



Reviving The Vanishing Art of Instrumental Vaginal Delivery in Tropical Obstetric Practice

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Dear Editor-in-Chief,

Our attention was drawn to a recent publication in the Tropical Journal of Obstetrics and Gynaecology (TJOG) by Alu et al titled “Instrumental Vaginal Delivery in Abuja, North-central Nigeria: A 5-Year Review”. We wish to commend the authors of this very illuminating manuscript, as it addresses a topical issue relevant to obstetric practice not only in Nigeria but globally. The authors reported an instrumental delivery rate of 0.65% and cited references from different parts of Nigeria over the last decade.¹ These references reported IVD rates ranging from 0.4 to 2%.^{2,3} These rates are quite low, compared to other countries globally such as the UK (up to 23%),⁴ and especially other sub-Saharan African countries (around 8%).⁵ These indices point to a low performance of this key skill in obstetric practice within the country. As a consequence, Caesarean section rates have increased geometrically in the country, further emphasising the relevance of IVD skills as life-saving measures.

The implications of the low rates of IVD can be considered to be two-sided: first is the ongoing deprivation of the benefits of these life-saving procedures for women and babies who may benefit from them as a very crucial determinant of the outcome of their labour. This may also have resultant implications on the outcomes of future pregnancies. Secondly, there is a high likelihood that this trend will continue in the foreseeable future, as the currently low rates of IVD suggest that many specialists and their trainees have neither observed nor performed enough procedures to achieve competence for independent practice. There is therefore a need to reverse the trends to improve the intrapartum care of parturients in Nigeria to a level comparable to that in other climes.

As doctors with clinical experience in both settings, we would like to propose practical approaches to a safe, improved and sustainable performance of IVD. There is a dire need for regular simulation training at local (institutional) and national (postgraduate colleges) levels. For example, in the UK, the RCOG Operative Birth Simulation Training (ROBUST) is a mandatory

requirement from the early stage of specialty training in obstetrics that provides a uniform training template for IVD.⁶ Furthermore, to achieve competence, a minimum number of workplace-based structured assessments should be a mandatory requirement for residents at different training levels, with formative and summative feedback to guide and improve proficiency. This could be structured as non-rotational IVD for junior residents and rotational deliveries for senior residents, as is available in other training programmes globally.

One may ask how the already qualified specialists who are not fully equipped with the practical skills for IVD would teach the specialist trainees? This calls for a collaborative drive with the more skilled colleagues. As the learning curve is expected to be steep, hands-on training on the labour ward through partnership and exchange programmes will be more realistic than occasional training courses which are mostly manikin-based simulation drills.

Once achieved, consultant-led or consultant-delivered care at the teaching hospitals is the only way to sustain transfer of skills. The availability of consultants on the labour ward floor at most times of the day will provide the necessary support for speciality trainees to receive experiential training and maintain their skills. Until these are considered, we will, at best, regrettably continue to substitute IVDs with avoidable caesarean sections in our hospitals.

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RESPONSES

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Thank you for your interest in and the sentiments expressed about our article on IVD in Abuja, North Central Nigeria, published in *TJOG* 2025, volume 43, issue 4.

The issues raised regarding the low rates of IVD and, as a consequence, the rising CS rate are quite pertinent and challenging. While some reasons for the art's decline were stated in the main article, I have provided additional clarification here.

The decline in the art rests more on Forceps than Vacuum delivery, the latter of which contributed a greater percentage (96.2%) of the reported IVD rate of 0.65%. Vacuum is still quite commonly practised by most Obstetricians when indicated, and by middle-level Health care providers (Nurses/Midwives/CHEWs). The steep learning curve for forceps, coupled with medico-legal concerns and practitioners' risk-avoidance attitude, makes its use less attractive. This is not surprising as a failed Forceps delivery poses more concerns to both the Obstetrician and patient because of the "instrument", hence the lower threshold for CS and preference for Vacuum

In line with your suggestions to stem the decline, the Faculty of O&G, National Postgraduate Medical College of Nigeria (NPMCN), in partnership with the RCOG (Nigeria chapter), has been conducting high-fidelity simulation training on IVD for Healthcare providers using mannequins. In addition, the faculty has included mandatory IVD performance cases in the checklist for the accreditation/reaccreditation of O&G training institutions.

Specialist Trainees are also encouraged to practice the art on cases of IUFD to perfect their competence before extending it to live fetuses. A mandatory minimum case record is also recommended in the training logbook for Residents by the Faculty of O&G (WACS) before presentation for the Fellowship examinations. However, the goal is not to increase IVD indiscriminately but for women to have access to them as a safe option and to offer them CS for the right indications.

All told, with appropriate case selection and the right indications, IVD remains a safer option than emergency CS and should be encouraged.