MINUTES of the GENERAL ASSEMBLY of UPIGO

FLORENCE 24-25 October 2022

The General Assembly of the International Professional Union of Gynaecologists and Obstetricians (UPIGO) was finally held in Florence, Italy, from 24 to 25 October 2022, to the great satisfaction of its members, after being interrupted for several years due to the corona virus pandemic. The meeting was attended by delegates from the following member countries: France, Italy, Greece, Mali, Mauritania, Central African Republic.

Two midwives from Mali were also present.

After welcoming the participants, the host of the meeting, Prof Piero Francisco TROPEA, was delighted to welcome them to the National Library of Florence, which is a symbol for the city.

A round-table presentation by the participants, who in turn described the current challenges and the situation of their profession in their respective countries.

The presentation of the scientific programme by Prof Guy SCHLAEDER was adopted and included the following five scientific themes:

1- Maternal mortality in sub-Saharan Africa by Abdoulaye SEPOU

2- Reasons for inflation in caesarean section rates by Cherif AKLADIOS

3- Training midwives in Sub-Saharan Africa in basic obstetric ultrasound by Moustapha TOURÉ

4- Cervical cancer prevention in France by Prof. Jean-Jacques BALDAUF)

5- Birth rooms in Florence by Marco SANTINI

6 A brief history of UPIGO by Guy SCHLAEDER

A social programme involving a visit to the National Library of Florence was proposed by the meeting's host, Prof TROPEA.

PRESENTATION OF THE THEMES

Theme I: THE PROBLEM OF MATERNAL MORTALITY IN SUB-SAHARAN AFRICA by Abdoulaye SEPOU

Since the 1987 Nairobi international conference on safe motherhood, the international community has become aware of the seriousness of maternal mortality worldwide, especially in developing countries.

According to the WHO, 287,000 women died worldwide in 2020 as a result of complications during pregnancy, childbirth or the postnatal period. Nearly 70% (200.000) of these deaths occur in sub-Saharan Africa. That is the equivalent for subsahian Africa of two planes full of 275 young women crashing every day.

Comparing mortality rates in different regions of the world helps us to understand the scale of the problem.

- World: 211 deaths per 100,000 live births
- Sub-Saharan Africa: 542
- North Africa: 112
- Central and South Asia: 151
- Latin America and the Caribbean: 73
- North America: 18
- Europe: 10
- Australia and New Zealand: 7

The main causes of death are as follows

- Health infrastructure and technic
- The lack of nursing staff
- The population (accessibility, participation in the care process)
- The social environment

The main complications, which account for 75% of all maternal deaths, are as follows:

- - severe haemorrhage (mainly after childbirth)
  - infections (usually after childbirth)
  - hypertension during pregnancy (pre-eclampsia and eclampsia)
  - HIV complications

- clandestine abortions

All these causes can be avoided if the staff providing the care are qualified, have the therapeutic resources and make the diagnosis in time in a population that has had access to health training.

PROPOSED SOLUTIONS

- strengthening national capacities in the field of maternal health
- preventing unwanted pregnancies
- management of obstetric emergencies
- reproductive health commodity security (RHCS)
- mobilising resources to combat maternal mortality
- pacified socio-political climate

Conclusion

Implementing these proposals should help to reduce maternal mortality in countries south of the Sahara.

To achieve this, the commitment of each and every one of us is required.

Theme II: WHY IS THE CAESAREAN SECTION RATE INCREASING? is the caesarean section rate increasing? By Cherif AKLADIOS, Jean-Jacques BALDAUF and Bruno LANGER

As a reminder, the recommended WHO rate is 15% and 20% in France.

After a presentation of the global situation regarding caesarean section rates, we looked at the situation in Europe, where there are variations ranging from 39% in Italy to 17% in Sweden, before focusing on the situation in France, where there has been an increase from 10.9% in 1981 to 21.7% in 2010. However, there are variations between regions in France-

Why is the rate constantly rising?

- well-honed technique
- change in target population
- definition of the expansion phase to be reviewed

- medico-legal issues and patient consent in special situations: breech, twin, scar uterus, macrosomia
- elective caesarean section 10% in France

Other causes:

- reduced competence of birth attendants
- convenience in scheduling the day of birth
- higher income in the case of caesarean section
- fear of vaginal delivery

Conclusion

The caesarean section rate is increasing. This situation can be explained by the changing profile of patients and a fear of litigation in the event of problems with the vaginal route.

Caesarean section: less risky

Obstetrics has become more cautious. The comfort of being able to plan the day of the birth, higher incomes for doctors and private clinics in the event of a caesarean section.

The fear of vaginal birth in some countries needs to be reconsidered.

The medical and legal aspects of elective induction and caesarean sections should be taken into account.

Given this excessively high rate, regular and accurate assessment could improve our practice.

Theme III: TRAINING MIDWIVES FROM SUB_SAHARAN AFRICA UN BASIC OBSTETRIC ULTRASOUN by Moustapha TOURÉ

This is a project initiated by the International Professional Union of Gynaecologists and Obstetricians (UPIGO) for midwives in Burkina Faso, Central African Republic, Equatorial Guinea, Mali, Mauritania and Chad.

The aim is to train these key reproductive health personnel in basic obstetric ultrasound in order to help reduce maternal and neonatal mortality. Around twenty midwives are involved in this project.

The training will take place in Bamako by UPIGO trainers in partnership with the Malian Society of Obstetrics and Gynaecology, under the sponsorship of the Fondation Amadou Toure pour l'Enfance. It will last one month, with a one-week theoretical phase and a three-week practical phase in university hospitals, the Centre Hospitalier Mère Enfant le Luxembourg in Bamako and several large private polyclinics.

The first group to have benefited from this training of trainers will be called upon to pass on the skills and knowledge they have acquired to colleagues based on certain geographical criteria.

A specific ultrasound report booklet and an activity monitoring register will be drawn up for the implementation of the activities.

Contacts have been established through the Fondation ATT pour l'Enfance with partners of the World Islamic League/Saudi Arabia to finance the project.

At the end of the presentation, the participants welcomed the project. Prof TROPEA emphasised the medico-legal aspect of the practice of ultrasound scanning by midwives in Africa. The clarifications on the type of activity, which does not concern morphological studies, a source of medico-legal conflict, were reassuring.

Prof Guy Schlaeder stressed the need to record the main clinical data relating to pregnancy, childbirth, the post-natal period and the condition of the newborn. Among other things, this will enable us to assess the relevance of our project at a later date. Proposal deemed relevant by participants.

The process indicated with precise directives for the submission of the project in an English version is in progress. The request will be addressed to the League of Muslims of Africa in Jeddah (Mr Omar Mahdi H. Wadi adviser on urgent relief Kingdom of Saudi Arabia PO BOX 14 843 Tel ; 966 532 792 698) The Secretary General is responsible for drawing up the document in consultation with the other members of UPIGO, which will be sent to the address indicated under the signature of the President of UPIGO by the Fondation pour l'Enfance.

UPIGO will be making further requests to the European Union, the UNFPA and UNICEF Regional Office for West and Central Africa and the WHO for funding for the project. Initiator: International Professional Union of Gynecologists and Obstetricians. (UPIGO).and Gynecology

Summary: Ultrasound Training for sub-Saharan African midwives

PARTNER : Fondation Amadou Toumani TOURE pour l'Enfance (FPE), Mali

Addressed countries:

- Mali
- Mauritania
- Burkina Faso
- Chad
- Central African Republic
- Equatorial Guinea

Public Target: 20 midwives (2 per country and 10 for Mali)

Duration: 1 month, i.e., 1 week of theoretical teaching and 3 weeks of practice

Theoretical training: Malian society of Gynaecology and Obstetrics (SOMAGO) and UPIGO

Practical training University hospital centers and private clinics: SOMAGO

Site of training: Bamako, Mali

Year: 2023

Theme IV: CERVICAL CANCER PREVENTION IN FRANCE by Prof. Jean-Jacques BALDAUF

Department of Gynaecology and Obstetrics; Hautepierre Hospital; Strasbourg University Hospitals, 67098 Strasbourg Cedex, France.

Introduction

The natural history of cervical cancer makes it particularly accessible to screening. The time taken for precancerous lesions to progress to invasive lesions is generally long, making it possible to repeat screening examinations at sufficiently frequent intervals to discover and treat these lesions effectively in order to prevent cancer.

Persistent infection of the cervical mucosa with human papillomavirus (HPV) is a necessary condition for the development of cervical cancer and its precancerous lesions. A prophylactic vaccination has been developed that induces the production of neutralising antibodies directed against the viral capsid of the two types of HPV responsible for at least 70% of cervical cancers. Under optimal conditions, this vaccination is almost 100% effective in preventing HPV infection and its consequences, making it a primary prevention measure for cervical cancer and its precursor lesions.

Screening: a highly effective secondary prevention measure

The absence of screening is the major risk factor for cervical cancer in all countries. Experts at the WHO and the International Agency against Cancer agree that the best remedy against cancer is to organise screening by inviting women to take part.

The cervical smear remains the reference method for cervical cancer screening. It's a simple, inexpensive and completely safe test, whose overall specificity of over 95% is its strong point, avoiding expensive and anxiety-provoking diagnostic tests and even over-treatment in the event of a false-positive test. Screening is recommended for women aged 25 to 65, and is repeated every three years after two negative smear tests one year apart. In 2019, two major changes will be introduced in France. National organisation in line with European recommendations and the use of the HPV test from the age of 30 as a replacement for the smear test.

A report on the state of play in France published by Santé Public France on 24 January 2022 shows that 59% of French women aged 25-65 were screened during the period 2018-2020, up 1% on 2018. This figure is far from the target coverage of 70%, and coverage is only 45% for women aged 60-65.

Conversely, the HPV test has been well integrated into the screening system, accounting for 65% of screenings carried out in the first 6 months of 2021. However, the regional screening centres responsible for organising the programme are not yet able to follow up positive results properly, with only 12.6% of results available on average.

ANTI-HPV vaccination: a preventive measure to complement screening.

The aim of prophylactic vaccination is to prevent infection by inducing neutralising antibodies against the L1 proteins of the viral capsid of HPV viruses. The most widely used vaccine in the world is the non-avalent vaccine targeting 2 types of HPV responsible for 90% of condylomatous lesions and 7 types of oncogenic HPV involved in 92% of cervical cancers, as well as carcinogenesis of the vagina, vulva, anus, penis and ENT.

The French health authorities have opted for a programme based on a doctor's prescription, so that the decision to vaccinate is taken with full responsibility and respect for individual convictions. As a result, this vaccination is neither organised nor practised in schools, unlike in many countries around the world.

Since March 2007, this vaccination has been the subject of several recommendations for use, the latest of which suggests vaccinating girls and boys aged between 14 and 19. Vaccination coverage remains sub-optimal, with barely 40% of girls having received the full schedule by the age of 19. This figure is one of the lowest in Europe. It can be explained by fears of side-effects and controversy linked to clinical observations, without any relevant scientific analysis confirming a real "cause and effect relationship".

Currently: the HPV vaccine is recommended for girls and boys between the ages of 11 and 14. Later vaccination is possible up to the age of 19 as part of catch-up vaccination. The vaccine can be given on the same day as other vaccines.

Questions about the safety and tolerability of these two vaccines are a legitimate concern for patients, their parents, healthcare professionals and the country's health authorities. Thanks to worldwide pharmacovigilance of more than 130 countries and territories that have introduced HPV vaccination into their national immunisation programmes since 2006, and of more than 370 million doses distributed over a period of more than 12 years, the safety profile of this vaccine is well established.

Conclusions

For maximum effectiveness, young girls should be vaccinated before any HPV infection occurs (this vaccination is not curative), and in accordance with the vaccination schedule (3 doses in 6 months). Screening remains essential, even in vaccinated patients, because of the risk of cervical cancers linked to HPV types

not targeted by the vaccines or to infection pre-existing the vaccination. Optimal implementation of the complementary nature of screening and vaccination should result in a 98% reduction in the individual risk of cervical cancer.

Theme V: BIRTH CENTER IN FLORENCE by Marco SANTINI

Birth Center are places where pregnancy, birth and postnatal care is provided by midwives and from which women are transferred to consultant-led units when complications occur.

BC for low-risk pregnancies Large maternity wards have to give answers to this specific needs of privacy, self-empowerment, wellness in birth experience.

Our answer is the “Daisy Project.”

BC with its daisy shaped two floor building, linked to the Ob/Gyn Dept. Where a team of midwives, Ob/Gyn consultants and a psychological support unit, collaborate in a more personal care program.

Space management

The main idea is to offer an homogeneous perinatal low risk pregnancy path.

On the ground floor there are counselling facilities, obstetricians’ office (from 36 w.), breast feeding support, after birth support, neonatology office, cocooning pool, meeting room.

On the first floor there are five birth rooms, each for a 60 h stay: a Midwives’ Led Unit specific attention to a personal and deeper dimension of birth.

The team Midwives, psychologist, ob/gyn; consultants, neonatologist, dietitians, physiotherapist, water trainer

Gold standard, safety, and wellness

In the Anglo-Saxon world the aspect of economic efficiency of BC due to lower costs for deliveries, as opposed to those in large Consultant Led Units, is very much taken into account.

The issue of unnecessary medical assistance in physiology must be approached from the woman's experience point of view.

With "La Margherita" we suggest a model aimed at complementarity in the name of safety and the possibility for each woman to get a better birth experience.

Difficulties, obstacles:
Meticulous work during the consultations intended for the selection of women at low risk.
The management of unforeseeable complications in the absence of the doctor during labor a transfer to the medicalized delivery room of the Obstetrics department of the CHU, 30 m. away from the birth center.

Relatively slow patient turnover. The number of places (5 labour rooms) in relation to the large number of requests and the current length of stay (48 hours after delivery).

Conclusion

A multidisciplinary cultural project aimed at promoting physiology during pregnancy, childbirth, assistance and support for expectant couples. a place dedicated to the extension of the physiology and the personalization of obstetrical care. An architectural project that values the aspirations and experiences of the pregnant woman in particular and of the couple in general an opportunity to develop integrated professional skills in the field of obstetrics, to transform them and to reinvest them in training and in new projects.

Theme VI: UPIGO: a brief history by Guy SCHLAEDER

The Union Professionnelle Internationale des Gynécologues et Obstétriciens - UPIGO - was founded in Paris in 1953. A few months later, in 1954, FIGO was founded in Geneva. In the minds of its founders, UPIGO was the professional counterpart to FIGO, whose aims were primarily scientific.

While FIGO very quickly expanded worldwide, UPIGO for a long time limited its activities to Europe.

From the outset, well before the Treaty of Rome, UPIGO was a fervent supporter of European unification. It devoted itself to setting in motion the new Europe of gynaecology and played a key role in the creation of the European Union of Medical Specialists or UEMS. Of the 13 founding members, 6 were gynaecologists.

UPIGO was the first international organisation to deal with the harmonisation of specialist training in Europe. Two commissions set up by UPIGO drew up the first European recommendations for the training of obstetrician-gynaecologists in Debrecen in 1995.

UPIGO is recognised by the Council of Europe as an INGO - non-governmental organisation - and enjoys participatory status. As such, it has been involved in a number of parliamentary reports on sexuality, health prevention and equal access to healthcare.

UPIGO's geographical territory, long limited to Europe, was extended to Africa at the Marrakech General Assembly in 2001. Several African countries belonging to SAGO - Société Africaine de Gynécologie-Obstétrique - are members of UPIGO. Mali, Mauritania and the Central African Republic are particularly active partners. UPIGO was thus made aware of the problems of maternal mortality, which is particularly high in the sub-Saharan region. The central theme of the Union's last General Assembly, in Florence in 2022, was the use of ultrasound by African midwives to improve the quality of their care.

Report from the Secretary General

After a disruption to our activities due to the COVID-19 pandemic, we are pleased to be holding our General Assembly in this beautiful city of Florence.

UPIGO's main objective over the last few years has been to train midwives from some French-speaking West African countries (Burkina Faso - Mauritania - Mali and Central Africa (Central African Republic - Chad plus Equatorial Guinea in the pipeline) in basic obstetric ultrasound.

Several contacts have been made in the search for funding, notably with the European Union and the United Nations Mission in Mali, without success.

We are continuing to explore other avenues with the Fondation Amadou Toumani Toure pour l'Enfance (of the late former president of Mali, Amadou Toumani Toure), which is currently run by his wife, a midwife by profession.

During a humanitarian mission by a Saudi NGO to Bamako in November, through the FPE, we had discussions about our project with the adviser in charge of emergencies, Mr Omar Mahdi H.Wadi adviser on urgent Relief Kingdom of Saudi Arabia PO box 14843 Jeddah 21434 Email smar.mahdi@themwix.org mobile +966 12 6512333. During this meeting, we were told to follow the procedures for

sending our project dossier via the Fondation pour l'Enfance to the above-mentioned address.

The dossier must include:

1 the receipt for the creation of UPIGO and SAGO of the SOMAGO??? and other partners

2 a presentation of these learned societies with their activity reports (at least for the last year)

3 a presentation of the main players (trainers),

4 the agreement of the midwifery associations of the countries concerned by the training

4 translation of documents into English (request)

Correspondence will be sent to the associations / order and association of midwives in the countries concerned.

A letter from the association at sub-regional level should be studied to facilitate procedures.

We propose that the President of UPIGO contacts the WHO, UNICEF and UNFPA regional offices for West and Central Africa, the Malian Ministry of Health and Social Development and other potential partners for support with this project.

NB: The proposed training programme was drawn up with the Chairman of SOMAGO.

As part of our future activities, and in view of the current constraints on obtaining visas for participants from Africa, we are proposing to organise (if these constraints still exist) the next General Assembly in Africa, and to combine it with ultrasound training for midwives, if the funding conditions are met.

Visa procedures can be started early to remove these constraints.

We suggest to invite young doctors and midwives from the host countries to help revitalise the association by attracting young members.

UPIGO should also look into finding a sponsor to pay for the travel expenses of African participants.

Consideration will be given to these proposals.

STATUTORY GENERAL ASSEMBLY

The Treasurer presented UPIGO's accounts, which had been approved by the General Meeting. The accounts were balanced. A call for subscriptions was made, again using the usual rates for each country: Mali 400€, Mauritania 400€, Central African Republic 400€, Greece 950€, France 2800€.

The meeting voted to renew the members of the executive committee, which is now as follows:

President: Prof TROPEA Piero Francesco (Italy) replacing Prof Chionis ending his mandate

Vice-president: Prof Aissata BAL (Mauritania) replacing Prof TROPEA ending his mandate

Past-president : Athanasios CHIONIS (Greece)

Treasurer in charge of relations with Africa: Prof Guy SCHLAEDER (France) reappointed

Secretary general: Prof Moustapha Toure (Mali) reappointed

Scientific advisor: Prof Jean Jacques Baldauf (France)

To discuss and promote the participation of Africans at the 2023 General Assembly, we decided to hold an extraordinary meeting of the Bureau by ZOOM on 10.3.23 and took the following decisions:

Date of the 2023 General Assembly: 6 and 7 October 2023, a few days before FIGO, which will be held from 9 to 12 October.

Venue: Paris.

Preliminary scientific programme:

1. Update on the ultrasound training project for African midwives by Moustapha Touré
2. The reaction of African midwives to the arrival of ultrasound, with a survey in several South Sahelian African countries by Aissata BAL
3. Women's expectations for their delivery (in Africa by SEPOU, in Europe by Santini) and medico-legal aspect by TROPEA.

4. Gynaecological contributions

   Endometriosis by Nesrin Varol from Australia, proposed by Moustapha Touré with the collaboration of Baldauf and Akladios from Strasbourg (invitation accepted by Dr Nesrin Varol).

   Polycystic ovary syndrome by Athanasios CHIONIS.

   In addition, we propose to accept free papers to encourage young colleagues to attend the AGM of the UPIGO and to become better acquainted with our work.

Moustapha proposed that **Aissata BAL**, **Abdoulaye SEPOU and himself should find out about the participation of colleagues in FIGO in their respective countries and contact them with a view to their participation in the UPIGO General Assembly**.

We would like to thank Prof. SCHLAEDER for his constant commitment to the work of UPIGO.

The General Assembly congratulated the past president for his contribution to UPIGO during his term of office.

The General Meeting congratulated the new President on his election.

The social programme included a visit to Florence's prestigious library, which has a rich history.

A festive dinner crowned the end of our stay in Florence.

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