C M S A
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JOHANNESBURG OFFICE
EXAMINATIONS & CREDENTIALS

March 2020

R E G U L A T I O N S

FOR ADMISSION TO THE DIPLOMA IN OBSTETRICS OF

THE COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS OF SOUTH AFRICA

Dip Obst(SA)

1.0	**INSTITUTION**	The Colleges of Medicine of South Africa
2.0	**DIVISION**	The College of Obstetricians and Gynaecologists of South Africa
3.0	**QUALIFICATION TITLE**	Diploma in Obstetrics of the College of Obstetricians and Gynaecologists of South Africa
4.0	**OFFICIAL DESIGNATION**	Dip Obst(SA)
5.0	**FIELD**	09 (Health Sciences and Social Services)
6.0	**SUB-FIELD**	Preventive, promotive, curative and rehabilitative
7.0	**NQF FIELD**	8

8.0 BACKGROUND AND MOTIVATION FOR THIS DIPLOMA

8.1 Perinatal and maternal mortality rates are unacceptably high in South Africa and severe morbidity in neonates and mothers is common. Improving the care of women during delivery and the prenatal and postnatal periods is of primary importance. During pregnancy the majority of women in South Africa receive care from medical officers working in district and regional hospitals. Providing an opportunity for medical officers and primary care physicians to improve their knowledge and skills in obstetrics is an urgent requirement for South Africa. This should be done through supervised experience and appropriate examinations

9.0 PURPOSE AND AIM OF QUALIFICATION

9.1 The purpose of the Diploma in Obstetrics of the College of Obstetricians and Gynaecologists of South Africa is to encourage postgraduate training in obstetrics and to raise the standard of obstetrical practice

9.2 It is the aim of the College of Obstetricians and Gynaecologists to ensure that the candidates who are awarded the Dip Obst(SA) will have an understanding of modern techniques in diagnosis and treatment; knowledge of the modern literature in the field; and an ability to relate physiological and pathological principles to obstetrics. In addition candidates should understand the principles of organisation, management and audit of primary and secondary obstetric services in health care centres, district and secondary hospitals. Candidates should know the most common causes of maternal and perinatal mortality in South Africa and understand the strategies to improve these

10.0 THE CAPACITY AND COMPETENCE OF CANDIDATES WILL BE INCREASED BY:

10.1 Undertaking obstetrics and gynaecology training in fulfilment of the Dip Obst(SA) examination regulations in:

10.1.1 Obstetrics and gynaecology training posts under the supervision of university departments in teaching hospital equivalents or in university satellite departments of non-teaching hospitals. (Information relating to these posts is available from the Heads of university departments of obstetrics and gynaecology)

10.1.2 Other posts in regional and larger district hospitals may be suitable for training. These hospitals must be recognised by the College of Obstetricians and Gynaecologists of the CMSA. Such hospitals will be required to have a fulltime or part time obstetrician or an experienced full time medical officer (preferably with a Dip Obst(SA)) as staff members. These hospitals will be required to conduct at least monthly perinatal and maternal mortality and morbidity meetings. Enquiries should be made by prospective candidates as to the acceptability of training posts prior to embarking on training

10.1.3 Primary care physicians and medical officers working in small district hospitals will be eligible if the requirements set out for part-time training have been met

11.0 PATIENT AND COMMUNITY CARE WILL BE IMPROVED BY:

11.1 Successful candidates having an understanding of modern techniques in diagnosis and treatment in obstetrics, early pregnancy complications and family planning. Candidates will also understand the principles of organisation, management and audit of primary and secondary obstetric services in health care centres, district and regional hospitals. Finally candidates should be aware of strategies to lower perinatal and maternal mortality

12.0 TARGET GROUP FOR THIS DIPLOMA:

12.1 Medical officers and primary care physicians (general practitioners)

13.0 ADMISSION CRITERIA

13.1 **Qualification:**

13.1.1 The candidate must have held for six months a post-internship qualification to practise medicine which is registered or registrable with the Health Professions Council of South Africa

13.1.2 The CMSA Senate, through its Examinations and Credentials Committee, will review all applications for admission to the examination, and may also review the professional and ethical standing of candidates

13.2 …/

13.2 **Education and training (Attached as Appendix A):**

13.2.1 Supervised training: A minimum of 6 months of supervised obstetrical training in teaching hospitals or in university satellite departments in non-teaching hospitals and CMSA accredited regional or larger district hospitals. See Appendix A on hospitals acceptable for Dip Obst(SA) training. This may be done in two 3-month periods of training over a maximum of two years. One of the six months of training may be in gynaecology

13.2.2 Part-time training: Certification is required from the chief executive officers, medical superintendents or heads of departments that candidates have fulfilled the requirements as stipulated in Appendix A

13.2.3 ***Course work:***

Recommended reading:

(i) Cronje, HS. Editor. *Clinical Obstetrics a South African Perspective; Fourth Edition, 2015*

(ii) Theron G, Editor. Maternal Care. A health professional's guide to pregnancy and childbirth 2017. Available at www.bettercare.co.za.

(iii) Pattinson, RC. Editor. *Saving Mothers 2014-2016, Seventh Triennial Report on Confidential Enquiries into Maternal Deaths in South Africa.* Department of Health, Pretoria

(iv) Pattinson, RC. Editor. *Saving Babies, Second Perinatal Care Survey of South Africa 2012-2013* ISBN: 0-620-29228-8. *MRC Unit for Maternal and Infant Health Care Strategies, University of Pretoria.* Available at www.ppip.co.za

13.2.4 Mortality and morbidity meetings: Monthly (at least) perinatal and maternal mortality and morbidity meetings must be conducted in accredited hospitals

13.2.5 Formal rounds and discussions: The obstetrician or senior medical officer should, at least, do a weekly teaching ward round with discussion of appropriate clinical problems

14.0 CONTENT GUIDELINES

14.1 **Syllabus:**

Attached as Appendix B

15.0 PREPARATION FOR EXAMINATION

15.1 **Recommended reading:**

See 13.2.3

15.2 **Training programmes:**

Attached as Appendix A

16.0 EXAMINATION STRUCTURE AND OBJECTIVES

16.1 **Overall standard expected:**

Importance is attached to the hospital training in obstetrics, the management of complications during early pregnancy and family planning; but candidates will be examined primarily to determine whether as general practitioners or medical officers they have good and practical obstetric skills and whether they will be able to render an obstetric service of adequate standard at primary care level and in district and secondary or regional hospitals

16.2 **Written paper:**

16.2.1 ***Structure:***

One 3-hour written examination consisting of 4 forty five (45) minute questions that could be divided into short and multiple choice questions.

16.2.2 ***Objective:***

To ascertain whether candidates have an understanding of obstetrics with regards to:

- modern techniques in diagnosis and treatment
- knowledge of the modern literature in the field
- an ability to relate physiological and pathological principles
- the principles of organisation, management and audit of primary and secondary obstetric services in health care centres, district and secondary hospitals
- an understanding of the main causes of maternal and perinatal mortality in South Africa and the strategies to lower these rates
- the management of complications during early pregnancy
- family planning

16.3 **Clinical examination:**

16.3.1 ***Structure:***

An Objective Structured Problem-Solving Examination (OSPE) of 120 minutes on 4 clinical problems in obstetrics. The candidate will be given 15 minutes to study the written clinical problem where after there will be a 15 minute oral examination on the specific problem

16.3.2 ***Objective:***

To test the candidates' clinical knowledge in obstetrics and to conduct a fair examination where all candidates get the same questions and examiners as well as a wider range of questions

16.4 **OSCE:**

The Objective Structured Clinical Examination will include questions on antenatal cards, partograms, cardiotocography and any other topics relevant to the clinical practice of obstetrics

16.4.1 ***Structure:***

A circle of at least 8 questions (stations) lasting 10 minutes each

16.5 **Carry-over:**

The following was agreed at the CMSA Senate meeting of 30 October2019: THAT if a candidate passes the written component of a Diploma examination, but fails the oral/clinical/OSCE/OSPE/practical component, they will be permitted to redo the oral/clinical/OSCE/OSPE/practical component only at the next set of examinations without having to rewrite the written component. This carry over of the written component results will only be permitted once, and only for the oral/clinical/OSCE/OSPE/practical examination directly following the failed examination. [1]

16.6 **Certification:**

Candidates must have their supervised or part-time training certification (Appendix A) approved 4 weeks prior to the date of the written examination

16.7 **Guidelines for examiners:**

See Appendix C

17.0 APPENDICES

- Appendix A : Training programmes
- Appendix B : Syllabus
- Appendix C : Instructions and guidelines for convenors and examiners

JOHANNESBURG
March 2020

1 Effective SS2019

A P P E N D I X A

TRAINING PROGRAMMES

HOSPITALS ACCEPTABLE FOR DIP OBST(SA) TRAINING

Candidates are informed that obstetric training in fulfilment of the Dip Obst(SA) examination regulations may be undertaken in:

1.0 SUPERVISED TRAINING

A minimum of 6 months of supervised obstetrical training in teaching hospitals or in university satellite departments in non-teaching hospitals. Regional or larger district hospitals accredited by the College of Obstetricians and Gynaecologists of South Africa of the CMSA. This may be done in two 3-month periods of training over a maximum of two years. One of the six months of training may be in gynaecology

2.0 PART-TIME TRAINING

2.1 **Requirements for part-time training:**

2.2 **Primary care physicians in private practice:**

2.2.1 The applicant must have performed at least 15 deliveries annually over a 3-year period, of which at least 15 of the total deliveries are caesarean sections

2.2.2 A list of the names, dates and method of delivery must be provided

2.3 **Medical officers working in small district hospitals:**

2.3.1 The applicant must have worked for a 2-year period in a hospital that conducts at least 400 deliveries annually, of which at least 40 of these are caesarean sections. At least 20 of these caesarean sections must have been performed by the applicant. A perinatal audit covering at least one year, eg a Perinatal Problem Identification Programme (PPIP) report must also be provided

2.3.2 The medical superintendent must certify that this information is correct

2.4 In addition, applicants from both above-mentioned groups must attend an academic hospital or regional hospital accredited by the College of Obstetricians and Gynaecologist of South Africa of the CMSA for 4 weeks (at least 40 hours per week) spread over a period of not more than 2 years

2.4.1 The aim of this training is to become acquainted with the newer developments regarding:

- Antenatal care including high risk cases
- Intrapartum care including operative obstetrics

2.4.2 In addition the following activities must be attended:

- Antenatal, postpartum and postoperative ward rounds
- Perinatal and maternal mortality and morbidity meetings
- Discussions with the obstetrician or senior medical officer

2.4.3 The CEO of the institution or head of department must certify that the candidate has fulfilled these obligations

3.0 COURSE WORK

3.1 **Recommended reading:**

(i) Cronje, HS. Editor. *Clinical Obstetrics a South African Perspective; Fourth Edition, 2015*

(ii) Theron G, Editor. Maternal Care. A health professional's guide to pregnancy and childbirth 2017. Available at www.bettercare.co.za.

(iii) Pattinson, RC. Editor. *Saving Mothers 2014-2016, Seventh Triennial Report on Confidential Enquiries into Maternal Deaths in South Africa.* Department of Health, Pretoria

(iv) Pattinson, RC. Editor. *Saving Babies, Second Perinatal Care Survey of South Africa 2012-2013* ISBN: 0-620-29228-8. *MRC Unit for Maternal and Infant Health Care Strategies, University of Pretoria.* Available at www.ppip.co.za

3.2 **Mortality and morbidity meetings:**
Monthly (at least) perinatal and maternal mortality and morbidity meetings must be conducted in accredited hospitals

3.3 **Formal rounds and discussions:**
A weekly formal ward round and discussion must be conducted by the obstetrician or senior medical officer

4.0 ACCREDITATION REQUIREMENTS OF HOSPITALS FOR DIP OBST(SA)

4.1 Candidates who wish to obtain the Dip Obst(SA) working in hospitals that have not been approved by the CMSA can ask the CEO or medical superintendent of the hospital to apply to the CMSA for approval. The following hospitals will be considered. It is the responsibility of these hospitals to provide the required information

4.2 Hospital with full-time Obstetrician and Gynaecologist consultant (evidence must be provided)

4.3 Hospital with part-time Obstetrician and Gynaecologist consultant and Medical Officer (with experience) full-time in a department of Obstetrics and Gynaecology. (Evidence must be provided, including duties of part-time Obstetrician and Gynaecologist consultant and number of years experience of Medical Officer)

4.4 Hospital conducting a minimum of 1000 deliveries per year and a full-time doctor on the staff with at least five years of experience in obstetrics, plus:

- at least six months perinatal mortalities audit data – eg PPIP reports
- evidence of the protocols as defined by NCCEMD – eg Protocols for hypertension, abortion, puerperal sepsis, HIV/AIDS, VBAC, post-partum haemorrhage
- clearly described referral routes to the next level of care
- performs caesarean sections and evidence that the candidate has performed at least 40 caesarean sections. (Certified by CEO of hospital).

5.0 POST-INTERNSHIP OBSTETRIC TRAINING POSTS HAVE BEEN APPROVED IN THE PAST AT THE FOLLOWING HOSPITALS

Addington/Mahatma Gandhi Memorial Hospital Complex
Barberton Hospital
Boitumelo Hospital
Bongani Regional Hospital/Welkom
Chris Hani/Baragwanath Hospital
Dihlabeng Regional Hospital/Bethlehem
Dora Nginza Hospital; Ciskei
Dr George Mukhari Hospital
Durban Hospital Complex
East London Hospital Complex
Eben Dönges Hospital
Elim Hospital
Ermelo Hospital
Eshowe Hospital
Far East Rand Hospital
Free State Hospital Complex
George Hospital
GF Jooste Trauma Emergency/Lentegeur/Mowbray Hospitals
Goldfields Hospital/Welkom Provincial
Grey's/Northdale Complex; Pietermaritzburg
Grootehoek Memorial Hospital; Lebowa
Groote Schuur Hospital/CHC
Harare Group of Hospitals
Helderberg Hospital
Helen Joseph/Coronation Hospital Complex
Johannesburg General Hospital
Jubilee Community Hospital; Hammanskraal
Kalafong Hospital
Karl Bremer/ Tygerberg/Kraaifontein Hospital
Khayelitsha Hospital
Kimberly Hospital
Klerksdorp/Tshepong Hospital Complex
Ladysmith Hospital
Lebowa Kgomo Hospital
Leratong/Dr Yusuf Dadoo Hospital Complex
Letaba Hospital Complex
Madadeni/Newcastle Hospital Complex
Mafikeng Provincial Hospital
Mahatma Gandhi Memorial Hospital
Mankweng/Polokwane Hospital Complex
Mapulaneng Hospital
McCord Hospital
Mofumahadi Manapo Mopeli Regional /Elizabeth Ross Hospital
Mokopane Hospital
Mpilo Hospital
Natalspruit Hospital
Nelson Mandela Academic Hospital
Ngwelezane Hospital/Umphu Health Clinic
Odendaal Hospital; Nylstroom
Oudtshoorn Hospital
Paarl Hospital
Pietermaritzburg Hospital Complex
Port Elizabeth Hospital Complex
Potchefstroom Hospital
Port Shepstone/Murchison Hospital Complex
Pretoria Hospital Complex
Prince Mshiyeni Hospital
Raleigh Fitkin Memorial Hospital
RK Khan Hospital
Rob Ferreira/Barberton Hospital Complex
Rustenburg Provincial Hospital
SAMHS: # 1 Military Hospital
SAMHS: # 2 Military Hospital
Sebokeng/Kopanong Hospital Complex
Shongwe Hospital
Somerset Hospital
South Rand Hospital
St. Ritas Regional Hospital
Stanger Hospital
Tambo Memorial/Germistion Hospital
Tembisa Hospital
Themba Hospital
Tshepong/Klerksdorp Hospital
Tshilidzini Hospital
Tshwane Dstrict Hospital
Tygerberg Academic/Stikland/ Bishop Lavis/Bellville Day & Eerste Rivier Hospitals
Uitenhage Provincial Hospital
Victoria Hospital
Vryburg/Taung Hospital complex
Wambaths Hospital
Windhoek/Katutura Hospital Complex
Witbank Hospital
Woodstock Hospital
Zithulele Hospital

AND CURRENTLY

5.1 **Post-internship obstetrics and gynaecology posts in the following hospitals in Zimbabwe:**

Harare Group of Hospitals
Mpilo Hospital, Bulawayo

Enquiries concerning acceptability of posts should be addressed to:

academic.registrar@cmsa.co.za

JOHANNESBURG
March 2020

A P P E N D I X B

1.0 ANATOMY AND PHYSIOLOGY

1.1 **Anatomy:**
- 1.1.1 Anatomy and architecture of the bones, joints and ligaments of the pelvis
- 1.1.2 Anatomy of the abdominal wall and intra-abdominal organs
- 1.1.3 Anatomy of the breast
- 1.1.4 Surgical applied anatomy of the pelvic floor and perineum
- 1.1.5 Surgical applied anatomy of the intrapelvic organs
- 1.1.6 The mature fetus especially fetal skull and circulation
- 1.1.7 The mature placenta: morphology, types, functions

1.2 **Physiology:**
- 1.2.1 Fertilisation, implantation and early development of the placenta and fetus including embriology
- 1.2.2 Ovarian and menstrual cycle
- 1.2.3 Physiological changes during normal pregnancy, normal laboratory values
- 1.2.4 The amniotic fluid formation, composition, functions

2.0 NORMAL PREGNANCY

2.1 Antenatal care
2.2 Assessment of fetal well-being and diagnostic aids during pregnancy and labour
2.3 Diagnosis of intrauterine pregnancy
2.4 Fetal growth and maturity tests and assessments including amniocentesis
2.5 Minor complaints
2.6 Obstetric history and examination and risk assessment
2.7 The danger of radiation during pregnancy
2.8 The use of drugs during pregnancy and lactation
2.9 Knowledge of the use of ultrasound in normal pregnancy including first and second trimester screening and chorionic villus sampling for chromosome abnormalities
2.10 Psychosocial aspects

3.0 NORMAL LABOUR

3.1 Episiotomy
3.2 Relief of pain during labour
3.3 Resuscitation of newborn baby
3.4 The initiation of labour, normal uterine function
3.5 The management of normal labour
3.6 The newborn, normal baby
3.7 The normal puerperium
3.8 Lactation and breastfeeding
3.9 The stages, mechanism and progress of normal labour and the use of the partogram
3.10 Induction of labour
3.11 Augmentation of labour
3.12 The post-natal visit and management of puerperal complications

4.0 ABNORMAL PREGNANCY

4.1 Abortion and complications
4.2 Anaemia in pregnancy
4.3 Antepartum haemorrhage
4.4 Blood group incompatibilities
4.5 Cardiac disease in pregnancy
4.6 Clinical features of advanced abdominal pregnancy
4.7 Conditions of the central nervous system and psychiatric conditions
4.8 Diabetes mellitus
4.9 Drug abuse, alcohol and smoking during pregnancy

4.10…/

4.10 Ectopic pregnancy
4.11 Hyperemesis gravidarum
4.12 Hypertensive states during pregnancy
4.13 Immunisations during pregnancy effects on fetus/neonate
4.14 Infections in pregnancy
4.15 Intrapartumfetal distress
4.16 Intrauterine death
4.17 Liver disease; jaundice
4.18 Placental insufficiency and intrauterine growth restriction
4.19 Polyhydramnios; oligohydramnios
4.20 Postdatism and the postmaturity syndrome
4.21 Preterm and prelabour rupture of membranes
4.22 Primary management of gestational trophoblastic disease
4.23 Sexually transmitted diseases (including AIDS)
4.24 The acute abdomen in pregnancy
4.25 The grande multipara and elderly gravida
4.26 The pregnant teenager
4.27 The thyroid and pregnancy
4.28 Thrombo-embolism and clotting defects
4.29 Urinary tract disease
4.30 Respiratory disease in pregnancy

5.0 ABNORMAL LABOUR
5.1 Abnormal uterine function
5.2 Congenital fetal abnormality
5.3 Birth injuries
5.4 Cord presentation and prolapse
5.5 Obstructed labour
5.6 Malpositions and malpresentations
5.7 Management of a patient with a scarred uterus
5.8 Multiple pregnancy
5.9 Obstetric injuries of the genital tract and repair
5.10 Antepartum haemorrhage
5.11 Postpartum haemorrhage
5.12 Sudden collapse in pregnancy
5.13 Preterm labour
5.14 Puerperal sepsis and other complications
5.15 Shoulder dystocia
5.16 The shocked obstetric patient

6.0 OBSTETRIC PROCEDURES
6.1 Caesarean section and its complications
6.2 Amnioinfusion
6.3 Fetal birth injuries due to obstetric procedures
6.4 Forceps delivery (outlet)
6.5 Induction of labour
6.6 Pudendal nerve block and other local anaesthetic techniques
6.7 Vacuum extraction
6.8 External cephalic version

7.0 OBSTETRIC STATISTICS AND AUDIT
7.1 Maternal morbidity and mortality
7.2 Perinatal morbidity and mortality
7.3 An understanding of strategies to reduce above

8.0…/

8.0 FERTILITY REGULATION
8.1 Barrier contraception
8.2 Combination oral contraceptives
8.3 Contraception during the puerperium
8.4 Intrauterine contraceptive devices
8.5 Emergency contraception
8.6 Progesterone only contraceptives
8.7 Sterilisations

9.0 COMMUNITY OBSTETRICS
9.1 A management strategy for obstetric services at primary and secondary levels of care
9.2 Obstetric services at a primary care level
9.3 Obstetric services at a secondary care level

10.0 TERMINATION OF PREGNANCY (TOP)
10.1 Choice of termination of pregnancy Act 1996
10.2 Counselling for TOP
10.3 Methods of TOP
10.4 Management of complications of TOP

11.0 ETHICS IN OBSTETRICS
11.1 Principles of bioethics and consent
11.2 Counselling about options for a peri-viable pregnancy

12.0 PSYCHOSOCIAL ASPECTS

12.1 Support during TOP, pregnancy and labour and counselling for bereavement

Curriculum category	Sub category	Topic
ANATOMY AND PHYSIOLOGY	Applied maternal anatomy	Anatomy and architecture of the bones, joints and ligaments of the pelvis Anatomy of the abdominal wall and intra-abdominal organs
		Anatomy of the breast Surgical applied anatomy of the pelvic floor and perineum Surgical applied anatomy of the intrapelvic organs
	Applied fetal anatomy	The mature fetus especially fetal skull and circulation
		The mature placenta:morphology, types, functions
	Applied maternal physiology	Ovarian and menstrual cycle Physiological changes during normal pregnancy, normal laboratory values The initiation of labour, normal uterine function
	Applied fetal physiology	Fertilisation, implantation and early development of the placenta and fetus (embryology)
		The amniotic fluid formation, composition, functions

NORMAL PREGNANCY:	Antenatal care	Diagnosis of pregnancy Obstetric history, examination and risk assessment
		Minor complaints; Drug abuse, alcohol and smoking during pregnancy
		The grande multipara and elderly gravid The pregnant teenager
		Assessment of fetal well-being and diagnostic aids during pregnancy and labour
		The danger of radiation during pregnancy and the use of drugs during pregnancy and lactation
		Knowledge of the use of ultrasound in normal pregnancy Fetal growth and maturity tests and assessments including amniocentesis First and second trimester screening for chromosomal abnormalities Chorionic villus sampling (CVS) Congenital fetal abnormality
NORMAL LABOUR	Labour	Episiotomy Relief of pain during labour Pudendal nerve block and other local anaesthetic techniques
		The management of normal labour The stages, mechanism and progress of normal labour and the use of the partogram
		Induction of labour Augmentation of labour
		The normal puerperium Lactation and breastfeeding The post-natal visit and management of puerperal complications
		The normal new-born baby Resuscitation of the new-born baby
	Medical disorders	Anaemia in pregnancy Cardiac disease in pregnancy Liver disease; jaundice Diabetes mellitus Blood group incompatibilities Hypertensive states during pregnancy Conditions of the central nervous system and psychiatric conditions The thyroid and pregnancy Thrombo-embolism and clotting defects Urinary tract disease Respiratory disease in pregnancy
	Haemorrhage in pregnancy	Antepartum haemorrhage Postpartum haemorrhage Sudden collapse in pregnancy
	Infection in pregnancy	Infections in pregnancy Sexually transmitted diseases HIV, AIDS and prevention of maternal to child transmission Puerperal sepsis, septic shock and other complications

	Early pregnancy complications	Complications of miscarriage and abortion Ectopic pregnancy Primary management of gestational trophoblastic disease Hyperemesis gravidarum
	Surgical complications in pregnancy	The acute abdomen in pregnancy Clinical features of advanced abdominal pregnancy Complications of Caesarean Section
	Fetal complications	Preterm and prelabour rupture of membranes Preterm labour Placental insufficiency and intrauterine growth restriction Polyhydramnios; oligohydramnios Postdatism and the postmaturity syndrome Immunisations during pregnancy effects on fetus/neonate Intrapartumfetal distress Intrauterine death
COMPLICATED LABOUR AND DELIVERY		Abnormal uterine function Birth injuries Cord presentation and prolapse Obstructed labour Malpositions and malpresentations Management of a patient with a scarred uterus Multiple pregnancy Shoulder dystocia
OBSTETRIC PROCEDURES		Caesarean section Amnioinfusion Forceps delivery (outlet) Vacuum extraction External cephalic version Obstetric injuries of the genital tract and repair
OBSTETRIC STATISTICS AND AUDIT		Maternal morbidity and mortality Perinatal morbidity and mortality An understanding of strategies to reduce above
FERTILITY REGULATION		Barrier contraception Combination oral contraceptives Contraception during the puerperium Intrauterine contraceptive devices Emergency contraception Progesterone only contraceptives Sterilisations
COMMUNITY OBSTETRICS		A management strategy for obstetric services at primary and secondary levels of care
ETHICS IN OBSTETRICS		Principles of bioethics and consent Counselling about options for a peri-viable pregnancy
PSYCHOSOCIAL ASPECTS		Support during TOP, pregnancy and labour and counselling for bereavement
TERMINATION OF PREGNANCY		Choice of termination of pregnancy Act 1996 Counselling for TOP Methods of TOP Management of complications of TOP

There are a total of 24 assessment opportunities for the Dip Obst, set out as below. There are more topics than assessment opportunities, and we have grouped topics together to make up a single question with enough weight.

Assessment opportunities…/

Assessment opportunities (as required by the College):

Written paper: 4x45 minute questions (The college stipulate 4 questions. If each has a a/b/c it is a total of 12 questions or assessment opportunities)

OSPE 4x30 minutes (4)

OSCE 8x10 minutes (8)

We have used a scale of 1-4 for the Impact and the Frequency (see definitions after the table). The Dip Obst(SA) is aimed at rural doctors working in district maternity settings, so we have used a district/regionalmaternity setup that does about 200 deliveries per month as the "norm" to calculate the possible impacts and frequencies.

Using the *impact* multiplied by the *frequency* to determine the weight. Weight = Impact x frequency/108; where 108 is the total of IxF.

Category	Impact*	Frequency**	I X F	Weight***	Nr of questions
Applied maternal anatomy	1	1	1	0.2	2
Applied fetal anatomy	2	2	4	0.88	
Applied maternal physiology	2	1	1	0.4	
Applied fetal physiology	1	2	2	0.4	
Antenatal care	3	3	9	2	2
Normal Labour	4	3	12	2.7	3
Medical disorders	2	4	8	1.8	2
Haemorrhage in pregnancy	1	4	4	0.9	1
Infection in pregnancy	2	4	8	1.8	2
Early pregnancy complications	2	1	2	0.45	2
Surgical complications in pregnancy	3	2	6	1.4	
Fetal complications	3	3	9	1.9	2
Complicated labour and delivery	4	2	8	1.8	2
Obstetric procedures	3	4	12	2.7	3
Obstetric statistics and audit	1	1	1	0.2	1
Community obstetrics	1	1	1	0.2	
Ethics in obstetrics	1	1	1	0.2	
Psycho-social aspects	1	2	2	0.4	
Fertility regulation	2	4	8	1.8	2
Termination of pregnancy	1	3	3	0.6	
TOTAL			**108**	**24**	**24**

***Impact: How severe the condition will be if not managed correctly**

1. Little, death not an issue
2. May lead to occasional morbidity
3. May lead to serious morbidity if not well managed
4. Death (maternal, fetal or both) can happen if not managed appropriately

****** Frequency: How common the topic would be addressed in the practice of the average medical officer in a district/secondary hospital maternity service with >200 deliveries per month

1. Very uncommon
2. At least once a week
3. On average 2 to 3 times per week
4. Daily basis

*** Total assessment opportunities: 24 (used to determine the weight)

The final blueprint…/

The final blueprint (below) has the curricular content, the weight given to each topic and the number of questions that should be allocated, as well as the relative weight given to the different tasks to be evaluated in each area as a general guide.

Task to be assessed in each content area		**DIAGNOSIS**	**INVESTIATIONS**	**MANAGEMENT**	**ETHICS &LAW**	**COUNSELLING**	**Number of Questions**
Curricular content	**WEIGHT %**	**15%**	**15%**	**60%**	**5%**	**5%**	
ANATOMY AND PHYSIOLOGY							
Applied maternal anatomy							
Applied fetal anatomy	**8%**						**2**
Applied maternal physiology							
Applied fetal physiology							
NORMAL PREGNANCY							
Antenatal care							
Risk assessment							
Substance abuse							
Teenage and elderly pregnancies	**8%**						**2**
Assessment of fetal wellbeing							
Medication and radiation							
Ultrasound and fetal growth							
NORMAL LABOUR							
Pain relief and episiotomy							
Partogram	**12%**						**3**
Induction and augmentation							
Puerperium							
COMPLICATED PREGNANCY							
Medical disorders	**8%**						**2**
Haemorrhage	**4%**						**1**
Infection in pregnancy	**8%**						**2**
Early pregnancy- and surgical complications	**9%**						**2**
Fetal complications	**9%**						**2**
COMPLICATED LABOUR AND DELIVERY							
Abnormal uterine function							
Birth injuries							
Cord presentation and prolapse							
Obstructed labour	**8%**						**2**
Malpositions and malpresentations							
Management of a patient with a scarred uterus							
Multiple pregnancy							
Shoulder dystocia							

Task to be assessed in each content area		DIAGNOSIS	INVESTIATIONS	MANAGEMENT	ETHICS &LAW	COUNSELLING	Number of Questions
Curricular content	**WEIGHT %**	**15%**	**15%**	**60%**	**5%**	**5%**	
OBSTETRIC PROCEDURES	**12%**						**3**
Caesarean section							
Forceps delivery (outlet)							
Vacuum extraction							
External cephalic version							
Obstetric injuries of the genital tract and repair							
OBSTETRIC STATISTICS AND AUDIT	**4%**						**1**
Maternal morbidity and mortality							
Perinatal morbidity and mortality							
COMMUNITY OBSTETRICS							
Management strategies							
ETHICS IN OBSTETRICS							
Principles of bioethics and consent							
Counselling for a peri-viable pregnancy							
PSYCHOSOCIAL ASPECTS							
Counselling and support during bereavement							
FERTILITY REGULATION	**10%**						**2**
Hormonal and non-hormonal methods							
TERMINATION OF PREGNANCY							
Counselling and methods							
TOP Act							
Complications							

For the diploma, with the emphasis on management of normal and complicated maternity care at regional and district level, the main task to be evaluated in each item is the management of the specific problem (weighted at 60% of the marks) with diagnosis and investigation weighted at 30% and the reminder given to ethics and counselling; as appropriate to the specific question.

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March 2020

A P P E N D I X C

INSTRUCTIONS AND GUIDELINES FOR CONVENORS AND EXAMINERS

CONTENTS:

1.0 INTRODUCTION

1.1 The primary function of the College of Obstetricians and Gynaecologists is to establish an objective and fair examination to ensure that high standards of training are maintained

1.2 Convenors and examiners are requested to study the recommendations carefully before organising the examinations

2.0 CERTIFICATION

2.1 Certification is required from the chief executive officers, medical superintendents or heads of departments that candidates have fulfilled the requirements as stipulated in Appendix A for:

2.2 Supervised training

2.3 Part-time training

3.0 …

3.0 WRITTEN PAPERS

3.1 **Objectives:**

3.1.1 The written papers are aimed to test knowledge at various levels summarised by Bloom as: 1) knowledge; 2) insight; 3) application; 4) analysis and integration; 5) synthesis; 6) evaluation. The lower numbers indicate lower levels of assessment and the higher values indicate better and higher levels of assessment

3.1.2 Several skills are thus addressed including factual recall, insight, integration of knowledge, utilisation of knowledge and experience to solve problems, and the skill to communicate the gained knowledge in writing

3.1.3 A further objective is that the written papers serve as a screening mechanism for invitation to the clinical part of the examination

3.2 **Setting a paper:**

3.2.1 One 3 hour paper compiled by the examiners of the previous examination. This is purely for practical and security reasons. The paper is marked by the current set of examiners, one question per examiner

3.2.2 The large extent of the obstetrics should be reflected in the topics covered. Therefore repetitions of questions in successive papers or within a single year cycle are not acceptable

3.2.3 Each full question should not take more than an hour to complete.

3.2.4 Dividing the long questions into a number of short questions is encouraged. Each part of the short questions should clearly state what percentage of the whole question is allocated to it

3.3 **Memoranda:**

3.3.1 Memoranda serve as guidelines for marking and are in no way an attempt to reflect the factual contents required in a question. Because different sets of examiners set and mark the paper, these guidelines may indicate what was expected from the question and eliminate some subjectivity on the part of the marker. Memoranda must be compiled by the examiners setting the paper and sent to the CMSA, which at the time of the next examination will send it to the examiners

3.4 **Marking a paper:**

Questions should be marked using percentages:

- **70-100% :** distinction, exceptional standard
- **65-69% :** more than satisfactory
- **50-64% :** satisfactory; acceptable standard
- **46-49% :** less than satisfactory
- **< 45% :** totally unsatisfactory, unacceptable standard

3.5 All marks must be sent to the convenor before the deadline date

3.6 **Invitations to clinical examinations:**

3.6.1 This is based on the combined mark achieved for the paper. The CMSA makes these decisions in conjunction with the convenor of the examination and/or members of the Dip Obst(SA) examination committee. A candidate can fail one question

3.6.2 Candidates with a mark < 45% for the paper will not receive an invitation to the clinical examination

3.6.3 Convenors will receive the marks of all candidates who are identified by their examination number only. **Convenors must ensure that no marks for the papers are made known to examiners before the final examiners meeting.**

4.0 ... /

4.0 THE OSCE

4.1 The OSCE has become an integral part of clinical examination. It is usually held on the first day of the examination. All examiners should be present and participate actively

4.2 **Objectives:**

The OSCE tests knowledge and skills at various levels. As its purpose is to present very specific questions (because of the time constraint) in a clinical way, it can be regarded as "short cases". It also tests the candidates interpretation of special investigations and manual skills to demonstrate procedures on models.

4.3 **Setting an OSCE:**

4.3.1 With the current number of candidates per Dip Obst(SA) examination it may become necessary to do the OSCE in two groups. Allocation into the two groups is done alphabetically. OSCEs need not be very long, as the objective is to address a defined question. A circle of at least 8 or more questions (stations) lasting 10 minutes each is recommended

4.3.2 The convenor has the responsibility to set the OSCE. It is essential to consult with other examiners and previous convenors. All examiners should meet before the OSCE to inspect the different stations and to decide on the memoranda that will be used to mark the answers objectively

4.3.3 For each station an instruction sheet should be prepared, and for each candidate an answering sheet should be provided at the station. Each question should indicate the total mark at the end of the question. CMSA examination scripts can be used as long as a single page is used per question. The convenor must ensure the OSCE is set out in a convenient venue and that a timekeeper is available

4.3.4 The process must be explained to the groups of candidates prior to commencing the OSCE. It is essential to ensure that there is no contact between the two groups when the circle is used for the second time

4.4 **Types of questions:**

4.4.1 The following types of questions are recommended:

- Clinical obstetrical simulations with partograms, cardiotocograms, non-stress tests, Doppler flow velocity waveforms, ultrasound images and antenatal records
- Interpretation of special tests (pathology reports, etc)
- Ethical issues posed as clinical problems

4.4.2 The convenor must be certain that the defined questions can be answered in the time allocated

4.5 **Manned stations:**

4.5.1 The 6 examiners of the Dip Obst(SA) examination will be used for the manned stations

4.5.2 Examples of these stations include:

- Obtaining a specific detailed history on a well-defined problem from a patient or mannequin
- Doing a clinical examination on a patient or model
- Testing specific skills such as a forceps or breech delivery on a model
- Obtaining informed consent for a specific procedure
- Answering questions using a mannequin on a specific problem

4.6 **Marking an OSCE:**

The OSCE questions are marked on the memorandum or checklist by the examiner during the examination. Written questions are marked by the examiners immediately after the examination according to the memorandum for that station. A final numerical mark is then calculated into a percentage. The convenor should take the responsibility to complete the mark sheet but must keep it secret from the other examiners until the final examiners' meeting.

4.7 **Value assessment:**

The OSCE has been accepted as an important component of the clinical examination and counts one third of the total mark

5.0.... /

5.0 OSPE (OBJECTIVE STRUCTURED PROBLEM-SOLVING EXAMINATION)

5.1 **Objectives:**
To test the candidates clinical knowledge in obstetrics, early pregnancy complications and family planning and to conduct a fair examination where all candidates get the same questions and examiners as well as a wider range of questions

5.2 **Range of questions:**
There will be 4 questions on obstetrics, early pregnancy complications and family planning. The questions will address clinical situations generally encountered in obstetrics. It will be put to the candidates in writing. Adequate time will be given to the candidates to study the question before explaining the proposed management to the examiner. All questions will be on medical officer/primary care physician level

5.3 **Technical aspects:**
At a meeting of all the examiners before the OSPE, all the questions will be selected. Essential knowledge for each question will also be discussed and the marks allocation will be according to a prepared memorandum

5.4 **Marking system:**
Examiners are requested to give a percentage for each question as this will help difficult decision making in borderline cases. At the end of the OSPE examinations a single percentage should be calculated

5.5 **Value assessment:**
Each OSPE counts one third of the total mark. Candidates should pass at least 3 of the 4 questions

6.0 DEALING WITH THE MARKS

6.1 **Technical aspects:**
All the marks, for the paper, OSPE and the OSCE should be presented by the convenor at the final examiners' meeting. Marks should be given in percentages and the total percentage mark should be calculated. Examiners should not be given any marks of parts of the examination before the final meeting. Examination numbers and not names should be used for the final discussion. Candidates who failed are identified. All marks are confidential and all mark sheets should be kept by the convenor

6.2 **Combining symbols:**
The examination consists of 3 components: the paper, OSCE and OSPE. Each of the 3 components weighs a third of the final mark. The candidate needs to get an average of 50% to pass. The rules of the CMSA state that a candidate failing in some parts of a series of questions need not necessarily fail the component. The final mark of the component is important and should be used on the final mark sheet. Candidates must pass the clinical (OSPE) part

7.0 DEALING WITH THE FINAL RESULTS

7.1 **Lists:**
A list of the successful candidates must be faxed to the CMSA at the number indicated on the form sent to convenors. The same list may be displayed at the examination venue after the final examination committee meeting

7.2 **Explanations:**
No explanations are currently offered to unsuccessful candidates at the time of the examination. Written notes may be made available to the CMSA in such cases to deal with enquiries from candidates

JOHANNESBURG
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