word but gave me a friendly punch on the shoulder. I could never be more kind to that patient as guilt and morose gave way to extra tender loving care for the patient.

There were many more mishaps in my early obstetrics career that I came to grieve. Patients have died or came to the brink of death. As time and experience go on these mishaps became the exception rather than the rule. I did not have to deal with heartache, guilt, morose, feeling of incompetence and blame as often as before.

And so why did I decide to become an iCOE trainer? I attended the first ever ICOE that was conducted and after attending the course I discovered my strengths and weaknesses. In that course a

common comment by senior obstetricians was "Why did my boss not teach me like this during emergencies". In my heart I would not want to wish the same sense of failure and guilt on my younger colleagues. After all, the knowledge and experience passed down to them will save them grief and more importantly, result in less patients who are injured by inexperience obstetricians.

Like I said, becoming an ICOE trainer is not easy or glamourous. The trainees look to you as if you are the greatest obstetrician but they do not know the exhausting travel that is involved and the hassle of the customs department of every foreign country. It was the first time that I learned that there is an oversized and odd sized cargo section tucked away in the airport and we had to hand over

our equipment for them to load onto the plane. Once on a trip to India with all our mannequin and other equipment we were suddenly stopped by the custom who excitedly pulled a carton one side and asked us to open it because his scanner showed a baby inside. We were suspected to be baby smugglers. I am not telling why he saw a baby in the carton. You figure that out.

Also some trainees are probably there to show off their knowledge rather than to learn. This occurs more often if the trainee has decided to title herself as professor. Some of them have cone to realize that being professors do not accord them competence in practical obstetrics emergencies but sadly one or two will refuse to learn believing that their method is better. One very senior obstetrician in Mongolia commented that it was the first time she learned CPR. We asked what happened if a patient collapsed? Her answer was simple; call the anaesthetist. That was one very honest and humble lady who eventually became a trainer herself. On the other hand in the same country I demonstrated how insertion of obstetrics forceps to a occiput transverse using low forceps would not work. Along came this senior lady who proceeded to load Wrigley forceps into the mannequin rotated the forceps and pulled the dummy fetus out and smugly telling the other juniors that it can be done just like how she demonstrated. No amount of explanation could convince her that Wrigley forceps are not rotational forceps.

And so to end, I wish to also share that the trainers also learn from each other as well and that is how we improve ourselves. The handful of ICOE trainers come from different parts of the country, of different race and religion and differing levels of seniority but we have a very close camaraderie and we are united by the sense of urgency in imparting our experience and knowledge to our junior colleagues. And may all ICOE trainees be honest in their weaknesses and learn from the course. The course is only possible because the trainers are not paid which makes the course affordable. So take advantage of this.

DR KHOO KONG BENG

VIDEO PRESENTATION OF INTERESTING GYNAECOLOGICAL LAPAROSCOPIC SURGERIES

This video session was organised by OGSM with the Aesculup Academy on the 8th October 2017. A total of 30 gynaecologists participated in this session. The aim of this video session was for gynaecologists to present surgical videos and we discuss on that particular topic.

The session started at 9:05 am with Dr. Senthi Muturaman (Sentosa Hospital, Klang) presenting a case of Total Laparoscopic Hysterectomy. It was a simple case and the discussion was as to the various techniques of performing a TLH. The second speaker was Dr Sheng SL who described the technique of Laparoscopic Tubal Reversal. Dr. Azmi (Putrajaya Hospital), then spoke on Laparoscopic Cystectomy in pregnancy, an interesting topic that created much discussion.

After the tea break Assoc. Prof. Aizura (UMMC) showed 3 nice videos on Laparoscopic Myomectomy and there was a discussion on all the difficulties of performing Laparoscopic Myomectomy. Dr. Azam (Pekan Hospital) then spoke on his difficulties in starting laparoscopic surgery services in Pekan, Pahang and showed a video on Laparoscopic Hysterectomy. Dr. Dahlia (Miri Hospital) spoke on the challenges faced by novices in performing laparoscopic surgery.

After lunch, Dr. Agilan (KL Fertility), showed his technique of performing laparoscopic surgery on endometrioma and discussed the controversies surrounding the need for surgery on endometrioma. Dr. Selva (Mahkota Medical Centre, Melaka) showed a video on Ovariopexy for endometrioma and there was a good discussion on the various methods of surgery for endometrioma. Finally Dr. Selva showed 18 short videos on different complications that he had encountered and the lessons learnt from these complications. The complications were divided into bleeding, bladder injury, bowel injury and ureteric injury.

The meeting ended at 4:45pm. Everyone enjoyed this informal video sharing session and another similar meeting will be held in 4 to 6 months time. My hope is for more doctors especially the beginners to come forward to present their videos for discussion.

DR. S. SELVA
Chairman of Endoscopic Subcommittee
Obstetrical and Gynaecological
Society of Malaysia

Frenchwoman Jeanne Calment, the oldest documented human being was 122 years old when she passed away in 1997. If Jeanne had menopaused at age 50, she spent 72 years of her life in the post menopause without the help of estrogen.

It is indeed ironical that women enjoy estrogen protection for about 5 decades of their life and then as a reward for increased life expectancy around the world, they are then forced into an estrogen deficient state. Would it not be much easier for women to continue having their hormones intact (albeit at a lowered dose) to continue protecting them, just as testosterone do the job for men. Unfortunately women do not have it so easy!

Big improvements in life expectancy around the world has brought forward the issue of post-menopausal health. Women are living longer than men. However the aging woman has a higher risk of heart disease (and dying from an infarct) compared to men. Their risk of osteoporosis is also 3-5 times higher than men. With living longer, come issues of mental health, mobility, medical problems and cancer risks.

Would putting women on hormone therapy not be the solution then, to them having a better quality of life? The solution has not been as straightforward. Hormones have been in the market for almost 100 years. In 1926, the first commercial estrogen preparation was available and this was used as menopausal replacement in the 1940's. Progestins were added in women with an intact uterus when the endometrial cancer risk was evident in the 1970's. Then came the golden years of hormone replacement therapy till the late 1990s when the HERS I and HERS II changed our perceptions of Hormone Therapy (HT) benefits on cardiovascular risks.[1, 2]

HERS I revealed that continuous HT on postmenopausal women with established cardiovascular disease did not reduce cardiovascular events with a possible increase in thromboembolic events. HERS II came up with the then often used slogan "don't start, don't stop". Implying that if one has not started on HT to not do so but if one was already on HT, continue as the benefits of HT may be better with time.

Of course, the 2002 WHI study (Women's Health Initiative Study) tightened the screw further on the negativity of hormone therapy. In over 27,000 post-menopausal women (with an average age of being in the mid 60's), the use of combination HT in women with an intact uterus showed an increase in heart disease, strokes, venous thromboembolism (VTE) and breast cancer over 5 years. Women who were only on estrogen for almost 7 years had an increase in stroke and VTE with no increase in breast cancer risk. This was paradoxical to what had been taught.

Almost overnight women stopped their hormone replacement. The number of hormone replacement therapy (HRT) prescriptions came down by over 50%. Doctors were not confident in prescribing HT to their patients who needed it, citing increased risk of medical problems and cancer. The counselling indeed took more time.

In the next decade, the risk of post-menopausal fractures doubled[4] and the Finnish registry showed a significant increase in coronary heart disease in post-menopausal women[5]. Quality of life of post-menopausal women became poorer. HRT opponents revealed observational studies showing a post WHI drop of breast cancer incidence, however retrospectively this was shown to be due to lesser screening once women went off hormone therapy[6].

In 2014, after a more in-depth look at the WHI data, the very same WHI investigators of 2002 concluded differently.[7] Menopausal HT (MHT) is now effective for vasomotor symptoms in younger recently menopaused women (within 10 years of menopause) when the risk of coronary heart disease, stroke and VTE is reduced whereas in women more than 20 years from menopause, this risk was increased. Individualized management is important especially in combined HT users, taking the baseline profile of the woman into consideration.

It is also becoming more obvious that BMI can be a single important risk factor for CHD, breast and VTE irrespective of MHT use. Non oral routes of MHT administration has also now shown to be safer due to its hepatic by pass advantage.

So are we now looking at changing dosages, changing delivery methods and possibly in future moving away from the conventional "made to order' "one fit all" ready-made preparations of MHT?

Keeping all this in mind the Revised Global Consensus Statement was released by 7 international menopause, endocrine and osteoporosis societies in 2016. The salient points are as follows:

1. Vasomotor Symptoms
MHT, including tibolone and the combination of conjugated equine estrogens and bazedoxifene (CE/BZA) (which is not available in Malaysia), is the

most effective treatment for vasomotor symptoms (VMS) associated with menopause at any age, but benefits are more likely to outweigh risks if initiated for symptomatic women before the age of 60 years or within 10 years after menopause.

2. Osteoporosis
MHT, including tibolone and CE/BZA, is effective in the prevention of bone loss in postmenopausal women. MHT has been shown to significantly lower the risk of hip, vertebral and other osteoporosis-related fractures in postmenopausal women.

MHT is the only therapy available with proven efficacy of fracture reduction in postmenopausal women who have normal or osteopenic bone mineral density.

Initiation of MHT after the age of 60 years for the indication of fracture prevention is considered second-line therapy and requires individually calculated benefit/risk, compared to other approved drugs. If MHT is elected, the lowest effective dose should be used.

3. Vulvovaginal atrophy
MHT, including tibolone, is effective in the treatment of vulvovaginal atrophy (VVA). Local low-dose estrogen therapy is preferred for women whose symptoms are limited to vaginal dryness or associated discomfort with intercourse or for the prevention of recurrent urinary tract infections.

4. Cardiovascular disease
Standard-dose estrogen-alone MHT may decrease the risk of myocardial infarction and all-cause mortality when initiated in women younger than 60 years of age and/or within 10 years of menopause. Data on estrogen plus progestogen MHT initiated in women younger than age 60 years or within 10 years of menopause show a better cardio protection profile than when initiated after the age of 60.

5. Venous thromboembolism (VTE) & Stroke
The risk of venous thromboembolism (VTE) and ischemic stroke increases with oral MHT, although the absolute risk of stroke with initiation of MHT before age 60 years is rare.

There is a probable lower risk of VTE and possibly stroke with transdermal therapy (0.05 mg twice weekly or lower) compared to oral therapy.

6. Quality of life, sexual function and other menopause-related complaints, such as joint and muscle pains, mood changes and sleep disturbances may improve with MHT.

7. Breast Cancer
The risk of breast cancer in women over 50 years of age associated with MHT is a complex issue with decreased risk reported for estrogen alone (CE in the Women's Health Initiative (WHI)) in women with hysterectomy and a possible increased risk when combined with a progestin (medroxyprogesterone acetate in the WHI) in women without hysterectomy. The risk of breast cancer attributable to MHT is rare. It equates to an incidence of <1.0 per 1000 women per year of use. This is similar or lower than the increased risk associated with sedentary lifestyle, obesity and alcohol consumption. This risk may decrease with time, but the data is inconsistent.

8. Premature menopause
Women experiencing menopause before the age of 45 years and particularly before 40 years are at a higher risk of cardiovascular disease and osteoporosis and may be at an increased risk of affective disorders and dementia. MHT reduces symptoms and preserves bone density in such women. Observational studies suggest MHT is associated with a reduced risk of heart disease, longer life span and reduced risk of dementia, however RCT's are required. MHT is advised till the average age of menopause.

9. Cognition and Dementia
MHT initiated in early menopause has no substantial effect on cognition but based on observational studies, it may prevent Alzheimer's disease in later life.

MHT may be beneficial in improving mood in early post-menopausal women with depressive and anxiety symptoms. It may also be beneficial for peri-menopausal women with major depression however anti-depressants remains the first line of therapy.

10. Individualized treatment of MHT.
The type, route of administration of MHT should be consistent with treatment goals, patient preference, and safety issues should be individualized. The dosage should be titrated to the lowest appropriate and most effective dose.

Duration of treatment should be consistent with the treatment goals of the individual, and the benefit/risk profile needs to be individually reassessed annually. There is presently no time frame of MHT use.

The North American Menopause Society just released its 2017 Hormone Therapy Position Statement[9] which further cemented the above statement by the international menopause

societies. They went on to add:

Sarcopenia or the loss of muscle mass, strength and connective tissue disturbances increase with estrogen loss. Taking MHT along with carefully selected exercises show a beneficial effect

MHT significantly reduces the incidence of new onset Type 2 diabetes. Mid riff weight is minimized decreasing the risk of metabolic problems.

MHT does not need to be routinely discontinued in women aged older than 60 or 65 years and can be considered for continuation beyond age 65 years for persistent vasomotor symptoms, quality of life issues or prevention of osteoporosis after appropriate evaluation and counseling of benefits and risks.

Annual reevaluation, including reviewing comorbidities and periodic trials of lowering or discontinuing HT or changing to potentially safer low-dose transdermal routes, should be considered.

Vaginal estrogen (and systemic if required) or other non-estrogen therapies may be used at any age for prevention or treatment of genito urinary symptoms of the menopause.

Dr. JoAnn Manson a principle investigator on the WHI study for over 2 decades says the pendulum has swung so widely from "hormone therapy is good for all women" to it being "bad for all women" to being somewhere in between. The pendulum has now got to rest. It's taken a long time to get here. Now let's just keep it here.

Are we now as gynecologists (treating our post-menopausal woman) equipped with enough knowledge to successfully put our patients on MHT if they need it? We are indeed in a better place than ever before, however the key management tool remains counselling and assessing the woman as a whole and on a regular basis.

We are in the Asia Pacific basin, where the epidemic of metabolic problems, osteoporosis and mental health abound. Weight management and long term health issues are important discussion points for our post-menopausal women, always keeping in mind that if they are an ideal candidate for menopausal hormone therapy, we should be confident in prescribing it and following them through. Start them on MHT early, monitor doses and mode of administration and not worry of time limit to MHT use. With regular follow ups, let them enjoy a better quality of life into the menopause.

"From year to year, it has become more obvious: the goal of medicine is not health today but for health tomorrow." - Anonymous

DR. PREMITHA DAMODARAN

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9. The 2017 hormone therapy position statement of the North American Menopause Society. Menopause Vol 24, No 7

www.menopausefacts.org
The Obstetrical and Gynaecological Society of Malaysia would be launching their public based Menopause Web Page in October 2017. This would be an ideal webpage for your patients to refer to with regards menopause, its signs and symptoms and options for treatment including menopausal hormone therapy.

2017

Date	Event	Venue	Contact
04-05 Nov	9th Intensive Course in Obstetric Emergencies for Midwives	Vistana Hotel, Kuala Lumpur	OGSM Secretariat Tel: 03-6201 3009 Fax: 03-6201 7009 Email: icoe@ogsm.org.my Website: www.ogsm.org.my
04-05 Nov	National Seminar on Female & Male Sexual Dysfunction	Hospital Tengku Ampuan Rahimah, Klang, Selangor	Auditorium Permata, HTAR Klang For information contact: Dr Rajeev - 013 396 2212 Dr Swama - 017 642 5265 Email: faizalina_82@yahoo.com
05 Nov	Basic Contraception Course	KOMTAR, Penang	Penang Family Health Development Association (FHDA) Tel: 04-281 3144 Email: info@fhdapenang.org
30 Nov-01 Dec	18th Regional MRCOG Part 2 Examination Course	KK Women's and Children's Hospital, Singapore	Congress Secretariat: Ms Pearly Gan Tel: +65 6593 7809 Fax: +65 6593 7880 Email: cogs@ams.edu.sg Website: http://www.kkh.com.sg
16-17 Dec	Workshop on the Anatomy of the Pelvis for Gynaecologists and Trainees	MAHSA University, Saujana Putra Campus, Jenjarum, Selangor	OGSM Secretariat Tel: 03-6201 3009 Fax: 03-6201 7009 Email: administrator@ogsm.org.my Website: www.ogsm.org.my
16-17 Dec	Ovarian Club X and CoGEN in Asia	Hong Kong	Congress Secretariat: Ms Bobo Chan Tel: (852) 2559 9973 Fax: (852) 2547 9528 Email: occ2017@icc.com.hk Website: http://www.occ2017.org

2018

Date	Event	Venue	Contact
20 Jan	1st National Seminar on Ultrasound in Obstetric Emergencies	Hospital Raja Permaisuri Bainun, Ipoh	AMO Syafiqah - 013-543 6780 AMO Ghani - 016-540 7797 Fax: 05-243 7389 Email: obsemergencyhrpb@gmail.com
23-25 April	World Congress on Obstetrics & Gynaecology	Valencia, Spain	Tel: +1-563-447-3392 Email: gynaecology@cenetriconferences.com Website: http://www.gynaecologyconference.org
3-4 Feb	Mastering Obstetrics and Gynaecology in a weekend as an Undergraduate	Armada Hotel, Petaling Jaya	OGSM Secretariat Tel: 03-6201 3009 Fax: 03-6201 7009 Email: administrator@ogsm.org.my Website: www.ogsm.org.my
3-4 Feb	12th Intensive Course in Obstetric Emergencies for Doctors	Vistana Hotel, Kuala Lumpur	OGSM Secretariazzt Tel: 03-6201 3009 Fax: 03-6201 7009 Email: icoe@ogsm.org.my Website: www.ogsm.org.my
21-24 Mar	RCOG World Congress 2018	Suntec, Singapore	Secretariat: Tel: +65 6379 5260 / 6379 5267 Fax: +65 6475 2077 Email: info@rcog2018.com Website: http://www.rcog2018.com
24-25 Mar	10th Intensive Course in Obstetric Emergencies for Midwives	Vistana Hotel, Kuala Lumpur	OGSM Secretariat Tel: 03-6201 3009 Fax: 03-6201 7009 Email: icoe@ogsm.org.my Website: www.ogsm.org.my