used very often. We also need to reassure politicians that severe harm is extremely uncommon."

Cost fears appear to be at the root of political relucatance to implement no-fault compensation for the vaccine damaged. BC was "reluctant to write a blank cheque as there were no statistics on how frequently there might be claims," Scheifele says.

Even now, the statistics are hazy, although the federal government is creating a national registry for health professionals to report adverse vaccine effects and this spring will establish a "hotline" for parental reporting.

Experts say no-fault compensation would be invaluable and justified. "It would be an important reassurance for parents," says Scott Halperin, director of the Canadian Centre of Vaccinology at Dalhousie University. "It's a social contract, it makes a strong statement, 'if something does go wrong, we'll take care of you.'"

But a Canadian program would have to be carefully thought out, says Dr. Monika Naus, associate director, epidemiology services at the BC Centre for Disease Control. "Compensation would have to be beyond a shadow of a doubt."

As well, Naus adds, "what events would be covered, what level of confidence do we require to compensate an individual and to establish that causality is associated with a vaccine. "

Kumanan Wilson, a researcher and assistant professor in the Department of Medical and Health Policy at the University of Toronto, says it's impossible to project the cost of a program without knowing its parameters.

But the US program (at 75-cents per dose) has a projected surplus of US$6-billion, Wilson notes. Compensation "makes sense. If there's no problem with vaccine safety then it won't be expensive since there will not be many compensation claims. If there is even a small problem with vaccine safety, then we should have been compensating families of vaccine-injured children all along and the program is clearly justified." — Anne Tempelman-Kluit, Vancouver, BC

DOI:10.1503/cmaj.071785

Dispatch from the Medical Front

Obstructed labours

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Emergency obstetric care is considered anathema in some African communities.

Somalia is a beautiful country at the horn of Africa. Ravaged by war and without a functional government for 15 years, it lacks basic health infrastructure and rates as 1 of the world's worst health performers. As field nurses at the Médecins Sans Frontières (MSF) health centre in Dinsor, we dealt with the usual array of problems: cholera, tuberculosis, lack of nutrition.

Yet, it is young, pregnant women that I recall, like the one I'll call "L," who'd been in obstructed labour for 2–3 days. She presented with cephalopelvic disproportion (the baby's head was too big to pass through her pelvis) and type 3 female genital mutilation, making vaginal delivery difficult and extremely painful. L seemed exhausted. The surgeon recommended a cesarean section.

In Somalia, consent for any manner of medical treatment must be given by a male relative. We had difficulty locating L's family and once we did, they refused permission to perform a C-section. Although warned about the risk to both baby and Mom, they took L home.

I thought about her that night as we unsuccessfully fought to save another young woman in her first pregnancy, who'd arrived semi-conscious and convulsing, presenting with obstructed labour and eclampsia.

The following day, looking frightened, L returned. Her contractions had stopped. By then, she'd been sleepless and in labour 5 days. The baby was dead in uterus. The surgeon decided to perform craniotomy, in hopes crushing the fetus' skull made it deliverable vaginally. The 4.5-kg baby was macerated, the smell awful. L asked me if she had twins and whether the baby was a boy or a girl.

Post delivery, L's perineum was examined. It was a complete mess. She had a large tear and a fistula. Her vagina and rectum were one. She also required blood transfusion but again, in Somalia, blood is donated by male relatives, which often proves a challenge.

While L was slipping in and out of consciousness, we were chasing donors. Some were finally found and she was transfused.

L made it through the night, and survived, but faced ongoing complications of fistula. If unrepaired, her stool would leak into her vagina, making her an outcast in the community, like another 18-year-old who presented to our outpatient clinic with urinary incontinence. A year earlier, she'd had prolonged obstructed labour and a C-section to deliver a stillborn baby. Urine was leaking into her vagina. She had vesicovaginal fistula. Her husband wanted to leave her.

When I think of her tears and the number of times consent for c-section was refused and a woman left to suffer chronic complications, or die, I feel hopeless, frustrated and demoralized. More so, when I recall that more urban parts of Somalia are less intransigent.

We need a deeper investigation and understanding about why emergency obstetric care is anathema to some in the community. To that end, MSF proposes to engage an anthropologist, and until then, a specialist to repair fistulas. — Joli Shoker MSN, Vancouver, BC

DOI:10.1503/cmaj.071750

CMAJ invites contributions to Dispatches from the medical front, in which physicians and other health care providers can provide eyewitness glimpses of medical frontiers, whether defined by location or intervention. The frequency of the section will be conditional on submissions, which must run a maximum 350 words or be subject to our ruthless editorial pencils. Forward submissions to: Wayne.Kondro@cma.ca