Abstracts

Innovations in the Management of Premenstrual Syndrome

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Many women of reproductive age experience dysphoria and physi- cal symptoms approximately 2 weeks before menstruation. These physical and psychological complaints, associated with the luteal phase of the menstrual cycle and typically resolving with the onset of menstruation, are defined as premenstrual syndrome (PMS). The pathogenesis of PMS is complex and likely multifactorial. What treatment options does current evidence support, and what are promising emerging therapies? *Selective serotonin reuptake inhibitors*: Expert guidelines recommend SSRIs as the first-line pharmacologic treatment for affective symptoms of PMS and PMDD. *Combined oral contraceptives*: COCs are believed to treat premenstrual disorders by suppressing ovulation and the associated hormonal fluctuations that trigger symptoms. *Sepranolone* (selective allopregnanolone antago- nist): Phase II studies demonstrated significant reduction in PMDD symptoms. Development has been paused since 2024 pending fund- ing. *Alternative therapies*: Cognitive behavioral therapy (CBT), re- laxation techniques, micronutrient supplementation, adoption of a healthy lifestyle. Shared decision-making is recommended, involving discussion of the patient's treatment preferences and goals, as well as the benefits and risks of available options, to support patients in selecting the most appropriate strategy. Many patients may benefit from a multimodal approach combining several interventions.

Contraception and Obesity: Finding the Right Fit for Every Body

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Objective: To explore the complex interaction between obesity and ontraceptive choices, examining safety, efficacy, and health risks, and to guide personalized, evidence-based contraceptive counsel- ling for women with obesity.

Method: A narrative synthesis of international guidelines and con- temporary literature was conducted to evaluate contraceptive safety profiles, pharmacokinetics, and associated risks in women with obesity, along with implications for counselling, method selec- tion, and care provision.

Results: Obesity alters contraceptive pharma- cokinetics by increas- ing hepatic clearance, blood volume, and adipose tissue steroid ab- sorption, potentially delaying therapeutic contraceptive hormone levels. Combined hormonal contraceptives (CHCs) are associated with a confirmed increased risk of venous thromboembolism, particularly in women with BMI ≥35 kg/m2. Intrauterine devices (IUDs),

progestin-only pills, and barrier methods generally remain safe and effective regardless of BMI with minimal metabolic impact. No substantial weight gain is associated with most contraceptives ex- cept for conflicting data on depot medroxyprogesterone acetate in adolescents. Post-bariatric surgery, non-oral hormonal contracep- tives are preferred after malabsorptive procedures. The copper IUD remains the most effective emergency contraceptive across all BMI categories. In PCOS, low-dose or natural estrogen-containing CHCs and LNG-IUDs offer additional benefits. Prolonged use of hormo- nal contraception and higher BMI increased the risk of menstrual irregularities.

Conclusion: Women with obesity can safely use most contraceptive methods with individualized, person-centered counselling. Method choice should balance efficacy, safety, comorbidities, and patient preferences, with caution for CHC use in those with BMI e"35 kg/m2 and around bariatric surgery.

The Multidisciplinary Approach to Endometriosis

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Endometriosis is a chronic, inflammatory, estrogen-dependent, as well as highly debilitating disease affecting approximately 10%–15% of women during their reproductive age. Its clinical manifestations are diverse, including chronic pelvic pain, significantly impacting patients' quality of life. Given its complex and multifacetic nature, effective management of

endometriosis requires an interdiscipli- nary and chronic approach, transcending mere surgical interven- tion or isolated hormonal treatment. The fundamental pillar of this comprehensive management lies in close partnership among various specialties. The chronic nature of endometriosis demands long-term management which adapts to the disease's evolution and each patient's changing needs. This managements involves regular follow-up, symptom re-evaluation, and adjustment of therapeutic strategies. There is no "cure" for endometriosis; however, the goal is to control symptoms, to improve the quality of life of the patient and to preserve fertility when it is desired. Shared decision-making with the patient is essential, allowing them to actively participate in choosing their treatment plan. In summary, an interdisciplinary and chronic approach is endometriosis is indispensable for optimizing clinical outcomes and improving patients' quality of life.

Trends in Cervical Cancer Screening

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Cervical cancer remains the leading cancer among women es- pecially in low and middle-income countries. The last few years have seen very significant advances in primary and secondary prevention. The mainstay of secondary prevention is widespread screening. We will describe the rationale for large scale universal screening while at the same time encouraging opportunistic screen- ing and discuss feasibility and cost in LMIC. Screening without ensuring follow up and access to treatment is wasteful and prob- ably unethical. We will discuss how screening may be best linked to low-cost treatment options. We will briefly review the evolu- tion of screening technologies, single and multiple visit approaches and provide an update on available and in-development screening technologies and discuss which of the many options may be most suited for countries with the highest burden of cervical cancer as well as for individual providers of opportunistic screening. Many LMICs are grappling with how exactly to support WHOs ambitious goals for eliminating cervical cancer. The costs of screen and treat programs for 70% coverage is many magnitudes higher than that for near universal primary prevention with HPV vaccines and resource constrained nations face an unacceptable choice between the two. For large scale screen and treat programs, newer technologies that are dramatically lower in cost, faster in results, and highly convenient and acceptable by women are urgently needed. In addition, program processes such as daughter-mother initiatives, single visit approaches and self-sampling could greatly accelerate towards the goal of 70% coverage.

Ethical Aspects of Surrogacy

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Surrogacy raises complex ethical questions surrounding auton- omy, informed consent, exploitation, and the rights and welfare of all involved—the surrogate, the intended parents, and the child. As surrogacy becomes increasingly common globally, especially in cross-border arrangements, FIGO urges the establishment of ethical practices rooted in human dignity and international standards.

Key ethical principles include:

- Autonomy and informed consent—All parties must receive non- coercive, independent counseling on medical, legal, and psycho- logical implications.
- Non-maleficence and justice—Surrogates must not be subject to exploitation—financial or social. Fair compensation and access to independent legal advice are essential, especially in low-resource settings and cross-border surrogacy.
- Beneficence—The surrogate's physical and mental health must be prioritized, with full access to care, support during and after pregnancy, and the right to make decisions about her body and delivery. The child's best interests must guide all arrangements, including the right to know their origins.
- Cross-border surrogacy—Requires international cooperation to prevent unethical practices, ensure health equity, and protect vulnerable populations.

FIGO calls on all countries to establish comprehensive legislation to protect the rights and well-being of everyone involved, placing the welfare of the child at the center of all decisions.

Labor Induction Update: When and How?

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Labour induction is increasing globally. The topic is complex because the interest of the mother and the fetus are sometimes contrary. When? The spontaneous duration of human pregnancy is remark- ably variable. Inducing labour routinely beyond 41 weeks reduces perinatal mortality. In the ARRIVE Trial, labour induction at 39 weeks in healthy first pregnancies reduced caesarean births and possibly improved perinatal outcome. The subsequent trend to curtail all pregnancies by 39 weeks has sparked controversy. Earlier labour induction requires substantial justification because of curtailed fetal neurological maturation, and before 37 weeks physiological maturation. How? The advent of misoprostol for labour induction in the 1990's caused a worldwide epidemic of uterine rupture, particularly with vaginal administration. Our novel method of two-hourly low-dose oral misoprostol solution, reported in 2001, has stood the test of time. In recent years mechanical cervical ripening and labour induction, most commonly using the Foley urinary catheter off-label, has in- creased, mainly for labour induction with an 'unfavourable' cervix. We have introduced the novel concept of 'extended balloon labour induction/ augmentation' (EBLIA). We have reported promising out- comes using two or three Foley balloons side by side. The objective of labour induction is successful vaginal birth. The la- bour induction package must include intrapartum care to promote a safe and positive birth experience. To achieve implementation of the WHO principles of respectful maternity care, we use the mne- monic checklist COPE: Companions, Oral fluids, Pain relief and elimi- nate the supine position. Sustained promotion of this checklist over 2 years reduced the proportion who reported a very bad birth ex- perience from 57% to 6%. For third stage care we use the checklist BOND: Baby skin-to-skin, Oxytocic, iNitiate blood loss monitoring and Delay cord clamping (particularly preterm).

Intrapartum Fetal Surveillance: What is Better Evidence?

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In 2023, an estimated 1.9 million stillbirths occurred globally—one very 17 s. Of these, 832 000 (42.3%) were intrapartum stillbirths, primarily in sub-Saharan Africa and South Asia, where 89.5% of the global stillbirths occurred. In contrast, only 6.4% on intrapartum stillbirths were recorded in Western Europe and North America, highlighting disparities in the quality of intrapartum care. Intrapartum fetal monitoring aims to prevent hypoxia-related injury while avoiding unnecessary interventions. For low-risk pregnancies, intermittent auscultation using hand-held Doppler has comparable outcomes to continuous cardiotocography (CTG) (RR 1.01, 95% CI

0.67–1.52). Admission CTG and continuous CTG in low-risk women increase unnecessary interventions in labor. In high-risk pregnancies however, continuous CTG reduces neonatal seizures (RR 0.50, 95% CI 0.31–0.80) but increases operative deliveries (RR 1.63, 95% CI1.29–2.07), without significantly improving perinatal deaths (RR0.86, 95% CI, 0.59–1.23). Other challenges include false-positive CTG rates, interobserver variability, and limited access in low- resource settings. Computerized CTG may reduce false positive rates, but large-scale validations are awaited. Adjuncts like ST segment analysis (STAN) reduce metabolic acidosis (OR 0.72, 95% CI 0.55–0.94) but demand strict interpretation. while fetal scalp sampling (FBS) aids in inter- preting ambiguous CTG and decision-making, though it is invasive. Near-infrared spectroscopy and continuous fetal pulse oximetry, show promise but remain investigational. Future improvements may involve AI-assisted CTG interpretation, refined non-invasive monitoring, and personalized protocols. For now, continuous CTG with adjunctive measures is optimal for high- risk cases, while IA, with emphasis on context-specific approaches suffices for low-risk labours.

Fourth Trimester: Post Obstetric Event Contraception

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Post-obstetric event contraception (POEC) refers to the initiation of contraceptive methods after obstetric events such as childbirth, cesarean section, miscarriage, or abortion. It is a crucial strategy for preventing unintended pregnancies and promoting maternal health, particularly in regions like Mexico and Latin America, where un- planned pregnancy rates remain high among adolescents and vul- nerable populations.

In Mexico, nearly 73% of teenage pregnancies are unplanned, and approximately 33% of women of reproductive age report at least one unintended pregnancy. In early 2024, 77.8% of women discharged after an obstetric event in public hospitals in Mexico City received a contraceptive method. However, significant regional disparities per- sist. In Yucatán, post-delivery contraceptive coverage declined from 85% in 2017 to 67% in 2019, while coverage after abortion was just

43%. In Coahuila, over 9200 POEC procedures were recorded be- tween 2018 and 2021, revealing inconsistent implementation across health facilities.

Barriers to effective POEC include limited provider training, inconsist- ent availability of methods, and cultural stigmas surrounding contra- ception, especially after abortion. These barriers disproportionately affect marginalized groups such as indigenous women, adolescents, and migrants, who often face discrimination and limited access to care. Strengthening POEC in Mexico requires standardized clinical pro- tocols, continuous provider education, and integration of family planning into routine obstetric care. Promoting culturally sensitive, rights-based counseling and ensuring access to a full range of con- traceptive options can improve outcomes. By expanding POEC cov- erage, Mexico and the broader Latin American region can enhance women's reproductive autonomy and contribute to gender equity and public health goals.

Cervical Cancer Elimination 90-70-90: Together We Can

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It all started way back in 2018 at Geneva at an official side event at the 71st World Health Assembly when I was the FIGO president and Dr. Neerja Bhatla was chair oncology committee FIGO.

Our Global Declaration on Cervical Cancer Elimination was signed in front of 11 000 OBGYNs from around the world in October 2018 at Rio, aligning FIGO's expertise and worldwide network to the call for action. Time flew until on 17th November 2020 Dr. Tedros Adhanom Ghebreyesus, the then director General of WHO announced the ambitious project for eliminating cervical cancer and set the target of 90-70-90 by 2030 as a goal to implement it. The working group outlined necessary steps for updating recommendations, use of health and social networks, mobilizing country-based work, Accelerating acceptance and deployment of HPV tests, Quality as- surance and Innovative approaches to speed access to screenings and treatment.

It was then that the world woke up to the call and many stakeholders from 194 countries were signatories for the strategic plan. Cervical cancer 90 percent of eligible girls need to be vaccinated, 70% eligible women need to be tested by a high performance test at least twice around 35 and 45 years and treatment of 90% of women screened positive including palliative care.

The journey has begun and we are expecting a sea change in the cervical cancer statistics in the near future, that really has no busi- ness to be here. We have a long uphill task ahead, but believe me, together we can!

Documentation and Reporting of PPH Key Performance Indicators Real World Experience from Kenya

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Objective: To accurately monitor roll out of new PPH recommenda- tions and innovations, there is need

to modify the existing health management information system. We summarize the real-world experience of Accelerating Measurable Progress and leveraging in- vestment for PPH impact (AMPLI-PPHI) project in documentation of new PPH recommendations in 36 public health facilities in Makueni County.

Method: Project review showed that some indicators relevant to measurement of PPH interventions were missing in HMIS tools. To capture additional indicators, stamps with new indicators were in- troduced on existing registers. To improve data quality, multi-cadre training, routine data quality assessments, data review, triangulation of service delivery and commodity management data were imple- mented. Advocacy to include some indicators into HMIS completed.

Results: From January to August 2024, 87.5% (*n*=24) of facili- ties had 100% data concurrence between data source and HMIS. Nearly all women received a uterotonic for PPH prevention, with 97.6% (*n* = 11 386) receiving heat stable carbetocin and 2.4% receiv- ing oxytocin. All 301 (100%) PPH cases used the clinical care bun- dle (tranexamic acid, uterotonic, and IV fluids) for treatment and no PPH-related maternal deaths were recorded in 2024.

Conclusion: Collecting PPH key performance indicators is feasible through modification of existing registers, while employing data quality approaches. Programs should focus on real-time client data documentation, effective reporting and advocacy for inclusion of these indicators into HMIS to enhance data use for decision making.