Menopause

- Addressing perceptions of HT
- Osteoporosis forum follow-up
- Canadian Menopause Coalition update

pages 10 and 11
UN thanks Dr. Lalonde for commitment to women’s health

SOGC executive vice-president Dr. André Lalonde recently received a personal letter of recognition from UN secretary general Mr. Ban Ki-moon. The secretary general thanked Dr. Lalonde for his efforts in 2009 and 2010 to improve the health of women in low-resource countries, with particular reference to the many volunteer hours Dr. Lalonde spent preparing for the June G8 meeting in Canada and the September UN Declaration on the Global Strategy for Women’s and Children’s Health in New York.

Dr. Lalonde has worked with a committee over the last two years developing strategies and lobbying governments and the international community for a renewed commitment to women’s health. Dr. Dorothy Shaw of UBC, a past president of both the SOGC and FIGO, joined this group as well and was a key contributor to these efforts, leading to a global commitment of $32 billion toward maternal, newborn and child health in low-resource countries.

Dr. Lalonde is honoured to receive this recognition, and will continue to fight for women’s health at home and abroad. He thanks the SOGC members and staff who made this possible.

New resources

Launch of Pap testing website for patients

The Society of Canadian Colposcopists (SCC) is pleased to announce the launch of a new patient education website, www.paptestinfo.ca. The focus of this website is on Pap testing and what abnormal test results mean for Canadian women.

The website has four sections, for women who are having a Pap test, who have received abnormal results, have been referred to a specialist or who need to undergo treatment.

The address of the French language site is www.infotestpap.ca.

The SCC executive would appreciate any comments or feedback on the website; these can be directed to Judy Scrivener, national coordinator, at jsrivener@sogc.com.

SOGC 2009-2010 annual report

The Society’s 2009-2010 annual report is now available online in English and French, covering the reporting period from July 2009 to June 2010. Visit www.sogc.org to view the document.

Upcoming clinical practice guidelines

Below is a tentative schedule for upcoming guidelines that will be published by the SOGC. Please note that the publication dates listed are subject to change. All guidelines are published in the Journal of Obstetrics and Gynaecology Canada (JOGC) and are available on the Society’s website, www.sogc.org.

December
- Returning Birth to Aboriginal, Rural, and Remote Communities
- Oral Contraceptives and the Risk of Venous Thromboembolism: An Update

January
- Genetic Considerations for a Woman’s Pre-conception Evaluation

RN/NP MEMBERS IN MANITOBA AND SASKATCHEWAN: We need your voice!

The SOGC’s RN/NP Advisory Committee has a vacancy for a representative from the central region. If you would like to be considered for this opportunity, and ensure the concerns and accolades of the Registered Nurses and Nurse Practitioners in central Canada are heard, please submit a short bio and letter of interest to Janet Walker, chair of the committee, at jwalker@phsa.ca.

A personal email to eligible members will also be sent inviting you to apply.
After a year of relief efforts in Haiti, our help is still needed…

By Dr. André Lalonde,
SOGC Executive Vice-President

Thanks to the SOGC’s Mothers and Newborns of Haiti Donation Campaign, the Croix-des-Bouquets Maternity Centre has seen incredible progress over the past year. Renovations of the second floor are completed and the centre is now accommodating 235 births each month, along with provision of family planning and neonatal services.

Yet despite this progress, our Haitian colleagues continue to struggle as reconstruction efforts in their country are set back due to the recent cholera outbreak, the controversial election campaign, security concerns and ongoing tropical storms. With increasing demand for services at the centre, the strain on staff and resources intensifies.

Our partners in Haiti have recently contacted the SOGC to express their need for additional equipment and materials. The SOGC is reviewing the possibility of sending the requested supplies and remains committed to providing long-term support to ensure that the Croix-des-Bouquets Maternity Centre has adequate means to provide quality health services to its community.

On January 12, the anniversary of this tragic event, let us reflect on the devastating misfortune that our colleagues and friends have endured over the past year and be reminded of the importance of providing continuous support to those less fortunate. We have seen that great progress is possible and we should celebrate the impact our contributions have had thus far.

The SOGC has provided detailed situation reports every month to keep members informed on the progress at Croix-des-Bouquets. Visit http://iwhp.sogc.org to read the latest update reports and to learn more about the ongoing needs identified by our partners.

Donations to the Mothers and Newborns of Haiti Donation Campaign can be made online via the Canadian Foundation for Women’s Health: visit www.cfwh.org.

An ultrasound machine, recently donated by the SOGC, is delivered to the Croix-des-Bouquets Maternity Centre.
Ixtapa, Mexico, Las Brisas Resort
February 28 – March 4, 2011

International CME Program – Update in Obstetrics and Gynaecology

Make learning a breeze
Visit our website @ www.sogc.org

This CME Program is offered in English.

West/Central CME Program
Update in Obstetrics and Gynaecology

In association with the Alberta Society of Obstetricians and Gynaecologists (ASOG)
March 24–26, 2011
Fairmont Chateau Lake Louise, Alberta

Hotel Reservations
Fairmont room: $219 single occupancy and $229 double occupancy
Fairmont Lakeview or Deluxe: $269 single occupancy and $279 double occupancy
Reserve before Friday, February 18, 2011
Tel: 1-800-441-1414
Group code: SOGC

This CME Program is offered in English.
### Upcoming meetings

**SOGC meetings**
- **International CME Program:** Update in Obstetrics and Gynaecology  
  February 28 – March 4, 2011  
  Ixtapa, Mexico
- **West/Central CME Program:** Update in Obstetrics and Gynaecology  
  March 24–26, 2011  
  Lake Louise, AB
- **Ontario CME Program:** Update in Gynaecology and Mature Women’s Health  
  April 14–15, 2011  
  Toronto, ON
- **67th Annual Clinical Meeting**  
  June 21–25, 2011  
  Vancouver, BC

### Program schedule

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<thead>
<tr>
<th>Location</th>
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<tr>
<td>Lake Louise, AB</td>
<td>March 27-28, 2011</td>
<td>(in conjunction with the West/Central CME Program)</td>
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<tr>
<td>Toronto, ON</td>
<td>April 16-17, 2011</td>
<td>(in conjunction with the Ontario CME Program)</td>
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<td>Toronto, ON – Instructor’s Course</td>
<td>April 18, 2011</td>
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<tr>
<td>Vancouver, BC</td>
<td>June 19-20, 2011</td>
<td>(in conjunction with the Annual Clinical Meeting)</td>
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### Other meetings

- **1st World Congress of Obstetrics, Gynaecology and Andrology**  
  Queen Elizabeth II Conference Centre, London, UK  
  March 20 to 23, 2011  
- **8th Singapore International Congress of Obstetrics and Gynaecology 2011**  
  Raffles City Convention Centre, Singapore  
  August 24 to 27, 2011  

### New fellowship in female pelvic medicine and reconstructive surgery

St. Paul’s Hospital, in partnership with UBC, has developed the Fellowship in Female Pelvic Medicine and Reconstructive Surgery. This is the first interdisciplinary urology and ob-gyn fellowship training program in Canada. The two- to three-year postgraduate program will train doctors in the evolving subspecialty of urogynaecology, female urology and ano-rectal disorders.

For more information on the Fellowship in Female Pelvic Medicine and Reconstructive Surgery, please call 604-682-8206.

### Don’t forget...

Thank you to the over 2000 members who have already renewed their memberships for the new year! As well, over 60 per cent of you used the SOGC’s online renewal system.

Not one of those people? Don’t let your membership lapse. **The deadline to renew** and guarantee the benefits of being an SOGC member for 2011 — including subscription to the JOGC and discounts on CME events — is **February 28, 2011**.

Go to [www.sogc.org](http://www.sogc.org) and log into the members section to renew online.

### Welcome, new members

The SOGC is pleased to welcome some of the newest members to our society:

**Associate member (Health-care):** Mrs. Juliette Le Roy; Dr. Joelle Malenfant

**Junior member:** Dr. Eman Ahme Ahsayegh; Dr. Abdulrahman Alserri; Dr. Ashley Gilman; Dr. Radomir Jarcevic; Dr. Elena Tamarkina

**Junior member (FP):** Dr. Allison Tanya; Dr. Kalene Adamus; Dr. Marie-Eve Boulais; Dr. Claire Kenny-Scherber; Dr. Diana Silva

**Associate member (FP):** Dr. Amy Megyesi

**Associate member (RM):** Mrs. Sandra Demontigny, RM; Ms. Isabelle Gelineau, RM; Mrs. Marie-Paule Lanthier, RM; Mrs. Valerie Leuchtmann

**Ob/Gyn member:** Dr. Caroline Beliveau; Dr. Peter Cheung Sui Leung

**Associate member (RN-NP):** Mrs. Manon Bordeleau; Mrs. Anne Boudreault; Ms. Jaclyn Puksa; Mrs. Linh Quach

**Associate member (Students in health-care training):** Mr. Andrew Ah-Seng; Ms. Catherine Bleau; Ms. Marianne Eleonore Caisissie; Ms. Elizabeth Chertkow; Ms. Stacy N. Cormack; Ms. Julie Ellsworth; Ms. Katrina Krakowski; Marie-Eve Murray; Ms. Christie Nichols; Miss Sabrina Piedimonte; Mrs. Melanie White
SOGC member Dr. Peter von Dadelszen is the principal investigator for a $7 million dollar Bill & Melinda Gates Foundation grant to UBC, to lead a global project related to pre-eclampsia, entitled PRE-EMPT (PRE-eclampsia – Eclampsia Monitoring, Prevention and Treatment).

The hypertensive disorders of pregnancy complicate five to 10 per cent of pregnancies and lead to serious maternal illness or death. Pre-eclampsia is the second leading cause of maternal death worldwide, and results in 63,000 to 76,000 maternal deaths each year, the majority of which are in low- and middle-income countries. Pre-eclampsia-related maternal deaths result primarily from delays in diagnosis, triage, transport, and treatment.

The PRE-EMPT initiative consists of five inter-related projects to be conducted over four years. The primary foci are three community and primary health centre level intervention studies tailored to low- and middle-income country settings. The secondary foci are developing a multifaceted international research collaboration and pre-eclampsia knowledge translation activities oriented to low- and middle-income countries. Reducing the maternal and perinatal consequences of pre-eclampsia is the overarching theme of this initiative, and the PRE-EMPT team aims to determine the impact of this research program on those outcomes, rather than solely the powerful surrogate of pre-eclampsia diagnosis. The projects will occur in low- and middle-income countries, predominately in South Asia and Africa.

Pre- and early-pregnancy calcium supplementation

The first study will be a placebo-controlled randomized controlled trial of pre-pregnancy and early pregnancy calcium supplementation in women with low calcium intake who are at high risk for pre-eclampsia in their next pregnancy. The goal of this South African and Zimbabwean trial is to determine whether or not pre- and early-pregnancy calcium supplementation prevents both the diagnosis and consequences of pre-eclampsia.

Accelerating triage and transport to facilities

The purpose of the second study will be to develop and validate the miniPIERS (Pre-eclampsia Integrated Estimate of Risk) and genPIERS models, as well as to externally validate the fullPIERS model in seven low- and middle-income centres. MiniPIERS is solely symptom- and sign-based, and configured for use in resource-restrained settings. GenPIERS will include, in addition to symptoms and signs, those few laboratory tests used in all participating centres. The miniPIERS and genPIERS models should aid in case identification, diagnosis, and risk stratification, thereby, accelerating triage and transport to facilities where women will receive effective and evidence-based treatment. This effective care will avert the adverse maternal and perinatal consequences of pre-eclampsia.

Reducing adverse maternal and peri-natal outcomes

The third study will prepare for a bold international multicentre cluster randomized control trial, called CLIP (Community Level Interventions for Pre-eclampsia). CLIP will test the impact of a community-level package of care to reduce adverse maternal and peri-natal outcomes related to pre-eclampsia. The CLIP package will be tailored to different levels of care. For community health workers, the package will include miniPIERS screening, diagnostic and triage tools, a loading dose of oral labetalol to treat severe hypertension, and a loading dose of MgSO4 to prevent seizures of eclampsia in women with severe hypertension or to treat seizures in women with eclampsia. Women diagnosed with either pre-eclampsia or eclampsia will be transferred to the nearest primary health centre or hospital. The same package will be available at primary health centres, to be administered by nurses, midwives or medical officers (loading doses not repeated if already administered).

Establishing international ties and facilitating knowledge translation

Our secondary foci will be establishing an international ‘CoLaboratory’ and promoting knowledge translation. The CoLaboratory will bring together investigators to share quality pregnancy cohort and other clinical data and carefully collected biological samples for collaborative studies, to facilitate new knowledge generation. As well, data and biomarker acquisition tools common to the entire PRE-EMPT project will be established. The knowledge translation group will update the WHO hypertensive disorders of pregnancy guidelines.

The net goal of PRE-EMPT will be a reduction in maternal and peri-natal mortality and a lasting improvement in maternal and child health.

There are a number of international collaborators involved in leading this project, including Dr. Jim Roberts (University of Pittsburgh), Dr. Justus Hofmeyr (University of the Witwatersrand and Fort Hare), Dr. Matthews Mathai (World Health Organization) and Dr. Zulfiqar Bhutta (Aga Khan University).

For more information, please contact SOGC member Dr. Diane Sawchuck, project director, at dsawchuck@phsa.ca.
Salutations à tous! Greetings to all!

Another academic year has started, following great summer festivities in Montréal, and our program is going through many exciting changes.

First of all, we would like to warmly welcome our new program director, Dr. Vincent Ponette, who is a recent addition to the maternal-fetal medicine group at the Royal Victoria Hospital (RVH). Born and raised in Belgium, Dr. Ponette travelled the world before settling in Montréal for his undergraduate studies. He is a recent graduate of our own residency program and MFM fellowship. Dr. Ponette has already voiced his fascinating vision for a new formal and hands-on teaching curriculum. His new monthly OSCE sessions and MCQ exams, and efforts for a more structured teaching curriculum as well as stronger laparoscopic surgical training, are much appreciated. Confidence in Dr. Ponette is high.

Nevertheless, all residents were sad to watch our beloved Dr. Krishnamurthy step down from the program director position after four dedicated years, to take on the position of chief of gynaecology at the RVH. His interactive teaching sessions, excellent guidance in the operating room and mentorship has and will continue to make us meticulous surgeons and compassionate doctors. We wish Dr. Krishnamurthy the best of luck in his challenging new position!

This smooth leadership transition was celebrated at our end-of-year dinner in June at Hotel Nelligan in Old Montréal, along with the graduation of our final-year residents.

To Berenice, Geneviève, Mousa and Sparky: congratulations on passing your Royal College exams with flying colors and starting new and exciting chapters of your careers. We will all miss you very much and wish you luck with your future endeavours!

This academic year started with the Annual Welcome BBQ at Beaver Lake on Mount Royal to initiate our new PGY-1s to the exciting world of McGill obstetrics and gynaecology. We welcome our newest residents to our growing family and look forward to getting to know you and your families.

We would also like to highlight the arrival of Sandra Celani as the new residency training program coordinator. She will join Mabel and Diane in the teaching office to make a great team! Her enthusiasm and organization are already infectious.

Last year was filled with several great additions to our staff. A special welcome to Dr. Violaine Marcoux and Dr. Lisa Merovitz, who will improve our exposure to minimally invasive surgery and to Dr. Amira El-Messidi, MFM, who is a very dedicated teacher to all of our R5s for exam preparation! The gyné-oncology team has grown with the much-appreciated arrival of Dr. Denis Querleu and Dr. Chris Jardon from France, who will join our advanced laparoscopy team.

Congratulations to Dr. Fady Mansour who just got married and to both Dr. Sarah Ghazali and Dr. Karen Buzaglo who recently delivered beautiful baby boys!

We certainly look forward to this coming year, which is sure to be exciting - filled with surgeries and deliveries, as well as journal club, holiday parties, popular 5 à 7s and the annual retreat! Good luck to all CARMS candidates – we look forward to meeting you this winter!
**UNIVERSITY UPDATE:**
Memorial University

*By Dr. Rosa Magalios*

It’s been a busy year here at Memorial. Congratulations to Dr. Erin Mayo on her recent wedding and huge congratulations to our latest graduates! Deanna Murphy is now doing her fellowship in reproductive endocrinology and infertility in Ottawa. Jennifer Mercer is a generalist in Grand Falls-Windsor. Our three PGY-5s are deep in the books — we know they’ll do great next spring. And, we now have a total of 20 residents in ob-gyn at Memorial University, after welcoming five new residents this summer — four PGY-1s as well as a resident transferred into our program at the PGY-2 level.

Academically, our program continues to evolve and our program director, Dr. Atamjit Gill, has been working with the residents to address needs. Our rotations outside of St. John’s are now well established. We do a two-month community block each year from PGY-3 to PGY-5. Our current locations are Fredericton and Grand Falls-Windsor, but within the next year or so we will also be incorporating Corner Brook as a new PGY-3 site. Year after year, our residents find these rotations to be a huge asset, especially with regards to OR training, both laparoscopically and otherwise. We continue to have dry-lab training for laparoscopic skills as well as pig labs twice per year. Journal club is well attended each month — we are lucky to be treated to a delicious meal each time as we learn!

Residents at the PGY-1 and -2 levels are now participating in Principles of Surgery. The first group will be writing their exam this year: good luck to each of them. Another noteworthy change to our program is the splitting of the Saturday and Sunday call into two shifts per day. It’s made weekend call much more tolerable for everyone. With regards to electives, this year’s residents are working within Canada but many also have upcoming international electives. Speaking of international health, Dr. Elias Bartellas has just returned from Haiti and presented a lecture on the challenges he faced while working there in the aftermath of the earthquake.

But, it’s not all work here in Newfoundland, and we’ve been finding ways to unwind as well. This year our resident retreat theme was ‘Physician Well Being’, a very important topic. It was the first year that we were able to arrange for all residents to be relieved of call duties; the staff had a backup person on call if needed. It was a fantastic weekend of yoga, golf, tasty food, lectures and a whole lot of dancing. We also had a fantastic turnout of residents at this year’s SOGC ACM in Montréal. After long days of learning, we explored and embraced the city! We are excited and proud that Memorial University was awarded the award for the Medical Student Program. Residents at the PGY-1 and -2 levels are now participating in Principles of Surgery. The first group will be writing their exam this year: good luck to each of them. Another noteworthy change to our program is the splitting of the Saturday and Sunday call into two shifts per day. It’s made weekend call much more tolerable for everyone. With regards to electives, this year’s residents are working within Canada but many also have upcoming international electives. Speaking of international health, Dr. Elias Bartellas has just returned from Haiti and presented a lecture on the challenges he faced while working there in the aftermath of the earthquake.

Beginning this month, the *Journal of Obstetrics and Gynaecology Canada (JOGC)* will feature on its back page visual art created by its audience. The journal’s editorial board has approved an initial 12-month run for this initiative, entitled The Healing Art.

“Our goal is simply to allow our colleagues a venue in which they may express their artistic visions in an inviting and open-minded space,” says Dr. John Jarrell, who spearheaded this project and chairs the newly-formed Art Review Committee.

Both skilled amateurs and professional artists are invited to share some of their own work with other readers. Drawings, etchings, paintings, photographs, weavings, murals, sculptural works or other pieces of visual art submissions are welcome. Selections will be made by the Art Review Committee, with the aid of professional consultation.

If your interest goes beyond appreciating the creativity of others and you would like to submit your own representative art, please email art@jogc.com. An image should be sent in a jpg, tif, or gif file and your description of the piece and how the work might have a special meaning for you should be provided. The last page is required by restrictions in the print issue to be black and white, but colour images will be available in the online version of the journal.

Check out the January issue of the JOGC to see the first featured piece of art, created by Dr. Ed Hughes, a fertility specialist at McMaster University. More information on The Healing Art can be found in the issue’s guest editorial, written by the Art Review Committee.
Sensible approach to prenatal and postpartum/breastfeeding supplementation

- Supported by a complete product monograph
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During the fall, the SOGC was actively engaged with media, responding to misleading coverage that perpetuates incorrect assumptions about the risks and benefits of hormone therapy for the treatment of menopause symptoms. We have been proactive because we continue to see, in clinical practices and in our Menopause Public Forums, distressed symptomatic menopausal women being denied or choosing to avoid hormone therapy because of these negative media reports which implicate menopausal hormone therapy as a causative factor for breast cancer. They have fuelled an incorrect, pre-existing misperception about personal levels of risk related to hormone therapy use.

These erroneous reports fly in the face of scientific evidence. Indeed, reports from the most recent North American Menopause Society meeting in Chicago indicate that there was a statistically significant reduction in mortality, and a positive benefit to risk ratio, for women started on hormone therapy in the first decade after onset of menopause when data from the two Women’s Health Initiative hormone therapy trials were pooled. (These findings only relate to hard clinical endpoints and do not address the well-established quality of life benefits for symptomatic women.)

But rather than reporting this important observation, the media has latched on to a recent publication which cites a slightly increased risk of breast cancer detection and mortality in women assigned to combined estrogen and progestin therapy. The increased detection of breast cancer in women on combined estrogen and progestin therapy (but not estrogen alone where breast cancers were fewer in women compliant with estrogen therapy) has been known since 2002. The level of increase with combined estrogen / progestin therapy was small (defined as a “rare” risk according to the World Health Organization’s CIOMS classification of adverse events) with 8 additional cases of breast cancer detected among 10,000 women using combined hormone therapy. Approximately 25 to 30 per cent of women with a breast cancer diagnosis will succumb to the disease. The most recent report from the WHI states that breast cancer accounted for 2.6 deaths /10,000 combined hormone users and 1.3 of 10,000 women assigned to placebo. So in fact, the actual difference was 1.3 additional deaths per 10,000 women.

The SOGC supports efforts to reduce breast cancer and has advocated for this cause for years. Unfortunately, it is becoming increasingly clear that misguided, yet effective, advocacy programs, combined with a media preoccupation with the breast cancer issue, has distorted women’s perceptions of their true risk for this disease.

A high profile example of this misguided advocacy: Marg Helgenberger, actress on the popular TV series CSI, recently did a short ad for breast cancer awareness which aired during 60 Minutes (October 24, 2010). In the ad she said: “I’ll tell you what is a crime; 1 in 8 women will get breast cancer this year.” Nothing could be further from the truth! Unfortunately, this 1 in 8 number has been misused so much that people forget what it refers to . . . the cumulative lifetime risk to age 85 if a woman does not succumb to other diseases first.

The reality is that cardiovascular diseases are much more likely to account for death and disease. For example, in the decade between age 50 and 59, deaths from breast cancer affect 5 women of 1,000 while 55 will die from other causes; between 60 and 69, breast cancer deaths affect 7 of 1,000 while 126 die from other causes. This disparity is further accentuated in succeeding decades (70-79: per 1,000 women, 9 deaths due to breast cancer versus 309 from other causes; 80-89: per 1,000 women, 11 deaths due to breast cancer versus 670 from other causes). Survey data show that women consistently overestimate their personal breast cancer risk and underestimate the impact of cardiovascular disease.

Where does the SOGC stand as 2010 draws to a close? Women and their physicians have been made fearful of menopausal hormone therapy to the extent that many distressed symptomatic menopausal women continue to suffer because they do not know the facts. The SOGC is promoting high quality reproductive health care for Canadian women and remains committed to careful and ongoing evaluation of research evidence upon which prudent clinical decisions can be made.

*For reference, please visit www.sogc.org.

To keep the true risks of breast cancer in perspective, women and their health-care providers need to consider three things:

First, the increased risk of breast cancer in users of combined hormone therapy is approximately the same as the risk of breast cancer that women accept when they consume alcohol, fail to exercise regularly, or become overweight after menopause. The risk associated with combined hormone therapy is actually lower than the breast cancer risk that results from a late first pregnancy (after age 30) or failure to breastfeed.

Second, when considering the usefulness of any medical treatment, it is essential to have an informed consideration of both the benefits and the risks of treatment. Aspirin, which is widely used for prevention and treatment of coronary artery disease, is thought to have a positive benefit to risk profile even though it is estimated to account for 2 cases of hemorrhagic stroke/10,000 users (of whom 1/3 will die) and gastrointestinal bleeding in 500-1,000 of every 10,000 users (with 150-200 cases where bleeding is life threatening).

Third, unbalanced information in the media about hormone therapy has led many health-care providers to abandon this approach to management of menopausal symptoms in favour of untested and largely ineffective complementary and alternative therapies. Symptomatic women have, for the most part, remained dissatisfied and prescriptions for selective serotonin reuptake inhibitors in Canada have soared as hormone therapy prescriptions fell after 2002.
November was Osteoporosis Month in Canada, and the SOGC marked the occasion with a series of four public forums in Quebec and Ontario. One in four Canadian women will be diagnosed with osteoporosis and many are largely unaware of the risk they have for developing this devastating disease.

“With an aging population, prevention and early detection are key to quality of life after age 50,” said Dr. Vyta Senikas, Associate Executive Vice-President of the SOGC. “The SOGC is committed to raising awareness about osteoporosis in peri-menopausal and post-menopausal women so they know what to do to stay healthier longer.”

Preventing Osteoporosis
the goal of public forums

Forums were held in Mississauga and Oshawa, presented by Dr. Donna Fedorkow; in Ottawa, presented by Dr. Elaine Jolly; and in Montréal, presented by Dr. Michel Fortier. The presentations were developed by a panel of SOGC experts to address a lay audience, with handouts and info sheets provided for participants to take home. The presentation is also available for download in French and English on the menopauseandu.ca website.

With the success of the first four public forums, the SOGC is proposing an additional eight forums be held across the country in 2011. Details will be posted on the SOGC website, as well as menopauseandu.ca, as locations are confirmed.

Patient education about midlife health and beyond will be front and centre on the 2011 work plans of the Canadian Menopause Coalition. Members met in November to report on their respective successes over the past year and brainstorm on priorities for the year ahead.

There are currently 16 national and provincial organizations participating in the coalition. Thirteen members were able to meet at the face-to-face meeting held in Ottawa, chaired by Dr. Michel Fortier, who sits as an SOGC representative on the coalition.

Members were asked to identify key results areas (KRAs) under four themes:
- Rural and remote women
- Public education
- Continuing medical education
- Lifestyle and wellness

After participating in breakout sessions, groups put forward KRAs for each theme, plus tactics that could be used to achieve results. A clear message surfaced within each theme: misinformation about menopause health and wellness is rampant in the media and the general public, as well as in various health professional communities. The coalition believes that women are not being well-served by many current sources of information, and working together, they have a role to play to help ensure women have the information they need to make good decisions about their health care.

The Canadian Menopause Coalition is currently in the process of confirming their action plan for 2011. For more information about the work of the coalition, and a complete list of members, go to www.canadianmenopausecoalition.ca.
Since 2006, the SOGC has taken on the role of mentor for FIGO’s Saving Mothers and Newborns initiative in five low-resource countries. These projects aim to build and sustain the capacity of ob-gyn and midwife societies in low-resource settings to implement safe motherhood projects in their communities. One country in particular, Uruguay, has achieved remarkable success.

This Uruguay FIGO project, entitled *To protect the life and health of Uruguayan women by reducing unsafe abortions*, set out to reduce the number of abortions performed under conditions of risk in Uruguay, in order to reduce maternal morbidity and mortality associated with abortion, and to implement a sustainable model at the national level for reducing the number of abortions performed under these conditions. Through FIGO’s twinning mechanism, the SOGC’s Dr. André Lalonde was appointed mentor for this project and provided support to both the Uruguayan Gynecological Society and the Uruguayan Midwives Association.

Dr. Lalonde has been intimately involved with the Uruguay project and team since its initiation. He recently visited Uruguay to attend the closing celebration of the FIGO project, where he shared a panel with the president of Uruguay, José Mujica, along with the minister of public health, Daniel Olesker, and professor Leonel Briozzo. The success of the project was celebrated widely, with extensive media coverage resonating the president’s message throughout the country: “We need to face the problems head on and take actions to save the lives of more women.”

Abortion has remained illegal in Uruguay since the 1938 Uruguayan Constitution was enacted. Under this restriction, health providers were legally obliged to report women who had undergone an abortion to the authorities for punishment by jail sentence. Clearly, this resulted in severe consequences, not only for the women, but for establishing relationships of trust between health-care providers and patients. It is a well-known fact that women with unwanted pregnancies seek to abort whether safely or not and whether legal or not. As is the case in any country, it is the poorest, least educated women who are most likely to seek an abortion in unsafe conditions, and risk their lives in so doing.

To address the high rates of deaths secondary to unsafe abortions in Uruguay, a group of concerned ob-gyns, midwives, anthropologists, psychologists and academics formed an NGO called *Iniciativas Sanitarias* (IS), designing a new strategy for reducing unsafe abortions based on a human rights approach. Rather than addressing abortion’s illegality, the IS group has lobbied for ethical patient treatment and has established a model of care delivery which emphasizes private counseling and women’s empowerment, to allow each woman to be aware of the consequences of unsafe abortion and to have the necessary information to make an informed decision. Women who were certain of their choice to abort were encouraged to self-administer misoprostol rather than resort to clandestine services.

After testing this model at one hospital over a period of 15 months and obtaining very positive results, the Uruguayan Gynecological Society submitted a proposal to FIGO’s Saving Mothers and Newborns initiative to replicate and scale up the IS model to eight additional health facilities, with the aim of reaching 70 per cent of the Uruguayan population, especially families of low socioeconomic status. Before accepting the project proposal, Dr. Lalonde, representing FIGO, insisted on the inclusion of the Uruguayan Midwives Association as a partner. After negotiating this condition and accepting the collaborative approach, the project was launched in September 2006.

With support from FIGO, the IS model has now been rolled out in a total of eight health centres in Uruguay. According to Dr. Lalonde, “the project has achieved its goal and is completely sustainable.” Indeed, the Uruguay FIGO project has not only achieved its set goals and objectives, but has surpassed expectations and achieved exceptional results. After the project came to an end in August 2010, a consulting firm was hired to evaluate
the project outcomes. In the final evaluation document, the consultant stated, “I have worked on improving Post-Abortion services in multiple countries where abortion is illegal but am not aware of any other strategy that can claim this success.”

Some achievements of the Uruguay FIGO project include the following:

- A change in attitude among health professionals and non professionals towards abortion, following workshops that were designed to address attitudes and prejudices, as well as to encourage mutual trust and confidentiality with patients
- Adoption of and training on the use of new guidelines and norms of practice
- Training for delivery of abortion counseling services
- Improvements to clinic infrastructure to provide complete privacy to patients
- Delivery of services to 2,717 women, including pre- and post-abortion counseling and family planning services
- Strengthened partnership between the Uruguayan Gynecological Society and Midwives Association

Among the most noteworthy results achieved is the adoption of the IS model by Uruguay’s Ministry of Health. Using a train-the-trainer technique, the Ministry of Health is currently scaling up implementation of the IS model throughout the entire country, with abortion counseling services expected to be offered in every health centre by 2011. Furthermore, lobbying on behalf of the IS group has resulted in the Uruguayan government adopting an ‘ordenanza’ (less than law but legally binding) in 2004 and subsequently passing Law 18-426 on sexual and reproductive rights in 2008, which states that women with an unwanted pregnancy who are considering abortion must be provided with pre-abortion counseling, as well as post-abortion counseling, and counseling for future pregnancy prevention by use of contraception.

The success of the Uruguay FIGO project exemplifies the need for a paradigm shift in attitudes, as well as implementation of protocols centered on harm reduction, to address the complex issue of abortion. By addressing the harm caused by dangerous abortions as a human rights and health problem rather than addressing the illegality of abortions, it has changed providers’ paternalistic, punitive attitudes and behavior towards the women who access services.

Based on the outstanding results of this project, new international efforts are underway to replicate the IS model in other low-resource countries where abortion remains illegal. As Dr. Lalonde explains, “The IS model has the potential of transforming health systems’ responses to abortions around the world and, more importantly, of influencing the attitudes of health professionals. I think all health providers can learn from Uruguay’s experience, even those working in developed countries, like Canada, where abortion laws are less stringent but women’s needs are just the same.”
Canada Endorses UN Declaration on the Rights of Indigenous People

On November 12, the federal government endorsed the United Nations Declaration on the Rights of Indigenous People. This document sets out a number of principles to guide harmonious and cooperative relationships between Indigenous peoples and States — such as equality, partnership, good faith and mutual respect.

When the Declaration was first adopted in 2007, Canada was one of four nations to abstain from its endorsement, feeling that it contained clauses that were open to interpretation concerning rights to land, territories and resources.

Canada’s new position represents an important milestone towards building and strengthening the relationship between the State and the Indigenous people that live within it.

The Society of Obstetricians and Gynaecologists of Canada is a proud supporter of the United Nations Declaration on the Rights of Indigenous People. Throughout the process that led to the endorsement of this important document, the SOGC’s Aboriginal Health Initiatives Committee was actively engaged in the persistent lobbying of the federal government, as well as actively communicating with partners, in order to form a united front in support of the Declaration.

The SOGC hopes that Canada’s commitment to uphold the principles outlined in the Declaration will help to reverse Canada’s current discriminatory policies, as well as encourage the federal government to further implement programs to improve the current health status and social determinants of the traditionally underserved Aboriginal people of Canada.

Policy statement by the Aboriginal Health Initiatives Committee: Returning Birth to Aboriginal, Rural and Remote Communities

A policy statement released by the SOGC’s Aboriginal Health Initiatives Committee on returning birth to Aboriginal, rural and remote communities was published in the December issue of the Journal of Obstetrics and Gynaecology Canada.

Through this policy statement, the committee seeks to heighten awareness of the current state of women’s health care in these remote communities, touching on topics like limited access to quality maternal care and the importance and significance of community birth in Aboriginal culture.

Currently, Aboriginal women are regularly forced to experience birth without the presence and support of family members and community. The removal of birthing support from communities jeopardizes cultural practices specific to birth that provide the mother, infant and family with a strong sense of identity, promote community cohesion and enhanced resilience, each of which contribute to overall health and well-being.

The SOGC’s position is firmly in favour of initiatives and projects promoting the return of community births for low-risk pregnancies. However, the statement is clear that certain criteria are essential to ensure the safety and success of returning birth to Aboriginal rural, and remote communities.

Doing so will require great collaborative efforts between Aboriginal women, community leaders, and health-care practitioners, both in the rural communities and at referral hospitals. The SOGC and the Aboriginal Health Initiatives Committee hope that improved partnership and communication between Aboriginal, medical and political organizations can lead to the adoption of a holistic, multidisciplinary, culturally-competent approach to birthing. We will continue to work in partnership toward an equitable future for the Aboriginal women of Canada.

For more information, please consult the December issue of the Journal of Obstetrics and Gynaecology Canada, or read the policy statement online at www.sogc.org.
Global network of SOGC members working abroad

Are you involved in international initiatives to improve women's health? The SOGC wants to hear from you! In an effort to facilitate networking and to inform SOGC members about the wide variety of international projects that their fellow members are involved in, the International Women's Health Program will be highlighting members who are working abroad in a special section of our website.

Let us know where you have been, where you are going, or what projects you are working on. Send a short description, along with a photo, to cbutt@sogc.com.

Visit the 'Get Involved' section of our website to learn more about SOGC members' work abroad: http://iwhp.sogc.org.

Celebrating Women, Health and Equality in 2011

March 8, 2011 marks the 100th anniversary of International Women's Day. To celebrate this monumental occasion, the SOGC is partnering with the White Ribbon Alliance for Safe Motherhood and the Canadian Foundation for Women's Health for a special, historic celebration. Canadians who are working in various fields related to women's health and equality will gather together for a special luncheon at the National Arts Centre in Ottawa.

Around the world on International Women's Day, millions of people will be taking part in this high level campaign to highlight efforts that improve the lives of girls and women and to celebrate the numerous achievements that have resulted from a century-long battle towards health and equality.

We have much to celebrate and also much to do to prepare for another 100 years of progress.

SOGC members are invited to take part in this special event by purchasing tickets ($100 each) via the Canadian Foundation for Women's Health. For more information about the 100th anniversary of International Women's Day and for more details about the event, visit http://iwhp.sogc.org.

Health-care professionals needed internationally

Do you want to apply your skills to international humanitarian work? NGOabroad offers customized international volunteer options and helps people enter international humanitarian work. More information can be found at www.ngoabroad.com, and applications are accepted on a rolling basis. There is currently a specific need for health-care professionals in the high Andes, various regions in Africa, and the Himalayas.

INDUSTRY NEWS

Vaccine for anal cancer?

The U.S. Food and Drug Administration's advisory committee on vaccines and related biological products has determined that evidence supports an indication for GARDASIL® [Human Papillomavirus Quadrivalent (Types 6, 11, 16, and 18) Vaccine, Recombinant] for the prevention of anal cancer and anal intraepithelial neoplasia (AIN) in both males and females nine through 26 years of age.

Provera 100 mg product discontinued

Pfizer is discontinuing production of its 100 mg Provera product. This will not affect the 2.5 mg, 5 mg and 10 mg concentrations. Pfizer will not accept the return of unexpired Provera tablets.

For additional information, please contact Pfizer's customer service at 1-800-387-4974.
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