BREAST AND CERVICAL CANCER:
Will screening programmes protect our daughters?
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EDITORIAL

by Assia Brandrup-Lukanow

The new concept of Reproductive Health includes the prevention of and early treatment of cancers of the reproductive tract. However, there is not yet a unified strategy on screening and early detection. Breast cancer is the single largest cause of cancer mortality among women in Europe, with up to 1 in 16 women affected at some point in their life. Breast cancer is rarer in Eastern Europe than in Western Europe, but in Eastern Europe cervical cancer is a significant public health problem, which is increasing with the present STD epidemic.

In this issue we want to contribute to the discussion on best practices by reviewing the work of the International Agency for Research on Cancer (IARC) and the screening policies of six countries in Europe with regard to breast and cervical cancers, the approaches differ widely and the impact of the individual strategies is not yet well known. Furthermore, the articles show clearly that even the concept of "screening" is understood differently from country to country. In some countries, like in the United Kingdom, breast cancer screening refers to performing mammographies in women of certain age groups, in other countries, like in Hungary, breast cancer screening is performed manually by paramedical personnel within the tuberculosis screening.

With respect to cervical cancer screening, the policies and strategies are more uniformed. In all countries, screening consists in taking pap smears at regular intervals, though the targeted age groups differ between countries. The article by Dr Herrero from the International Agency for Research on Cancer through the light on what may be possible in future: the development of a vaccine to prevent cervical cancer.

Sara Davenport's article brings us the more personal perspective on what private initiatives can contribute to improving care for women with breast cancer.

Cancers of the male reproductive tract have not received as much attention with regard to prevention and screening. The debate on the usefulness of prostate cancer screening is still ongoing and in most countries, there is no national policy on this. With regard to testicular cancer affecting young men, an interesting initiative has been started by the Danish Cancer Society in producing leaflets on self-examination, similar to those that had been produced for breast awareness. These leaflets are distributed through the primary health care system.

In our country reports, we report on the effect of the new abortion law in Poland from two different perspectives, on an epidemiological study on abortions in Russia, on the attempt to promote a more holistic view of women's health in the city of Graz in Austria, and on the progress in the reproductive health project in Bosnia and Herzegovina.

In the research section, we report on new studies on oral contraceptives and the risk of stroke, hormonal contraceptives and breast cancer, breastfeeding and post-partum contraception.

As in our previous issues, the resource and training sections of Entre Nous present new materials and opportunities for training. Finally we would like to thank our readers for all their comments and feedback to the readers questionnaire, and we hope that this will not be the last issue of Entre Nous.

We wish all our readers a happy, prosperous and successful New Year.

INTERNATIONAL AGENCY FOR RESEARCH ON CANCER

Research on cancer of the cervix

Is a new vaccine on the way?

by Rolando Herrero

Cervical cancer remains a major public health problem worldwide, with 500,000 new cases and more than 200,000 deaths every year. Nearly 80% of the cases occur in developing countries, whereas in developed countries the incidence of the disease has markedly declined in recent decades. IARC collects and publishes information on incidence and mortality from all cancers around the world. This information is essential for the planning and evaluation of control measures and provides important clues as to the possible etiology of the different cancers.

The Unit of Field and Intervention Studies has conducted multiple epidemiologic studies over the last 20 years on the etiology of cancer of the uterine cervix. One of the main recent conclusions is that most cancers of the cervix, as well as their precursor lesions, the cervical intraepithelial neoplasia (CIN), are caused by certain types of human papillomavirus (HPV), a sexually transmitted virus. Infection of the virus is acquired via sexual intercourse by an important proportion of women shortly after initiation of sexual activity. However, the majority of women are able to eliminate the infection by immunologic mechanisms. Only a small proportion of women develop persistent infections that have a potential to progress to more severe disease. This progression usually occurs over a period of several years from one stage of the disease to the next. During several years the disease remains asymptomatic and almost always curable, but sheds cells that reveal the pre-neoplastic condition, constituting the basis for the potential benefit of cytologic screening programs.

Current research focuses on investigating the determinants of persistence and progression of lesions from HPV infection to CIN to cancer. Among these possible determinants are immunologic or genetic characteristics of the host, viral types and subtypes, as well as environmental co-factors including smoking, infection with bacteria or other viruses, specific diets and hormonal influences.

Cytologic screening programs have proved to be a cost-effective method for the control of cervical cancer, and organized programs are the recommended approach. Such programs operate with a public health perspective and are directed to individual women in an effort to cover the highest Continued on page 4
Research on cancer of the breast

by Annie J. Sasco

SOME BASIC FACTS ABOUT BREAST CANCER

Occurrence: The most common cancer in women, breast cancer causes 500,000 deaths a year worldwide and about 900,000 women a year are diagnosed with the disease. More than half of these cases are in the industrialised countries - about 220,000 in Europe and about 180,000 in North America, for example - and the disease is not yet as common among women in developing countries although incidence is increasing. The highest reported rates, around or above 100 per 100,000 woman-years, are for white or Hawaiian women in the USA. High rates are also found for North America in general, Israel and some parts of Europe. In contrast, low rates are found among African and Asian populations. Migrant studies indicate that when women migrate from low to high risk regions, after two or three generations they slowly acquire the rates of the host country, which illustrates the importance of lifestyle in addition to genetics.

Breast cancer incidence is still increasing in most parts of the world and, in particular, in regions which previously had low rates. Breast cancer also exists in men, although it is a rare disease with most incidence rates being lower than 1 per 100,000 man-years. It seems slightly more frequent in black than in white men.

Risk factors: The strongest risk factor for the disease is age, with more than half of the cases occurring after menopause. Among women, the risk of disease is linked to reproductive and hormonal factors. Breast cancer risk is increased by early menarche, late age at first birth, nulliparity and late menopause. All of these reflect a hormonal pattern with exposure to high levels of endogenous estrogens, in particular free estradiol. Other risk factors include obesity after menopause and diet, in particular animal fats and alcohol; exposure to ionizing radiation, especially at the time of breast development and exogenous hormones such as oral contraceptives at an early age and estrogen replacement therapy at menopause.

Recently, genetic predisposition has been much better understood with identification of at least two genes (BRCA1 and BRCA2) which give rise to a very high risk of breast cancer. Other genetic conditions will probably soon be identified.

Clinical features/diagnosis: The most common clinical sign is a lump in the breast, but nipple discharge and modification of the skin can also be indications of disease. Prognostic of the disease is conditioned by local or distant occurrence. The final diagnosis is dependent on histological proof (biopsy or fine-needle aspiration), but clinical examination and mammography are also able to provide important elements.

Treatment: Depending on tumour stage, treatment may include surgical removal of the tumour and surrounding tissue from the breast (lumpectomy); surgical removal of the whole breast (mastectomy); radiotherapy; chemotherapy. Combinations of surgery followed by chemotherapy or hormonal therapy improve the chances of long-term survival.

Survival: At least half of the cancer cases will survive for five years including those occurring in the developing world. Trends in survival show clear improvement over time. The main determinant of survival is tumour stage, with localised disease being associated with an excellent prognosis. In contrast, metastasis entails a high risk of death in the five years following diagnosis.

Prevention: For the time being, the only effective prevention strategy is mammography which is able to reduce by one third the risk of death from breast cancer among women over 55. In the developing world, detection by breast examination may lead to a worthwhile down staging of the disease.

Outlook: Improved facilities for radiological but also clinical diagnosis should be made available to women throughout the world. General health promotion, including avoidance of obesity from childhood onwards could also help. Chemoprevention is only a research exercise for the time being. No optimal strategy has yet been defined for very high risk women. Advances in the control of cancer pain, in palliative care and in psychological counselling for cancer sufferers are also needed.

THE IARC ACTIVITIES IN BREAST CANCER

Breast cancer being one of the most frequent cancers in the world, several IARC programmes include it as one of the important cancers to be carefully monitored. This includes studies of descriptive epidemiology, such as incidence (Cancer Incidence in Five Continents, IARC Scientific publication N° 120, 1992) trends in incidence and mortality (IARC Scientific publication N° 121, 1993), and survival (IARC Scientific publication N° 132, 1995).

Currently, a lot of work is being devoted to the genetic epidemiology of breast cancer, in particular in the Unit of Genetic Epidemiology. The effect of nutrition and hormones on breast cancer occurrence will be studied in the Epic project of the Unit of Nutrition and Cancer. Finally, several studies are conducted by the Programme of Epidemiology for Cancer Prevention. A large multinational series of case-control studies of selected second cancers following breast cancer are conducted in national networks of population-based cancer registries in Europe. The main topic is the evaluation of the carcinogenic or anti-carcinogenic effects of Tamoxifen for various organ sites. Other studies deal with the natural history of breast cancer and determinants of breast cancer survival.

Dr Annie J. Sasco
Head, Programme of Epidemiology for Cancer Prevention
International Agency for Research on Cancer
150, Cours Albert-Thomas
F-69372 Lyon Cedex 08, France

Dr Rolando Herrero
Unit of Field and Intervention Studies
International Agency for Research on Cancer
150, cours Albert-Thomas
F-69372 Lyon Cedex 08, France

Continued from page 3

possible percentage of the population, include supervision and quality control of the laboratories involved in the process and guarantee adequate follow-up and treatment of all abnormalities detected through screening. Programs fulfilling these requirements require important investments and are therefore rarely feasible in developing countries.

The identification of HPV as the main cause of cervical cancer has recently opened the door for the development of vaccines against this disease, and several animal models have demonstrated that effective vaccines are feasible for the prevention and control of papillomavirus-associated disease. The development of human vaccines is still under investigation, but virus-like particles produced with recombinant technology are the most promising immunogens, and phase I and II trials will be initiated by several research groups in the near future to determine the safety, immunogenicity and adequate dose of the potential vaccines. Phase III trials will be conducted in larger numbers of people to determine the efficacy of the vaccine to prevent cervical HPV infection and CIN. In the meantime, cytologic screening should continue and be implemented in areas where it does not exist.
THE BREAST CANCER TRUST

A personal story

by Sara Davenport

I am not a doctor, a therapist or a counsellor, or even a person who has had cancer, but the more that I talked to people and listened to their stories, the more I felt that something had to be done to make the current information and services more universally accessible. One in three people will get cancer sometime in their lives - that's you or me, or someone close to us - and it is a very real problem that needs to be addressed now. I decided to set up a new charity, "The Breast Cancer Trust", to work hand in hand with the medical profession and the existing charities. Initially, we want to set up a day-care centre which will concentrate all the available information regarding treatment under one roof. So that every aspect of breast cancer - treatment, options, counselling, diet and complementary therapies - is easily accessible, in a friendly, comfortable environment, free of charge for anyone who needs that help.

Wendy Ricketts is now 34, and has looked after our two daughters, Sophie (6) and Alexia (2) since they were born. Three years ago, in August 1993, she went for her annual mammogram. Two weeks later she was called back, to check a suspected abnormality, and fluid taken from her right breast was then sent for analysis. Two weeks after that, she was given the results of the tests during a brief 10 minute interview which was to change her life forever.

Wendy was booked in for an operation on September 22. The doctor told her that they would remove her right breast and that she was lucky - they had hopefully caught the cancer early enough. She tuned up at the hospital two days before for blood tests and checks, went in on the Tuesday, and was operated on the Wednesday. After 9 days on the ward recovering she was sent home to continue with her life. Medically, the whole procedure was a triumph for the National Health Services - speedily and professionally handled. But for Wendy, both then, and in the months and years afterwards, it was a frightening and lonely time. For me, it opened my eyes to a world of which I had had no experience. I had never before had anyone close to me suffer from a life-threatening illness, and I had never paused to think about what such an illness might mean either for the sufferer, or for those close to them.

Gradually, as we came out of the initial paralysing fear, and life reverted to something akin to normal, I began to ask questions and talk more and more to people who had been through the same experience. Where once I had thought that Wendy had been unlucky, had "slipped through the net" (a phrase that was often repeated to me when I quizzed the facts that she was never offered any kind of continuing support), I found that her story was repeated over and over again throughout the country.

She was never offered any sort of counselling before or after her operation, and neither, apart from at her 3 month checks, did anyone follow her up to see how she was getting on, whether she needed any help or was having problems of any kind. She rarely saw the same consultant twice and letters confirming appointments were not personalised. None of it helped to make her feel that she was an individual or that anyone cared. At no stage was she offered any way of participating in her own recovery.

Breast cancer care in this country is still a lottery - medically much depends on the experience of the hospital to which you are admitted, and facilities vary from place to place. Mental/psychological counselling is available, and there are exceptional support groups throughout the country. Charities such as Macmillan, Breast Cancer Care and Bcup offer support to patients too, but is very much a question of knowing where to look for advice. The help is out there, but only if you know the right questions to ask or have a well informed GP to point you in the right direction. Wendy and I did not, and it took a long time, bit by bit, to build up a picture of the facilities that were available.

People often think about death when they hear the word cancer, but in reality there's a lot of living to do

We in Britain have the highest mortality rate from Breast cancer in the world, and currently 1 in 12 women in the UK will develop it in their lifetime, with figures predicting that by the year 2000 1 in 9 will be affected. They are frightening statistics, and it is hard not to conclude that we need to look more closely at treatments and complementary therapies used with success in other countries around the world.

I sat down one day, and thought about what I would want, if this happened to me. It seemed to me that long term, continuous support both during and after treatment would make all the difference to a patients recovery. To have the same people to talk to whenever you felt the need - people that had the time to listen to your problems, whether practical or emotional - that you could build up a relationship with, and that had been through everything that you had, must make a difference psychologically.

Support groups and counselling on a regular basis has been shown (most notably in David Spiegel's study published in the Lancet in October 1989), to improve quality of life and extend it. It is very healing to share your experiences with people who are in the same boat, and similarly, as studies from the Ohio State University show, feelings of isolation and loneliness have a quantifiable detrimental effect on patients physical well-being.

Diet and vitamin therapy are a crucial aspect of recovery. By building up the immune system you give the body the strength to fight on its own behalf. Many studies have been carried out with interesting results which might have been useful to have known about. High levels of oestrogen, for instance, are lined with breast cancer. Soya has been found to affect hormone levels in a way that mimics the effect of an anti-cancer drug and moderates the levels of oestrogen. It is perhaps because of this that Japanese women, whose diets are high in soya, vegetables and contain low levels of fatty foods, have the lowest breast cancer: rates in the world.

Australian studies into high fibre diets, with plenty of bread, cereals, fruits and vegetables, state that this can cut the risk of breast cancer by half. Again, they believe that there is some element in the fibre thought to affect the body's oestrogen metabolism.

Swedish doctors of the Karolinska Institute in Stockholm have shown that women with oestrogen dependent tumours are more likely to remain tumour free after the initial treatment if they follow a low fat diet.

I also believe that the mind plays an important part in cancer remission, and this is an area that the patient can have complete control of. Relaxation, meditation and visualisation can reduce the side effects of cancer treatment, the nausea and depression that often result from chemotherapy and radiotherapy. They have also been shown to make a difference to sleeplessness, pain and weight loss, and to promote a healthier appetite.

But the crucial aspect that needs to be recognised is that people are individuals; that what works for one is not necessarily appropriate for another. A diet may suit one patient, but be inappropriate for the next, and the same applies to every aspect mental, emotional and physical - of disease in relation to the individual. I strongly believe that every patient needs to be looked at as that individual, and the treatment varied accordingly.

People often think about death when they hear the word cancer, but in reality there's a lot of living to do. During and after treatment, and anything that can improve the quality of that living must be worth considering.

Ms Sara Davenport
Sara Davenport Fine Paintings Gallery
206 Walton Street
London SW3 2JH
United Kingdom

ENTRE NOUS 34-35, December 1996
Screening for breast and cervical cancer

Austria

Prevention of breast cancer

by Ernst Kubista

Austria has a population of about 7 million and covers an area of about 38,000 square km. About 60% of the population lives in cities of more than 300,000 inhabitants. The other part of the population lives in small towns and villages in the rural region of the country. About 70% of the country is covered by mountains and hills.

About 5,000 new breast cancer cases are to be expected every year with a typical rise in every age group. Austria is very well equipped with devices for radio-diagnostic mammography, ultrasonography, and the training standard of radiologists and sonographers is very high. In Austria, diagnostic mammography is performed by specialists for radio-diagnostic and not by gynecologists as for example in Germany.

So the conditions for screening programs from this point of view would be quite good but on the other hand the limitations for a program like this are the costs of its organisation.

So in Austria we are aware of the necessity to install a screening program. A few pilot programs have been performed in different areas of the country and have been finished successfully.

Although we have unfortunately no national wide screening programme yet in Austria, we have a very high standard of information on the problems of breast cancer and detection of breast cancer. This information has been given by the doctors (radiologists, gynecologists, general practitioners) and is distributed more or less in regular periods by print media, television etc.

Therefore the attendance of regularly mammography investigations in Austria is very high and the awareness of the threat of breast cancer is kept in the mind of women steadily. The following recommendations for breast cancer detection have been worked out on the basis of the US-recommendations and have been modified to the Austrian situation. They are as follows:

1. a so-called basic mammography at the age of 35;
2. regular mammography every two or three years until the age of 50;
3. regular mammography every one or two years after 50 till the age of 70.

With this strategy it was possible to increase the number of mammography's steadily and it was possible to increase the number of small tumours detected in the last decade.

Due to increased early detection, it was possible to increase the rate of breast conserving cancer therapy in our country and to release the women from their fear of being mutilated by total breast removal.

Cervical cancer screening

by Gerhard Breitenecker

Cervical cancer screening is the most efficient preventive measure for early detection of malignancy.

With regard to the organization of screening, there are two possible methods:

1. Organized screening of women of a defined age group who are invited to the cytologic tests at predetermined intervals (as is practised in the Scandinavian countries).

2. Opportunistic screening, which includes a cytologic smear, when women come for a gynaecological check-up (as practised among others in Switzerland and Austria).

Though the Austrian model allows only a limited statistical evaluation, the administrative expenses are low and the costs for a central data bank (which in organized programs amount up to 2/3 of the financial costs) are being omitted. In Austria, at this time 45% of all women beyond the age of 19 are cytologically examined annually. The number of annual examinations increased from 250,000 in 1969 to presently 1.5 million.

As a result, in the same period the mortality decreased by half from annually 900 to 450 deaths (from 23,000/100,000 to 11,5/100,000 respectively).

In addition to the gynaecological examination, a state implemented program for preventive medicine including cytologic examinations is offered and available free of charge to all women aged over 19, but utilized only by 4% of the female population.

Due to the lack of so-called "invitation-to-screening"-system in Austria, women in the age group between 25-40 are grossly over represented, whereas the frequency of cytologic examinations of women over 50 is seriously decreasing.

This is explained by the fact that young women in the course of pregnancy or because of requests for contraception are subjected to a gynaecologic examination including a cytologic test, whereas post menopausal women usually do not consult the gynaecologist until they have symptoms.

This explains why the average age of women with invasive cervical carcinoma is 60.

Laboratory structure

Austria is served by 60 cytology laboratories (for a total population of seven million) with a processing rate of 1.5 million smears. Thus, the average number of smears amounts to 20,000 per laboratory a year. Two thirds of the laboratories are run within public hospitals and about 1/3 are out under private management.

The laboratory directors are usually pathologists and sometimes represent gynaecologists or specialists in laboratory medicine. The laboratory directors of all three disciplines must additionally be certified as specialists in cytodiagnostics. This title may be granted after a three years training in cytology in addition to the six years of post graduate training in the various fields. It was implemented in order to guarantee a cytology with high quality and performance.

Similar regulations are valid for the screening personnel, who must be certified medical technologists with a three year training, and additionally undergo training in cytology before being appointed as cytotechnologist.

The introduction of organized screening with the invitation system and a centrally based data bank is scarcely to be expected in Austria because of limited financial means. However, there is overall support for the implementation of a quality control system with the approach for improving accuracy of the cytologic screening.

Incorporated in the quality control system are directions regarding the training of cytopathologists and technical personnel, regulations regarding continuing education as well as measures of quality assurance such as rescreening strategies, statistical evaluation and follow-up measures with histologic correlation.

Dr Gerhard Breitenecker
Director and Chairman
Gynecopathology and Cytology
University of Vienna, Medical School
Währinger Gürtel 18-20
A-1090 Vienna
Austria

Entre Nous 34-35, December 1996
CERVICAL CANCER IN EUROPE

Denmark
by Hanne Risør

KUN FOR KVINDER

The national health care system in Denmark is partly centralised and partly decentralised. The National Board of Health (NBH) makes recommendations and regulations for the primary and secondary health care services on behalf of the Minister of Health, but it is up to the health authorities in the 14 counties and Copenhagen and Frederiksberg municipalities to set their own priorities for the services offered. In general Danish citizens will have the same possibilities for treatment and preventive care wherever they live, but when it comes to cancer screening programmes there are regional differences.

BREAST CANCER
There is no nationwide screening programme.

In 1989 and in 1994 the NBH issued two statements on breast cancer screening concerning the use and organisation of mammography screening based on a 1987 report from the Danish Breast Cancer Cooperative Group (DBCCG). The statements recommend mammography screening every second year for all women in the age group between the ages of 50 and 69.

Only three areas of Denmark offer regular mammography screening as per the above recommendations. Copenhagen municipality began in April 1993, the county of Fuen in the end of 1993 and Frederiksberg municipality in the end of 1994. The first results from the screening programme in Copenhagen have just been published. They show a prevalence of invasive breast cancer of 1.2%. Compared to other recent Europe breast screening studies this result is much higher (Ireland 0.7%, Spain 0.6%, France 0.5% etc.). The report concludes: "that the first mammography screening in Denmark showed the highest breast cancer prevalence published so far".

As the breast cancer screening programmes in Denmark has only been running for a very short time it is difficult to say something about the screening programmes effect on mortality. Information from the Danish Cancer Society about the expectations in the future (when reading studies from other countries where breast cancer screening programmes exist) is that a 20-25% reduction in breast cancer mortality is possible among women who start screening at the age 40-49 years.

CERVICAL CANCER
In 1986 the NBH recommended screening for cervical cancer organised as follows:

1. A screening test every third year offered to women.
2. The examination should primarily target women in the age group 23-59 years.
3. Women between 60-74 years should in a number of years after a screening programme has started have the offer of a test, to make sure that women in this age group, who may never before have had a test, are tested at least once for cervical cancer.
4. The SMEAR method to be used, and
5. The Programme must be electronic data base registered and coordinated with invitation to women not examined.

In some areas of the country the screening began very soon after the recommendation was issued, but not all the recommendations were followed everywhere.

The county of West-Sealand began its SMEAR-screening programme along the 1-5 NBH recommendations in September 1996. It was the last country to join the programme. The programme invites all women between 23-59 years by a personal letter to have a smear-test every third year and women between 60-74 years to have at least one examination.

The examinations will normally be performed by General Practitioners (GPs), who already take smears as part of the primary health care they provide, when it is appropriate. The new approach is that the woman is invited by a letter to have the examination.

When the programme started, all GPs received a handbook with detailed procedures on how to take a smear, what to take special care of and how to proceed with further examinations and referrals based on smear results.

Five counties now have programmes organised as recommended by the NBH. Four counties and Copenhagen and Frederiksberg municipalities invite only women between the ages of 23-59 years. In the last counties the age group offered organise examination by invitation is narrower. These counties offer examinations every three years but only to women between 23-54 years (one county), between 25-45 year (one county) or between 35-49 years.

In 1995, 85% of Danish women aged 23-59 years were covered by cervical cancer screening programme, but only 29% of the women in the age group 60-74. As the last county has started in September 1996 the coverage will be higher next year.

When West Sealand County as the last county began its cervical cancer screening programme, it followed after a long debate also in the media showing that the highest procents of cervical cancer in Denmark was found in West-Sealand.

Only now, when every county and Copenhagen and Frederiksborg municipalities offer screening of cervical cancer, it will be possible to show how the screening influences the mortality of cervical cancer in Denmark, but in counties, when screening has been going on for some years, it has already shown to have a positive influence both on morbidity and mortality. The overall data (see table 1) show a decrease of cervical cancer incidence by 50% since 1963, and a decrease of deaths by 50% in the same period.

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PROSTATE CANCER SCREENING
There is no screening programme or recommendation for prostate cancer screening in Denmark.

TESTICULAR CANCER
The Danish Cancer Society has begun a broad based information campaign on testicular cancer, and has produced information leaflets on self-examination for men, with the aim of increasing early detection rates. It is yet to early to evaluate the impact of this campaign.

Dr Hanne Risør
President
Danish Family Planning Association
Skindergade 28, 1. & 2 sal
DK-1159 Copenhagen K
Denmark

Entre Nous 34-35, December 1996
Germany
by Elisabeth Rauterberg

Since 1971, people insured under the statutory health insurance scheme (i.e., 90% of the population) have been entitled to annual investigation for early detection of cancers (women from 20 years, men from 45 years).

The cancer screening programme for men and women covers cancers of the colon, rectum (occult blood test as from 45 years), skin and external genitalia (inspection); in addition, for women it covers cervical cancer (gynaecological investigation and cytological tests) and breast cancer (targeted history-taking and, from 30 years, breast palpation and guidance about regular breast self-examination), while for men it includes prostate cancer (rectal investigation). These cancers can be clearly identified by diagnostic measures at the precancerous and early stages and can be effectively treated at those stages.

The content of the screening tests is decided by a national committee made up of representatives of doctors and health insurance funds (Bundessausschuss der Ärzte und Krankenkassen); in particular, this committee also lays down the content of the related documentation. The findings obtained from the action taken in accordance with these guidelines are collated at national level, assessed and published by the health insurance funds and the associations of their registered physicians.

INFORMING THE PUBLIC IS THE KEY TO THE PROGRAMME

Preparations for introducing mammograph screening are currently under way. In the Federal Republic of Germany, levels of uptake of screening tests are some 16% for men and 40% for women. Since we are increasingly finding that it is precisely those people at greater risk of cancer who are poorly or not at all aware of the programme, we welcome the fact that a "Project to promote early detection of colorectal carcinoma" is being organized in southern Bavaria from 1996 to 1998 by the German Cancer Association (Frankfurt), with funding from the German Cancer Aid Fund.

Under this plan, colorectal carcinoma will be deliberately singled out from the screening programme. This strategy is justified by the new and persuasive scientific evidence of the effectiveness of screening for this tumour and is based on the recommendations for prevention of intestinal cancer issued by the World Health Organization (WHO) in 1994. The main aim of the project is to explain the purpose and value of colorectal screening to people who are entitled to it and, as a result, to markedly increase the uptake of this screening test. The positive attitude towards screening thus engendered will then be used to foster acceptance of the other screening services offered under the programme.

A lavish public relations campaign to be mounted in conjunction with the project (on bill-boards and in the printed media, at events focused on target groups and involving prominent personalities) has two aims: to give information about the project to people who are entitled to take up the service offered, and to strengthen the commitment of "outreach" professionals (above all, general practitioners) to the goals of the project. Doctors receive regular information about the current status of the project, are invited to attend further training/continuing education events and are kept involved in the project through other special occasions.

Professor Elisabeth Rauterberg
Ministerial Councillor
Federal Ministry of Health
Bonn, Germany

Portugal
by Maria da Purificação Araújo

Preventing cancers of the reproductive tract has been a major concern for public health policy makers over a long period of time. In the early seventies, the cervical smear test was being used regularly in Family Planning services and in postnatal examinations. In 1989, the National Oncology Program was introduced, which follows the recommendations of the European Union Program "Europe against Cancer".

Breast- and Cervical cancer screening is performed at the primary health care level by General Practitioners in Health Centers.

CERVICAL CANCER SCREENING

The target population are women between the age of twenty and sixty-four. Women are invited to attend the screening program by letter. The program aims particularly at reaching women who have never had a cervical smear test and women with high risk factors, such as: multiple sexual partners, a sexual partner with multiple contacts, women with a history of sexually transmitted diseases (especially of viral etiology), use of hormonal contraceptives and smoking, beginning of sexual life before the age of twenty.

According to the national recommendations, the first cervical smear test should be performed at the age of twenty, and repeated one year later. If both tests are normal, screening should be repeated every three years up to the age of thirty, thereafter every five years until the age of sixty-four. Generally, screening is not recommended in women above sixty-five, unless they have never had a cervical smear before. The recommendations regarding the periodicity and age at first screening are presently being revised.

Mortality rates for cervical cancer have remained fairly constant over the past ten years 3.2 per 100,000 in 1982 compared to 3.4 per 100,000 in 1992. Morbidity rates have also remained fairly constant with an incidence of 17.5 per 100,000 in 1989 and 17.65 per 100,000 in 1992.

BREAST CANCER SCREENING

The mortality rates from breast cancer have been increasing steadily since 1982. The rate was 23 per 100,000 in 1982, and 30.0 per 100,000 in 1992. Morbidity rates have also increased steadily. In 1989, breast cancer incidence was 48.8 per 100,000 while by 1992, it had already risen to 55.8 per 100,000. The national breast cancer screening program has therefore been reinforced.

The target population of this screening program are women from the age of twenty, particularly women with a family history of breast cancer, collateral breast cancer or atypical breast hyperplasia before menopause. Again, women are invited for screening by letter.

General practitioners and gynaecologists are advised to perform breast examinations every three years in women between twenty and forty, and every year after the age of forty.

The first mammography is recommended between thirty-five and thirty-nine as a baseline mammography. Between the age of forty and fifty it is repeated every two years, and above the age of fifty annually. For women with high risk factors, annual mammography is recommended above the age of forty.

Dr Maria da Purificação Araújo
Member of the National Committee for the Health of Women and Children
Ministry of Health
Lisbon, Portugal

Entre Nous 34-35, December 1996
Hungary
by István Batár

The recent report on demography and health by the Hungarian Central Statistical Office shows a negative demographic trend due to the decrease of live births and an increase in deaths since the early eighties. One of the major causes of deaths in Hungary today is female breast cancer. Among women, this cause of death rates fourth after ischemic heart disease, cerebrovascular disease and liver disease.

Over the past 50 years, the death rate due to breast cancer has tripled from 12 per 100,000 in 1947 to 35.41 in 1994. The increase is even more (more than fourfold) when the rate is calculated from the actual number of the Hungarian population (Table1). These figures include both the female and male breast cancer. Since the latter is almost negligible in numbers compared to the female one, the most dramatic change occurred in the frequency of the female breast cancer. In a 25 years period (1970-1994) female breast cancer almost doubled (Table 2) from 2.40 to 4.42 per 10,000. The increase is seen in every age group. The health care system has responded to this by initiating a mass-screening programme.

Combined Screening Programmes
It seemed most practical to combine breast cancer screening with screening for tuberculosis, which is also rising again in Hungary. In many centres paramedical personnel performing the chest X-rays are trained in manual breast examination, and examine every woman routinely. In case of a clinical suspicion of a breast tumour, mammography is recommended.

In addition, the board of gynaecologists has decided to make manual breast examination a routine part of every gynaecological examination. Since this has only been introduced recently, there are no data as yet as to how far this has increased the rate of early cancer detection.

Self-examination
A third component of the screening programmes is based on training women how to examine their own breasts, and to notice relevant changes. A number of pamphlets and brochures have been developed by the health authorities. These leaflets are distributed at health centers and gynaecological consultations. Again, it is difficult to assess the impact that self-examination has, but doctors have noted that more women are reporting changes they have noticed.

Although there are no exact figures on this, the experiences show that self-examination increased the awareness of women and not only early malignant cases but also benign tumors are recognized in increasing numbers.

BREAST CANCER CARE - Women are starting to help each other
Once breast cancer is detected, the patient is referred to a surgical department for further consultation and surgery. The main method of treatment was usually total mastectomy, but in the recent years partial mastectomies with removal of the axillary lymph nodes, if necessary, have been performed in increasing numbers. The surgery is combined with radiotherapy when needed, and adjuvant chemotherapy is also available. The decision is always based on the individual case. Psycho-social care at this time is, unfortunately, not provided routinely. Although there are self-help groups, the number of these is still too small.

CERVICAL CANCER - increasing in young women
Cervical cancer is not among the 8 leading causes of death. However, the fact that the disease was usually only recognised in its advanced stages was a major cause of concern and has led to the establishment of a screening programme for early detection. Thus more often, the premalignant or early malignant phases are discovered and treated, leading to longer life expectancy and better quality of life.

According to the last complete report on cervical cancer from 1988, morbidity from cervical cancer was between 26.7 and 28.3 per 100,000. The published data of the Central Statistical Office showed no significant change in the number and frequency of the malignant diseases of the female genital organs (Table 3). The overall death rate due to cervix cancer did not change in the last 25 years: 0.93 per 10,000 in 1970 and 0.99 in 1994 (Table 4). While the frequency decreased or remained basically unchanged in the age groups of 40-59 and 60-69, it slightly increased between age of 70-79 and dramatically doubled between 15-39 and over 80. The increase seen in the young population underline the importance of screening in any age groups.

Screening for cervical cancer is done by gynaecologists exclusively, the routine method used is oncology, but where available, a colposcopic examination is added. Smear tests are recommended bi-annually, but a routine annual gynaecological examination is recommended, this usually includes a colposcopic and oncocytoplogical examination. The existing screening capacity is sufficient to cover the whole of the target population, but many women do not take advantage of the available facilities and fail to come to the screening tests. Other women go to several gynaecological examinations per year, and a smear test is performed each time. Thus the high number of oncocytoplogical examinations performed per year does not necessarily reflect the number of women examined.

Ideally, screening tasks should be extended to general practitioners and paramedical personnel, but this depends on the general structural changes that the health care system is undergoing at present. Partial privatisation of health care has meant that the health insurances must take on the cost of preventive care, but the modalities of this have yet to be finalised.

Informing the population, and particularly women, of the importance of screening and preventive care and motivating them to take part in screening programmes remains a major challenge for us as health professionals.

Dr István Batár
Head, Family Planning Center
Department of Obstetrics and Gynaecology
University Medical School of Debrecen
P.O. Box 37, Debrecen, 4012, Hungary

Table 2
Number of deaths due to female breast cancer, by age groups, in Hungary between 1970 and 1994 (WHO ICD 9th Rev., 174)

<table>
<thead>
<tr>
<th>Year</th>
<th>&lt;14</th>
<th>15-39</th>
<th>40-59</th>
<th>60-69</th>
<th>70-79</th>
<th>&gt;80</th>
<th>Total</th>
<th>Rate/10000</th>
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<tbody>
<tr>
<td>1970</td>
<td>0</td>
<td>49</td>
<td>459</td>
<td>341</td>
<td>292</td>
<td>144</td>
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<tr>
<td>1980</td>
<td>0</td>
<td>84</td>
<td>608</td>
<td>399</td>
<td>444</td>
<td>265</td>
<td>1800</td>
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<tr>
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<td>696</td>
<td>576</td>
<td>534</td>
<td>486</td>
<td>2365</td>
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Table 3
Deaths due to malignancy of female genital organs in Hungary between 1948 and 1994 (WHO ICD 9th Rev., 179-184)

<table>
<thead>
<tr>
<th>Year</th>
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<td>1551</td>
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<td>1.80</td>
</tr>
<tr>
<td>1994</td>
<td>1803</td>
<td>1.76</td>
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Table 4
Number of deaths due to cervical cancer, by age groups, in Hungary between 1970 and 1994 (WHO ICD 9th Rev., 180)

<table>
<thead>
<tr>
<th>Year</th>
<th>&lt;14</th>
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<th>40-59</th>
<th>60-69</th>
<th>70-79</th>
<th>&gt;80</th>
<th>Total</th>
<th>Rate/10000</th>
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</thead>
<tbody>
<tr>
<td>1970</td>
<td>0</td>
<td>33</td>
<td>222</td>
<td>122</td>
<td>98</td>
<td>32</td>
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<td>0.93</td>
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<tr>
<td>1980</td>
<td>0</td>
<td>52</td>
<td>263</td>
<td>155</td>
<td>137</td>
<td>62</td>
<td>669</td>
<td>1.21</td>
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<tr>
<td>1990</td>
<td>0</td>
<td>70</td>
<td>199</td>
<td>142</td>
<td>117</td>
<td>74</td>
<td>602</td>
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<tr>
<td>1994</td>
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<td>117</td>
<td>111</td>
<td>65</td>
<td>532</td>
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United Kingdom

by Sue Row

As part of its “Health of the Nation” initiative, the UK Government has set itself two targets relating to cancers of the reproductive system. These are:

1. To reduce mortality from breast cancer among women invited for screening by 25% by the year 2000;
2. To reduce the incidence of invasive cervical cancer by 20% by the year 2000.

A major factor in achieving these targets will be the success of the two national screening programmes currently in operation in the UK. This article attempts to explain how these programmes operate, how successful they are and what further improvements are currently being considered.

BREAST CANCER SCREENING

The UK was the first country within the European Community - and one of the first in the world - to launch a nationwide breast cancer screening programme based on computerised call and recall. Women registered with a family doctor (known as a “general practitioner” or GP) aged between 50-64 are invited to be screened by mammography every 3 years, with screening for older women available three yearly on request. Regular screening of women aged 50 to 64 should eventually save 1,250 lives per year.

The National Screening Programme is modelled on recommendations of a Working Group set up in July 1985, chaired by Professor Sir Patrick Forrest. In February 1987 the government announced acceptance of the report and the setting up of a breast cancer screening programme throughout the UK. This was mainly implemented over the 3 years to 1990 to allow time to train staff and provide backup facilities for diagnosis, treatment, counselling and aftercare. The service is now operational throughout the UK and the majority of eligible women received their first screening invitations by 1993 (1994 in Scotland and Wales).

To meet the desired reduction in breast cancer mortality, a number of target standards have been set. In particular, the Forrest Committee set targets for the number of women taking up their screening invitations and recall, biopsy and detection rates. In 1994/95, the average UK rate for women accepting their screening invitations was almost 77% (target was 70%), a five percentage point increase over 1993/94. A heartening endorsement of the programme by British women, it shows that the service offered is, on the whole, welcomed by them. It is encouraging that almost 90 per cent of women who have been screened before return for screening three years later.

Of the 398,000 women in the UK aged 50-64 screened by invitation for the first time, 29,000 (7.2%) were referred for further investigation, biopsy or treatment. A total of 6500 cancers were detected in the target age range. Of these almost 4,000 were small cancers (less than 15mm across or at a pre-invasive stage). These small cancers present a challenge.

There is a need to strike a balance between enough treatment to damage the cancer and too much treatment which might damage the patient.

One of the key challenges for the breast screening programme now is to increase the number of women being screened both for the first and subsequent screen. This could include targeting areas of historically low take up or addressing ethnic concerns and continuing to evaluate the programme.

Additionally, three pilot sites are being established in the UK to evaluate the likely take-up and practicability of screening women aged 65-69. The results will be considered alongside the outcome of current research on screening more frequently than every three years and screening from age 40. Decisions can then be made on the most cost-effective way to improve the breast screening programme.

CERVICAL SCREENING

Cervical cancer is the single most common cancer in the developing world. Although less common in the UK, it still accounts for significant morbidity and mortality with some 2000 women dying from cervical cancer in the UK each year.

That is why we were the first country within the European Community to introduce, in 1988, a comprehensive cervical screening service based on computerised call and recall with computerised systems implemented in all District Health Authorities.

Cervical screening, using the smear test, is designed to detect abnormal cells before they become cancers and enable treatment to be given to prevent cervical cancer occurring. It is a priority to ensure all women aged 20-64 have the opportunity, and are encouraged, to have a cervical smear at least every 5 years unless this is inappropriate, for example if a woman has had a hysterectomy. Women aged 65 or over who have never had a smear or have not had 2 consecutive negative smears in the last 10 years should be screened too. Otherwise, it is recommended that women outside the 20-64 age group should only have smears when clinically indicated. The recommended maximum screening interval is 5 years. A 5-yearly screening programme can reduce deaths among women screened by over 80 per cent. Health authorities are free to invite women more frequently in the light of local decisions about resource use and priorities. Where an authority decides to screen more often than 5-yearly, it is vital that it maintain a high uptake rate and is satisfied that laboratories can cope with the increased number of tests.

Most cervical screening is undertaken in general practitioner (GP) surgeries. In order to improve take-up of cervical screening amongst eligible women, in 1990, a system of payments was introduced for GPs for achieving screening targets in women aged 20-64 (20-60 in Scotland) on their practice lists. Payments to GPs are triggered when targets of 50 per cent and 80 per cent of eligible women (aged 25-64) on their lists have been screened in a 5 and a half year period. At April 1993, 98% of GPs had received such payments, with 87% achieving at least 80%. Substantial progress has been made in increasing the number of women screened, and cervical cancer mortality is already falling by 7% per year.

The eventual success of the cervical screening programme will be measured by reduced cervical cancer incidence. The first full round of screening finished in 1993 but the natural history of the disease and the delay before cancers are registered means that it will be some years before the full effect on incidence can be demonstrated. In the interim, surrogate measures (uptake of screening invitations and interim cancer registration data) are being closely monitored. Coverage increased in 1994/95. Almost 86% of women aged 25-64 resident in England had been screened in the previous 5 years. Overall 0.6% of the tests demonstrated possible CIN III and 4.5% of tests were recorded as otherwise abnormal.

Maintenance of this high level of coverage means that the target reduction of 700 lives saved per year should be achieved. However, high uptake in many areas may mask lower uptake in metropolitan areas. Region averages range from around 75% to over 90%. Key challenges include targeting resources into areas of historically low take up or addressing ethnic concerns; and to find out why women do not attend for screening.

PROSTATE CANCER SCREENING?

Unlike cancer of the breast and cancer of the cervix, there is at present no established case for a national screening programme for cancer of the prostate. This is because the currently available screening tests are neither very specific (capable of providing a confident diagnosis of cancer if the test result is positive) nor sensitive (capable of detecting all prostatic cancers). Also, there is no professional consensus on how to treat men diagnosed with very early prostate cancer.

Ms Sue Row
Health Care Directorate
Department of Health
Eileen House, 80-94 Newington Causeway
London SE1 6EF, United Kingdom

ENTRE NOUS 34-35, December 1996
Screening for Prostate Cancer

Controversies and ideas

Though prostate cancer is the most common malignancy affecting European men, screening policies are still at the stage of development and subject to controversy in most European countries. Drs. Waxman, Sheer, and Savage of Hammersmith Hospital in London, have long been involved in the discussion and published several articles in the Lancet and the European Journal of Cancer on this issue. In England and Wales alone, there are 12,000 new cases per year and 8500 deaths. Prostate malignancy is present in 30% of all men aged over 50, rising to 50% of men in their eighties. The disease is increasing in incidence, and may well become the most common cause of cancer deaths in men by the year 2010.

Due to the fairly slow growing rate of prostate cancer (doubling time 4 months to two years), clinically apparent malignancy usually occurs at a median age of 72 years. This fact alone has made screening programmes seem superfluous, since it was argued that early detection of a disease occurring so late in life would hardly influence life years gained or the quality of life in the years remaining.

Current screening methods used for prostate cancer are a physical rectal examination and blood testing. Digital rectal examination has been the most important method used in screening men who are not presenting any symptoms ("well men screening"). However, the sensitivity of this method depends largely on the experience of the examiner, and nearly two-thirds of cancers detected by this method are advanced cancers. In more recent years, transrectal ultrasonography has been added to the examination procedure, and this is reported to have doubled the rate of detection, but again, this method is very dependent on the experience of the sonographer.

The most sensitive screening test currently available is the measurement of prostate-specific antigen (PSA) in the serum in combination with digital rectal examination and ultrasonography. The levels of PSA are closely related to tumour volume, and the concentration of PSA in the serum is closely related to the stage of tumour development. Measuring levels of PSA also helps in monitoring the impact of radio- or hormonal therapy in prostate cancer treatment.

Screening of an asymptomatic population using PSA may have its limitations, however. Several authors have shown that when PSA measurement is used in combination with digital rectal examination in patients who have urological symptoms, PSA measurement does increase the detection rates. Clinical trials are currently in progress in the USA and Europe in order to establish the cut-off points and respective PSA values.

What do we do, once early stage prostate cancer has been detected? Management options include observation, radical radiation or radical surgery. Cancer progression rates depend upon grade and stage of the tumour.

Do early invasive procedures really make a difference, or are their side-effects such that waiting until the disease becomes symptomatic is more sensible? Surgery is associated with serious side-effects. 40% of patients become incontinent, and impotence is present in 70% of cases. Radical radiation is associated with proctitis or cystitis, and long-term side effects include impotence. Until the question of appropriate treatment is decided by the scientific community, public health policy makers will not be able to make clear decisions on mass screening policies.

The editor

EUROPEAN NEWS

Money and Health:

In the West as in the East

By Marc Danson

THE EAST IN SEARCH OF A PROTOTYPE

In the nations of Eastern Europe, the health sector, regarded as non-productive, had only limited resources in the 1980s, representing between 2.5 and 6 percent of GDP, depending upon the country. Due to lack of funds, budgets reserved for health have risen very little in recent years, and in some cases may even have fallen. Characterised by extreme centralisation of resources and total control by the state, which financed total expenditure, the health system of the Eastern European states ensured total coverage of the population. Its faults are well known: an overabundance of over-specialised personnel, and over-hierarchical structures, lack of motivation and prestige among professionals, obsolescence of medical equipment, inefficient management in the health services and, as a result of all these weaknesses, poor quality of care. But it must be acknowledged, while admitting all its inadequacies, that this system had its advantages: the closeness of the health care user to the local organisation, and, above all, equal access for all, without distinctions or restrictions. Making all due allowances, health was truly regarded as a right in the countries of Eastern Europe.

The nations of Eastern Europe are now
reforming their health care systems, both in order to make a clean break with the past, and in order to face the severe economic problems that confront them. The transformation that is currently in progress is based largely upon the introduction of a market economy and privatisation. Almost everywhere, the declared intention is to set up a system of health insurance, in preference to financing by taxation. The most liberal models in the West are often used as a prototype, at the same time as they themselves are undergoing serious crises, and are being challenged in the countries where they operate. But structural reforms alone cannot compensate for lack of resources; on the contrary, they are likely to make the problems even more dangerous and dramatic. Clandestine financial transactions, which were endemic in the past, find fertile ground in which to flourish in the present turbulent climate.

One must also question the soundness of some international aid, which has been encouraging the rapid development of privatisation and a market economy in the health systems of these countries. The immediate consequence of these changes is that costs rise, outstripping the means of a growing proportion of the population to meet them, thus leading to greater inequality. The sudden rise in prices of pharmaceuticals is a good example. In some cases, imported products are found on the market, which cost many times more than medication of the same quality, previously manufactured locally. This is one of the causes of the present shortage of vaccines.

This policy risks contributing to the deterioration of the health of the population, which is already precarious. At present, life expectancy is, on average, six years lower in the countries of Eastern Europe than in the West. The major concerns are the rise of epidemics such as diphtheria, poliomyelitis, tuberculosis, typhoid, malaria, respiratory and diarrhoeic diseases which increasingly strike children, and cancers and cardio-vascular diseases which are particularly common among males around the age of fifty. Women, for their part, pay a heavy price in the form of abortions, still regarded in some countries as a means of contraception more flexible and economical than the pill or the condom. The situation is exacerbated by the risks attendant upon a poorly-controlled environment, and lifestyles that may be dangerous. Evidence of this is provided by rising consumption of tobacco and alcohol, and the increasing accident, suicide and murder rates.

**ECONOMY AND HEALTH: TREATING ONE EVIL WITH ANOTHER?**

In the West, as in the East, reform seems to be based upon the hypothesis that the only remedy for the crisis faced by health care systems is an economic one. This rather limited preconception leads to various inconveniences, or even tangible risks for the health of the population, especially the underprivileged. Strangely, it takes no account of the evolution of attitudes and knowledge which have developed in the domain of public health in the past few decades. The fundamental idea of this approach is that improvement in health cannot be limited to the treatment of illness. Important gains in health can be achieved by means of action from above, affecting the environment and behaviour, by legislative measures, education and information, and by developing coherent programmes of prevention and health promotion. The success of such measures requires real will and political courage, which have sometimes been lacking in this part of the world. A good illustration of this is the vaccination which has marked, all over the world, policies on prevention of tobacco use and alcoholism. Policies which are resistently oriented towards prevention and promotion of health contribute, without any doubt, to reduction of expenditure. They also have the advantage of mobilising health professionals, and the population at large, towards positive and stimulating objectives. The missing link in all these reforms is the people themselves, while their active participation in the promotion of their health, and their support for change, are indispensable for success.

**TOWARDS A NEW MEDICINE**

This plea for prevention and for promotion of health must not lead us to forget the importance of caring for the sick. Most of the time, health professionals are called upon, in order to motivate them to rationalise their services and prescriptions. This form of participation in control of expenditure is legitimate. There is no question of challenging this, especially where it leads to the development of innovative mechanisms of economy, ensuring a more equitable coverage for patients and higher quality care. Physicians, especially young ones, aspire towards this kind of development of their practice; but it remains to clarify, with them, the framework, and to give them the necessary means, without disguising the scope of such a change. Instead of being perceived solely as one who cares for the sick, the doctor will also have the task of participating more fully in protection and promotion of health of individuals and of the community as a whole. The doctor’s intervention will no longer therefore be only diagnostic and therapeutic, but also educational and communal. Whatever the system and form of remuneration that is in operation, it is necessary to introduce incentive-based financial measures, in order to reward at their true value activities such as preventive counselling of patients, for instance in the realm of contraception, or on the use of tobacco and alcohol. Participation by physicians must also be encouraged in collective campaigns to promote health in schools, workplaces, and other living environments of the population.

**BETTER INTEGRATION OF KNOWLEDGE INTO REFORMS**

These ideas are not entirely new. They were stated in the joint declaration of WHO and UNICEF of Alma Ata, adopted in 1978, and in the Ottawa Charter of 1986. They form the basis of the policy of “Health for All,” developed by the WHO European Office since 1984. This policy has, in recent years, stimulated the production of many studies, the establishment of networks, and elaboration of strategies for promoting public health action. The current reforms to health systems do not profit sufficiently from this expert knowledge, and too often confine themselves to economic and financial treatment of the present crisis. Hence they risk an economic failure, exacerbated by an aggravation of the health situation, already seriously compromised for the most underprivileged populations and nations in Europe.

Dr. Marc Danzon
Director of the Department of Health Promotion and Disease Prevention
WHO Regional Office for Europe
Copenhagen, Denmark

Dr. Priscille Poltrinal, intern in public health.

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ENTRE NOUS 34-35, December 1996
The effects of the 1993 Anti-Abortion Law in Poland

by Wanda Nowicka

Polish abortion law belongs to the most restrictive ones in Europe. In a definite majority of European countries abortion is accessible on women's request. Even in those countries where accessibility of abortion is limited, it is still more accessible than in Poland. In Spain, Portugal and Switzerland, abortion is legal when pregnancy constitutes a threat to the life or health of the woman, including the threat to her mental health, as well as when the pregnancy is the result of rape or other sexual crimes and in the case of embryo damage. In Hungary, abortion is legal additionally in a case when a woman has difficult life conditions. Only Ireland has a more restrictive law than Poland. Abortion is legal in Ireland when the woman's life is threatened, including a situation when there is danger of suicide.

Outside Europe, abortion is accessible on request in the USA, Canada, the Newly Independent States, China, Mongolia, Singapore. Abortion is available in case of a difficult personal situation in six countries of Africa, in Australia, New Zealand, India, Japan, Corea and Malaysia. Restrictions, similar to those existing in Portugal, operate in most Latin American countries, one third of African countries, Pakistan, Thailand, New Guinea. Regulations, like those in Ireland exist in several South American countries, half of Africa and most south-east Asia.

ACCESS TO ABORTION IN POLAND

The law on family planning, human embryo protection and conditions of legal abortion, commonly known as "anti-abortion" law, has been in force in Poland since March 1993. According to the law abortion is legal in the following cases only when:

1. pregnancy constitutes a threat to life or a serious threat to the health of the mother, which is confirmed by two doctors other than the doctor involved in the abortion;
2. prenatal examination, confirmed by two doctors other than the doctor involved in the abortion, indicates heavy, irreversibly damage of the embryo;
3. there is justified suspicion, confirmed by a prosecutor, that the pregnancy is a result of an illegal act.

The doctor who performs illegal abortion is subject to the punishment of up to two years of prison. Any abortion must be performed in a public hospital. Women in difficult personal situation seek the termination of unwanted pregnancy at all costs, regardless of the fact that they break the law, often risking their health or life.

The anti-abortion law is not observed and, moreover, it results in various abnormal phenomena. One of them is the existence of illegal abortions performed by means of "abortion underground" and "abortion tourism".

ABORTION UNDERGROUND

The underground abortion services are highly developed. This is evident from:

• Abundant advertisements of individual doctors and cooperatives that appear regularly in both national and local press: "Gynaecological services - full range". Recently, new advertisements can be found like: "Gynaecologist - everything (the cheapest)" or "Gynaecologist - absolutely everything" etc. Permanent and regular appearance of these announcements and their growing number constitute an indirect proof of an existing and growing demand for this type of services.

• Testimonies of many women given to the Federation for Women and Family Planning or published in mass media. Women who have used or wanted to use private gynaecologists services are a source of information on their average prices. It is estimated that the average price for an abortion is 400 USD. An average monthly salary in Poland is ca 300 USD. Some doctors, however, and particularly some doctors' cooperatives collect much more: 600 USD - 800 USD. In Warsaw prices are much higher than anywhere else in Poland.

• It seems that abortion services are performed mainly in big cities; in smaller ones the doctors are too afraid of getting caught. They may decide to perform abortions on women whom they know or who have been sent to them by their acquaintances and their decision is often spurred by humanitarian reasons and not only financial interests.

• The existence of underground abortion services is also confirmed by some doctors. An example is a statement of an anonymous doctor who said, answering in a poll conducted by Polish most popular daily Gazeta Wyborcza (July 14, 1995):

"I have been performing abortions for a year. In our cooperation there are only two doctors who do not the rest are scared. But you cannot send away a desperate woman. This is how I understand the Hippocratic Oath. Undergraduate abortions? They flourish - and not due to old women, who use crochet hook and herbal brew. Polish underground abortions are performed in sterile conditions and by people wearing white uniforms." 

• The presence of abortion underground is also confirmed by the government report that informed about several dozen investigations and legal cases initiated in reference to these services.

ABORTION TOURISM

Abortion tourism is also highly developed. Most women go to Poland's eastern and southern neighbouring countries, e.g. to Lvov (Ukraine), Druskieniki (Lithuania), Kaliningrad (Russia), Minsk (Belarus), to Czech Republic and Slovakia. Polish media repeatedly informed about abortion trips to Kaliningrad. The cost of an abortion there is comparatively low (200 USD), but the sanitary conditions are bad and women often suffer medical complications.

Much fewer women can afford to seek abortion in Western countries. The abortions performed there are much more expensive but the medical services are of much better quality. Polish women most frequently go to Holland, Germany, Belgium and Austria. In one of the Berlin clinics of family planning we were told that their centre is visited by 15 Polish women a week. The price depends on how advanced the pregnancy is and on the type of anaesthesia (from 400 to 1,300 USD)

The Federation for Women and Family Planning possesses the materials provided by an anonymous agency which was organising abortion trips to one of Polish southern neighbours. The agency started its service immediately after the "Code of Medical Ethics" came into force. The Code of Medical Ethics adopted by the Medical Council introduced serious restrictions to abortion, two years before the Parliament passed the anti-abortion law. It was that early that Polish doctors were threatened and refused to perform abortion. Before the anti-abortion law came into force we performed circa 20 abortions. The representative of one agency says: "After the anti-abortion law came into force for 2 or 3 months the doctors were so scared that they
refused to do any abortions. The greatest demand for our services existed in 1993, in the first 3 months after the law came into force. At that time in one private clinic, 2 state hospitals, 6 gynaecologists, 3 anesthesiologists and several nurses and we facilitated about 220-250 abortions. Later in 1993 we helped perform on average 60-70 abortions a month. In 1994 we facilitated on average 40-50 abortions a month. In this period we facilitated in total 1200 abortions. The demand for these services is seasonal, most are performed in spring and autumn."

AN ESTIMATED 16,000 POLISH WOMEN SEEK ABORTIONS ABROAD EVERY YEAR

On the basis of research done by the Federation, it is possible to attempt to estimate the number of illegal abortions performed on Polish women both in and outside Poland.

The data obtained confidentially from the above mentioned agency confirm that within two years it "organised" about 1,500 abortions. On the basis of press advertisements it was concluded that at least 20 similar agencies operate in Poland. Assuming that each agency facilitated on average at least 800 abortions, the outcome is roughly 16,000 abortions performed yearly on Polish women abroad. One has to also take into account that a remarkable number of women living close to the border go to foreign clinics without the help of any agencies. Moreover, our research shows that in private doctors' surgeries in Poland at least two time more abortions are performed than abroad.

In all, that make roughly 40,000 - 50,000 abortions a year.

UNPROFESSIONALLY PERFORMED ABORTIONS

There are cases of the poorest, uneducated women who do not want to have a child and they decide on desperate acts.

Information concerning such cases is difficult to obtain. For different reasons the health service informs only about the most severe cases. Doctors and other health service employees inform only anonymously that there are frequent cases of women who come to hospital to "finish off" an abortion which was started by artificial widening of the cervix, which led to infection and miscarriage.

OTHER SOCIAL CONSEQUENCES

Abandoned children

The number of children abandoned by their mothers increased since the introduction of the act in 1993.

Table 1. (Data from the Computer Office of the Statistics Department of the Main Police Headquarters in Warsaw)

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Babies abandoned in hospitals

The data on the babies abandoned by their mothers in hospitals are not regularly collected by the Ministry of Health. This data was collected only once in 1993 because of the Ministry’s obligation to present a report on the implementation of the anti-abortion act. But the Ministry does not possess this data for 1994. In the previous years, the statistics were the following: (Table 2)

Table 2

Number of infants abandoned in hospitals in selected voivodships (Report on the implementation of the act on family planning, governmental paper, Ministry of Health, 1993)

DEMOGRAPHIC TENDENCIES

Some significant changes concerning the birth rate have been noticed in Poland. According to the Statistical Yearbook of Demography (1995) it can be observed that while the birth rate has been decreasing for several years (1.85 in 1994, 1.8 in 1995), there is growing number of teenage pregnancies (8% of births) and late pregnancies (11% of births); in 80-ties early and late births constituted 6% and 6% of all births.

LEGAL ABORTIONS

The fearful phenomenon that was observed already in 1992, when the Code of Medical Ethics came into force, still exists: The anti-abortion law is much more restrictive in real life than on paper.

Women who have right to legal abortion are often refused it even though they have all necessary certificates.

This is a specifically Polish phenomenon and it results from the imperfect character of the anti-abortion law. The law allows for free interpretation of provisions regulating accessibility of legal abortion. Lack of mechanisms of control as well as "feudal" relations governing hospitals allow for situations when the director of the hospital on his own makes a decision to refuse the abortion and does not take into account the opinion of other doctors who, privately, have a different view on the issue. The conscience clause gives an individual doctor, not a whole hospital, the right to refuse to perform abortion. In other countries, the question of refusal to do abortion on the ground of the clause of conscience is precisely described by law. It gives the doctor the right to refuse to perform the abortion but also provides for the woman’s right to have an abortion. The doctor who refuses to do it is obliged to direct a woman to a doctor who will perform it. In Poland this issue has not been regulated. Observation shows that the doctors are afraid not only of priests but even of orderlies or nurses who may inform on the doctor. The Federation has obtained information on many cases in which the woman was not able to execute her right to abortion in the hospital.

It happens that the director of the hospital who is responsible for the decision questions the certificate that was issued by other doctors, and thus, he questions their honesty and competence.

The government report on implementation of the anti-abortion law does not mention this problem, since women do not report on doctors who refused to perform abortions. "The fact that patients do not lodge complaints the Ministry considers a proof that this right is recognised".

The Federation is convinced that women do not lodge complaints to the Ministry of Health for the following reasons:

1) They often want to forget about the nightmare that they had to go through when they were trying to get an abortion: running around to find the doctor ready to perform the intervention or each day having new medical examinations which delay the abortion and give a pretext finally not to perform it because it is too late. Moreover, this pretext is also illegal because it is not stated in the law that abortion cannot be performed after the 12th week of pregnancy. Women, however, do not know about it and it never occurs to them that they could make a complaint.

2) They are afraid of being “caught” and prosecuted. If, according to the certificates they once were pregnant and afterwards they are not, immediate question arises: what happened to this pregnancy?

EFFECTS FOR THE ANTI-ABORTION ACT ON MENTAL HEALTH

The Polish psychologist Andrzej Samsoor,
claims that the anti-abortion act has had a strong influence on the life of Polish families. In our society, sex has always been a taboo and was treated as a source of guilt and sin but this attitude to sexuality has been strengthened after the introduction of the act and particularly due to the teachings of the Roman-Catholic Church and public discussions on abortion.

Above all, sexuality is not treated as a source of satisfaction and pleasure but a source of fear and danger.

This aspect of human life stopped being private and became a public issue on which one has to report. Samson says that fear of unwanted pregnancy and usage of ineffective natural methods of family planning caused avoidance of sexual life by women out of fear of unwanted pregnancy. It seems that Poles have sex less frequently than before and less frequently than they would want to. The fear of unwanted pregnancy is so strong also because those patients who are Catholic refrain from using any other contraceptives than the natural methods of family planning but at the same time they do not believe that they are effective. Thus, on the one hand they do not use effective methods of family planning and on the other, using the methods allowed by the Catholic Church, they live in permanent fear. Those Catholic women who use a pill or an IUD are bothered by guilty conscience.

So what if a woman gets pregnant? Many women who got pregnant decided to have an illegal abortion, even though they feel terribly guilty. Samson also pointed to the fate of those unwanted children who will be born anyway.

Samson’s observations are fully confirmed by other psychologists and sexologists. Doctor Anna Sierpowska-Ketner points to the fact that gynecologists often not only do not recommend to women any contraceptives but strengthen in women the conviction that contraceptives are harmful. Many of them follow by recommendation of Doctors’ Councils (the bodies regulating matters of ethics) and tell women about contraceptives only on their own request.

Dr Sierpowska claims, on the basis of her medical practice and many letters from women all over Poland which she answers for the women’s weekly Przyjaciolka, that many women are “frighted to death” of pregnancy and they avoid sexual contact with their partners.

Also doctor Arnold Pawelski, sexologist, has commented on sexual problems resulting from the introduction of the law. He divides his patients into two types - those with more liberal and those with more traditional views. He claims that in women who belong to the first group “the feeling of guilt rooted in the moral values received in childhood (…) and skillfully strengthened by the supporters of the act, develops unnoticed but comes to the surface in a very harmful way. This feeling of guilt is irrational, it contradicts the system of their values so it is strongly suppressed and it often remains subconscious. But suppressed feeling of guilt, its permanent presence in the subconscious makes it stronger, which leads to internal dissonance, dislike towards their own body and themselves generally. They become depressed and reluctant to have sex which before used to be a source of much satisfaction.

On the other hand, women who accept traditional, Catholic moral values, in face of stronger and stronger feeling of guilt aroused by sex, experience sexual problems such as frigidity and inability to reach orgasm. “Initial research conducted by the Centre of Clinical Sexology provides data that since the introduction of the anti-abortion law the number of patients in the first group increased by 45% and in the second group by 70%.

When the anti-abortion law came into force similar problems were mentioned by women that called the hotline, operated by the Federation since 1992.

FAMILY PLANNING

Family planning is only used by a small portion of Polish society. Poland, unlike other countries, does not collect statistical data on contraceptive prevalence. The government report states, on the basis of data obtained from pharmacies that only 2.2% of women use the pill.

There are many obstacles that limit the availability and usage of contraceptives in Poland. Among them are:

• Small number of institutions promoting family planning. This issue is covered predominantly by non-governmental organisations with limited capacity and almost no support from the government to develop their services adequately.

• No access to education and information. Information on family planning is practically non-existent in the institutions whose duties include its promotion, like health centres or schools.

• Financial obstacles. Many women say that they cannot afford contraceptives since they are too expensive.

• Doctors. Many doctors do not promote contraceptives because they either do not have sufficient knowledge or they are against contraceptives themselves. Some doctors do not propose contraceptives to women because they are afraid of the Church criticism. Definite majority of doctors follow the instructions of the Doctors’ Councils to offer contraceptives only on woman’s own request. Many women, and not only in small towns, complain that they have problems obtaining a prescription each month.

• Consistent propaganda of the Roman-Catholic Church against family planning; this is done in sermons as well as during confessions or religion classes. Also Catholic media and organisations that promote natural family planning methods lead a campaign against contraceptives. This campaign is fought in two ways: on the one hand, religious arguments are used and on the other - quasi-medical arguments are engaged (that contraceptives are harmful).

SEX EDUCATION

The anti-abortion law obliges the Ministry of Education to introduce sex education to school curricula. Maria Trawinska prepared a report on sex education provided in Polish schools on the basis of research conducted in 707 schools represented by their teachers: 61.7% teachers of primary schools (41% in cities, 20.7% in villages), 15% of secondary comprehensive schools and 22.5% of vocational schools.

The sex education program, introduced following the Ministerial order, was not preceded by any preparatory process like training of teachers of preparation of school textbook etc. The definite majority of textbooks recommended by the Ministry of Education are based on the Roman-Catholic Church’s teaching on family planning. Only 10% of schools stated that they could easily implement the instructions of the Ministry of Education.

Another 10% of schools have done nothing to provide sex education. The remaining schools took up different action depending on their means and good will. 43% of schools have created their programs, but 53% have prepared no such programs. “There is chaos in terms of the subjects and the organisation of classes. Neither the teachers nor the students have a consistent program to follow and subjects are treated at random, nobody controls what effects the classes bring in terms of education, socialisation, teaching patterns of behaviour or even providing information.”

Those teaching the subject are: school counsellors (22.6%), teachers of Polish (29.2%), biology (24.6%), mathematics, history, sport, teachers of vocational subjects and nuns and priests teaching religion (2.5%).

Self-evaluation of those teachers is low: 60% claim that neither they nor their colleagues are qualified to teach this subject. The research on the basis of objective criteria confirms this self-evaluation. The level of knowledge on sexual life among the youth is poor. Apart from the lack of basic knowledge Trawinska confirmed that many false beliefs are cherished by young people.
The story of abortion law in Poland

by Bogdan Chazan

In 1956 an abortion law was introduced in Poland. It permitted a woman to have an abortion for medical and social reasons. In practice the "social reasons" were flexible enough to cover any cases of requested abortion, other than indicated within the law. Abortion on demand was practised widely in public hospitals and private outpatient clinics. According to official data the highest number of 200,000 abortions was performed in 1962. The real number was estimated as being twice as high. Nobody asked women requesting abortions about the reasons of their decisions, the pregnancies were interrupted under clinic conditions without any control by state authorities and reporting. After the political changes in Poland, dissatisfaction from hitherto existing unfair laws and regulations became universal. The existing abortion law was perceived as a relic of Communist regime reducing the value of human life, and a threat to the biologic substance of the nation.

The new law called "On legal protection of the conceived child" referred to Christian social ethics and the moral authority of the Roman Catholic Church and was passed by Parliament in March 1993.

Abortion was permitted when pregnancy constituted a serious danger to life or health of the mother, when the fetus was heavily and irreversibly damaged and when pregnancy resulted from incest or rape. The unprecedented debate in the mass media, universities, social circles and parliament commissions preceded this act resolution. The abortion law was a compromise between different radical drafts.

Opponents of new regulations expected horrible consequences. Pro-abortion groups attempted several times to liberalise it. They saw in their imaginations a huge number of poor imprisoned women. The significant rise of maternal mortality rate was foreseen as well as the worsening of women's health status and rise of low birth weight rate. All these occurrences were anticipated as result of massive number of illegal abortions performed by non authorized people outside the health service or abroad.

Abortion law in Poland was and still is seen by liberal and left-winged societies as non modern or even backward oriented and contrary to regulations in other European countries with the exception of Ireland. But they are not right utterly. Law regulations in Italy (1978) and Spain (1985) term the abortion from social reasons as illegal. According to the Federal Constitutional Court of Germany, abortions for criminal reasons and medical indications are legal but abortion on simple request of the pregnant women is illegal, unless a woman has received counselling beforehand. To protect the unborn child not prosecution but counselling was stressed.

The practice is similar in Poland. In spite of penal impenancy only a few trials were submitted to law courts and hardly anybody was imprisoned to date.

What is the scope of underground abortion or abortion tourism? No one knows the exact data. According to official figures 559 abortions were performed in 1985 comparing to 82,000 in 1989. As I have already mentioned abortion data had never been totally comprehensive in Poland.

However, in spite of previous expectations maternal mortality as well as low birth weight rates are decreasing. The increasing number of miscarriages reported by public hospitals would be another indicator of increasing illegal abortion rates (spontaneous abortions "induced" outside hospitals). This however, was not found. What is more, the number of miscarriages in 1994 was six thousand less than in 1993.

There is no proof that women's reproductive health indicators have actually worsened.

The whole country discussion about abortion, fetus appearance, moral, social and medical grounds resulted in a growing awareness of the fetus as a real human being not as simply clot of tissues.

Common observations indicate a growing interest in various methods of family planning. Modern contraceptives are available in pharmacies.

The UNFPA and Polish Government Project "Reinforcing Maternal and Child Health Care and Family Planning Activities" is realised in three regions of Poland with a chance to be expanded to the whole country after 1997. Another UNFPA Project "Promotion of Responsible Family Planning and Healthy Family Lifestyles" is introduced in schools within the majority of Polish regions. Natural methods of family planning are widely accepted and practised with probably no harm to women's and families health.

According to the recent public opinion survey (12-14 September CBOS) only a small number of abortion opponents are uncompromising antagonists of abortion. 85% will accept it when the life of the mother is threatened, 71% when pregnancy results from rape and 61% when fetus is hopelessly damaged. 42% of respondents accept the social reasons.

However, the changes in public opinion are not followed by law makers. The Lower chamber of the Polish Parliament dominated by the post-communist coalition liberalised an abortion law on October 24 this year by 228 to 195 votes, eight more votes than were needed to override a veto by the Senate. Women will be able to request abortions if they face financial or personal problems after counselling and three days for thought. President Mr A. Kwasniewski said that he would sign the law bill.

The question about longevity of this act remains unanswered.

Dr Bogdan Chazan
Head
Clinical Department of Obstetrics and Gynecology
National Research Institute of Mother and Child
ul. Kasprzaka 17a, 01-211 Warsaw
Poland

Post abortion Care - A reference
Manual for Improving Quality of Care.
This manual was developed in part, to increase awareness of the high rates of maternal mortality and morbidity caused by incomplete abortion in many areas of the world. It is designed to provide clinicians (physicians, nurses and midwives) with essential information on the provision of comprehensive postabortion care services. It is intended to assist clinicians in treating incomplete abortion and its life-threatening complications. The manual outlines the full range of activities needed to provide appropriate, high-quality postabortion care, including family planning and referral to health care services needed after emergency treatment.
Reproductive health and family planning in Bosnia and Herzegovina

Results from the first year of a post-war programme

by Fedja Omeragic

hagen for a seven-day "Train the Trainers" workshop. From April to July, Cantonal Teams organized four monthly workshops for 15-20 local health providers.

In most cases, the health institutions received supplementary reproductive health materials in the form of reproductive health kits. However, a major emphasis of the programme lay outside the medical sector. Cantonal Teams set about to engage youth groups in discussions and educational activities.

Practical information on sexual health, hygiene, and contraception was delivered through seminars and lectures in primary and secondary schools. As a follow-up, radio and television broadcasts were organized on related topics: "Youth and contraception", "STDs", "Safe sex", and others. Round table discussions were held in Tuzla with more than 200 youth. Zenica organized a television talk-show on cervical cancer. East Mostar has established a weekly "sexual health hot-line" radio programme.

The response from these communities, and the youth in particular, has been overwhelming. It is perhaps the consequence of a restored flow of information which has been so desperately desired for the past five years. Or perhaps it is the introduction of new channels and formats for information dissemination. In any case, it should be interpreted as an extremely positive sign for Bosnia and Herzegovina. Once again the population is being empowered to assume control over their health and happiness.

Dr Fedja Omeragic
National Reproductive Health Project Coordinator
WHO Regional Office
Midicinski Fakultet
Univerzitetska 1
75 000 Tuzla
Bosnia & Herzegovina

Nearing the end of 1996, more than 500 health professionals have been trained in reproductive health issues. reproductive health materials have been widely distributed, and youth have become actively involved in public discussions. These are the principal achievements of a joint UNFPA/WHO project in the Federation of Bosnia and Herzegovina.

At the outset of the project, the obstacles were enormous: a devastated health system, a weary population, a taboo subject, great and continuous migrations, and the absence of accurate demographic data. Many of these impediments still exist but the programme's success stems from the commitment and enthusiasm of a core group of health professionals. Cantonal Reproductive Health Teams, consisting of a gynaecologist, a general practitioner, and a patronage nurse/midwife, were established early in the year. These teams met together in Copen-

A 'Storyboard' after the first local workshop, April 1996

ENTRE NOUS 34-35, December 1996
Epidemiology of Abortions in Russia

by Ekaterina M. Vikhlyayeva and E. Nikolaeva

The prevailing high rates of abortions in Russia have been a concern of the Public Health authorities during the past years. The Ministry of Health as well as Oblast health authorities have been making efforts to provide information and to make modern contraceptives available at an affordable price where possible. Despite this, many women still seem to see abortion as the main or only effective mean of fertility regulation.

In order to find out why many women have to resort to abortions and to lay the foundations for more effective strategies of abortion prevention, a pilot study on the epidemiology of abortions in Moscow and the Moscow region was conducted by the Research Center of Obstetrics, Gynecology and Perinatology in cooperation with the Sexual and Family Health Unit of the European Regional Office of the World Health Organization.

Three hundred and fifty two women who had just had an abortion were interviewed by means of a standardised questionnaire by their consultant physicians. 221 women were from the city of Moscow and 131 women lived in the rural areas around Moscow. The age distribution in both groups was comparable, covering women from the age of 15 to 44 years. The majority of women questioned were of Russian nationality (93.9% in the rural, and 83.2% in the urban areas). About 73% of the women were married, 17% were in union with one partner, the rest were single, divorced or widowed.

The majority of women in both the urban and rural group were civil servants or employees, about one quarter to one third were factory or farm workers, only 8% in the urban and only 5% in the rural population were housewives. The majority of husbands or partners in the urban areas were employees, in the rural areas workers. A question regarding the profession of parents of women coming for abortions was also included - in both groups, the majority of both mothers and fathers were employees.

Russian women marry young

Most patients had their first sexual contact before the age of 19, with an equal distribution in the age groups of 15 to 17 and 18 to 19. Less than one quarter of patients had had their first sexual experience when they were over 20. The average marital age was surprisingly young with 49% of patients having married before their twentieth birthday. On average, husbands were five years older than their wives.

The first pregnancy is welcomed

Most (89%) of the patients presenting for an abortion had already had previous pregnancies. Over three quarters of the first pregnancies had been carried to term and resulted in live birth. Of the following pregnancies, many had been terminated by abortions, so that only about one third (31.6%) of all previous pregnancies had resulted in live births. Only 10% of abortions were performed on the first pregnancy.

At the time of the present abortion, over 80% of the women from urban and rural had children. About 15% of these children were still under one year old.

"We can't afford more children"

The reasons given for the present abortion were as follows: The majority of pregnancies were unplanned (96%), nearly half of the women said that the living and economic conditions were too difficult. Many women were worried about their own health status. Several women gave the health status of the husband or alcohol abuse by the husband as a reason for the abortion.

Physical examination showed that, in fact, about 40% of the patients presented with inflammatory diseases and infections of the vulva, vagina, uterus or adnexes. Benign and malignant tumours were discovered in 4.2% of cases. Of the infections treated prior to the abortion, candida had been diagnosed in 187 cases, there were two cases of gonorrhoea, and two of syphilis.

"We wish we had been told more about contraceptives"

Only very few (15% of the urban and 13% of the rural women) had been counselled on contraception before beginning their sexual life. After the first deliveries or abortions, this figure rose to 45 and 36% respectively. More women had been counselled on contraception after deliveries than after abortions.

There is not enough post abortion counselling

At the time of the present conception, over 30% of the urban women and 18% of the rural women were using modern contraceptives (mainly condoms), and about 20% in each group were using coitus interruptus as a method of fertility regulation. This means that contraceptive failure or improper use of contraceptives accounted for about 50% of the present unplanned pregnancies.

Teachers and parents do not give girls enough information

Information on contraceptives had been received mainly from the mass media (41.5%), from medical personnel (36.6%), from friends (32.7%). Only a minority of women said they had received information from school teachers or from their mothers.

Most patients said they would have liked to have received more information on contraceptives from their schools. Women who had not been using contraceptives at the time of conception said they did not have enough information (33%) or insufficient information and fear of side effects or ineffectiveness. No patient mentioned the price of contraceptives as an obstacle.

Unwanted pregnancies are not seen as a joint responsibility

Less than half of the patients had taken the decision to have an abortion together with their husband, the majority of women had taken the decision alone.

About 76% of the women experienced the present abortion as psychological torture, and 35% experienced moderate or severe pain. Nevertheless, 42.3% said they would have an abortion again, 37% said they did not know, and about 20% wanted to give birth.

In summary

- The age at first sexual contact as well as the marital age of women in Russia is relatively young.
- The first pregnancy usually occurred within the first six months of sexual life.
- The first pregnancy usually results in childbirth (in over 76% of cases).
- Abortion is mainly used as a method of fertility regulation after the desired family size is reached.
- There is a lack of correct information on modern contraceptive methods, and a lack of counselling by medical staff, and a lack of information through schools.
- Abortion is experienced as mental and physical hardship, and not as a method that is easier to use than contraception.
- Given the choice, most women would probably prefer to rely on a contraceptive method which they feel safe about rather than having to use abortion. Information and education on proper contraceptive methods must therefore be a prime concern of the Public Health, Education and Information sector.

Professor Ekaterina M. Vikhlyayeva and Dr. E. Nikolaeva
Research Centre of Obstetrics, Gynecology and Perinatology
Academy of Medical Sciences of the Russian Federation
4 Oparin Street, Moscow 117815
Russian Federation
Women’s Health Promotion  
- from Vision to Action  

European impulses for Graz and Styria (Austria)  

by Sylvia Groth  

Women’s health promotion was the topic of a panel discussion and conference held in Graz, Austria on September 26 and 27. The meeting was organised by the Women’s Health Center Graz, the Magistrate of the City of Graz, women’s office and the Government of Styria, Minister for Health. Participants from various health institutions in Graz, Styria and from other Austrian states discussed how women-friendly and adequate services could be secured.

City counsellor Tatjana Kaltenbeck emphasized that women’s health promotion will have a central role on the agenda of the newly founded health forum of the city. A women’s health report would be necessary. Women’s health promotion is a new field, it needs a more systematic approach but it is on the right track. Eva Maria König spoke for the minister and focused on the need for gender specific data collection on health indicators. Both politicians pointed out the importance of the Women’s Health Center Graz providing direct services and lobbying for women friendly and adequate services in the health system at large.

The speakers at the conference presented outstanding models from other European countries. Assia Brandrup-Lukanow spoke on the WHO program: Investing in women’s health. Anne Hamilton portrayed Glasgow’s women’s health policy and Maria van Bavel presented the strategies which Aletta, center for health care in Utrecht, has chosen to improve women’s health care in the Netherlands. The conference offered many possibilities for exchange and networking. It provided impulses for Styria to change the health policy in order to address the needs of the women and thus initiate an important reorganisation. In the plenary and in workshops the participants discussed concrete options for cooperating locally and internationally and the challenges women’s health promotion provides for the region.

Further questions may be addressed to Sylvia Groth, Frauengeundheitszentrum Graz, Brockmannngasse 48, A-8010 Graz, Austria
RESEARCH

Comments on Breast cancer and hormonal contraceptives

A major study which examines the links between the use of oral contraceptives and breast cancer has been published in the medical journal The Lancet on 21 June 1996. This study was conducted by a team from the Imperial Cancer Research Fund’s Cancer Epidemiology Unit, in the United Kingdom, bringing together detailed information on more than 53,000 women with breast cancer and more than 100,000 women without breast cancer from 54 international studies. The results provide evidence to suggest that:

- Women are taking combined oral contraceptives (COCs) and up to 10 years after stopping there is a small increase in the risk of having breast cancer diagnosed relative risk in current users 1.24; 1-4 years after discontinuing 1.16; 5-9 years after discontinuing 1.07.
- There is no increased risk of having breast cancer diagnosed 10 or more years after discontinuing use of COCs.
- The cancers diagnosed in women who have used COCs are identified at an earlier stage than those diagnosed in women who have never used these contraceptives. This would be expected to result in better prognosis after treatment.

The small size of increase risk shown in the study suggests a weak association, if any, between the use of COCs and the risk of breast cancer. The size of the study reduces the possibility of chance as an explanation for the increased risk, but it does not eliminate the possibility of bias as an explanation (for example, that women taking the pill may be more likely to have regular screening and therefore more likely to have an early detection of breast tumours).

The results of this study are consistent with those of previous studies in showing that if there is an increase in the risk of breast cancer it would be very small. For example, among 10,000 women who had used the Pill from age 25 to 29, only about 5 additional cancers would be diagnosed. When assessing the relevance of these findings they should be balanced against the benefits of taking the Pill, which include protection against cancers of the endometrium and the ovary, but more importantly, effective protection against unwanted pregnancy.

Dr Olaf Meirik, WHO Special Programme of Research, Development and Research Training in Human Reproduction (Compiled for IPPF Medical Department - 19-Jun-96)

New data on Oral Contraceptives and the Risk of Stroke

In the 24 August 1996 issue of the medical journal The Lancet the World Health Organization (WHO) published new data on the risk of stroke associated with the use of oral contraceptive pills.

The newly published findings are from a large study started in 1986 by the Special Programme of Research, Development and Research Training in Human Reproduction (HRP). The study, coordinated at the University College London Medical School, London, England, was conducted in 21 centres in 17 countries (12 developing and 5 developed), and involved 2198 women with stroke (cases) and 6086 women who did not have the disease (controls).

The WHO data show that pill use does not increase the risk of haemorrhagic stroke in women below the age of 35 years. In current pill users over age 35, however, the study found a small increase in the risk of this type of stroke.

In the case of the ischaemic stroke a small overall increase in risk was observed in current pill users. But this risk was lower in younger women (those below age 35), in non-smokers, and in those who did not have high blood pressure. For both types of stroke, no increase in risk was observed in women who had used the pill in the past.

Since the 1970s, in a bid to make the pill safer, the quantity of the two hormones (oestrogen and progestogen) in combined oral contraceptive pills has been reduced. The newer pills, also called low-dose pills (as opposed to the older higher-dose pills) are now the most widely used type all over the world. A specific objective of the WHO study was to evaluate the safety of the low-dose pills as they are currently used in different parts of the world. Overall the study found that the low-dose pills carry a lower risk of stroke than the higher-dose pills.

In European women the overall additional risk of either of the two types of stroke from using the low-dose oral pills was two cases per 100,000 users per year. In women less than 35 years of age, the extra risk was only about one case per 200,000 users per year, and among those who were non-smokers the risk from pill use was even lower.

For further information, please contact Dr O. Meirik, Head of HRP’s Research Component on Surveillance and Evaluation, WHO, Geneva, Switzerland Tel: (41) 22 791 3334, Fax: (41) 22 791 4171; or Dr N. Poulter, University College London Medical School, London, England, Tel. (44) 171 391 1721, Fax: (44) 171 813 0280.

All WHO Press Releases, Fact Sheets and Features can be obtained on Internet on the WHO home page http://www.who.ch/
Breast-feeding, fertility and post-partum contraception
(excerpts from the statement of the International Medical Advisory Panel, IPPF)

INTRODUCTION

Breast-feeding plays an important role in infant nutrition and health. Breast milk is the best and most complete food for the infant and alone provides enough nutrients for the first six months of life for the majority of infants. Antibodies are passed from the mother to the baby, conferring protection against certain infections. Breast-feeding also protects the infant from exposure to gastro-intestinal infection, which may occur with bottle feeding, especially in unhygienic circumstances. It provides hormones, growth factors and sensorial stimuli. It also may be important for mother/child bonding. Breast-feeding is associated with prolonged birth intervals which confer major benefits for maternal, infant and child health. Breast-feeding has a major role in fertility regulation.

A woman should be aware of the advantages of breast-feeding, the demands it imposes on her, the alternatives available and the implications for infant health so that she can make a free and informed choice.

BREAST-FEEDING AND FERTILITY

Breast-feeding delays the return of ovulation after childbirth and amenorrhoea is a marker of such suppression of ovulation. Amenorrhoea in breast-feeding women may last months or even years. However, in women who do not breast-feed, menses can occur as early as 35-40 days after the delivery.

The return of ovarian activity and fertility is dependent on the time elapsed since delivery, the breast-feeding patterns, and nutritional, geographic, social and cultural factors.

The inhibition of ovarian activity is largely dependent upon the frequency and distribution of nursing episodes day and night and the time the baby spends suckling at the breast. Amenorrhoea lasts longer in women who breast-feed more frequently at night as well as during the day, and for a longer time.

The provision of supplementary milk or food to the infant reduces considerably the inhibitory influence of breast-feeding upon ovarian function and fertility and is associated with a higher risk of pregnancy. Amenorrhoea lasts longer when supplemen-

gntary foods are introduced gradually, and at a later age of the child.

As far as is practicable, women should be advised and encouraged to breast-feed fully. Many women need counselling and education in breast-feeding. Efforts must be made to help those women acquire the necessary knowledge and practices in order to breast-feed satisfactorily. Training courses for health workers should include information on breast-feeding and family planning including methods most appropriate for the breast-feeding woman.

Supplements and particularly bottle feeding, should not be routinely recommended during the first six months post-partum unless there is an earlier indication of inadequate infant growth.

Women who wish to rely on lactational amenorrhoea for protection against pregnancy should be warned that the risk of pregnancy increases: with the first post-partum menses (defined as the woman’s perception that her menses have returned or the occurrence, after eight weeks post-partum, of two consecutive days of bleeding/spotting) with the introduction of supplementary milk or food to the infant. after about six months post-partum.

Contraceptive measures should be used as soon as any of the risk factors for pregnancy mentioned above is present. Women should be advised that there is no need to discontinue breast-feeding when contraception is begun or to postpone the initiation of contraception because they are breast-feeding.


ENTRE NOUS 34-35, December 1996
Ten steps to successful breast-feeding

WHO/UNICEF statement

Every facility providing maternity services and care for newborn infants should:

1. Have a written breast-feeding policy that is routinely communicated to all health care staff.

2. Train all health care staff in skills necessary to implement this policy.

3. Inform all pregnant women about the benefits and management of breast-feeding.

4. Help mothers initiate breast-feeding within a half-hour of birth.

5. Show mothers how to breast-feed, and how to maintain lactation even if they should be separated from their infants.

6. Give newborn infants no food or drink other than breast milk, unless medically indicated.

7. Practise rooming-in - allow mothers and infants to remain together - 24 hours a day.

8. Encourage breast-feeding on demand.

9. Give no artificial teats or pacifiers (also called dummies or soothers) to breast-feeding infants.

10. Foster the establishment of breast-feeding support groups and refer mothers to them on discharge from the hospital or clinic.

Books

Research on the Menopause in the 1990s - Report of a WHO Scientific Group. WHO Technical Report Series 866. World Health Organization, Geneva, 1996. This report reviews current research on the menopause, including studies on its symptoms and their treatment and its effects on the cardiovascular and skeletal systems, and assesses the relevance of existing data to women in developing countries. It discusses the importance of contraception for women approaching the menopause (i.e. in the late premenopause) and examines the benefits of hormone therapy in reducing the risks of cardiovascular diseases and osteoporotic fractures in postmenopausal women and the effects of such therapy on the risks of cancers of the breast, endometrium, ovary and cervix. The report also makes a number of specific recommendations for further research. ISBN 92 4 120866 X. Available from: WHO Distribution and Sales, 1211 Geneva 27, Switzerland. Price: Sw.f. 20.-. Price in developing countries: Sw.f. 14.-.

The Health of Youth - A Cross-National Survey, by Alan King et al. WHO Regional Publications, European Series No. 69. World Health Organization, 1996. This survey is the fourth in the Health Behaviour in School-Aged Children (HBSC) Study, since 1983-84, a collaborative cross-national research study sponsored by WHO. The research should provide the analytical framework necessary for the design of effective health promotion intervention and health education programs. WHO along with Health Canada, provided support for the publication of this report of the international findings of the 1993-94 survey. It represents only the beginning of the data analysis that will be conducted by researchers from almost 40 participating countries to take advantage of the wealth of information now available. ISBN 92 890 1333 8 and ISBN 0378-2255. Available from: WHO Distribution and Sales, 1211 Geneva 27, Switzerland. Price Sw.f. 59.-.


Documents

Improving Access to Quality Care in Family Planning. Family and Reproductive Health, World Health Organization, Geneva. This document is one important step in a process for improving access to quality of care in family planning by reviewing the medical eligibility criteria for selecting methods of contraception. It contains recommendations for revising family planning policies and prescribing practices in line with updated medical eligibility criteria which are supported by the latest scientific evidence. For most of the recommendations, the scientific rationale is given and the supporting research is cited. It is intended to be used by policy-makers, family planning programme managers and the scientific community. It aims to provide guidance to national family planning/reproductive health programmes in the preparation of guidelines for service delivery of contraceptives. Available from: Division of Family and Reproductive Health, WHO, 1211 Geneva 27, Switzerland. (Ref. WHO/FHR/FP996.9).

MVA in the Treatment of Incomplete Abortion: Clinical and Programmatic Experience. Published by IPAS, 1995. In order to further the cause of improving women's health through access to quality services, this monograph presents data and information supporting the availability and use of manual vacuum aspiration (MVA), a method of vacuum aspiration of the uterus that can be effectively used throughout the developing world where the problem of unsafe abortion is most critical and broad access to complete quality health care is most limited. This monograph is an educational and reference volume only, not for diagnosis or treatment. Available from: IPAS, P.O. Box 100, Carrboro, NC 27510, USA. Tel. 1-919 967 7052, Fax 1-919-929 0258.
HIV/AIDS Surveillance in Europe 1994-1996. Published by the European Centre for the Epidemiological Monitoring of AIDS with the support of the Commission of the European Communities, the French Ministry of Health and the World Health Organization Regional Office for Europe. This document presents current statistics on HIV and AIDS in Europe to March 1996. It is intended for public health planners, researchers, policy makers and others who are concerned with the public health implications of HIV infection and AIDS. It comprises four sections: the surveillance of AIDS, the surveillance of HIV, estimates of HIV prevalence and future AIDS incidence, and HIV and Tuberculosis. Available from: European Centre for the Epidemiological Monitoring of AIDS, 14 rue du Val d’Osne, 94415 Saint-Maurice cedex, France. Tel. (33) 1 43 96 65 45. Fax (33) 1 43 96 50 81.

Verbal Autopsies for Maternal Deaths. Report on a workshop. Division of Family Health. World Health Organization, Geneva (1995). (Ref. WHO/FHE/MSM/95.15). A workshop was convened to bring together investigators from around the world with experience in the use of verbal autopsies for maternal deaths. The aims of the workshop were to share experiences and to move towards a consensus on methods. The workshop was held at the London School of Hygiene and Tropical Medicine with support from the Safe Motherhood Programme of the World Health Organization. Available from: Division of Family Health, WHO, CH-1211 Geneva 27, Switzerland.

Diary

15th World Congress of Gynaecology and Obstetrics, Copenhagen, Denmark 3-8 August 1997 Organized by the International Federation of Gynaecology and Obstetrics. Further information from: ICS, Strandvejen 171, P.O. Box 41, DK 2900 Hellerup, Denmark. Tel.: +45 31 61 21 95. Fax: +45 31 61 20 68

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Centre International de l'Enfance
CENTRE INTERNATIONAL DE L’ENFANCE
48 Rue Michelet
75014 PARIS - France
Tel: 01 44 30 20 00 - Fax: 01 45 25 73 61
E-Mail: 100631.1101@compuserve.com

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INSTITUTE OF POPULATION STUDIES

Applications

In common with other IPS training programmes, the course is aimed at professionals or prospective professionals in the family planning and reproductive health fields. The course will be particularly suited to NGO and public sector family planning managers and researchers. Please apply to:
The Training Officer, Institute of Population Studies, University of Exeter, Hoopern House, 101 Pennsylvania Road, Exeter, Devon, EX4 6DT, UK.

Telephone: (01392) 57936
Fax: (01392) 490870
Telex: 42894 EXUNIV G
E-mail: E.M. Davies@exeter.ac.uk

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Current Training Programmes

The Institute offers a range of training activities from short attachments to a three-year PhD programme. Two MA programmes, each of one year’s duration, are offered annually. The MA in Applied Population Research provides training in research methodology applicable to the study of family planning/health-care service provision and reproductive behaviour. The MA in Family Planning Programme Management provides training in the planning and management of family planning/health-care programmes. The modular approach adopted in these taught programmes permits a selection of topics relating to research and management which can also be studied for shorter periods of time. Six short courses and a number of month-long ‘attachments’ are available. The short courses are listed below:

Course 1: Determinants of Fertility
Course 2: Family Planning Service Provision
Course 3: Promoting and Managing HIV/AIDS Prevention Programmes
Course 4: Family Planning Programme Management
Course 5: Collection and Analysis of Family Planning and Reproductive Health Data
Course 6: Family Planning and Reproductive Health Programme Evaluation

Details on all the training activities at the Institute can be obtained from the Training Officer at the address for applications given previously.