Unbalanced Burden: Cervical cancer in low-resource countries

New project looks at screening of alcohol use in pregnancy

“My Most Memorable Case”: Read the winning entry of SOGC’s 2008 Junior Member Writing Contest

Education Summit explores future of Continuing Medical Education
A Special Thanks to Our COUNCIL MEMBERS

The SOGC would like to offer a special thank you to all of our Committee Chairs and Members who are completing their terms this year. The SOGC’s success is largely due to the contributions of its volunteers, and we thank you all for taking up the challenge, and joining us in our mandate to improve women’s health in Canada.

In particular, we wish to offer a special thank you to the following outgoing members of the SOGC Council:
- Dr. Donald Davis, Past President
- Dr. Christina Dolhaniuk, Chair, Junior Member Committee
- Dr. Michel Fortier, Vice-President
- Dr. Owen Hughes, Associate MD Representative
- Dr. Terry O’Grady, Chair, Atlantic Regional Committee

On behalf of the entire SOGC staff and membership, we wish to thank you all for your dedication and contributions to the goals and objectives of our Society.

These members will be honored at the Council Dinner on June 26, at the 2008 Annual Clinical Meeting in Calgary.

On The Cover
This month’s cover photograph depicts women walking with their children in Burkina Faso. The photo was taken in September 2007 by Dr. Michel Fortier, during the International Women’s Health Program’s first field visit to the country. The visit was to formalize a new Partnership Program with the country’s ob/gyn society, la Société des Gynécologues et Obstétriciens du Burkina (SOGOB).

Cover photo courtesy of Dr. Michel Fortier.

NOTICE TO All Voting Members

The SOGC Annual Business Meeting will be held Saturday, June 28, 2008, from 7:30 am to 8:30 am at the TELUS Convention Center.

We invite all voting members to attend this meeting. A hot breakfast will be served.

Summer HOURS

From July 1st until September 1st, the SOGC national office will be open:
- Monday to Thursday: 7:30 am until 5:00 pm
- Friday: 7:30 am until 12:00 pm

CORRECTION

The 2008 SOGC Desk Calendar, distributed to SOGC Members, includes a small error relating to the 20th Quebec CME, which will be hosted Oct. 2-4 at the Fairmont Tremblant hotel in Mont Tremblant, Quebec. On the entries for the dates Oct. 2nd, 3rd, and 4th, the calendar incorrectly lists the event as being hosted in Quebec City. The SOGC apologizes for any confusion this may cause.
The G8 needs to do more to stop six million MOTHERS AND CHILDREN DYING

By Dr. André B. Lalonde
Executive Vice-President, SOGC

For many years, SOGC and its members have been very concerned about the lack of progress and commitment from the world’s richest countries to reduce maternal and newborn mortality and morbidity worldwide. While we have seen some progress in a few countries, the situation for much of sub-Saharan Africa has continued to deteriorate over the past decade.

Global action is needed to secure adequate funding to develop a policy that will encourage human resource development and retention in the Developing World. In April, the Partnership for Maternal, Newborn, and Child Health (PMNCH) issued a statement calling on G8 leaders to pledge an additional $10.2 billion dollars annually, in order to achieve the Millennium Development Goals on child deaths and maternal health. The Partnership represents the collective voice of over 240 member organizations from around the world who are working on child survival and maternal health, including the SOGC. According to Thoraya Ahmed Obaid, Executive Director of UNFPA, it would cost the world less than two-and-a-half day’s worth of military spending to save the lives of 6 million mothers, newborns and children every year.

Here in Canada, the SOGC and its members need to do more to lobby the Canadian government to increase foreign aid to the acceptable international level of 0.7 percent of GDP. From my work with the SOGC’s International Women’s Health Program, I can attest that Canada can make a difference. Our midwives, nurses, family physicians and obstetricians possess the expertise needed to save lives and effect real, positive change. We need to lobby the Canadian government and ask our leaders to work with leaders of the developed world to increase funding for projects in lower resource countries.

The frustrating reality is that we know what needs to be done to reduce maternal mortality. To many, the numbers of women and children dying may seem truly overwhelming, and that this is an impossible situation to right. As health professionals, we know that simple public health measures — the kind of things that we practice every day in our country — could make an immense difference internationally.

I am proud to say that many of my colleagues and fellow members have selflessly taken up this cause, working around the world to make pregnancy and childbirth safer. As a society, we have been pushing hard for Canadian involvement on a strategy to prevent postpartum hemorrhage, which would offer innovative, low-cost treatments that will save lives. In addition, our ALARM International Program brings necessary training to health professionals in low resource countries, focusing on the five main causes of maternal mortality: dystocia, preeclampsia, postpartum hemorrhage, sepsis and infectious disease.

But we can all do more. The SOGC is therefore requesting that each of you write to your Member of Parliament expressing your concern, and asking that Canada do a little more to reduce maternal and newborn mortality and morbidity the world over.

To learn more about the Partnership for Maternal, Newborn and Child Health, or to read their recent statement Countdown to 2015: Tracking Progress in Maternal, Newborn & Child Survival, visit www.who.int/pmnch/
Upcoming Meetings

SOGC Meetings

64th Annual Clinical Meeting
June 25–29, Calgary, Alberta

20th Quebec CME
October 2–4, Mont-Tremblant, Quebec

4th Quebec Obstetrics CME
November 13–14, Montreal, Quebec

27th Ontario CME
December 4–6, Toronto, Ontario

Program Schedule

<table>
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<tr>
<th>Location</th>
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<tr>
<td>Calgary, AB</td>
<td>June 23–24 (in conjunction with the 64th ACM)</td>
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<tr>
<td>St. John’s, NL</td>
<td>Sept. 21–22</td>
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<tr>
<td>Vancouver, BC</td>
<td>Oct. 24–25</td>
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Other Meetings


18th World Congress on Ultrasound in Obstetrics and Gynecology. Hosted August 24-28, 2008, at the Navy Pier, Chicago, USA. To register or to find out more visit www.isuog.org. For inquiries, email congress@isuog.org.

Seventh International Scientific Meeting - Royal College of Obstetricians and Gynaecologists (in conjunction with SOGC and ACOG). Hosted September 17-20, 2008, Fairmont Queen Elizabeth Hotel, Montreal, Canada. For complete details visit www.rcog2008.com
Dr. Norman Barwin Receives the Biomedical Science Ambassador Award

It was on May 7, 2008, in a room filled with accomplished and aspiring scientists, that Partners in Research celebrated 20 years of “educating and promoting understanding about the value and promise of the Canadian scientific endeavor embracing the health and natural sciences, technology, engineering and mathematics.”

It was also during this gala evening that Partners in Research awarded the Biomedical Science Ambassador Award, a prestigious honour established in 1996 to recognize individuals, both lay and scientific, for their exceptional personal contribution in advancing the understanding of, and support for, biomedical research. Recipients of the award are described as “individuals who have made stellar contributions and whose influence radiates from the strength and outreach of their personalities and commitment.”

This year, SOGC member Dr. Norman Barwin was the recipient of the award in the lay category. Presented by Dr. Jacques Bradwejn, Dean of the Faculty of Medicine at the University of Ottawa, the award acknowledged Dr. Barwin’s contributions as an outstanding fertility researcher and noted volunteer, known by many for his “long-standing selfless acts of benevolence.”

Dr. Norman Barwin was born in South Africa, and completed his medical degree at Queens University in Northern Ireland, where he also obtained his doctorate in medicine by thesis in reproductive physiology. He specialized in obstetrics and gynecology at the Royal College of Obstetricians and Gynaecologists. He was appointed associate professor of obstetrics and gynaecology at the University of Ottawa where he was voted the best clinical professor for four consecutive years. Currently in private practice, he continues to be involved in teaching and research, and is a sought after speaker in Canada and abroad. Dr. Barwin has been actively involved in several national and international health-related organizations and committees.

A member of the Order of Canada for his contribution to medicine and public education in health issues and family building, Dr. Barwin adds the Biomedical Science Ambassador Award to a number of other impressive awards including the Barbara Cass Beggs Award for Women’s Reproductive Rights; the Jansen Ortho Award for significant contribution to family planning in Canada, the Queen’s Golden Jubilee Medal, and the Canada Volunteer Award.

The SOGC is privileged to have Dr. Barwin as a member of its organization. It is with great pride that the Society attended The Ottawa Evening 2008: Embracing the Future to support and congratulate Dr. Barwin on receiving his award. His professional career has appropriately positioned him as a distinguished peer and key role model for today’s aspiring young scientists. However, Dr. Barwin actively embraces the future through his ongoing efforts and the creation of The Norman Barwin Scholarship in Women’s Health and Reproduction, a scholarship that is open to students at all Canadian universities.

Congratulations Dr. Barwin on this well-deserved award, and continued success to you!

Left to right: Dr. Norman Barwin, Ms. Sylvie Cadrin (Director – Corporate Affairs, SOGC), and Ms. Natalie Wright (Director – Communications and Public Education, SOGC) at the Partners in Research Gala, May 7, 2008. Photo compliments of Tony Alloggia.

New Members

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

Member Ob/Gyn: Dr. Hani Magdy Farag; Dr. Daniel Hugo; Dr. Maan Malouf

Junior Member: Dr. Alya Ali; Dr. Elise Dubuc; Dr. Marla Elaine Lujan; Dr. Raed Sayed Ahmed

Junior Member – Family Practice: Dr. Durya Ali; Dr. Cynthia Czaika-Fedirchuk; Dr. Pascal Gellrich; Dr. Lianne Gerber Finn; Dr. Karen Iny; Dr. Pam Kryskow; Dr. Carrie Lafournaisse; Dr. Tanis Secerbegovic; Dr. Zubaida Siddiqui; Dr. Rebecca Starpoole; Dr. Ruthanne Williams; Dr. Margo Wilson

Associate Member – MD: Dr. Christine Marie Louise Brenczmann; Dr. Vanessa Cardy; Dr. Janneke Gradstein; Dr. Catherine Gudmundson; Dr. Shannon Hamersley; Dr. Lindsay Hancock; Dr. Sharen Madden; Dr. Lynne Murfin; Dr. Veronique Pelchat; Dr. Blair D. Stanley; Dr. Hendrik Matthias Van Roc

Associate Member – Midwife: Ms. Sindy Cheung, RM; Ms. Melissa Langlais, RM

Associate Member – RN: Ms. Catriona J. Buick, RN; Mrs. Veronique Guimont, RN; Ms. Janice Lynn Liski-Skinner, RN; Julie Tashereau, RN

Associate Member – Students in Healthcare Training: Marie-Helene Auclair; Lise-Anne Bisaillon; Miss Stephanie Byrne; Miss Katherine Vanessa Cabrejo-Jones; Ms. Diana Craciunescu; Miss Paulina Cybulskia; Ms. Genevieve Gagnon; Ms. Heather Gottlieb; Pascale Guerin; Ms. Carla Holinaty; Ms. Kelsey Erin Mills; Ms. Claudia Georgina Naber; Mrs. Larissa Pawluck; Ms. Joyce Ramsay; Ms. Ruth Roon; Amelie Roy Morency; Ms. Chelsea Schemenauer; Miss Mariko Anne Shibata; Mr. David Smithson; Miss Helene Simone Weibel; Miss Andrea Weirathmueller; Mr. Ben T. Williams; Mrs. Jackie Wolting; Ms. Lyndsey Wong.
STRANGER THAN FICTION: My Most Memorable Case

By Dr. Andrea Skorenki, University of Alberta

Each year, the SOGC presents its annual Junior Member Writing Contest. This year, participants were asked to write on the topic of “Stranger than fiction!...On call experiences of this exciting field”. The SOGC received many great entries and we thank all of those who participated. Below the SOGC News is pleased to present our winning entry, submitted by Dr. Andrea Skorenki from the University of Alberta:

Early in my second year of residency I was on call in a community hospital in South Edmonton, and we received a transfer from a remote community in northern Alberta. This patient was in labour and her local hospital couldn’t handle deliveries, so she was flown down to us.

Mrs. K arrived very uncomfortable, obviously contracting, with her husband beside her looking worried. I asked all of my usual questions.

“When did your labour start?”

“This morning,” she managed between contractions.

“Has your water broken yet?”

“Nope.”

“How far along are you?”

“Don’t know.” Breathing through a contraction. “Never had regular periods”. Breath in, breath out. “Nurse measured me at 40, said I’m term.”

“Have you had an ultrasound?”

“Nope. We don’t have one at our hospital.”

I checked her cervix, and she was five centimeters dilated, about 75% effaced. I wasn’t confident about the presenting part of the baby so I brought over the bedside ultrasound machine for a quick scan. Sure enough, the baby was head down, but something wasn’t quite right. I was still learning to use the ultrasound, so finding the position of the head was more or less the limit of my skills. I was seeing something unusual right up next to the head, moving. A cord? It looked my skills. I was seeing something unusual right up for the posterior shoulder. The rest of the body slipped out easily into my hands and we suctioned, clamped and cut the cord and wrapped the baby. “It’s a boy!” I announced as the baby let out a yell. I showed him to his parents and brought him over to the warmer where the NICU team took over.

Baby B came out frank breech, right after his brother. The Staff OB delivered the baby, all the while explaining the steps of a breech delivery to me. “It’s another boy!” I called. The staff OB eased baby B’s head out and we suctioned, clamped and cut the cord. Baby B was screaming too as we handed him to the NICU team.

As we delivered the placentas we heard from the NICU team that both babies were breathing on their own, and actually looked bigger than they expected. They would need to stay in the NICU for a while, but would likely do very well. Mr. K, had left his wife’s side and was carefully trimming the babies’ umbilical cords with the NICU team. I will never forget the look on his face – nervous, shocked and elated, all at the same time.

There was a small, tentative grin sneaking onto his face and tears welling up in his eyes as he met his new baby boys.

Mrs. K arrived back from ultrasound minutes later and it was a good thing she didn’t need transfer, because she was 8cm dilated and would never have made it across town. The staff doc and I went in to talk to the Ks and explain what was happening. They were holding hands and looked scared. A few hours ago, they were flying to Edmonton for a single full term baby and now they were facing delivery of premature twins.

Within the hour, Mrs. K was fully dilated and moved to the OR for delivery. Mr. K was sitting beside her, dressed in a set of scrubs and holding her hand. Twin A was coming head first, so the staff OB let me deliver. The baby crowned, then I lowered the head for the anterior shoulder and up for the posterior shoulder. The rest of the body slipped out easily into my hands and we suctioned, clamped and cut the cord and wrapped the baby. Mr. K, had left his wife’s side and was carefully trimming the babies’ umbilical cords with the NICU team.

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RESIDENT RELAXATION
By Dr. Ariadne Daniel, University of Alberta

Is there time for residents to relax and have fun with all the demands of call, research and academia? Of course!

Ob/gyn residents across Canada have many academic, service and research components to their programs, but it is not all work. We also participate in many activities together just for fun and to bring the team closer. Here are some examples of what the residents are up to from coast to coast.

On the East Coast, after Memorial University residents analyze important papers at Journal Club, everyone gets together for dinner where they unwind and catch up with one another. This fall, their retreat included a competitive game of curling. In the hot summer months, there are informal drinks on a patio after Half Day.

The residents at the University of Sherbrooke hold a Sugar House every year to welcome the new residents. With a dedicated Social Club, each month the residents gather at a restaurant or someone’s house for dinner and camaraderie.

At the Université de Montréal, the holiday season is celebrated with Christmas parties at each of the hospital sites. There is dancing and skits by the nurses, staff and residents. In March, the annual Department Day is held during a weekend at Tremblant, with the program also paying for a little something special. Last year, residents were treated to an afternoon at a luxury spa.

What better way to welcome in the new PGY-1s than with a summer BBQ and hot tub party? The residents at Queen’s University do exactly that. But if you are second on call, watch that pager attached to your swimsuit when the water fights start! TGIF at Tango, a nearby bar, is another way they relax together after a stressful week.

At the University of Western Ontario, board games are a favourite, and residents often get together for game nights where they go head-to-head strategizing to win. At the end of the year, the residents unite to celebrate and roast their old chiefs as they transition into fellowship or staff positions.

The annual Mentorship Event at the University of Ottawa consists of a fun night including box seats at the hockey game for staff, residents and fellows. This event is a great way for everyone to bond. When the weather gets nice, a catered picnic at a staff member’s house is always a welcome treat.

Half Days become fun days at the University of Manitoba as they share the task of bringing in treats for everyone. Once a month, everyone heads out to a bar or one of the resident’s houses to unwind. You may also find them competing in a game of mini-golf or bowling.

The Christmas season is a special time for the residents at the University of Calgary, with multiple parties hosted at staff members’ homes, complete with laughter, games and refreshments. With the mountains just a short drive away, the first Friday of February is reserved for Resident Ski Day. For the entire ob/gyn department, it is an opportunity to unite the team on the slopes of Sunshine.

At the University of Alberta, residents love to gather for Christmas parties, baby showers and BBQs. The annual Research Day dinner is a highlight as the staff and residents dress up in fancy gowns or suits to say farewell to the chiefs and dance into the wee hours of the morning.

On the West Coast, staff and residents alike need to be recognized for their hard work, so the Resident Appreciation Day at UBC is always a popular event. Last year, sailing with the staff was a particularly special treat. And with the beautiful mountains nearby, the annual ski trip to Whistler is a great chance for everyone to enjoy the outdoors and build friendships.

Despite the intensity of a residency in ob/gyn, it is these fun bonding times that will make us remember these years as some of the best of our careers.

Residents at the University of Alberta enjoy some much deserved downtime.

Congratulations to the winners of our 2008 Stump the Professor competition, who will present their cases at the 2008 Annual Clinical Meeting in Calgary. Dr. Tara Singh (University of British Columbia) presented the Best Obstetrical Case, and Dr. Amanda Selk (University of Toronto) presented the Best Postpartum Case. Our two winners will present their case to our panel of experts in the field, in hopes of stump the professors. SOGC members who cannot make it to our ACM in Calgary are invited to log in to the Junior Members section of www.sogc.com in July 2008 to view the winning entries.
Royal College of Obstetricians and Gynaecologists

Setting standards to improve women’s health

7th International Scientific Meeting 2008

17 - 20 September 2008, Montréal

joint meeting with

The American College of Obstetricians and Gynecologists

Key Dates

26 June 2008

End of Reduced Rate Registration

17 - 20 September 2008

Royal College of Obstetricians and Gynaecologists

7th International Scientific Meeting

www.rcog2008.com

Congress Secretariat: RCOG 2008, c/o 4B, 50 Speirs Wharf, Port Dundas, Glasgow G4 9TH, Scotland, UK
Tel: +44 (0)141 331 0123  Fax: +44 (0)207 117 4560  E-mail: info@rcog2008.com
UNBALANCED BURDEN: Cervical Cancer in Low Resource Countries

In Canada, women who receive abnormal Pap tests can be assured that the necessary follow-up and treatment is available to detect precancerous conditions and to help prevent the onset of potentially fatal cervical cancer. The process can be inconvenient and worrisome, but without doubt it saves many lives each year. In the developing world, however, no such assurances exist. It is here that the burden of cervical cancer impacts entire communities by taking the lives of their women.

Screening is the front line in the battle against cervical cancer, but let us imagine the resources involved. An ideal screening program includes, in no particular order: good coverage of the target population, referral services, patient follow-up, adequately trained staff, the essential equipment, treatment protocols, quality control of the screening tests, timely and adequate care, effective public education and outreach campaigns, documentation, and patient notification systems. This list is to name but a few of the requisites. In low resource countries, health centers and hospitals commonly lack infrastructure, equipment, personnel, funding, resources and training. As such, these centres can often hardly serve the needs of the emergency ward. While many of the “make due” solutions discussed in this article don’t require such an extensive list of resources, one can easily respect the significant challenges involved. A holistic and preventative approach to health care, with regular check-ups and active management of primary symptoms, remains a goal even in the most well equipped and effective health care systems. In middle and low resource countries people tend to seek health care only when problems arise. In the case of cervical cancer, this means that a woman often will not seek help until the cancer has reached an advanced stage. By this point, she may require invasive surgery or radiation therapy, which are often unavailable in these countries and come with significant impacts on the woman and her family. If untreated, her cancer will typically result in an agonizing death.

Regular Pap tests? What are those?

Cervical cancer is the second most common cancer affecting women worldwide. In the year 2000 alone, 288,000 women died from cervical cancer. Over 80 percent lived in developing countries. In low resource countries it is the most common cancer affecting women, and is a significant cause of death among women. In low resource countries women are usually the primary care givers, managing the home and doing their best to provide for their children. Here, when women die, families, communities, and countries suffer. The loss of a woman has many macro and micro impacts. The youngest children are the most vulnerable, and will suffer the most. For women who are struggling to make ends meet and working to provide meals for the day, spending money on preventative check-ups is hardly a priority. In these countries, Pap tests are essentially unheard of, not to mention unaffordable.

Reasonable Solutions:

Once in a lifetime screening. Luckily, many solutions yielding significant results don’t require the aforementioned extensive list of screening program needs, and creativity along with research has indicated more simple screening methods.

The WHO estimates that one-time screening among women around the age of 40 could reduce the chance of mortality due to cervical cancer by 25 to 30 percent. When treated, it is a very successful test. The WHO recommends Pap tests every 3 years.

Death by Cervical Cancer: Long and Painful

Women suffering from advanced stage cervical cancer tend to present at hospitals and clinics reporting bleeding, pelvic pain and urinary symptoms. Even with excellent medical care, if the cancer has spread to areas outside of the reproductive zone, to other organs such as the bladder, rectum and pelvis, treatment is successful in less than five percent of cases. When untreated, the growths on the cervix enlarge, pushing through the vagina and into other areas of the body causing irregular bleeding and obstruction of the urinary tract. Women will essentially bleed to death and die from anemia and uremia. Little discussed is the pain. To die of cervical cancer, without access to medications, is excruciating. In HIV/AIDS prevalent countries, many HIV positive women are unable to combat an HPV infection, leading to an eventual death by cervical cancer, enabled by AIDS.

It is a matter of injustice to have a large part of the solution to the majority of cervical cancers presented only to the population who suffers its burden the least.

“We call on industry to provide adequate supplies of these new technologies at radically tiered prices” Global Call to Stop Cervical Cancer

The wonders of vinegar - VIA. The most recommended and accessible method of screening for cervical cancer in low resource settings is called Visual Inspection with Acetic acid (VIA). A comparatively cost effective method, this test involves swabbing the cervix with vinegar (acetic acid) which will effectively highlight differences in cell structure and absorption rates, turning the precancerous...
cells white. The health care provider can use this method without magnification, utilizing a light source and their eyes to identify a need for further investigation. Studies have been demonstrating that this is a very effective method of identifying the precursors or existence of cervical cancer, with different studies indicating that VIA is able to detect between 65 and 95 percent of cases requiring further examination. While not as in depth as a Pap test, and less effective on post menopausal women due to physiological changes, the accessibility of the VIA makes it a great solution for low resource settings. With adequate training, this test can also be performed by nurses and midwives in various locations, better ensuring that women are screened. In some cases, the VIA is conducted using a low power magnification to the procedure, indicating even more accurate results. Requiring comparatively minimal infrastructure, this low tech approach provides a great opportunity for low resource countries and countries in transition to detect cervical cancer — one step toward stopping it from needlessly taking women’s lives.

**HPV Vaccine—A Matter of Time?**

Recently, developed countries have seen the advent of the HPV vaccine, now accessible to girls and women as an effective means of preventing cervical cancer. Although not without controversy, the vaccine has been accepted as a method to protect people from cancers related to HPV. Will this vaccine trickle down and be accessible in low resource countries? Likely not without pressure on governments, institutions and pharmaceutical companies. It is a matter of injustice to have a large part of the solution to the majority of cervical cancers presented only to the population who suffers its burden the least. The vaccine is seen as one of the best and most realistic methods of preventing cervical cancer in developing countries. While building the infrastructure and capabilities for a system that could provide Pap testing and other comprehensive exams remains ideal, the vaccine would rapidly reduce the number of new cases of women contracting HPV, of which there are over a half million each year. While the vaccine works best in combination with screening, it provides an opportunity for prevention. Research is currently underway to determine the requirements and best practices for lobbying and implementing of a vaccine program in low resource countries.

**Impossible: No Way!**

While overcoming the barriers for women in low resource settings to access quality screening programs and the HPV vaccine might seem difficult under the circumstances, we must remember battles that have made significant gains when armed with justice, motivation and good planning. When antiretroviral drugs (ARV’s) were first developed and accessible in high resource countries to prolong the lives of HIV-positive people, the concept that they would be accessible for those in developing countries was considered impossible. People said the prices were too high, that the dissemination programs could not be organized effectively. There is still a long way to go to get everyone the ARVs they need, however, skeptics would never have imagined the progress gained, or the advocacy, mobilization and action by people and organizations everywhere to insist that all people have access to these life-enhancing medications. In our push to get better care for women with cervical cancer, let us remember these important lessons learned.

**Critical Context**

Understanding Women’s Sexual and Reproductive Health and Rights Internationally

Marking Ten Years of the SOGC’s International Women’s Health Program

(Continued from page 9)

Now what? What can be done?

- Governments, donors, development partners, and other stakeholders should dedicate the needed financial resources to allow life saving technologies to be accessible to all.
- Industry can provide appropriate pricing and minimize barriers in accessing new technologies.
- Raise public awareness and encourage the community to put pressure on their health care systems to make HPV vaccination available.
- The medical community can learn and educate each other and their patients about cervical cancer and its prevention as well as approve and issue guidelines about new prevention and treatment technologies.
- Foster better use of existing knowledge, resources and research for more effective partnerships and for rolling out treatment.
- Governments, health agencies and others working in the health domain can prioritize cervical cancer and dedicate the necessary resources for sustained impact.
- Civil society organizations can work in partnership to create global change and place and maintain cervical cancer on the agenda.
- Monitor and hold stakeholders accountable.

“Cervical cancer accounts for a high percentage of cancer deaths in women in Latin America and the Caribbean — as high as 49.2% in Haiti, compared with 2.5% in North America. These high rates result from problems in access and quality of services.”

Dr. Mirta Roses, Director, Pan American Health Organization / WHO-ACCP

**Resources:**

- Global Call to Stop Cervical Cancer: www.cervicalcanceraction.org
- Prevention International: www.pincc.org
- PATH: www.path.org
- International Agency for Research on Cancer: screening.iarc.fr
- RHO Cervical Cancer Prevention www.rho.org
- World Health Organization www.who.int/cancer/en/
- AVAC — HPV Watch: aidsvaccineclearinghouse.org/hpwwatch.htm
NEW HPV TOOLKIT to assist in counselling and educating

Human papillomavirus (HPV) is a hot topic in today’s health landscape. In light of persistent knowledge gaps about HPV infection, and the unfortunate controversy that has developed around school-based vaccination, it is clear that Canadians, more than ever before, need reliable and medically sound information about HPV.

The SOGC, with funding from the Public Health Agency of Canada (PHAC), is in the final stages of producing a comprehensive HPV Toolkit for educators and public health professionals as a means to educate and counsel the general public (primarily youth and their parents) on HPV, its associated diseases, and vaccination. The kit will include resources for brushing up on the most recent HPV knowledge, lesson plans, fact sheets to hand-out, interactive games for youths, video testimonials and interviews with doctors.

We are confident that this new HPV education tool will help address existing knowledge gaps.

Educators, physicians, nurses and other health professionals help parents make informed decisions about HPV vaccination. For this reason, it is paramount that we provide front-line public health professionals with science-based, objective information about HPV and vaccination. We must put the education tool directly in the hands of as many educators and public health professionals, including public health nurses, community nurses, nurse educators, teachers, sexual health educators and sexual health counselors, as possible. We must empower them to debunk myths, correct misinformation, and provide parents and teens with the information they need to make the right decisions.

For more information on this free toolkit, visit www.hpvinfo.ca/toolkit.

Vancouver Island…
the perfect climate for your future!

Obstetrician/Gynecologist
Campbell River, British Columbia

Do you want balance between your personal and professional life in a location where the outdoor living is easy? With its enviable West Coast climate, stunning natural beauty and endless recreational opportunities, Campbell River offers a quality of life second to none!

The surrounding waters of Discovery Passage are a paradise for fishing enthusiasts, boaters and ocean kayakers alike. Enjoy year-round access to our world-class golf courses and hiking and cycling. Nearby Mt. Washington Resort offers spectacular winter skiing and summer mountain biking.

Campbell River & District General Hospital (59 acute care beds and 5 closed ICU beds) provides a wide array of services to a district population of 35,000.

Campbell River has an average of 400 births per year and a Level I nursery (46 weeks or more). You will share call (1:3) with another full-time Obstetrician/Gynecologist and will complement a dynamic group of General Practitioners and Midwives providing primary care.

Specialist colleagues include: ENT, plastic, general and orthopedic surgery, anesthesiologists, pathologist, pediatrics and radiologists (on site CT).

Rural incentives for Obstetricians/Gynecologists in Campbell River include:
- 6.09% fee-for-service premium
- $6118 flat fee retention premium per annum
- Rural CME funding
- highly competitive on-call per diem
- $10,000 recruitment incentive (based on eligibility).

For more information please contact:
Brenda Warren, Leader, Physician Recruitment,
1200 Dufferin Crescent, Nanaimo, BC V9S 2B7
Tel: 250.755.7687 or fax: 250.716.7747
Email: brenda.warren@viha.ca
EDUCATION SUMMIT explores the future of CME

Members of SOGC can look forward to seeing some new innovations in CME at future SOGC events, thanks to a summit hosted in late April. From April 25-27, the SOGC invited delegates to participate in a two-and-a-half-day summit to explore the future of Continuing Medical Education (CME). The first of its kind in over a decade, the event explored innovative ways to incorporate technology and new programming ideas into the Society’s CME formula.

Delegates from membership and partner organizations were invited to participate in the event, hosted at the Grand Hotel in Toronto. The event included interactive sessions and discussions delving into the latest innovations, and included presentations by several expert speakers from the field of education. A key objective of the event was to explore new education techniques, as well as information and communication technologies that may be employed in future SOGC education events.

Participants at the event were divided into one of six groups, each exploring a unique facet of SOGC’s educational programs. The focus of these groups included: SOGC’s Annual Clinical Meeting, our regional and offshore meetings, ALARM courses, the MORE² Program, SOGC Guidelines, and one group which focused on an overview of SOGC’s education programs. Each group was tasked with exploring how these programs could evolve into the future, with a focus on identifying “user-friendly” methods for incorporating new techniques and technologies.

Feedback received from participants was overall very positive, and many interesting directions for the future of SOGC educational programs were explored. Currently, the SOGC is working on a report detailing the most promising findings of the meeting, which will be incorporated into future SOGC events, likely beginning in 2009. Stay tuned for these new innovations at our upcoming CME events.

SOGC project examines screening of alcohol use for women of child-bearing age and pregnant women

By Dr. Vyta Senikas, Associate Executive Vice-President

The SOGC recently completed a project on the screening and recording of alcohol use among women of child-bearing age and pregnant women. This one-year project, funded by the Public Health Agency of Canada (PHAC), facilitated exchange and discussions by the Fetal Alcohol Spectrum Disorder (FASD) Advisory Workgroup. This multi-stakeholder group, which included individuals with expertise in FASD, analyzed current screening tools and available recording systems and made recommendations on the most appropriate screening and recording process for implementation in the clinical setting. The information is included in the group’s consensus report tabled with the PHAC at the end of March 2008.

In the Consensus Report, the FASD Advisory Workgroup describes three levels of screening:

- **Level I screening** involves practice-based approaches that can be used by health care providers when talking to women about alcohol use, such as motivational interviewing and supportive dialogue.
- **Level II screening** includes a number of structured questionnaires that can be used with direct questioning (TLFB) or indirect/masked screening (AUDIT, BMAST / SMAST, CAGE, CRAFFT, T-ACE, TWEAK).
- **Level III screening** includes laboratory-based tools that can be used to confirm the presence of a drug, its level of exposure and determine the presence of multiple drugs.

A decision tree produced by the workgroup provides a practical guide for the screening of alcohol use in women of child-bearing age and pregnant women.

The FASD Advisory Workgroup proposed eleven recommendations to improve the screening and recording processes. A copy of the full report and decision tree is available on the SOGC website.

The SOGC recommends that a standard of care be established for effective screening and recording of pre-natal alcohol exposure and for counselling of women by front line health care providers. As such, the SOGC intends to establish Consensus Guidelines and has submitted a funding proposal to the Public Health Agency of Canada. Consensus Guidelines will be an effective tool to improve the screening process and recording process for alcohol use in women of child-bearing age and pregnant women, and intervention for all women and their families.

NEW RESOURCE

Communicating with your patient about harm

The Canadian Medical Protective Agency has introduced a new resource booklet for health professionals titled Communicating with your patients about harm: Disclosure of adverse events. The new booklet provides advice on how to communicate with your patient if an unanticipated poor clinical outcome has occurred during care, particularly when health care delivery might have contributed to the outcome.

This important reference booklet is available free of charge on the CMPA website at www cmpa-acpm.ca.
SOGC’s Aboriginal Health Initiatives represented at gathering on NORTH AMERICAN INDIGENOUS BIRTHING AND MIDWIFERY

By Marilee Nowgesic, Director of Aboriginal Health Initiatives, SOGC

As SOGC’s Director of Aboriginal Health Initiatives, I recently had the opportunity to join over 60 delegates who were invited to Washington, DC, to participate in the first ever gathering of indigenous people, federal governments and midwifery organizations. The four-day conference, hosted May 5-8, included many fantastic presenters from Canada, the United States and Mexico. The focus of the gathering was based on three objectives: to share information and promising practices; to understand the underpinnings of indigenous midwifery; and to discuss potential areas and approaches to midwifery.

You might be wondering how 60 presenters are supposed to highlight the key issues, concerns and successes for the entire Indigenous community. It was a lofty objective, but the conference used an innovative design utilizing breakout group discussions on many themes, following which the groups would bring back their recommendations to all the participants.

The conference offered a variety of presentations, plenary panel discussions, and poster presentations. Highlights included panel discussions on collaborative care and the incorporation of traditional birthing knowledge into midwifery education and practice; a comparison of midwifery systems in the U.S. and in Canada; and a sharing circle and presentation from Robbie Davis-Floyd titled “What existed, What was lost, What is Being Recaptured”.

But the fun didn’t stop there. In an effort to provide more networking and inclusion of indigenous organizations and representatives from external organizations, our evening activities included a presentation at the National Museum of the American Indian (NMAI). During a special honour ceremony, three Elders were recognized for their devotion to birthing and midwifery: Martha Greig, an Inuit Elder and Midwife; Rita Blumenstein, an Alaskan tribal doctor and midwife; and Beatrice Holy Visitor Long Dance, an Oglala midwife and member of 13 Grandmother’s society.

More than 40 presentations given at the conference will be made available from the National Aboriginal Health Organization (NAHO) website for future reference. The access will be limited to conference delegates, but SOGC will work with NAHO to share these with our members.

In a final and special roundtable discussion, participants were again invited to the museum for “Women’s Ways of Knowing: Lessons from Indigenous Midwifery Traditions”. The presenters were the three Elders and special guest, Rosa Hernández Girón, a midwife from Mexico.

Delegates from SOGC’s Aboriginal Health Initiatives Program have received several invitations to participate in the continued development of these projects in both Canada and the USA. Updates will be provided as the events unfold. Until we meet again…

COUNTDOWN TO 2015 CONFERENCE CALLS FOR MAJOR INVESTMENT IN HEALTH SERVICES TO PREVENT 10 MILLION MATERNAL AND CHILD DEATHS EACH YEAR

Provided by the Partnership for Maternal, Newborn & Child Health

On April 14, a group of international Parliamentarians, Ministers and participants of the Countdown to 2015 Conference in Cape Town, South Africa, called for scaled up investment in basic health services and human resources to reduce the preventable deaths of over 10 million children and women each year.

The call was made at the three day Countdown to 2015 conference, which was convened to assess progress in providing essential health services for women and children in the 68 developing countries which account for 97 percent of maternal and child deaths worldwide. According to the 2008 report Tracking Progress in Maternal, Newborn & Child Survival released here, few of the 68 countries are making adequate progress to reach Millennium Development Goals (MDGs) 4 and 5 on reducing maternal and child mortality.

Parliamentarians who participated in joint sessions with the Countdown Conference added their voices of support. The delegates attending the 118th Assembly of the Inter-Parliamentary Union have committed to scaled up action to reach the MDGs 4 and 5, and agreed to review progress at their next assembly to be held in Addis Ababa, Ethiopia in April 2009.

Participants in the Countdown Conference agreed to hold their next gathering in 2010, vowing to accelerate country action, monitoring of donor investments in maternal, newborn and child health and data gathering.

In a statement issued at the conference, the Ministers, Parliamentarians and conference participants committed themselves to an intensive effort to:

- Sustain and expand successful efforts to achieve high and equitable coverage of effective and high-impact interventions that save lives and improve the health of mothers and children, and thereby contribute to the fight against poverty;
- Integrate efforts to address undernutrition with broader maternal and child health strategies;

(Continued on page 16)
Don’t Miss your chance to bid on some of these great auction items at Makeover Medicine: An Evening of What to Wear, hosted Saturday, June 28th at SOGC’s 2008 Annual Clinical Meeting in Calgary

- Bottle of “Osoyoos Larose” Wine, 2005 Great Estates of the Okanagan (Approximate value $45.00)
- Ottawa Senators Tickets, 2 sets of 2 tickets, 2008-2009 Season (Approximate value $250.00 per set)
- Toronto Raptors Tickets, 2 Lower Bowl End Zone tickets for the 2008-2009 Season, (Approximate value $225.00)
- Day at the Members-only Turf Club Dining Room at Woodbine race track with Dr. Blake and Dr. De Petrillo.
- Pink Blackberry Pearl 8130 Smartphone (Value: $499.00)
- Fashion Design Council of Canada – 2 VIP passes to L’Oreal Fashion Week 2008 (with complimentary gift bag)
- Myka Necklace, earrings and bracelet (Approximate value $350.00)
- In Accessories sterling necklace, bracelet, earrings (Approximate value $365.00)
- Originals by Andrea semi-precious necklace (Approximate value $190.00)
- Karen McClintock necklace (Approximate value $328.00)
- High Fashion leather Croco fushia handbag (Approximate value $200.00)
- Chistopher Kon leather bag (Approximate value $350.00)
- Golf Town gift card (Ottawa) (Value: $100.00)
- Milestones Restaurant gift card (Ottawa) (Value: $100.00)
- Julie Dorion Painting “I see @ 6 A.M.” (Approximate value $1250.00)
- Calgary Stampeded Tickets, 4 tickets for the Calgary Stampeder owners box (Approximate value $650.00)
- Ottawa Senators Tickets, 4 100-level tickets for the Ottawa Senators vs. Toronto Maple Leafs (Approximate value $550.00)
- Lunch with the Right Honourable Joe Clark and Maureen McTeer (Rideau Club in Ottawa or the Ranchman’s Club in Calgary)
- Sea Kayaking Lessons with Dr. Scott Farrell (SOGC President-Elect)
- Country place near Fredericton Accommodates 8 people near Fredericton, NB on the St-John’s River (Mid-July to Mid-August 2008)
- One week accommodation in Tuscany, Italy
- Stay at a mountain house in the Laurentians (Approximate value $3000.00)
- Golf game at Camelot and dinner for 3 people with Dr. André Lalonde
- Lucian Matis designer dress from his fall 2008 collection (Value: $795)
- Overnight Burberry bag (Approximate value $99.00)
- Urbane Scrubs

In celebration of the tenth anniversary of the SOGC’s International Women’s Health Program (IWHP), SOGC has commissioned a painting to be used in the program’s promotional materials. The painting represents the work done by the International Women’s Health Program to improve the lives of mothers and newborns around the world. The result is a beautiful piece entitled “Givers of Life” by Métis artist Leah Dorion.

The original painting depicts a group of women and children under the light of a bright and hopeful sun, sheltered by the tree of life. Describing the imagery of the piece, Dorion said that “[T]he tree has deep roots into mother earth which is symbolic of the roots that women give their children.” At the same time, the positions of the women are reminiscent of the collaboration between individuals and organizations that form the core of the IWHP’s work.

The painting also reflects the artist’s Métis heritage, incorporating subtle beadwork and Aboriginal imagery. Combined with the representation of a global community of women, the painting is truly representative of the IWHP’s philosophies and accomplishments.

Leah is a leader in her home community of Prince Albert, Saskatchewan. She is a university and art school teacher, filmmaker, children’s book writer, academic author and community activist, who always incorporates teachings from her Métis heritage. Her work reflects the strength of women, who she believes to be “the first teachers of the next generation… passing vital knowledge for all of humanity”.

You can take a look at some other examples of Leah’s work on www.leahdorion.com. Keep an eye out for an IWHP poster featuring this beautiful work, courtesy of the IWHP and our ten year anniversary celebrations. You will also find it on the new IWHP website to be launched in mid June. For those of you attending the Annual Clinical Meeting this year, be sure to participate in our exciting Makeover Medicine evening, hosted by the Canadian Foundation for Women’s Health. At the event, another equally beautiful piece of Leah’s work will be auctioned off, and the proceeds will be used to support women’s health. Thank you, Leah!
Canada has fallen far behind other developed countries in terms of appropriate clinical care of women who are having difficulty having a child, according to an article published in May’s Journal of Obstetrics and Gynaecology Canada (JOGC).

In his article Distributive Justice and Infertility Treatment in Canada, Dr. Jeff Nisker exposes the ethical, economic and clinical implications of the very limited access to publicly funded in-vitro fertilization (IVF) in Canada. The article compares government policy and accessibility of IVF treatments here in Canada with that of European nations and Australia, and identifies the barriers that Canadian women face. The article also explains that, because most Canadian women do not have access to IVF and single embryo transfer but can sometimes afford fertility drugs, Canada is a world leader in triplets, quadruplets and higher-order multiple pregnancies.

"Only 15 percent of Canadian women who need in-vitro fertilization to conceive are able to afford the cost of IVF," says Dr. Nisker. “Canada is one of the only developed countries where IVF is not publicly funded.” Even many HMOs in the United States fund IVF.

For women who do not have access to public funding the high costs of IVF treatment can present a significant barrier.

“When you have women being excluded from something as fundamental as childbirth because of their inability to pay, it might be time to reexamine the priorities of our health system,” says Dr. Nisker.

The oft-cited alternative, adoption, can also be challenging. The costs of adopting a child can be highly prohibitive, and long waiting lists and selection criteria may prevent potential socioeconomically disadvantaged women from successfully adopting a child through International Adoption or the Children’s Aid Society.

In his article, Dr. Nisker examines the economic implications of additional funding for clinically appropriate in-vitro fertilization. He believes public funding of IVF and single embryo transfer would save the provinces money by offsetting the costs of caring for twins, triplets and higher-order multiple births that result from the use of fertility drugs. As these children are often born very prematurely, extremely high costs for neonatal intensive care and for the long-term support of any physical and cognitive problems commonly ensue. Dr. Nisker argues that by providing public funding for IVF, these costs could be avoided.

Dr. Nisker’s article, Distributive Justice and Infertility Treatment in Canada, appears in the May 2008 issue of the Journal of Obstetrics and Gynaecology Canada (JOGC).