International Federation of Gynecology and Obstetrics
FIGO Mission

- The International Federation of Gynecology and Obstetrics (FIGO) is a unique organization, being the only international professional body that brings together **130 obstetrical and gynecological associations** from all over the world.

- FIGO is dedicated to the improvement of women’s health and rights and to the reduction of disparities in health care available to women and newborns **as well as to advancing the science and practice of obstetrics and gynecology**. The organization pursues its mission through advocacy, programmatic activities, capacity strengthening of member associations and **education and training**.
International Federation of Gynecology and Obstetrics
Working Group on Good Clinical Practice in Maternal-Fetal Medicine

**Chair:** G C Di Renzo

**Expert members:**
- E Fonseca, Brasil
- E Gratacos, Spain
- S Hassan, USA
- M Kurtser, Russia
- F Malone, Ireland
- S Nambiar, Malaysia
- M Sierra, Mexico
- K Nicolaides, UK
- H Yang, China

**Expert members ex officio:**
- C Fuchtner, FIGO
- M Hod, EAPM
- GH Visser, SM Committee
- E Castelazo, CBET Committee
- L Cabero, WG GDM
- V Berghella, SMFM
- Y Ville, ISUOG
- M Hanson, DOHaD, WG Nutrition
- PP Mastroiacovo, Clearinghouse
- JL Simpson, March of Dimes
- D Bloomer, GLOWM
International Federation of Gynecology and Obstetrics
Working Group on the Challenges of Labour and Delivery

Chair: R Romero

Expert members:
D Farine, Canada
MT Gervasi, Italy
J M. Robson, Ireland
T Duan, China
S Rosales, Mexico
T Kimura, Japan
L Yeo, Korea-USA

Expert members ex officio:
C N Purandare, FIGO
G C Di Renzo, FIGO
M Stark, NESA
GH Visser, SM Committee
E Castelazo, CBET Committee
C Lees, RCOG
A Conde’ Agudelo, NIH NICHD
D Bloomer, GLOWM
International Federation of Gynecology and Obstetrics
March of Dimes
Working Group on Preterm Birth Prevention

Chairs: J L Simpson
       G C Di Renzo

Expert members:
Ernesto Castelazo
Mary D’Alton
Eduardo Fonseca
Chris Howson
Bo Jacobsson
James Martin
Jane Norman
T Y Leung

Expert members ex officio:
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J Howse, March of Dimes
G Visser, SM Committee
D Bloomer, GLOWM
Jim Larson BCG
David Ferrero, BCG
International Federation of Gynecology and Obstetrics
GDM initiative

Chair: M Hod

Expert members:
Mukesh Agarwal
Blami Dao
Gian Carlo Di Renzo
Hema Divakar
Eran Hadar
Anil Kapur

Expert members ex officio:
CN Purandare, FIGO
GH Visser, SM Committee
D Ayres do Campo, SM Comm
L Cabero, CBET Committee
D Bloomer, GLOWM
R Fabienke, Novo Nordisk
Good practice advice

- Folic acid supplementation
- Prediction and prevention of preterm birth
- Non invasive prenatal diagnosis and testing
Good practice advice

- Thyroid diseases in pregnancy
- MgSO4 use in obstetrics
- Appropriate use of ultrasound in pregnancy
- Hyperglycemia and pregnancy
Good practice advice
finalised in June 2016

• Aspirin Use in Pregnancy
• Iron deficiency anaemia
• Management of Twin Pregnancy
• Micronutrients in Pregnancy
Good practice advice to be discussed on December 2016

- Intrauterine growth restriction
- Recurrent Miscarriage
- Prediction of pre eclampsia
MAGNESIUM SULPHATE USE IN PREGNANCY
PRETERM BIRTH and CEREBRAL PALSY

• HOW BIG IS THE PROBLEM?
• CP 2-2.5 per 1000 LB
• Prematurity, LBW
• 30% attributed to prematurity
Meta analysis

- 2009
- 5 RCTs, 6145 babies
- CP RR 0.68 (5)
- GMD RR 0.61 (4)
- No significant paed mortality, neurologic impairment, mat complications
- NNT 63
• No difference for primary outcome of death or CP
• Combined death and CP RR 0.85 (3)
• CP any severity RR 0.70 (5) mod – severe RR 0.60
• Similar when results for under 30 weeks
• NNT 52
• No effect on mortality
WHY THE HESITATION?

- We are not convinced
- Trial sequential analysis
- Reluctance to change practice
- Ignorance
- Resource limitations
- Too many unanswered questions?
Still no consensus

5 trials - 5 regimens

Suggestion of increased mortality with higher dosage used for tocolysis

Similar benefit from lower dosages
Reasonable to use the lower dosage 4g bolus followed by 1-2 g /hour up to 24 hours
1. For imminent preterm birth which is either active labor diagnosed with or without rupture of membranes or elective delivery for maternal or fetal concerns, antenatal magnesium sulphate should be considered for fetal neuroprotection.

2. Although there is controversy about the upper gestational age, antenatal magnesium sulphate should be considered from viability until 31 week + 6 days gestation.

3. Magnesium sulphate should be discontinued if delivery is no longer imminent or after a maximum of 24 hours of therapy.
Recommendations from FIGO MFM Working Group

- Magnesium sulphate should be administered as a *4g loading dose over 30 minutes*, ideally 4-6 hours before delivery followed by an infusion of *1g/hour until delivery occurs*. However there still may be benefit if given less than 4 hours prior to delivery.

- There is insufficient evidence for use of a repeat course of antenatal magnesium sulphate for fetal neuroprotection.

- Delivery should not be delayed in order to administer antenatal magnesium sulphate if there are maternal or fetal indications for emergency delivery.
• When magnesium sulphate is given for fetal neuroprotection, maternity care providers should use existing protocols to monitor women for signs of toxicity as those used in cases of pre eclampsia/eclampsia.

• Neonatologists should be alerted to assess neonates for hypotonia and/or apnea as therapy with magnesium sulphate has the potential to cause hypocalcemia.
CONCLUSIONS
FOCUS ON GLOBAL STRATEGIES

AMELIORATE OUR PROFESSION OVERCOMING THE LIMITS OF NATIONAL SOCIETIES

GUIDELINES: THE BEST PRACTICE ADVICE

GLOBAL STRATEGIES FOR:
PRETERM BIRTH PREVENTION
NON COMMUNICABLE DISEASES
PREVENTING EXPOSURE TO TOXIC CHEMICALS
Gathering data on maternal mortality and maternal health is notoriously difficult. However, one thing is clear from all the statistics: although maternal and perinatal mortality and morbidity is falling globally, the perspectives for women-infants in poor resources countries are much worst than for those in industrialised countries.
Pregnancy offers a window of opportunity to provide maternal care services to mother and offspring.

Reduce traditional maternal and perinatal morbidity and mortality indicators.

Address intergenerational prevention of preterm birth and NCDs, such as diabetes, hypertension, cardiovascular disease, and stroke.
On Sept 2015 the UN General Assembly adopted the “Agenda 2030: Transforming our World”, with a consensus of the World Government Community - introduced **17 sustainable development goals** SDGs. Many of the suggested SDG’s have Environmental and Reproductive health embedded in their goals.
It is a sheer co-incidence that September 2015 witnessed the 20th anniversary of the Beijing World Conference on Women under the slogan - “Planet 50-50 by 2030: Set it up for Gender Equality”.

‘The Agenda 2030; Transforming our world’ or Planet 50-50 by 2030’ i.e. SDGs will not materialise without the contribution of 50% of its population i.e. women - This can be achieved only with gender equality, equal education and employment opportunities + providing sexual reproductive health and rights.

Reproductive Health and Rights will not be complete unless we improve environmental Health

FIGO was not and will not be a passive observer to bring about this required change and will act to make these dreams real for women.