Good morning to you all. I am honored and delighted to be standing here today as your new president.

YOUNG WOMEN YOUNG DOCTORS: OUR INSPIRATION OUR FUTURE

This is my theme for the coming triennium. We must celebrate the outstanding achievements we have made over the last 100 years. But, looking to the future, we must remain constantly vigilant to protect the progress we have made, and to identify new challenges. We owe this to our young doctors and medical students and to the many young women around the world who still face major barriers and unacceptable prejudice.

In this talk I plan to tell you a little about myself, and how I came to be your president. I will then focus on what we might achieve in the next 3 years, guided by the 2017 MWIA Membership survey, and what I have learned from many of you at regional meetings in the last 3 years.

I graduated from the University of Sydney in Australia and became interested in a career in Pediatrics. I was also interested in travelling, and after a year of residency set off to work in Canada. One of the most interesting parts of my Pediatric job at Queens University, was a month spent in Moose Factory in northern Ontario, looking after Indian and Eskimo children. Just as with the aboriginals in Australia, alcohol was an enormous problem, as well as unemployment, living on welfare, and no real goals to strive for. We flew to remote settlements to run out-patient clinics.
After a year in Canada, I came to London where I obtained further postgraduate qualifications while based in various London teaching hospitals. I met my future husband, a medical academic, also Australian, in London. We moved to Oxford and I became a research registrar in Pediatrics at the John Radcliffe Hospital for 3 years. We then had 3 children and moved to Sussex.

This is a picture of my 2 daughters. Both are qualified doctors. Claire, on the right is now a Pediatric consultant in the Children’s Hospital in Edinburgh, and Margarete is an academic trainee in Hematology, doing a PhD in Cambridge.

Unlike most women doctors nowadays, I had a career gap of 7 years. When my son was 3, I returned to work. There were many hurdles to overcome to return to Pediatrics. I therefore re-trained in family medicine and have remained there ever since. I became a full-time partner, and under my leadership, the practice expanded over the years from 2000 to 11,000 patients. We became a training practice for medical students and young doctors.

When my children were older, I became active in medical politics. My involvement with the U.K. Medical Women’s Federation (MWF) began in Oxford, just before the birth of my first child. From that moment, having a family impinged on my career. When my children were older, Dr Dorothy Ward, whom some of you will remember as a past president of MWIA, asked if I would consider
becoming Honorary Secretary of MWF. This was a very exciting role which I enjoyed very much, and I progressed to Vice President and then MWF President in 2010.

Dorothy Ward is shown here second from the left, with MWF colleagues at an MWIA regional meeting in Iceland, just after a night swim in the Blue Lagoon.

Dorothy also encouraged me to stand for the British Medical Association’s General Practitioners’ Committee. This highlights for me one of the very important roles of MWF and MWIA - to encourage young women to put themselves forward for positions of influence they might never have considered.

If Dorothy had not encouraged me, I would probably not be standing here today.

When my MWF presidency finished in 2012, I asked MWIA Secretary-General, Dr Shelley Ross if there were any roles in MWIA that I could fill. She suggested representative to WHO. And that has been my way into the hierarchy of MWIA. It was a life-changing appointment.

I shall just say a few words about my mother, an Economics graduate who became an ardent feminist when I was 15 years old.
This picture shows her, in the purple sweater at the age of 95 marching for Euthanasia in Australia.

She became President of the Family Planning Association in Australia. She spent much of her life campaigning for Abortion Law Reform, Homosexual Law Reform, the Women’s Electoral Lobby, and finally Euthanasia. She received a medal from the Queen for her activities.

I shall move on now to what I would like to achieve over the next few years.

The MWIA Membership survey was an online survey conducted in 2017. 1150 women doctors and medical students responded. The numbers in the survey are too small to make definitive comments. However, they do show trends to guide us in our future priorities. Members were asked if they felt they had ever been discriminated against in their careers because they were women. It is interesting that the level of discrimination was high throughout the world, with a trend for discrimination to be higher in North America in comparison with Europe or Africa and the Near East.

Members were asked ‘Have you ever suffered from sexual harassment or bullying related to your work? Levels of sexual harassment and bullying were high everywhere, with the North Americans reporting a greater problem than the Europeans and Africans.
What are the most important issues MWIA needs to address?

Members were given 15 options and could tick more than one. Work life balance, Violence Against Women and Girls, leadership and mentoring and sexual harassment came out on top. And there was no great difference between older and younger doctors.

Guided by findings from the survey, what are some of our plans? What do we want to achieve?

There are 5 broad areas.

One of my priorities will be a focus on young women doctors, looking at career development and return to work after having children.

We must encourage leadership and mentoring worldwide. We must put in place structures which facilitate both career development and good motherhood. It is possible to do both.
Looking at maternity and parental leave in different countries

Over the period of maternity leave, the woman doctor’s job is protected. It is interesting that the United States is one of only 3 countries in the world where there is no legal right to paid maternity leave. The other countries are Papua New Guinea and Suriname. Moreover, in the US, the period of leave permitted is relatively short. Small employers in the US with fewer than 50 employees are exempt from providing even this basic level of parental leave. Some women go back to work in less than a week, which for many is a highly stressful experience best avoided.

Looking briefly at work life balance in Japan

in 2018 we heard that officials at Tokyo Medical University had been systematically lowering test scores of women applicants, so that far fewer women gained entry to medical school.

There were profuse apologies from those responsible for this outrageous behavior and it was widely reported in the international press.

It is interesting that only 21% of doctors in Japan were women in 2016, the lowest of the OECD countries.
Here are some observations and proposals made by the Japanese women doctors in a publication in the BMJ. There was a low level of confidence, resulting in low career aspirations. Full-time practice is one of the requirements for specialist status in Japan. There is a need to cut down the long hours culture in medicine in Japan. Temporary posts should be introduced to cover maternity leave to reduce burden on colleagues.

To end this section, here is a quote from an article by my husband published in Clinical Medicine a few years ago: “The major burden of childcare still falls on the mother, but the key issue (for parents and administrators) is that the period of intensive childcare is limited and, once complete, both careers can proceed at full pace.”

Moving now to Violence against women and girls, and the related issues of sexual harassment, and child and elder abuse

MWIA have developed an online training module on violence which has been used very successfully in workshops at our meetings. I would highly recommend its use at your meetings.

I plan to focus on what we as doctors can do, and on the critical issue of prevention.

We must ensure that doctors and medical students are trained in detection of violence, and on appropriate referral pathways.

And regarding prevention, we need to begin with boys and girls in schools, to change cultural attitudes.

[Image of MWIA's training module on violence]

Partnerships can greatly strengthen the influence and impact of MWIA.

We have strong links to the WHO and to the UN through our representatives and collaborative work plans.

There are 3 areas I plan to concentrate on in the coming triennium, where partnerships are valuable. These are HPV vaccination, the Prevention of Unplanned Teenage Pregnancies, and Post-partum Hemorrhage.
One of the UN and the WHO’s top priorities is **HPV vaccination and the Elimination of Cervical Cancer.**

It has become clear that HPV vaccination of girls at age 11 or 12 is proving a very effective way of preventing cervical cancer.

Ideally, young boys should be vaccinated as well.

In Canada and the US, the national Medical Women’s Associations have introduced a very effective HPV Awareness Week

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**What can MWIA do?**

We must encourage our national organizations to engage with government and advocate for HPV vaccination

We can advise our national organizations on how to organise HPV Awareness campaigns and we can supply appropriate materials (posters, leaflets, videos, webinars, films etc)

We can educate and support health workers in low- and middle-income countries, and provide technical assistance where necessary

We can encourage and facilitate cervical screening, including HPV testing

I am confident that MWIA, working with partners such as the UN, WHO and others, can make a real difference in this area, to eliminate cervical cancer.

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**Moving on to the prevention of Unplanned Teenage pregnancies: an Unmet Need**

In November last year, I attended the MWIA Africa and Near East Regional meeting in Nairobi. Dr Bev Johnson of the Canadian Medical Women and I met with several young doctors and medical students who were working in this area.

**Just a few facts**

One in five 15-19-year-old girls in Kenya has a child or is pregnant

80% of these girls drop out of school

They are often forced into marriage or face great stigma

95% of pregnant girls did not use any form of contraception
Healthcare staff are often unsympathetic to teenagers' requests for contraceptive advice. There is a negative attitude from many parents and Church leaders.

The following slide shows a health clinic owner and my guide, a speaker at the conference, on the left, standing outside a healthcare facility in one of the Nairobi slums.

Below, a male health worker is demonstrating various forms of contraception to women waiting to be seen in the clinic.

Bev and I made many contacts at the conference and have been in touch with many of these groups. We are very keen to progress this project in the coming triennium.

Below is a group of medical students I met in Nairobi from an organization called RESPEKT, which is funded by the Danish Youth Council.
It uses volunteer Kenyan medical students to go into schools to talk to adolescents about Sexual and Reproductive Health. Currently there are volunteers from 10 medical schools, and the organization is growing. They have developed a curriculum for schools, as well as training and action plans. They have approached the government, and have partnered with gender-based violence centers.

**Another interesting new development is the use of Apps and social media, for example the LucyBot.** This is a Facebook Messenger Chatbot. It was show-cased at the recent Women Deliver conference in Vancouver at a plenary session chaired by Melinda Gates. It uses Artificial Intelligence and is a reliable source of online information on contraception and sexual and reproductive health. It answers questions and points to resources. Users can talk to a doctor directly. 

Below we see Dr Bev Johnson at the recent Women Deliver conference, with the developers of the LucyBot.
We have already begun bringing our Kenyan partners together to expand the use of the LucyBot.

We plan to expand the Prevention of Teenage pregnancy project to Ghana and Nigeria in the first instance, but we know there is a similar need in countries like Thailand and elsewhere.

**The third partnership, in this case with the WHO, is the Prevention and treatment of Post-Partum hemorrhage.** This is one area where MWIA could make a significant impact in reducing maternal mortality. Several drugs have been found to be very effective, but are not often available in remote settings. For prevention, Oxytocin and heat stable Carbetocin in areas where there is no refrigeration have been shown to be helpful. And for treatment, Tranexamic acid given intravenously within 3 hours of birth. Working with partners, MWIA could facilitate the supply of these drugs to those areas where it is needed.

**In conclusion: MWIA is a powerful force in advancing the cause of women's health and welfare throughout the world, as well as improving the lives of women doctors.** There are dangers to women’s progress, and we need to remain vigilant. Given the nature of men and women, we need a women’s organization to look after women’s rights. Nothing ever stands still.

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