Hyperglycemia in Pregnancy (HIP): FIGO offers a pragmatic guide to diagnosis, management and care
HIP is a major global health problem

Hyperglycemia is one of the most common medical conditions women encounter during pregnancy.

1 in 6 live births occur to women with some form of hyperglycemia, 84% of which are due to GDM.

Hyperglycemia/GDM is associated with:

- Leading causes of maternal mortality
- Higher incidence of maternal morbidity
- Higher incidence of perinatal and neonatal morbidity
- Later long term consequences for both mother and child
Contributors for Maternal Morbidity and Foetal Programming

- Maternal Anaemia
  ~56 million pregnancies
- Maternal Undernutrition
  ~26 million pregnancies
- Maternal Malaria
  ~20 million pregnancies
- Maternal Obesity
  ~42 million pregnancies
- Maternal Hyperglycemia
  ~21 million pregnancies
- Maternal Hypertensive Disorders
  ~7 million pregnancies

~127 million live births
The HIP Challenge

127 million live births per year

India, China, Pakistan, Indonesia, Bangladesh, Brazil, Mexico account for >65 million deliveries

~3 to 4 million detected and treated

~21 million per year complicated by hyperglycaemia

Receive postpartum follow up and lifestyle advice?
“...Facing a “Slow-Motion Disaster”
UN Meeting on Non Communicable Diseases

Margaret Chan, Director-General,
World Health Organization (WHO), Sept. 2011

- There is an increasing global crisis in NCD
- NCD are associated with mortality, morbidity, and long-term disability
- Two of three deaths globally are attributable NCDs

Non Communicable Diseases are Programmed & Imprinted during Pregnancy

Diagnosis and management may help turn the tide of the Diabetes - NCD pandemic
The HIP Challenge
~3 to 4 million detected and treated
Receive postpartum follow up and lifestyle advice?
~21 million per year complicated by hyperglycaemia
127 million live births per year
India, China, Pakistan, Indonesia, Bangladesh, Brazil, Mexico account for >65 million deliveries

St. Vincent Declaration
St. Vincent (Italy), 10-12 October 1989
Organized by WHO and IDF

“...Achieve a pregnancy outcome in the diabetic woman that approximates that of the non-diabetic woman – 10 years.....”

Pregnancy Induced Complications
Was it achieved in 27 years ...???

Fetal
- Congenital anomalies
- Spontaneous abortions
- Intrauterine growth restriction (IUGR)
- Perinatal mortality (PNM)
- Traumatic delivery
- Long term effects - DOHAD

Maternal
- Abortions
- Hypoglycemia
- DKA
- Pre-GDM
- (PET/PH)
- Vascular
- Traumatic delivery
- Overt diabetes - (Post GDM-Type 2 DM)
- Metabolic Syndrome

Can we do better ...???
Where is HIP now on the International Development Agenda?

"We affirm a life-long approach with a focus on the nutrition of women of reproductive age, pregnant women, nursing mothers and children under five, with particular attention to the first 1000 days from pregnancy to a child’s second birthday."

A life-course approach to prevention
FIGO and the GDM Initiative

FIGO brings together professional societies of obstetricians and gynecologists.

Member Societies in 130 countries.

FIGO’s vision is for women of the world to achieve the highest possible standards of physical, mental, reproductive and sexual health and wellbeing throughout their lives.
Identified GDM/HIP as a priority area for FIGO to work in and started the Initiative in 2013 by establishing an expert group to develop and disseminate an evidence-based, practical and pragmatic standards of care protocol for national associations to adopt and promote a uniform approach to testing, diagnosis and management of GDM for all countries and regions based on their financial, human and infrastructure resources.

With the overall aim:
- Advancement of women’s reproductive health and rights
- Promotion of newborn and child health
- Prevention of type 2 diabetes & other NCDs

= FIGO “joins the game”
FIGO Guidelines produced

- Dec 2013: FIGO Expert Group on GDM established
- Oct 2015: Launch of guidelines on diagnosis, management and care

Content from International Journal of Gynecology and Obstetrics:

The International Federation of Gynecology and Obstetrics (FIGO) Initiative on gestational diabetes mellitus: A pragmatic guide for diagnosis, management, and care

- Moshe Hod
- Anil Kapur
- David A. Sacks
- Eran Hadar
- Mukesh Agarwal
- Gian Carlo Di Renzo
- Luis Cabero Roura
- Hema Divakar
- Harold David McIntyre
- Jessica L. Morris

Contents list available at ScienceDirect
FIGO GDM guidelines

Executive summary
The target audience
Assessment of quality of evidence and grading of recommendation
Gestational Diabetes Mellitus (GDM) – Background, Definition, Epidemiology, Pathophysiology
Diagnosing Gestational Diabetes Mellitus
Glucose Measurement: Technical considerations in laboratory and point of care (POC) testing
Management during pregnancy
Post-Partum Management
Pre Conception Care
Research Priorities
Appendix
  Current Approaches to GDM diagnosis in selected high burden developing countries
  Gestational Diabetes Formulas for Cost-Effectiveness - GeDiForCE®
  Research Priorities in Gestational Diabetes

Recommendations graded by quality of evidence
Provides a call for action to policy makers
Provides options according to resource setting
Identifies key points of intervention
FIGO GDM guidance: Some highlights

1: Describes and differentiates GDM

- Hyperglycemia in pregnancy
  - Diabetes in pregnancy
    - Diagnosed before the start of pregnancy
      - Type 1
      - Type 2
    - Diagnosed for the first time during pregnancy
      - Type 1
      - Type 2

- Gestational diabetes mellitus

Diabetes in pregnancy
- Pregnancy in previously known diabetes
- OR
  - Hyperglycemia diagnosed for the first time during pregnancy that meets WHO criterion for diabetes mellitus in the nonpregnant state
  - May occur anytime during pregnancy including the first trimester

Gestational diabetes mellitus
- Hyperglycemia during pregnancy that is not diabetes
- May occur anytime during pregnancy but most likely after 24 weeks

Figure 1: Types of hyperglycemia in pregnancy.
Figure 2: The difference between diabetes in pregnancy and gestational diabetes mellitus.
2. Highlights the significance for global health

Table 3
Maternal and fetal morbidity associated with gestational diabetes mellitus.

<table>
<thead>
<tr>
<th>Maternal morbidity</th>
<th>Fetal/neonatal/child morbidity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early pregnancy</td>
<td>Stillbirth</td>
</tr>
<tr>
<td>Spontaneous abortions</td>
<td>Neonatal death</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>Nonchromosomal congenital malformations</td>
</tr>
<tr>
<td>Pre-eclampsia</td>
<td>Shoulder dystocia</td>
</tr>
<tr>
<td>Gestational hypertension</td>
<td>Respiratory distress syndrome</td>
</tr>
<tr>
<td>Excessive fetal growth (macrosomia, large for gestational age)</td>
<td>Cardiomyopathy</td>
</tr>
<tr>
<td>Hydramnios</td>
<td>Neonatal hypoglycemia</td>
</tr>
<tr>
<td>Urinary tract infections</td>
<td>Neonatal polycythemia</td>
</tr>
<tr>
<td>Delivery</td>
<td>Neonatal hyperbilirubinemia</td>
</tr>
<tr>
<td>Preterm labor</td>
<td>Neonatal hypocalcemia</td>
</tr>
<tr>
<td>Traumatic labor</td>
<td>Erb's palsy (as consequence of birth injury)</td>
</tr>
<tr>
<td>Instrumental delivery</td>
<td>Programming and imprinting; fetal origins of disease: diabetes, obesity, hypertension, metabolic syndrome</td>
</tr>
<tr>
<td>Cesarean delivery</td>
<td></td>
</tr>
<tr>
<td>Postoperative/postpartum infection</td>
<td></td>
</tr>
<tr>
<td>Postoperative/postpartum hemorrhage</td>
<td></td>
</tr>
<tr>
<td>Thromboembolism</td>
<td></td>
</tr>
<tr>
<td>Maternal morbidity and mortality</td>
<td></td>
</tr>
<tr>
<td>Hemorrhage</td>
<td></td>
</tr>
<tr>
<td>Puerperium</td>
<td></td>
</tr>
<tr>
<td>Failure to initiate and/or maintain breastfeeding</td>
<td></td>
</tr>
<tr>
<td>Infection</td>
<td></td>
</tr>
<tr>
<td>Long-term postpartum</td>
<td></td>
</tr>
<tr>
<td>Weight retention</td>
<td></td>
</tr>
<tr>
<td>GDM in subsequent pregnancy</td>
<td></td>
</tr>
<tr>
<td>Future overt diabetes</td>
<td></td>
</tr>
<tr>
<td>Future cardiovascular disease</td>
<td></td>
</tr>
</tbody>
</table>

FIGO Boxes highlight salient points

- FIGO recommends and supports the call for greater attention and focus on the links between maternal health and noncommunicable diseases in the sustainable developmental agenda.
3: Advocates for Universal Testing

**Universal testing**: All pregnant women should be tested for hyperglycemia during pregnancy using a one-step procedure and FIGO encourages all countries and its member associations to adapt and promote strategies to ensure this.

- FIGO adopts and supports the IADPSG/WHO/IDF position that all pregnant women should be tested for hyperglycemia during pregnancy using a one-step procedure.
- FIGO encourages all countries and its member associations to adapt and promote strategies to ensure universal testing of all pregnant women for hyperglycemia during pregnancy.

- All countries have an obligation to implement the best GDM testing and management practices they can.
- FIGO acknowledges that for global progress to be made, India, China, Nigeria, Pakistan, Indonesia, Bangladesh, Brazil, and Mexico must be key targets for focused GDM attention.
Criteria for diagnosis: The WHO criteria for diagnosis of diabetes mellitus in pregnancy [1] and the WHO and the International Association of Diabetes in Pregnancy Study Groups (IADPSG) criteria for diagnosis of GDM [1,2] should be used when possible.

- FIGO adopts the WHO (2013) criteria for diagnosis of diabetes mellitus in pregnancy.
- FIGO adopts the WHO (2013) and IADPSG (2010) criteria for diagnosis of gestational diabetes mellitus. Given the resource constraints in many low-resource countries, other strategies described herein are considered equally acceptable.
## 5: Recommendation for diagnosis

While this is the optimal recommendation, alternatives are given in acknowledgement of limitations faced in diverse settings.

### Table 4
Options for diagnosis of gestational diabetes mellitus based on resource settings.

<table>
<thead>
<tr>
<th>Setting</th>
<th>Who to test and when</th>
<th>Diagnostic test</th>
<th>Interpretation*</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully resourced settings</td>
<td>All women at booking/first trimester</td>
<td>Measure FPG, RBG, or HbA1c to detect diabetes in pregnancy</td>
<td>If negative: perform 75-g 2-hour OGTT</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>24–28 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully resourced settings serving ethnic populations at high risk*</td>
<td>All women at booking/first trimester</td>
<td>Perform 75-g 2-hour OGTT to detect diabetes in pregnancy</td>
<td>If negative: perform 75-g 2-hour OGTT</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>24–28 weeks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any setting (basic); particularly medium- to low-resource settings serving ethnic populations at risk</td>
<td>All women between 24 and 28 weeks</td>
<td>Perform 75-g 2-hour OGTT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Pragmatic guides for testing, diagnosis and management must be based on each country’s available:

- **Finances**
- **Human Resources**
- **Infrastructure Resources**
Technical considerations in laboratory and point of care (POC) testing

- GDM diagnosis should be ideally based on blood tests done in an accredited laboratory on properly collected and transported venous plasma samples.
- FIGO recommends the use of a plasma-calibrated handheld glucometer with properly stored test strips to measure plasma glucose in primary care settings, particularly in low-resource countries, where a close-by laboratory or facilities for proper storage and transport of blood samples to a distant laboratory may not exist. This may be more convenient and reliable than tests done on inadequately handled and transported blood samples in a laboratory. It is recommended that from time to time a few samples are parallel tested in an accredited laboratory to document the variability.
- FIGO recommends that all laboratories and clinical services document their baseline quality and work toward improvement irrespective of the resources available.
Management of GDM: Management should be in accordance with available national resources and infrastructure even if the specific diagnostic and treatment protocols are not supported by high-quality evidence, as this is preferable to no care at all.

Box 1
Recommendations for prenatal supervision in women with gestational diabetes mellitus.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Resource setting</th>
<th>Strength of recommendation and quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine prenatal care should include visits to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Healthcare professionals skilled in care of women with diabetes in pregnancy</td>
<td>High</td>
<td>1=0000</td>
</tr>
<tr>
<td>(obstetrician, perinatologist, diabetologist, diabetes educator, nutritionist etc):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-3 weeks as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Nurse: Weight, blood pressure, dipstick urine protein: 1-2 weeks as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal follow-up determined locally according to available resource:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• A minimum of monthly check-ups with a healthcare provider knowledgeable in diabetes in pregnancy</td>
<td>Mid and Low</td>
<td>2=0000</td>
</tr>
</tbody>
</table>
7: Describes care for women with GDM

**Box 2**
Recommendations for fetal growth assessment in women with gestational diabetes mellitus.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Resource setting</th>
<th>Strength of recommendation and quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical and sonographic growth assessments every 2–4 weeks from diagnosis until term</td>
<td>High</td>
<td>1</td>
</tr>
<tr>
<td>Periodic clinical and sonographic growth assessments from diagnosis until term</td>
<td>Mid and Low</td>
<td>2</td>
</tr>
</tbody>
</table>

**Box 3**
Recommendations for fetal well-being surveillance in women with gestational diabetes mellitus.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Resource setting</th>
<th>Strength of recommendation and quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use cardiotocography and/or biophysical profile or kick-count as indicated according to local protocol</td>
<td>All</td>
<td>1</td>
</tr>
</tbody>
</table>
7: Describes care for women with GDM

**Box 4**
Recommendations for timing and mode of delivery in women with gestational diabetes mellitus.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Resource setting</th>
<th>Strength of recommendation and quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>As per local protocol or as suggested in Figure 4</td>
<td>All</td>
<td>2B000</td>
</tr>
</tbody>
</table>

Figure 4. Timing of delivery in women with gestational diabetes mellitus and diabetes in pregnancy.
Pharmacological management: If lifestyle modification alone fails to achieve glucose control, metformin, glyburide, or insulin should be considered as safe and effective treatment options for GDM.

Box 5
Recommendations for glucose monitoring in women with gestational diabetes mellitus.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Resource setting</th>
<th>Strength of recommendation and quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-monitoring of blood glucose is recommended for all pregnant women with diabetes, 3-4 times a day.</td>
<td>All</td>
<td>2</td>
</tr>
<tr>
<td>• Fasting: once daily, following at least 8 hours of overnight fasting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Postprandial: 2-3 times daily, 1 or 2 hours after the onset of meals, rotating meals on different days of the week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-monitoring of blood glucose is recommended for all pregnant women with diabetes at least once daily, with documented relation to timing of meal</td>
<td>Low</td>
<td>2</td>
</tr>
</tbody>
</table>
7: Describes care for women with GDM

**Box 9**
Recommendations for nutrition therapy in women with gestational diabetes mellitus.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Resource setting</th>
<th>Strength of recommendation and quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>We recommend that the following principles should be adhered to in women with diabetes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Design an appropriate diet with respect to prepregnancy BMI, weight, physical activity, habits, and personal and cultural preferences.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Provide routine follow-up and diet adjustments throughout pregnancy to help women achieve and maintain treatment goals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Offer individualized, education, support, and follow-up by a qualified dietitian experienced in care of women with diabetes. Issues for discussion include: weight control, food records, carbohydrate counting, monitoring blood glucose, hypoglycemia, healthy foods, and physical activity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We suggest that caloric intake be calculated based on prepregnancy weight and adjusted for gestational changes in energy needs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- FIGO recognizes that nutrition counseling and physical activity are the primary tools in the management of GDM.
- FIGO recommends that women with GDM receive practical nutrition education and counseling that empowers them to choose the right quantity and quality of food.
- Women with GDM must be repeatedly advised to continue the same healthy eating habits after delivery to reduce the risk of future T2DM.

**Box 10**
Recommendations for physical activity in women with gestational diabetes mellitus.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Resource setting</th>
<th>Strength of recommendation and quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>We suggest that appropriate, personally adapted, physical activity be recommended for all women with diabetes:</td>
<td>All</td>
<td>2</td>
</tr>
<tr>
<td>• Planned physical activity of 30 min/day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Brisk walking or arm exercises while seated in a chair for 10 min after each meal.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Women physically active prior to pregnancy should be encouraged to continue their previous exercise routine.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Box 11**

Recommendations for pharmacological treatment in women with gestational diabetes mellitus.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Resource setting</th>
<th>Strength of recommendation and quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin, glyburide, and metformin are safe and effective therapies for GDM during the second and third trimesters, and may be initiated as first-line treatment after failing to achieve glucose control with lifestyle modification. Among OADs, metformin may be a better choice than glyburide [109].</td>
<td>All</td>
<td>2[triangle up]△△△△△</td>
</tr>
</tbody>
</table>

Insulin should be considered as the first-line treatment in women with GDM who are at high risk of failing on OAD therapy, including some of the following factors [129]:
- Diagnosis of diabetes <20 weeks of gestation
- Need for pharmacologic therapy >30 weeks
- Fasting plasma glucose levels >110 mg/dL
- 1-hour postprandial glucose >140 mg/dL
- Pregnancy weight gain >12 kg

**Box 12**

Recommendations for insulin treatment in women with gestational diabetes mellitus.

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Resource setting</th>
<th>Strength of recommendation and quality of evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following insulins may be considered safe and effective treatment during pregnancy: regular insulin, NPH, lispro, aspart and detemir.</td>
<td>All</td>
<td>1[triangle up]△△△△△</td>
</tr>
</tbody>
</table>
8: Includes recommendations for Pre-conception and inter-pregnancy

- FIGO calls for public health measures to increase awareness and acceptance of preconception counseling and to increase affordability and access to preconception services to women of reproductive age, as this is likely to have both immediate and lasting benefits for maternal and child health.
9: Includes recommendations for Postpartum care

- FIGO supports the concept that the postpartum period in women with GDM provides an important platform to initiate early preventive health for both the mother and the child who are both at a heightened risk for future obesity, metabolic syndrome, diabetes, hypertension, and cardiovascular disorders.

- FIGO encourages obstetricians to establish connections with family physicians, internists, pediatricians, and other healthcare providers to support postpartum follow-up of GDM mothers linked to the regular check-up and vaccination program of the child to ensure continued engagement of the high-risk mother-child pair.

PREGNANCY OFFERS A WINDOW OF OPPORTUNITY TO:

- Establish services
- Improve health
- Prevent intergenerational transmission of non-communicable diseases

POSTPARTUM AIMS

- Early DETECTION of infections
- SUPPORT of breastfeeding
- ADVICE on pregnancy spacing
- RETEST all women with GDM at 6-12 weeks postpartum
- Future blood glucose TESTS
Approved

- Chinese Society of Perinatal Medicine
- European Board and College of Obstetrics and Gynaecology (EBCOG)
- European Diabetic Pregnancy Study Group (DPSG)
- African Federation of Obstetrics and Gynecology (AFOG)
- Latin America Diabetic Pregnancy Study Group (LADPSG)
- The Australian Diabetes in Pregnancy Society (ADIPS)
- International Association of Diabetes in Pregnancy Study Groups (IADPSG)
- International Association of Diabetes in Pregnancy Study Groups (IADPSG)
- European Association of Perinatal Medicine (EAPM)
- Diabetes in Pregnancy Study Group of India (DIPSI)
- RCOG - pending
- International Diabetes Foundation (IDF)

FIGO Committees endorsement:
- Executive Board
- Best Practice on Maternal-Foetal Medicine Working Group
- FIGO Clinical Obstetrical Committee
- FIGO Maternal Nutrition Initiative Expert Group
- FIGO Challenges in Care of Mothers and Infants during Labour and Delivery Working Group
- FIGO Antenatal assessment
- FIGO Safe Motherhood and Newborn Health Committee
FIGO became serious partner in effort to fight HIP

The Vancouver Declaration
Vancouver (Canada), October & December 2015
Organized by FIGO and IDF
Focus and dissemination

All countries have an obligation to implement the best testing and management practices they can!

**PRIORITY COUNTRIES:**
India, China, Nigeria, Pakistan, Indonesia, Bangladesh, Brazil and Mexico

*These 8 countries account for 55% of global live births and 55% of the global burden of diabetes*
New HIP Working Group

Jan 2016

FIGO Working Group on HIP instated

Oct 2018

Report on successes at FIGO World Congress

“Training, advocacy and evidence generation on hyperglycaemia in pregnancy to reduce poor pregnancy outcomes; decrease maternal and neonatal morbidity and mortality; and cut future risk of diabetes & cardio-vascular disease”
The next three years ....

Leadership, support and collaboration from international experts.

Capacity Building & Training

International organizations & key governments implementing targeted communication & advocacy strategies.

Comprehensive, role-based training programs being rolled-out to healthcare workers.

Evidence being generated on priority areas to fill knowledge gaps & feed into service delivery.

Raised knowledge & skills of FIGO and 130 affiliated member associations.

Awareness & Advocacy

Research & Implementation Science
1 – Awareness and Advocacy

GOAL - International organizations and key governments implementing targeted communication and advocacy strategies

FIGO will strive to ensure that key organizations are identified and engaged in defining and implementing a collaborative and comprehensive communication and advocacy strategy.
Progress made so far

4th Global Conference

16-19 MAY 2016 • COPENHAGEN, DENMARK

The world’s largest global conference on the health, rights, and wellbeing of girls and women in the last decade.

ALSO

Presenting at international and regional conferences – promoting the HIP agenda
Multiple meetings with partners and stakeholders
A number of advocacy tools in development
2 – Capacity Building and Training

GOAL - Comprehensive, role based training programs being rolled-out to healthcare workers; and to improve the knowledge, skills and attitudes of FIGO affiliates in the management of HIP

FIGO will develop and implement comprehensive and competency based learning resource package (LRP) training on HIP to healthcare workers at all levels. FIGO will assist its member organizations to roll out the training on HIP using the newly developed LRP.
Progress made so far

Learning Resource Package is currently in development. Watch this space!
GOAL: To identify and implement a research agenda which will address priority gaps in knowledge of HIP

FIGO will develop a prioritized research agenda based on the broad needs identified by the FIGO recommendations, create a research network which will work towards conducting research aimed at addressing priority gaps.
Progress made so far

Collaborations with partners
Sharing information with strategic stakeholders
Paper on research gaps – coming soon!
Development of a cost-effectiveness tool
Starting with South Asia – The ‘Colombo Declaration’  September 2016

FIGO was involved in the creation and signing of a landmark document calling for increased focus and commitment on Hyperglycemia in Pregnancy (HIP) in the South Asian region.

The ‘Colombo Declaration’ was signed during the opening ceremony of the 1st South Asia and Asia Pacific International Congress on Diabetes, Hypertension & Metabolic Syndrome in Pregnancy held in Colombo, Sri Lanka on 8-10 September.

The Declaration is a regional call to action to address the link between maternal health and diabetes as a public health priority. The document also highlights FIGO recommendations on HIP and advocates for their implementation.
The Colombo Declaration
Signing of the Colombo Declaration
Towards Global Commitment – our vision

Regional Declarations in the following:

<table>
<thead>
<tr>
<th>Region</th>
<th>Location</th>
<th>Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAIDIP</td>
<td>Colombo, Sri Lanka</td>
<td>Sept. 2016</td>
<td>Accomplished</td>
</tr>
<tr>
<td>AFOG</td>
<td>Addis, Ethiopia</td>
<td>February 2017</td>
<td></td>
</tr>
<tr>
<td>Europe</td>
<td>Barcelona, Spain</td>
<td>March 2017</td>
<td></td>
</tr>
<tr>
<td>Asia</td>
<td>Bangalore, India</td>
<td>April 2017</td>
<td></td>
</tr>
<tr>
<td>Greater China</td>
<td>Beijing, China</td>
<td>September 2017</td>
<td></td>
</tr>
<tr>
<td>FLASOG</td>
<td>Cancun, Mexico</td>
<td>November 2017</td>
<td></td>
</tr>
<tr>
<td>GULF/MENA</td>
<td>Abu Dhabi, UAE</td>
<td>December 2017</td>
<td>- with IDF</td>
</tr>
</tbody>
</table>

Taking us to a Global Declaration at FIGO Congress in Rio de Janeiro in October 2018
Other progress so far

- Working Group meetings
- Strategic partnership developments
- Post-graduate courses and conference presentations
- Press conferences
- Development of advocacy materials
- Paper on research priorities – coming soon!
- In the media!
Hyperglycemia In Pregnancy

- The most common medical conditions women encounter during pregnancy
- Is associated with:
  - Leading causes of maternal mortality
  - Higher incidence of maternal morbidity
  - Higher incidence of perinatal and neonatal morbidity
  - Later long term consequences for both mother and child

- Pregnancy offers a window of opportunity to:
  - Establish services
  - Improve health
  - Prevent intergenerational transmission no communicable diseases
FIGO recommendations

All pregnant women should be tested for hyperglycemia during pregnancy

- Universal testing
- A one-step procedure

Postpartum period as an important platform to initiate early preventive health for mother and offspring who are both at higher risk of:

- Future Obesity
- Metabolic Syndrome
- Diabetes
- Hypertension
- Cardiovascular Disorders
The Strength of FIGO

➤ Commitment from FIGO
➤ Strong Partnerships with International Organizations
➤ 130 National Member Associations
➤ FIGO Perinatal involvement

• HIP Initiative Working Group (M. Hod)
• Good Clinical Practice in MFM Working Group (GC Di Renzo)
• Care of Mothers and Infants during labor and Delivery (R. Romero)
• Safe Motherhood and Newborn Health Committee (G. Visser)
• Adolescent, Pre-conception and Maternal Nutrition (M. Hanson)
Call to action!

Disseminate!
Share the FIGO guidelines and infographics with your colleagues

Advocate!
Talk to policy makers and government representatives about the need to highlight HIP

Collaborate!
Join with other professional societies to ensure improved testing, diagnosis and care for women with HIP
Thank you for listening

See: www.figo.org

Read the recommendations: http://www.figo.org/figo-project-publications

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