

MISHANINA

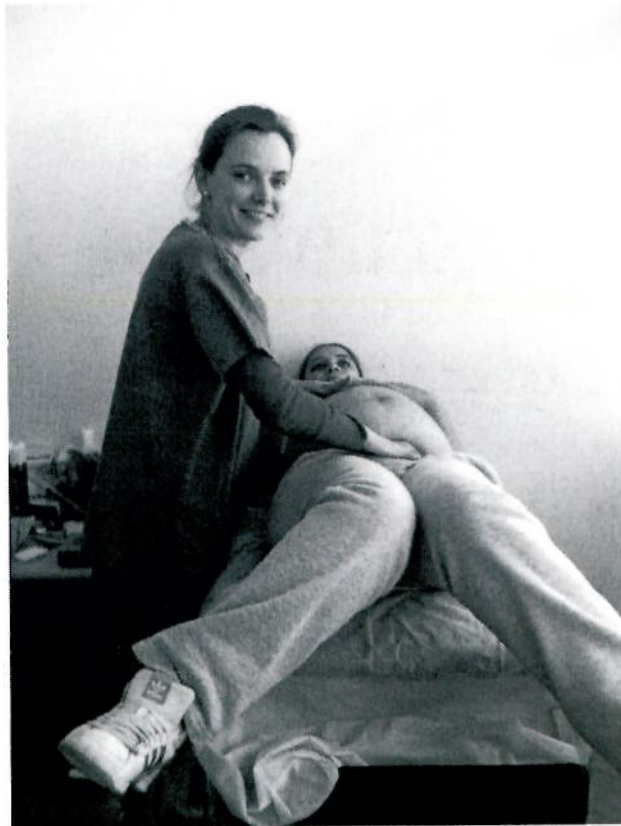
OBST

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Elective report

Obstetrics and Gynaecology in Argentina.
Making research evidence on maternal health
more accessible to policy makers in the low and
middle income countries.

Ekaterina Mishanina



1. How are obstetric and gynaecological services organised and delivered in Argentina? How does it differ from the UK?

Argentina's health care system is composed of three sectors: the public sector, the social security sector, and the private sector. The public sector is free and is financed through taxes. Around 45% of Argentinians do not have health insurance and use public services. Social security (or Obras Sociales) is financed through obligatory insurance schemes obtained through workers' unions as part of the employment agreement. The services are organised according to the occupation of the beneficiary and vary greatly in quality and effectiveness. Around 50% of population are covered by Obras Sociales. The private sector is comparatively small and is financed through voluntary insurance schemes.⁽¹⁾

Obstetric and gynaecology services are delivered in all three sectors and are divided into primary and secondary care. Primary care is delivered in the *centros de salud* (health centres), which comprise of various specialists. Annual women's healthchecks, uncomplicated pregnancies, general gynaecological and breast complain are managed in primary care. High risk pregnancies, gynaecological problems that require surgical intervention and breast cancer are investigated and managed in hospitals. Women give birth in general hospitals or in separate standing maternity hospitals. Unlike in the UK, there are very few midwives and deliveries are attended my doctors in specialist training (equivalent to senior house officer and registrar level in the UK)..

2. What obstetric and gynaecological conditions are prevalent in Argentina? How do they differ from the UK?

Overall, obstetric and gynaecological conditions that are prevalent in Argentina are similar to the ones in the UK, however their incidence differs.

The rates of cervical cancer are higher in Argentina (19.7/100,000) than in the UK (8.7/100,000) with mortality rate 8.9 /100,000 (2.4 in the UK).^(2, 3) Although women start being tested earlier than in the UK and are tested every year, there is a big variation in health care delivery with some women getting annual smear tests and others never being tested.

Unlike in the UK, gonorrhoea and chlamydia are not checked routinely as part of smear test screening in young women. In fact, there are very few sexual health screening programs and services available for young people. However, all pregnant women and their partners are checked for HIV and syphilis during their pregnancy three times. According to WHO, Prevalence of HIV among adults aged 15 to 49 in Argentina was 0.5% in 2009 and 0.2% in the UK.⁽⁴⁾

The biggest difference in obstetrics is that abortion is not legal in Argentina. I encountered many more multiparous women in Argentina, although the official statistics states that total fertility rate per woman is 2.2, which is quite similar to the UK (1.9).⁽⁴⁾ In addition, in the aboriginal population the rate of teenage pregnancy is very high, with the adolescent fertility rate (age 15–19 years) being around 62 per 1,000. This is much higher than in the UK with the rate of 25.4/1,000.^(5, 6)

Antenatal analyses are similar to the British ones, however unlike in the UK, all pregnant women are tested for gestational diabetes in the second trimester and Chagas (parasitic illness spread by insects) in each trimester.

Interestingly, there is no Down syndrome screening program in Argentina. This is mainly due to an ethical dilemma that arises in the situation of antenatal diagnosis of Down syndrome and illegalised abortion.

Although I observed good antenatal and general health care, Argentina's reproductive health indicators are relatively poor with maternal mortality rate being 77 per 100,000 births (12 per 100,000 in the UK).⁽⁴⁾

3. Transform tabulated summary guidelines of SUPPORT Collaboration into graphic plots to make them more accessible to policymakers and bring change to women's care.

Supporting Policy relevant Reviews and Trials (SUPPORT) is an international Collaboration Network of Maternal and Child health that aims to improve the use of reliable research evidence in policy and management decisions and identify the gaps of insufficient evidence. They summarise available research and its quality in a tabulated form capturing various quality parameters using the Grading of Recommendations Assessment, Development and Evaluation approach.⁽⁷⁾ However, large amount of tabulated data across several comparisons and outcomes often spread over hundreds of pages and makes it laborious to read.

Khan et al (2011) identified a need to present evidence summaries in a more effective way and proposed a new graph plotting approach. According to proposed methodology, the information is summarised in two-dimensional charts with 5 spokes starting from the same point and representing evidence grading parameters (study design, risk of bias, inconsistency, indirectness and imprecision). The length of each spoke and the angles of the spokes are the same in all comparisons making it easy to visually interpret. The overall quality of the evidence is color coded, with green for high quality evidence, amber for moderate, red for low and very low and no color where no quality of evidence was recorded.⁽⁸⁾

In Centro Rosarino de Estudios Perinatales (CREP, Argentinian partner of SUPPORT collaboration), I was transforming tabulated quality evidence of a recently conducted meta-analysis "The early versus delayed discharge systematic review" into graphs. In this systematic review the authors wanted to assess the effectiveness and safety for healthy mothers and infants of a policy of early discharge compared to the standard hospital discharge policy as there is ongoing controversy concerning whether staying less time in hospital is harmful or beneficial.












Following Khan *et al's* methodology, I have transformed 11 GRADE tables summarising evidence quality of this systematic review into graphs (Appendix 1). This made it easier for clinicians and policymakers to appreciate the gaps in quality of the studies used in this meta-analysis and decide whether they can rely on this evidence when making clinical decisions and formulating policies.

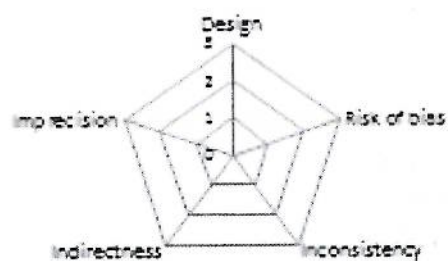
4. Translate created graphic plots into Spanish to make them available to the Spanish speaking world.

With supervision of the translators in CREP, I translated the English version of the graphs into Spanish language (please see Appendix 2).

Word Count 1195 (without references)

Appendix 1. Graphic summary of the evidence quality of 10 outcomes of the systematic review “Early versus late discharge”.

Infant readmissions to hospital for neonatal morbidity	
Infants attending hospital emergency department within 28 days	
Women readmissions to hospital for complications related to childbirth	
Women with depression at 6 week	
Contacts with health professionals regarding infant health issues within 7 days	
Women not breastfeeding (exclusively or partially) at 6 weeks	
Women attending hospital emergency department within first 6 weeks after birth	
Contacts with health professionals regarding maternal health issues within first 6 weeks after birth	
Women reporting infant feeding problems in the first 6 weeks	
Women reporting lack of confidence about caring for their baby in the first 6 months	
Costs of pregnancy and postnatal care	



High quality evidence



Moderate quality evidence














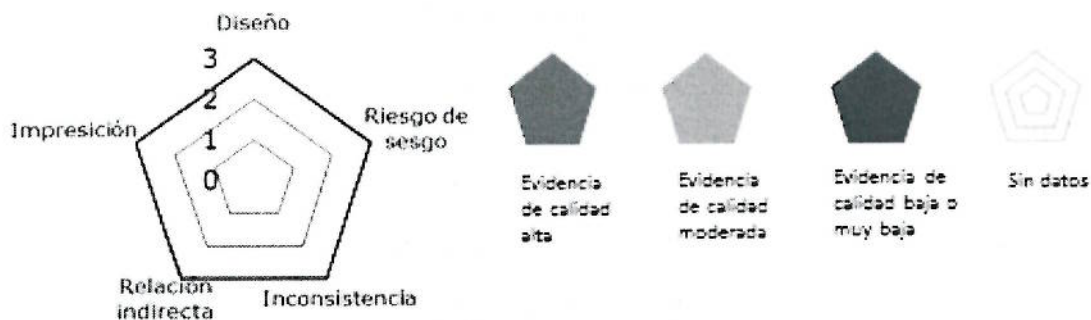
Very low and Low quality evidence



No data recorded

Appendix 2. Resumen grafico de la calidad de la evidencia de 10 resultados de la revisión sistemática "Alta temprana versus alta tardía".

Readmisión hospitalaria de recién nacidos por morbilidad neonatal	
Recién nacidos atendidos en la emergencia del hospital dentro de los primeros 28 días de vida	
Readmisión hospitalaria de mujeres por complicaciones relacionadas con el parto	
Mujeres con depresión a las 6 semanas del parto	
Contacto con profesionales de la salud por temas relacionados con la salud del recién nacido dentro de los primeros 7 días de vida	
Mujeres que no amamantan (exclusiva o parcialmente) durante las primeras 6 semanas	
Mujeres atendidas en la emergencia del hospital dentro de las primeras 6 semanas luego del parto	
Contactos con profesionales de la salud por temas relacionados con la salud materna dentro de las primeras 6 semanas luego del parto	
Mujeres que informan tener problemas para amamantar a los recién nacidos durante las primeras 6 semanas	
Mujeres que informan falta de confianza para cuidar a los bebés durante los primeros 6 meses	
Gastos en cuidados posnatales y del embarazo	



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