

# Reflections on Three Years as President of the International Federation of Gynecology and Obstetrics

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The last three years for FIGO have been a whirlwind of activity. There has been unprecedented momentum—finally!—in addressing maternal and newborn morbidity and mortality.

Recent events that confirm this include the resolution from the UN Human Rights Council on maternal mortality, and the unanimous all-party motion in our Canadian Parliament to recommit to addressing maternal and newborn morbidity and mortality at home and abroad. The latter occurred through the collaboration of FIGO, ICM, SOGC, and the White Ribbon Alliance, which is illustrative of the team approach we see as the way forward to bring about universal access to reproductive health. Probably the most significant individual with whom we have developed a relationship is Sarah Brown, the remarkable wife of the UK Prime Minister and patron of the White Ribbon Alliance. It was through her passion, advocacy, and determination that the Global Campaign for Maternal Mortality was launched, with FIGO as a founding member.

The focus on maternal newborn health has resulted in major grants being awarded to FIGO for an initiative for the prevention of unsafe abortion (from an anonymous donor) and for organizational capacity building (from the Bill and Melinda Gates Foundation). The first of these grants is in large part responsible for the greatest increase in member associations applying to join FIGO during any triennium. By the time of the Cape Town FIGO Congress, we will have guidelines on cervical cancer prevention and management and on sexual assault, both taking into account the impact of HIV. In addition to the work related to our committees and projects, FIGO has become recognized for leadership internationally, including the

Partnership for Maternal Newborn Child Health, where Dr Andre Lalonde has been outstanding. In this undertaking, health professionals have collaborated to contribute significantly to an evidence-based advocacy approach and to effective interventions for maternal, newborn, and child health. FIGO's technical expertise has been increasingly sought after in reproductive health activities at international, regional, and national levels. In my role as President, this has meant opportunities such as attending the UN General Assemblies and related special events, attending the Civil G8 NGO forum, participating in advocacy and awareness raising, meeting high-profile people including film and television personalities, donors, leaders and representatives from the UN (including WHO and the World Bank), parliamentarians, G8 sherpas, colleagues, religious leaders, leaders of health professional organizations, media—anyone who potentially has influence directly or indirectly on the health of women around the world.

My travels and interactions have provided much opportunity for reflection. The context of women's lives is critically important to our ability to improve their health and survival. How well do we, as educated and privileged health professionals, really understand the context of a woman's life in a low-resource setting? Why do we leap as a matter of course to embrace new technologies, rather than adopt a public and population health approach? At a recent WHO meeting to discuss diagnostic imaging in primary health care, one of the participants recommended that we seek to provide fetal surgery to address spina bifida globally. Wolfgang Holzgreve was the obstetrician-gynaecologist representing FIGO at that meeting, and he pointed out that folic acid supplementation to prevent the problem would be a far more appropriate approach, possibly combined with a contraceptive method. While the suggestion of adopting fetal surgery may be atypical, we should not have been surprised by it; we train specialists and often primary

care health professionals in a tertiary setting featuring the latest technology, and we live in a global culture in which technology is seen as the solution to everything. It is therefore not surprising that many care providers and the public focus on technological approaches rather than less expensive, less glamorous, but evidence-based solutions. It was distressing for me to hear advocacy for routine ultrasound in pregnancy from high profile individuals. These individuals included a minister of health, who publicly promoted technology as the solution to the poor state of health indicators in his low-income country. It is well known that the evidence that ultrasound significantly decreases perinatal mortality is difficult to find; as for decreasing maternal mortality, I suspect rates were too low in countries where ultrasound research was first introduced to make this a viable study.

While technology is providing amazing, innovative opportunities, such as cell phone texting of confidential messages for HIV-positive women, HPV vaccines, and point of care testing for HIV and other infections, there seems to be a lack of public health training, a lack of skills for management of human resources in health care, and a poor understanding of the context of a woman's life. Sri Lanka and Malaysia managed to reduce their maternal mortality rates by providing trained midwives in adequately resourced facilities for rural areas, rather than by using newer technologies or routine ultrasound in pregnancy.

I find myself asking questions such as: Are uterotonic agents and magnesium sulphate available and used in the community? Is maternity and child care available without cost at point of care? Is active management of the third stage of labour actually implemented? Why are we jumping to expensive technologies as solutions if basic needs are not being met? Are we learning from countries that have been successful? Is their model applicable? What is the unmet need for contraception? Whose values are determining policy and laws affecting the lives and health of women? Is culture or ideology used as an excuse for not respecting the rights of women, children, and youth?

In 2006 in Nicaragua, abortion was made illegal, even to save a woman's life. Consequently, our Nicaraguan colleagues are faced with the choice of either going to jail or not complying with standards of care previously agreed upon in their ministry of health. Essentially they commit malpractice if they do not provide appropriate care for a pregnant woman with a life-threatening condition such as ectopic pregnancy, cancer, or severe hypertension, even

arising from a molar pregnancy. If a woman is found to be HIV-positive during antenatal care in a country where she does not have equal rights in terms of property, inheritance, and custody of children, will she inform her partner—who may well be the source of her infection? I despair every time I visit a hospital in a low- or middle-income area of a country and see a delivery suite containing steel delivery tables with stirrups and often with no curtains for privacy, because it shows how “developed” countries, through opinion-based teaching, managed to export the supine position for giving birth as the standard of care. How difficult it is to change to more physiological and woman-centred care, when the facilities are overstretched and health care budgets are inadequate.

History has shown us that it can take up to 10 years to halve maternal mortality when rates are very high, even with high levels of commitment from governments. Education and training are critical; perhaps we should be re-thinking our role in these systems based on population needs and using a public health perspective. The innovations derived from needs in poor resource settings in Africa may have more relevance for our own health systems than we currently understand in countries like Canada with its geographic access challenges and escalating health care costs.

On a visit to Kenya in 2003, to discuss activities to advance women's sexual and reproductive rights, I was given a beautifully carved giraffe. This was a very appropriate symbol for what I would need during my FIGO presidency: the vision to see far into the distance; the need to stretch to reach goals; and the capacity to develop symbiotic relationships and risk-management skills. Interestingly, giraffes do not sleep much, either. Giraffes move in groups and support each other; similarly, the support I have had from FIGO's officers, Executive Board, the secretariat and the global community has been tremendous. I have been impressed and touched by the outstanding voluntarism of our colleagues in FIGO member associations around the globe. They have contributed many thousands of hours on FIGO's behalf to make progress in the lives and health of women and their newborns. I have full confidence that the momentum we have been building will lead to measurable change over the next several years, although it will take time to build sustainable health systems that provide universal access to reproductive health, as articulated in Millennium Development Goal Number 5. It has been an enormous privilege for me to serve as President of FIGO, and I am very grateful to have had the opportunity.