CONTEMPORARY ISSUES IN WOMEN’S HEALTH

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The editors of Contemporary Issues in Women’s Health solicit reporters and correspondents from throughout the world to make contributions to this section. Please email the editors if you have reports or items that you would like to have included. We would be happy to attribute the items to those reporters and correspondents who give permission in their transmittal. Otherwise, we will share those reports that we think are of the greatest interest to our readership without attribution.

Induction of labor for advanced maternal age

The number of women aged 35 years and older giving birth is increasing worldwide, and markedly so in high-income countries. The reasons for this are multifactorial, including pursuit of careers by women as a priority over having children, the availability of assisted reproductive techniques and increasing success rates among women irrespective of maternal age, and the changing roles of women in society where the focus has shifted away from childbearing.

Concerns have arisen, however, about increased obstetric complications as a result of advanced maternal age. These include placental abruption, placenta previa, pre-eclampsia and gestational diabetes, malpresentation, low birth weight, preterm and post-term deliveries, and postpartum hemorrhage. Pre-existing maternal conditions such as hypertension, diabetes, and obesity as a result of advanced maternal age also have an adverse effect on pregnancy and an increase in neonatal mortality has been reported [1].

The risk of unexplained stillbirth in both nulliparous and multiparous women over 40 years of age has been shown in epidemiological studies to be significantly higher after 39 weeks of pregnancy compared with 25 to 29-year-old mothers at the same stage of pregnancy. The incidence of stillbirth at 39–40 weeks is 1 in 1000 in women younger than 35 years, whereas it is double this for women aged 40 years and older at the same stage of pregnancy. This risk is higher in older nulliparous women compared with older multiparous women. In Afro-Caribbean women, the risk of unexplained stillbirth is over 2-fold higher than in white and Asian women. In view of these findings, it may seem justifiable to offer women of advanced maternal age an early induction of labor between 39 and 40 weeks of pregnancy with the aim of reducing perinatal mortality and preventing late stillbirths [2].

There is still need for further research on the effects of early induction of labor for women of advanced maternal age. Currently ongoing is a multicenter randomized controlled trial comparing induction of labor at 39 weeks of pregnancy with expectant management in nulliparous women aged over 35 years [3]. Patients are still being recruited for this study and interested departments are encouraged to contact the principal investigators.

References


The GAVI Alliance and the HPV vaccine

The Global Alliance for Vaccines and Immunisation (GAVI) is an international effort to introduce lifesaving vaccines [1]. The Alliance comprises many partners, including the World Health Organization (WHO), UNICEF, the World Bank, the Bill and Melinda Gates Foundation, donor governments, financial organizations, and pharmaceutical companies. The main objective is to close 3 critical gaps directly associated with the provision of vaccines: (1) between children for whom immunization is a given and the 22 million children worldwide with no access to basic vaccines; (2) between the introduction of a new vaccine in rich countries and the average 10–15 years required for the same vaccine to reach low-income countries; and (3) between the need for new vaccines in low-resource countries and the lack of research and funds to provide them. The Alliance was launched to fund vaccines in the 70 poorest countries of the world. Since 2000, GAVI has committed US$ 7.9 billion for vaccinations, allowing more than 370 million children to be immunized against preventable diseases.
On February 4, 2013 (World Cancer Day), it was announced that 7 countries would be the first to receive GAVI support to start HPV vaccine demonstration programs (Ghana, Kenya, Lao PDR, Madagascar, Malawi, Niger, Sierra Leone, and Tanzania) [2]. HPV vaccines protect against HPV types 16 and 18, which cause more than 70% of cases of cervical cancer cases and the deaths of 275 000 women each year. Since 2007, HPV vaccines have been available in many high-resource countries and it is currently estimated that over 50 countries worldwide have national HPV vaccine programs. The GAVI Alliance is working in two main areas: (1) providing the HPV vaccine at affordable prices; and (2) supporting the selected countries to build capacity and infrastructure to deliver the HPV vaccine. One challenge to achieving effective delivery of the vaccine is that many countries do not offer routine health services for girls (the vaccine is given to girls aged 9–13 years). However, it is expected that the HPV vaccine will be offered through schools in Africa and Asia. The demonstration programs allow countries the possibility of testing whether they have the ability to roll out the HPV vaccine at a national level. Gardasil (Merck) and Cervarix (GlaxoSmithKline) are the only approved vaccines designed to protect against HPV. It is expected that both HPV vaccines will be offered at a hugely discounted price—such as US $5 per dose—to allow the success of the project. An initial estimation is that by 2020, more than 30 million girls from over 40 countries are expected to have been vaccinated against HPV with GAVI support.

Maternal health agenda for post-2015

The Maternal Health Task Force held the Global Maternal Health Conference in Arusha, Tanzania, in January 2013. At this conference there were discussions about Millennium Development Goal (MDG) 5 and the fate of maternal health after 2015. With only 10 countries having currently achieved the MDG 5 target, this discussion was extremely relevant. The discussions resulted in a recently published manifesto, which comprises 12 main points [1]:

- The global community must build on the successes of the MDG era by setting new targets for maternal health. These targets must be owned by countries and not donor agencies.
- The new maternal mortality goals must include political, economic, and social rights of women since focusing exclusively on health issues will not lead to much improvement in maternal health.
- The world should begin to focus on the prevention and treatment of maternal morbidities.
- The successful framework of the continuum of care should be revised so that women become the focus of reproductive, maternal, newborn, and child health.
- We need to come up with viable means of financing interventions to improve maternal and sexual reproductive health.
- Emphasis must be placed on reaching women who have been excluded from accessing existing care because of issues such as social status, culture, geographical location, or education.
- There should be improved comprehensive quality of care for pregnant women with emphasis on respectful care during labor and delivery.
- The voices of women must be heard more and loudly in shaping the future of maternal health care.
- Preterm births, preventable stillbirths, and neonatal deaths must be addressed.
- Reliable information on maternal deaths and health outcomes is needed as well as increased accountability.
- Mobile and electronic health technologies must be harnessed to the full in the improvement of emergency obstetric and newborn care.
- Universal access to high quality care that is free at the point of health delivery within a thriving health system should be a target for all countries.

Reference


Syphilis in pregnancy—still a problem

A report on the WHO website reports that syphilis continues to be a problem in pregnancy in the 21st century [1]. Recent publications reveal that more than 1 million pregnant women globally are infected with syphilis. Syphilis in pregnancy is known to result in mother-to-child transmission, which is responsible for major congenital malformations in the newborn. This can be prevented by universal testing of pregnant women for syphilis and treating those who test positive. Although this has been proven and is a well-known intervention, not all pregnant women are tested for syphilis. Testing 95% of pregnant women in a population will lead to elimination of maternal transmission of the disease.

Eighty percent of pregnant women infected with syphilis have received prenatal care at health facilities. This brings into question the quality of prenatal care services, because good care is the way to address syphilis in pregnancy. Current data show that maternal syphilis infections led to over 500 000 poor health outcomes, with over 200 000 stillbirths, 90 000 neonatal deaths, 65 000 preterm or low birth weight deliveries, and 150 000 cases of congenital malformations. A quarter of these poor outcomes could have been avoided by treating the women who tested positive for syphilis with benzathine penicillin.

These findings should serve as a call to health managers, especially in low-income countries, to ensure that syphilis testing is available at all prenatal clinics. The statistics about stillbirths and neonatal deaths are alarming and efforts must be made to ensure that known cost-effective interventions to improve fetal and neonatal outcomes are available and accessible in health systems.

Reference


Procedures to be avoided in obstetric and gynecologic care

The American College of Obstetricians and Gynecologists (ACOG) has released a list of 5 procedures that are not beneficial to women [1]. In a press release, ACOG’s Vice President stated: “We carefully selected the 5 procedures and tests in obstetrics and gynecology based on their potential to improve quality health care and avoid potential harm. As obstetrician-gynecologists, our goal is to provide women the very best evidence-based medical care.”

The recommendations are:

1. Elective, non-medically indicated inductions of labor or cesarean deliveries should not be scheduled before 39 weeks of gestation. Delivery prior to 39 weeks has been shown to be associated with an increased risk of learning disabilities and a potential increase in illness and death.
(2) Elective, non-medically indicated inductions of labor between 39 weeks and 41 weeks of gestation should not be scheduled unless the cervix is deemed favorable.

(3) Routine annual Pap tests are not needed in women aged 30 to 65 years. In average-risk women, an annual screening offers no advantages over screening every 3 years.

(4) Treatment is not needed in average-risk women who have "mild dysplasia," which is associated with HPV, for a period of less than 2 years.

(5) For average-risk women with no symptoms, there is no need to screen for ovarian cancer. In these women, the potential harms of screening outweigh the potential benefits.

Reference


Resources for women’s health

The Demographic and Health Surveys are nationally representative surveys of women’s reproductive health, child health, and maternal health carried out in over 100 low- and middle-income countries. The surveys are carried out every 5 years and are the most reliable source of women’s health data for many of these countries. The survey reports, as well as other publications on maternal and child health, are freely available at: www.measuredhs.com. Researchers who wish to perform further studies of the survey data can apply for permission to have access to the data and carry out further analysis. At the website, graphs and charts showing current levels and trends in indicators can also be created.