FEMM Fertility Education + Medical Management

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- Women need a Mulligan
- The path that Reproductive Health has wandered needs to back up and start over
- A Do-Over
- Women deserve it
- FEMM will provide it

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What do I mean?

Let’s look at what women wanted
and what they were given…

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Throughout history, with respect to reproductive health, women have desired:

- Menstrual relief
- Infertility treatment
- Child spacing
- Safe childbirth

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What have we given them?

- Suppressive therapy
- IVF
- Contraceptive technology
- Safe abortion

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- If that is what women received, what makes me think they wanted something different?
- Why do women want a Mulligan?
  - Because they are not getting the full range of choices
- What we all want is freedom
- To be free is to have choices

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Why were women's choices limited?

The Big Bang Theory of the 1950's

Safe abortion = Safe childbirth

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History of advancements in reproductive health

- 1930's ovulation, progesterone, rhythm
- 1940's antibiotics, surgery, blood
- 1950's population control, oral progesterone, ovulation method, infertility treatment, FDA approval of progestin for cycle/sab
- 1960's FDA approval of progestin for contraception
- 1970's legal abortion (failed contraception), IVF

Began the study of reproductive health with quest for understanding, emerged with new set of diseases

- Menses
- Fertility
- Pregnancy

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- Why a Mulligan?
  - Menses, fertility and pregnancy are not diseases
  - Women need choices that do not treat them as such
  - What if that “ovulation method” did not have to compete with the fabulously profitable drug, IVF and abortion industry?
  - Would women’s choices be different?

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Are women happy with their choices?

- STD's
- Single parenthood
- Unplanned pregnancy
- Suppressive treatments
- Abortion as the solution to safe motherhood

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Let’s go back 50 years ago to that fork in the road.

Research could explore corrective interventions

- Women would be given the choice to
  - Understand her fertile cycle vs. Manipulate her fertility

Her choices would be increased

Let’s be pro-choice…

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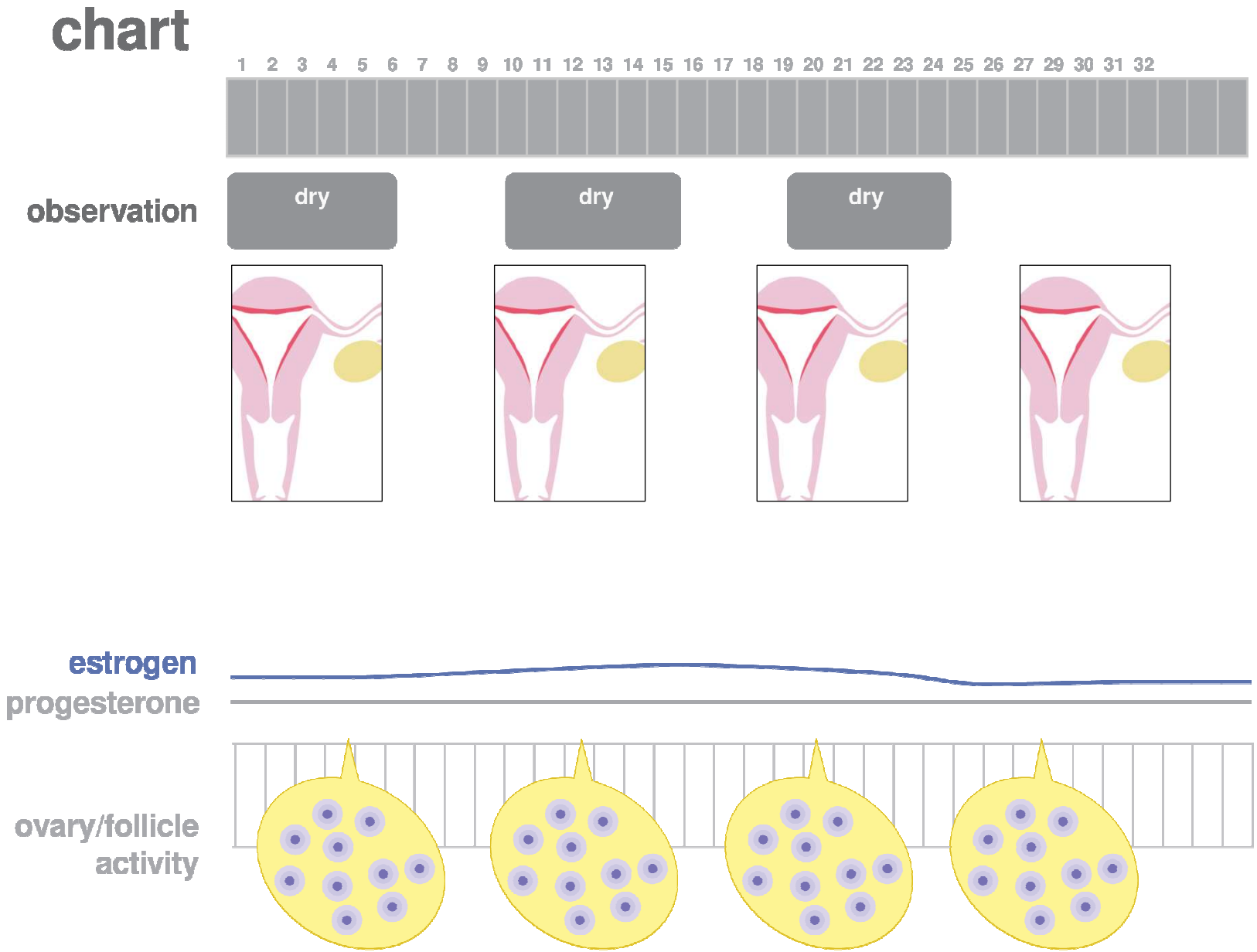

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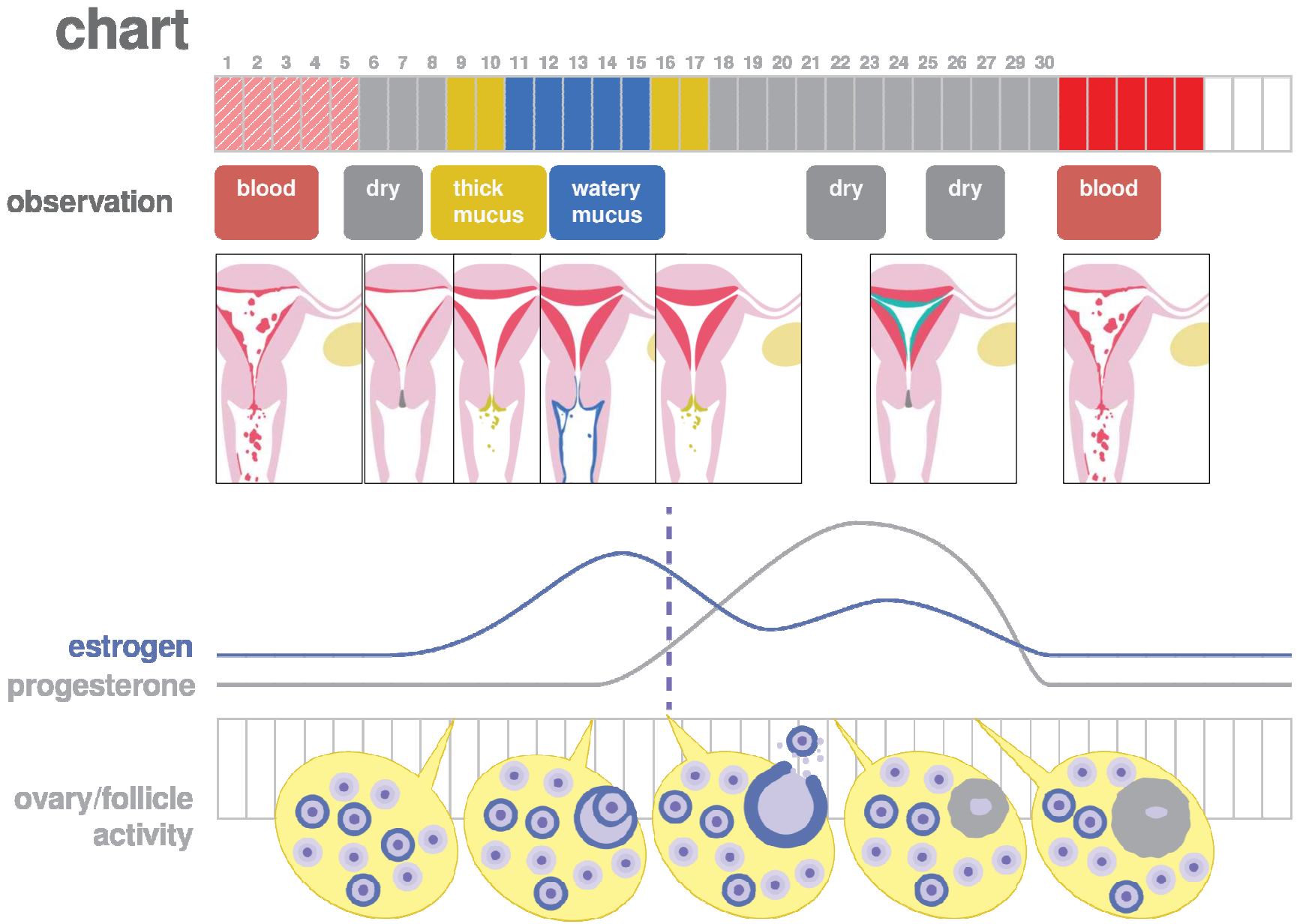

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- Women should understand their fertility
- Doctors should understand women's fertility
- What a powerful tool their observations can be to their health maintenance
- Consider what we would know today if 50 years ago women began to understand and record their cycles

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- Would women looking to control their fertility still utilize the pill, choose to use an IUD or undergo a tubal ligation?
- Would doctors still treat irregular menses with ovulation suppression?
- They would know their alternative
- Today, they do not
  - Choice is being denied
  - Women deserve better

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- FEMM will teach women
- FEMM will collect the data
- FEMM will empower women and their physicians with choices that for 50 years have not been mainstream treatment options
- FEMM is built on the science without the bias
- Women will be aware of choices that can alter their relationships and their health
- Choices that at present are being offered only in a limited fashion

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- Why were women's choices limited
  - The Big Bang Theory of the 1950's
  - Safe abortion = Safe childbirth

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- Safe abortion is not the solution
- History has shown us this

Maternal Health Care--Why?

- Childbirth is a natural process
- Pregnancy is not a disease
- Why does the health care system need to get involved?

Natural Childbirth does not always go well

Women die during this
“natural” process

Maternal Mortality Ratio (MMR)

- Defined as the # of maternal deaths for a given number of births
- Typically MMR= # maternal deaths / 100,000 births

“Natural” Childbirth (Unattended)

1000 mothers die for every 100,000 children born

MMR=1000

1000/100,000=1/100=1%

What if my town had a MMR of 1000?

- That would mean 1% of mothers would die in childbirth per year
- Our community has about 2000 babies per year
- That would mean 20 mothers would die in Huntington NY every year from childbirth

What is the MMR in the USA?

- It's 10
- Not 1000
- It's 100 times less than what "nature" would produce
- Why?
- Women in childbirth are attended by someone who knows what to do

In 2010 do that many women really still die in childbirth?

Yes!

- WHO statistics indicate that 14 countries have MMR in excess of 1000
- Indiana had a group that had a MMR of 872 by avoiding all pregnancy care
- Women can die in the natural process of giving birth and if left unattended, 1% will
- In Chad it is said that “A women with child has one foot in the grave”

Why do women die in childbirth?

- Obstructed labor
- Infection
- Bleeding
- High blood pressure

When do women die?

- Window of vulnerability
- Most maternal, and for that matter newborn deaths, take place during the week of birth
- Lead to the expression “The gates of heaven stay open 7 days for a women in childbirth”

Historically, how have we reduced maternal deaths?

Trained and equipped maternal health care workers

Phase One

- Educate midwives
- Midwives educate their patients

Example of Phase One
Sweden

- 1850 Sweden, England and the USA had similar MMR of 600-800
- 1900 Sweden had reduced their MMR to 200, despite being economically disadvantaged
- Sustained the differential in MMR for the next 30 years

How did Sweden do it?

- Identified why women die
- Trained midwives to deal with these problems, in the field
- Did not build hospitals
- Did not require patients to go to the city to deliver
- Yet, were very successful

So MMR could go to 200 with Phase One: Education

- MMR= 200
- USA MMR is about 10
- Most of the developed world has MMR below 60
- Better education?
- No, Phase two

Phase Two Technology

- Give educated midwives and doctors equipment
- Antibiotics for infections
- Medicine to prevent bleeding
- Transfusion capability
- Forceps and vacuums for obstructed labor
- Medicine and induction capacity for hypertensive disease
- Operating rooms for cesarean sections

Modern Maternal Health Care

- Cared enough to ask the question, “Why and when are women dying”
- Applied that understanding: Phase I, education
- Proved it worked, evidence based
- Make it better: Phase II, apply technology
- Prove it again

Modern Maternal Health Care Versus Unattended Childbirth

- Unattended childbirth has a MMR of 1000, rate of 1 maternal death per 100 births
- Attended childbirth, by a trained attendant, has a MMR of 200, rate of 1 maternal death per 500 births (Phase One)
- Attended, equipped childbirth has a MMR of 50, rate of 1 maternal death per 2000 births (Phase Two)

Maternal Health Care
Why?

- Childbirth is a natural process
- Pregnancy is not a disease
- Why does the health care system need to get involved?
- Because we can prevent many maternal deaths
- Don’t forget the baby and the fact that many problems produce disability, not only death

What Good Maternal Health Looks Like

Practice and Theory

Case Study: Mary's Labor

- Mary has been in labor all day
- The baby is "not coming"
- What will happen?

Mary's Labor Unattended

- Continues to bear down
- Experiences multiple internal exams
- Nothing changes
- Path to stillborn, fistula, ruptured uterus, infection, hemorrhage, death

Mary's Labor Attended

- Mary's midwife has been monitoring her labor
- Drains bladder
- Allows her to rest and re-hydrate
- Changes position
- Facilitates delivery
- Resuscitates newborn
- Mother and baby survive

Case Study: Theresa's Labor

- Theresa has just delivered a healthy baby girl
- Thirty minutes later she is still bleeding, not real heavy, but persistent
- What should she do?

Theresa's Labor Unattended

- She is told to walk
- She is given a tea to drink
- She will slowly bleed to death

Theresa's Labor Attended

- Theresa's midwife delivered the baby
- After delivery of the baby, the placenta is expected
- When it does not arrive and bleeding begins, the placenta is removed
- The uterus is messaged
- Mother and baby survive

Case Study: Elizabeth's Pregnancy

- Elizabeth has a bad headache and is very swollen
- Her husband is very worried as she looks "ill"
- What should he do for his wife?

Elizabeth's Pregnancy Unattended

- Elizabeth is given a strong tea
- She is then placed in a "hot hut" to sweat out the extra fluid that is making her swell and be "ill"
- Historically, she was felt to have a toxin in her body and treatments focused on removing the toxin (leaches, blood letting, purging, etc.)
- If you do nothing, the next day she has a fit, begins to bleed, and soon after has a prolonged fit and dies

Elizabeth's Pregnancy Attended

- Elizabeth is brought to the midwife
- High blood pressure is found
- She is given medicine and sent to the health center
- Upon arrive at the health center her labor is induced
- Mother and baby survive

Difference?
Attended versus Unattended

Sounds too Simple

Why do women die in childbirth?

- Obstructed labor
- Infection
- Bleeding
- High blood pressure

Why Do Women Still Die in Childbirth?

Lack of Family Planning?

No!

- MMR fell in Sweden and other countries that educated midwives by 1900
- MMR fell throughout the developed world when educated heath workers were given the proper tools, this happened by 1960
- Contraception did not hit the market until after 1960

Why Do Women Still Die in Childbirth?

Unsafe Abortion?

No!

- MMR fell in Sweden and other countries that educated midwives by 1900
- MMR fell throughout the developed world when educated heath workers were given the proper tools, this happened by 1960
- Abortion on demand did not become prevalent until 1970

Maternal Health

- Life affirming
- Person centered
- Evidence based

We Know What to Do!

- History has given us a roadmap
- Current best practices offers many alternative approaches to care
- Many models achieve excellent MMR
- Success in the future will occur for the same reason it did in the past, because the focus was on the life and dignity of a mother and her unborn child

Remember

If we do nothing 1 out of 100 births will end in tragedy.

Thank You

Questions?

Obstructed Labor

- Common, not just women with epidurals
- Labor is a balance between powers, passage and passenger
- In obstruction there is a mismatch between the passage and the passenger
- Root cause of many maternal conditions: stillbirth, infection, hemorrhage, ruptured uterus and obstetric fistula
- Treatment is anything that will address the mismatch: position change, instrumental delivery and c-section

Obstetric Fistula

- Prolonged obstructed labor
- Pressure necrosis
- Marker for maternal health system in need

Infection

- Uterus is sterile
- Vagina is not
- Risk factors are length of labor, number of exams
- Prior to understanding of infectious disease was leading cause, by far, of maternal death
- Treatment is prevention and antibiotics

Hemmorhage

- Uterus grows in pregnancy
- Blood volume expands to accommodate
- Need iron
- At delivery have the extra blood to lose
- Placenta separates, uterus contracts and bleeding is controlled
- Whatever prevents the seperation and contraction leads to excessive bleeding

Hypertensive Disorders

- Unknown cause
- Treatment is the removal of the placenta
- Untreated, vaso-spasm leads to multiple organ failure
- Stabilize and deliver

Abortion

- “Unnatural”
- Will always have risk: infection and bleeding
- Not the same as a spontaneous abortion
- How is it part of motherhood programs?

Traditional Birth Attendant
TBA

- Culture
- Economic
- Role in a maternal health system