Message from the President

Prof. David L Healy
President of IFFS

Our IFFS mission includes the dissemination of education. IFFS stands for encouraging superior clinical care of patients in reproductive medicine world wide.

This came to mind as I looked over our IFFS Workshops. With the help of many clinical doctors, and many scientists, member societies of IFFS use our IFFS Workshop Series to assist them to disseminate education to their own communities.

Forty IFFS Workshops are complete. Four more are in preparation. Requests from member societies have focussed on scientific advances, especially embryological advances, in assisted reproductive technology (ART). By contrast, dissemination of education to encourage superior clinical care has had few requests. Two clinical topic areas have never had an IFFS Workshop: reproductive surgery and ovulation induction.

Reproductive surgery is a vital skill in the repertoire of any doctor specialised in reproductive medicine in any IFFS member society. It requires regular practice. It certainly benefits from dissemination of reproductive surgical education. IFFS can supply that. Reproductive surgery is not, as some of my local colleagues say, just being a glorified “egg sucker”. And yet - no IFFS Workshop in reproductive surgery and evaluation induction.

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Ovulation induction (OI) is the second topic area never requested for an IFFS Workshop. After 50 years using gonadotropins, perhaps all clinicians in all member societies are well trained in reproductive endocrinology. I hope so. The Generation of The Obese is upon us. It shall be challenging. Or perhaps reproductive endocrinology is extinct. ART for all. And yet - several countries are world leaders in these treatments. Theirs is a subtle skill. But how can IFFS, and its member societies, help a doctor to get for us. And we want them at the peak of their career. And in top form. How can IFFS, and its member societies, help a doctor to get there? Although it seems unfashionable, encouraging superior reproductive surgery, and reproductive endocrinology, should form part of IFFS dissemination of education.

Or will reproductive surgery, reproductive endocrinology, and even clinical care, become extinct?
HIV AIDS AND REPRODUCTIVE HEALTH
AN AFRICAN PERSPECTIVE
Zephne M Van Der Spuy

Health care in Sub-Saharan Africa has many challenges. These countries carry 24% of the total burden of disease worldwide, have only 3% of the medical workforce and 1% or less of the world wealth. 36 of 59 countries within Sub-Saharan Africa have a critical shortage of health professionals and the needs far exceed any realistic expectations of supplying this expertise. It is therefore essential that we recognize the health requirements in Africa but also the fact that our strategies need to be innovative and often different to those in the industrialized world.

Reproductive ill-health among women is responsible for 36% of the total burden of disease and is mainly related to pregnancy, STIs and HIV. In South Africa 5.5 million South Africans are HIV-positive and about a million men and women are currently on HAART. Our Minister of Health reports that about 29% of pregnant women are HIV positive, 43% of maternal mortality is HIV related, 57% of child deaths under 5 are due to AIDS and 78% of women living with AIDS also have tuberculosis which is the major cause of death.

Reviewing the Millennium Development Goals, MDG6 specifically deals with HIV/AIDS and other diseases but undoubtedly AIDS impacts on MDGs 3, 4 and 5 as well. It is a grim reality, as reported by UNAIDS in both 2007 and 2009, that each year twice as many people become infected with HIV as start on treatment and twice as many people die of AIDS as start on treatment. This has resulted in a major change in life expectancy particularly in countries with high HIV prevalence and in some African countries life expectancy for women has fallen as low as below 40 years.

In Sub-Saharan Africa AIDS has been regarded as universally fatal and is now the leading cause of death. The pandemic impacts on adults in their productive years and results in a major loss of expertise within communities. The impact on pregnancy outcomes are most pronounced in developing countries and the recent review within our own Department in Cape Town by Kennedy and Fawcus (personal communication) has revealed that there has been little change, despite advances in treatment and surveillance, in the last decade. Women who are HIV positive remain at risk of higher pregnancy loss than those who are HIV negative (21.7 vs 11.5 per 1 000 deliveries. P<0.0001). In women who are untested and therefore do not access our services and the PMTCT programme the PNMR in this study was as high as 87.6 per 1 000 deliveries.

Despite the AIDS pandemic, fertility remains valued in Africa for many reasons. It is perceived as bringing happiness and love, completing a relationship and ultimately providing assistance in subsistence related tasks. The gender identity of a woman and her social security are often related to her ability to bear children.

“… men leave me as I cannot have children. You must have your own children, even if the child dies later on, they say at least you have one.”


Unfortunately in most countries in Sub-Saharan Africa infertility is a major health problem which is critically under-resourced. Firstly because the health budgets are constrained and fertility is regarded as a non-essential expense and secondly because the treatment which is available often exceeds the availability of either expertise or resources. It has been clearly demonstrated within Africa that despite the high prevalence of HIV infectivity there has been little or no change in sexual behaviour and fertility decisions do not depend on HIV status. The tragedy of the pandemic has been that couples lose their children due to AIDS and two responses have evolved. Firstly the precautionary demand for children – in short having larger families because it is perceived that children will die or else attempting to replace children who have already died the so-called replacement strategy. In addition HIV/AIDS impacts on reproductive health, reducing fecundity and impacting on both male and female fertility. This compounds the already difficult problem within Africa where tubal factors remain the leading cause of infertility.

Infertility In African And Industrialized Countries

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<th>Industrialized</th>
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<tr>
<td>Tubal factor</td>
<td>35%</td>
<td>85%</td>
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<tr>
<td>Endocrine related</td>
<td>39%</td>
<td>27%</td>
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<tr>
<td>No cause found</td>
<td>40%</td>
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[HIV/AIDS is a tragedy of global proportions and in a pronatalist society such as is found in Africa, this reproductive health problem needs attention which must include the safe care of women who become pregnant. They need to be confident that there will be adequate antenatal care which will ensure their children are not born infected. Strategies in Africa which will offer infertility treatment always need to embrace the need for safe maternity services. This presents an enormous challenge for all of us working in Africa but one which it is essential we address.

[Cates et al, 1985 Lancet 2(8455) 596-598]
The World Health Organisation (WHO) launched their Reproductive Health Guidelines project at a two day meeting hosted at their headquarters in Geneva 16/17 January 2012. As a key partner with NGO status the IFFS was well represented at this meeting with three officers (Richard Kennedy, Secretary General; Gabriel de Candolle, Assistant Secretary General; Paul Devroey, Director of Education) and one Board Member (David Adamson, ASRM) in attendance. The meeting was co-chaired by Paul Devroey and Bart Fauser. The WHO project is an ambitious collaborative venture set up by their long serving Reproductive Health Coordinator, Sheryl van der Poel who brought together representation from FIGO (President, Gamal Serour); ASRM (President, Dolores Lamb); ICMART (Chairman, David Adamson); ESHRE (Chair, Anna Veiga) and Aldo Campana on behalf of the Geneva Foundation for Medical Education and Research (GFMER). The meeting was given its momentum with six pre-chosen Executive Working Group Chairs: Chris Barrett (UK, Male Infertility); Hans Evers (Netherlands, General Infertility); Willem Ombelet (Belgium, Intra Uterine Insemination); Adam Balen (UK, Poly Cystic Ovarian Syndrome); Anders Nyobe Andersen (Denmark, Ovarian Stimulation); Andre van Steirteghem (Belgium, Overview).

The meeting was introduced by Michael Mbizwo, Director Reproductive Health Research Special Programme, WHO, who set the scene by underscoring the importance that WHO now holds this area of development. The objectives for the two days were set out by Sheryl van der Poel and most of the first day was devoted to a series of presentations detailing the WHO approach to guideline development. For the majority of topic chairs and attending organisations this insight was essential to enable the project to move forward. At the top of the chain is the WHO Guidelines Review Committee chaired by Charles Penn and the outputs over the coming months will have to satisfy this committee before distribution and implementation. Two important issues emerged in discussion; firstly how the topic chairs would scope their work to enable this seemingly enormous task to be completed in extremely ambitious timescales; secondly how the issue of conflict of interest would be addressed given that almost all those involved has some degree of conflict whether it be sponsorship or previously publicly expressed opinion on a specific issue.

Through the second day greater clarity developed as each of the topic chairs presented their preliminary ideas about subject areas. What came out of this was, not surprisingly, the broad range of subject headings providing a starting point for potential guideline development in reproductive health and one of the first tasks for the Topic Chairs will be prioritisation of this long list. The Chairs also presented their proposals for teams to support their work, chosen for their recognised expertise in the field. The wealth of material that already exists from national organisations for example National Institute of Clinical Excellence (NICE, UK), ASRM and ESHRE was evident to the group and it as clear that where possible this material would play an important role in informing the WHO project. The main roles for the IFFS in this project moving forward will be through its educational expertise, understanding of the global issues and many contacts to aid the topic prioritisation, share its own material on standards care and promote and disseminate the WHO outputs. The IFFS believes this to be an important development and welcomes the WHO commitment to raising the standards of care in reproductive health.
There is no doubt that IFFS is active in organizing educational activities. The first 2012 workshop took place in Lima-Peru on January 31 and February 1. The topics related to gametes and embryos. Full attention was given to sperm and oocyte biology. Also different strategies were presented related to cryopreservation and vitrification. For sure in vitro maturation was part of the evaluation. Embryo fertilization and development were accessed in depth.

The second meeting took place in Jakarta - Indonesia. The meeting is organized with the Indonesian Association for In-Vitro Fertilization on February 13-15 2012. The themes of the meeting were towards an easier, safer, affordable more successful treatment. The item related to safety was of paramount importance. Two main factors are involved namely the occurrence of multiple pregnancies and the occurrence of ovarian hyperstimulation syndrome.

The avoidance of multiple pregnancies is closely related to the number of replaced embryos. If the number of replaced embryos is reduced the percentage of multiple pregnancies will drastically reduce. This reduction of the number of replaced embryos implies an accurate embryo cryopreservation or vitrification program. Even twin pregnancies have to be avoided.

Besides the occurrence of multiple pregnancies the Ovarian hyperstimulation syndrome remains a dangerous event. Nowadays it is known that 2% of stimulated women develop a Ovarian Hyperstimulation syndrome. It is also reported that 3 out of 100 000 stimulated women die from this syndrome. These data have been published in England and The Netherlands. The crucial question relates to the avoidance of the syndrome. The important reason to develop the OHSS syndrome relates to the injection of HCG to trigger final egg maturation. The aim of any research is to replace the maturation trigger by GnRH agonist. There is one stimulation protocol, which allows the replacement of HCG by GnRH agonist. This specific protocol implies the combination of GnRH antagonist to down regulate, FSH to stimulate follicular growth and finally GnRH agonist to trigger final egg maturation.

In this strategy two options are open. The first option is to freeze in patients at risk all eggs or all embryos after GnRH triggering. In GnRH agonist triggered cycles the occurrence of OHHS is zero. After thawing the embryos can be replaced in a non stimulated cycle, either in a spontaneous or in a substituted cycle.

If it is decided to replace a fresh embryo, the following option is proposed in an GnRH antagonist cycle. Final egg maturation is performed with GnRH agonist an 36 hours later a low dose injection of HCG is administered. Following this strategy the OHSS syndrome is almost erased.

During the meeting full attention was given to a patient centered approach. Several urgent questions were posed. The programming of cycles were presented, especially related to the use of contraceptive pills an oestradiol valerate. Is the day of start of stimulation crucial? Can FSH be replaced at the end of the follicular phase? Can weekend days be avoided? Which is the ideal stimulation protocol for IVF?

Also the endometrial receptivity in stimulated cycles were studied. If in stimulated cycles luteal phase supplementation is not administered implantation will not occur. Different luteal phase supplementation regimens are in use. Also the length of luteal phase supplementation in case of a beginning pregnancy is a matter of research.

At present a meeting has been programmed in Manila-the Philippines. This IFFS meeting will be organized in collaboration with the Philippine Society of Reproductive Endocrinology and Infertility. The meeting will take place in the Fall.
The International Federation of Fertility Societies (IFFS) is pleased to have collaborated with its member society the Sociedade Brasileira de Reprodução Humana (SBRH), together with the Sociedade Brasileira de Endometriose (SBE), in organizing the first meeting in the IFFS International Symposium Series in São Paulo, Brazil on May 4, 2012. The theme of the meeting was “Recent Advances in Endometriosis and Reproductive Medicine.”

Bringing science and practice home, the IFFS International Symposium Series focuses on topical areas of reproductive health relevant to regional concerns, presenting cutting edge research, contemporary review and topical debate. IFFS has a proven 60 year history of such expertise and represents over 60 member societies in these endeavors.

The event in São Paulo was opened by IFFS President Elect Joe Leigh Simpson who welcomed the participants to the first annual symposium. He briefly described the history of IFFS, noting that prior to 1951 no international organization existed devoted to the problems of human infertility. In that year during an event in Rio de Janeiro, the “International Fertility Association” was formed; IFA was the predecessor to IFFS. It was fitting to launch the first International Symposium Series event in the same country, Brazil, where IFFS was conceived.

The 2012 São Paulo event was greatly enhanced by the participation of prestigious international speakers invited for their prominence in the field, including: Joe Leigh Simpson (United States, IFFS President Elect) who gave the dynamic keynote lecture “Genetics Selection: From the Gamete to the Embryo”; David Adamson (United States) who presented two keynote lectures “Do We Need a Classification Just for Infertile Patients with Endometriosis?” and “Should a Single Embryo Be Transferred to All Women Undergoing IVF?”; Carlos Sueldo (Argentina) who lectured on “Treatment of Infertility”; and Dominique de Ziegler (France) who offered the keynote lecture “Endometrium and Implantation”. In addition to the four keynote lectures, three panel discussions were led by local Brazilian specialists on the topics: “PCOS - Past and Future”, “Cancer and Reproduction”, and “Endometriosis Treatment and Infertility– Is IVF the best option?” The complete program with the names of all speakers, session presidents and moderators can be found on the IFFS website www.iffs-reproduction.org.

IFFS is honored that this one-day scientific meeting was coupled with the Ferring UIT Program presented on May 5, 2012. This second day offered a broad range of topics related to fertility. IFFS is especially proud to note its partnership with Ferring Pharmaceuticals and is grateful for their support.

Joe Leigh Simpson, IFFS President Elect, summed up the feelings of the day “The IFFS leadership was very pleased with all aspects of our first International Regional Symposium, especially the choice of South America as envisioned by our President David Healy. Artur Dzik, President of IFFS member society SBRH, as well as SBE President and IFFS Assistant Treasurer Mauricio Abrao, were outstanding hosts. Participants were attentive and engaged our international speakers with vigor. Collaborative work and ongoing relationships were initiated. This first IFFS International Symposium has certainly set the bar high for those that will follow”.

IFFS looks forward to sponsoring similar programs in the future in support of our continuing mission to provide worldwide educational outreach.
The X World Congress of IFFS was held July 5-11, 1980 in Madrid, Spain. The IFFS President was Patrick Steptoe and the host congress President was J. Cortes-Priento of Spain. Spain was still experiencing significant political unrest and this resulted in limited attendance figures for the meeting. A novel aspect of the congress was the opportunity given to national societies to hold their own workshops to discuss issues of particular concern to their societies. At this meeting many members on the Executive Committee completed their terms and were replaced with new physicians. Staggered terms, so that only three of the nine members of the Executive Committee could be replaced every three years, were not fully implemented until 12 years later.

The XI World Congress of IFFS was held in Dublin, Ireland, June 26-July 1, 1983. The IFFS President was A. Mendizabal, Buenos Aires, Argentina and the congress host President was J. Bonnar, Dublin, Ireland. In the election of officers, Ingelman-Sundberg was replaced as treasurer, a position he had held for 15 years since the beginning of IFFS in 1968. Simultaneously, for all these years he had also continued as President of the now inactive IFA. The World Health Organization (WHO) organized two workshops as part of the program. The congress drew over 2000 registrants and was well supported by industry. All the profits went to the local society of obstetrics and gynecology. This was the first IFFS congress organized by a professional congress organizer (PCO) and the first to publish a book with the proceedings of the congress.

The XII World Congress of IFFS was held in Singapore, October 26–31, 1986. The President of IFFS was William C. Andrews, Norfolk, VA, USA. The host congress President was S. Ratnam, Singapore. The congress which drew 2000 participants was held in the excellent congress center of a newly completed luxury hotel. It was a great success having opened up the IFFS to the Asian-Pacific medical world. Pre-congress post graduate courses were offered and were very well attended. Among the dignitaries present at the opening ceremonies was the President of Singapore.
Join us in Boston!
October 12-17, 2013

IFFS/ASRM
A Conjoint Meeting of the
International Federation of Fertility Societies and the American Society for Reproductive Medicine

Boston, Massachusetts, USA, 2013

Photographs courtesy of the Greater Boston Convention & Visitors Bureau.

Contact Information for IFFS Secretariat

INTERNATIONAL FEDERATION OF FERTILITY SOCIETIES
IFFS Secretariat Office
19 Mantua Road, Mt. Royal, NJ 08061
Tel.: +1 856 423 7222, Fax: +1 856 423 3420
E-mail: secretariat@iffreproduction.org
Website: www.iffes-reproduction.org