# THE FIGO VANCOUVER MORNING BRIEF

October 6, 2015

Check your email each day for our morning bulletin. Each issue will profile one conference speaker, offer a summary of three sessions you may have missed, and let you know about important events of the day.

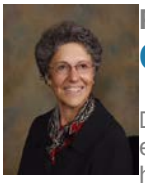
## PLAN YOUR DAY

**HANDS-ON SESSIONS:**Have you signed up for one of the obstetrical hemorrhage hands-on sessions? Today and Thursday are your last chances!

**FIGO TEAMWORK DEMO:** Can you increase the safety and quality of women's health care by building better teamwork? A must-see demonstration. (9:55 – 11:25 a.m., Ballroom A – C).

## THIS EVENING

The special event that should be on your radar for this evening is the FIGO Evening for All. Kicking off at 7:30 pm and running until 10 p.m., this free event is an exclusive Street Festival evening showcasing BC wines, local craft beers, and



FIGO MEET THE SPEAKER

## Q&A with Dr. Linda Giudice

Dr. Linda Giudice, MD, PhD, is a reproductive endocrinologist whose research has focused on steroid hormone effects on the human female reproductive tract and endocrine-disrupting chemicals on the uterus and ovaries. She is Professor and Chair of the Department of OBGYN and Reproductive Sciences, University of California, San Francisco, and Past President of the American Society for Reproductive Medicine. Today at FIGO Congress, she will be delivering the Markku Sepala Ovidon Lecture: *Environmental Exposures and Reproductive Outcomes: A Call to Action!*(Ballroom A – B, 11:30 a.m. to 12:30 p.m.).

***Q: One of your primary clinical interests is the impact of the environment on reproductive health. What are some of the most concerning impacts?***

A: Non-communicable diseases in adults, such as obesity, hypertension, diabetes and neurodevelopmental abnormalities, have their origins, in part, during fetal development. In utero exposure to environmental contaminants—especially endocrine-disrupting chemicals—contributes to a predisposition to these disorders. These chemicals can also affect adult health directly, influencing fertility (female and male), risks of endometriosis, fibroids, and miscarriage and pregnancy outcomes. Exposures to pesticides, smoking, and air pollution are common globally; just as concerning are indoor air pollution in the developing world and personal care products and household chemicals in developed, industrialized countries.

***Q: Your FIGO presentation today is subtitled "A Call to Action!" How should women and their physicians respond to environmental influences?***

A: It is imperative that women and health care professionals have evidence-based information about harm to health—especially reproductive and developmental health—due to exposures to environmental chemicals, including ways to avoid them. In addition, these groups can educate health policy decision-makers and advocate for responsible industrial chemical toxicity testing, waste disposal, and recycling. They can also advocate for a healthy food system for all, making environmental health part of health care and environmental justice. The FIGO initiative is anticipated to facilitate this on a global scale.

hearty fare inspired by the many Vancouver street carts and farmers' markets.

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***Q: What are the most critical issues in women's reproductive health today?***
A: Besides reproductive infectious diseases and effective family planning, other issues leading the list are infertility, menstrual irregularities, uterine fibroids, abnormal bleeding, endometriosis, chronic pelvic pain, endocrine-related cancers, and obstetrical risks to mothers and children. As well, toxic chemical exposures and air pollution are compromising women's reproductive health and the health of future generations. This is why the FIGO initiative is so important: its goal is to optimize human health and women's reproductive health now and moving forward by working with key stakeholders, educating the next generation, and changing policies on chemicals and women's health around the globe.

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## WHAT YOU MAY HAVE MISSED

## President's Session: The Future of Women's Health: Key Actions to Achieve Sustainable Development Goals 3 and 5

This session featured a panel of speakers including FIGO President Sabaratnam Arulkumaran; William Keenan, International Pediatric Association; Frances Day-Stirk, International Confederation of Midwives (ICM); Kim Dickson, UNICEF; Marleen Temmerman, WHO; Angela Enright, The World Federation of Societies of Anaesthesiologists; and Jerker Liljestrand, donor community.

Moderated by FIGO's Dorothy Shaw, the session addressed a series of questions related to achieving the Sustainable Development Goals (SDG) and how each panel members' organization was approaching the work. Shaw asked each panel member to make a single statement about something they'd learned during the morning, and one commitment they'll make, personally or on behalf of their organization.

The panel members' statements offer an interesting glimpse into their priorities for the near term. Here is a selection of answers:
Kim Dickson: *Engaging communities is critical—educating them, making them more aware of their needs, rights, actions that needed to be taken. We can do more by working with communities on the ground.*

Marleen Temmerman: *Engage your parliamentarians. There are working groups, and many of them include female parliamentarians, and their voices are getting stronger. They are often the agents of change.*

William Keenan: *With the convergence of policy and partnership, we can do just about anything. It's not as if problems with reproductive and family health, survival, etc., are just too difficult to manage. That's what we heard in the past. The lesson is that we can make a*

*difference. I'm optimistic about the next steps.*

## Special Issues in the Reproductive Health and RIghts of Migrants

This FIGO-sponsored session—the first one ever to focus on migrants—kicked off with an overview of migration-related reproductive issues and outcomes by FIGO Chair and moderator Birgitta Essen (Sweden), followed by an examination by Anita Gagnon (Canada) on what we have learned so far. Marcelo Urquia (Canada) spoke about prenatal sex selection among immigrants to Canada.

Junichi Sugawara (Japan) spoke about perinatal health care among internally displaced refugees after Japan's tsunami in 2011, and Faysal El-Kak (Lebanon) provided details on how Lebanon's health care system is coping with the influx of Syrian refugees.

El-Kak noted that Lebanon hosts more than 1.3 million Syrian refugees. Heathcare providers working with the refugee community face challenges such as a high fertility rate and low rate of contraceptive usage, along with the fact that most women receive interrupted or inadequate care, if any at all. About a third of pregnant refugees receive just one medical appointment; up to 8 percent have never had a skilled antenatal care checkup.

Fertility is also increasing among refugees for a variety of reasons. Women are not using contraceptives for fear their husbands will find another wife; others avoid seeking care due to fear of being mistreated by Lebanese doctors. Still others want more children to compensate for those they have lost.

Recommendations from El-Kak's presentation include emphasizing wider coverage from preconception to postpartum, and working more closely with the Syrian refugee community; improving contraceptive use; combatting gender-based violence and sexual abuse; and placing a higher priority on women's health care as a crucial pillar in the long-term response to the crisis in Syria.

## Sexual and Reproductive Health of Indigenous Women

In this session organized by FIGO and the Society of Obstetricians and Gynaecologists of Canada (SOGC), Canadian experts presented findings on improving sexual and reproductive health care for Indigenous women.

Katsi Cook launched the session with a presentation that touched on Indigenous ways of knowing and learning. Next, Elizabeth Harrold focused on how Canadian health systems and policies have impacted the provision of reproductive health care to indigenous women. Pierre Lessard then spoke about the importance of understanding the long-

reaching impacts of colonialism, and how illness and behavioural disorders can be the result of the feelings of alienation, purposelessness and shame that come from attacks on Aboriginal culture.

Finally, Robin Johnson provided clinical tips on how to offer culturally competent care, such as:

- Know the history. You need to know what happened in the past to apply it to the person sitting in front of you.
- Up to 50 per cent of Aboriginal adults may be affected by sexual abuse by age 18. Everybody should have a sensitive gynecological exam.
- Some Indigenous cultures recognize a third or fourth gender. Two-spirited is a term that refers to Aboriginal individuals who are LGBT.
- Women accessing care may feel safer in a group setting. The sense of community is important.
- Offer sensitive gynecological exams and try to prevent re-traumatization during childbirth:
    - Treat all women as though survivors of sexual abuse.
    - Be aware of body language and position.
    - Ask permission—cover body parts as you go.
    - Be mindful of your language and tone and choice of words.
    - Be aware that even despite your best efforts, a woman can still experience trauma.
    - Trauma can be triggered by the physical sensation of giving birth.

## Caesarian Section vs. Vaginal Birth

This international panel weighed the pros and cons of vaginal versus Caesarian birth. Jeanne-Marie Guise (USA) compared the risks and benefits of vaginal birth after Caesarian (VBAC) and elective repeat Caesarian section (ERCS). Sikolia Wanyonyi (Kenya) focused on the safety of VBAC in low-resource settings, concluding that attempting VBAC without adequate safety measures is a dangerous practice unless strict prenatal and intrapartum conditions are met. Angela Enright (Canada) also discussed low-resource childbirth settings, with a focus on safer obstetric anaesthesia.

Bruno Carbonne (France) offered insight into what drives global C-section rates, pointing out that studies have shown the ideal rate for C-sections is 5 to 15 per cent. Under 5 percent, there is a higher maternal mortality risk, while beyond 15 percent, there is no benefit in maternal mortality. However, there is considerable global disparity, with some world regions under 5 percent and others at 30 percent or higher. Overall, the rate is increasing.

Carbonne reviewed the medical reasons for the increasing global C-section rate, which include cardiotocography use; increased rates of labour induction; and elective C-section in breech and twin births. C-sections are also associated with increasing BMI, multiple pregnancies,

increasing maternal age and increasing rate of previous C-sections. Social reasons are also driving demand, and include personal/family organization, the “too posh to push” trend, and inaccurate media articles that emphasize the benefits and offer little discussion of risks.

Medico-legal reasons include increased litigation, huge increases in compensation amounts, increased premiums for professional insurance, and obstetricians convicted for not performing a C-section or for performing one too late, leading to an operating atmosphere that generally favors defensive medicine.

Carbonne also noted that patients are increasingly aware of C-sections being performed for non-medical reasons, such as tight schedules, office hours, not wanting to work on weekends or holidays, expectations of revenue, and doctors letting personal convictions overrule professional guidelines. He concluded by reminding the audience that each obstetrician carries an individual responsibility to make the right decision.