Cancer control in reproductive health services

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Summary
The shift from a focus on family planning, with its demographic outcomes, to the broad-based approach of reproductive health has led to major challenges for integrated care in service delivery. The selection of interventions for the control of reproductive cancers exemplifies the need for judicious decisions in the deployment of limited resources.

Population growth

In February 1981, a London-based group of medical students held its annual conference around the theme of moral and social issues of fertility. This event demonstrated the wide-ranging interest of the medical community beyond matters of a clinical nature by addressing issues of importance to society at large. Also, the selection of those topics by a general medical group demonstrates the importance attached to population issues. The conference discussed the ideal population size, absence of women in decision-making, and failure of policies to influence fertility levels. They also noted that despite the availability of antibiotics over the previous 25 years, sexually transmitted diseases, pelvic inflammatory disease and ectopic pregnancy had all become more common. It was pointed out that the concept of sex for the purpose of nurturing children within marriage "had been rent asunder by the increasing use of contraception, thereby separating sexual intercourse and procreation".[1] The concluding presentation stressed the importance of limiting population growth and suggested various courses of action.

The failure of existing family planning programmes to reduce fertility levels was deplored. Messages and supplies were not reaching individuals because effective interventions were being ignored in order to avoid local conflicts. It was felt that the common situation whereby "each country takes its own view of the cultural 'hot potato'" could be addressed through regional collaboration to overcome the isolation of family planning programmes in individual countries.[2] The exchange of experiences between countries helps professionals gain a different perspective on their tasks. During an overseas visit, a British doctor noted that the surgeon who performed 150 vasectomies within 8 hours "worked with quiet and smooth efficiency like a Rolls Royce motor engine".[3]

Integrated care

Efficiency in performing an effective procedure should be complemented by quality of care and adequate coverage of the population in need of the service. The pivotal role of general practitioners (GPs) was recognised to address the "voiced and unvoiced needs" of patients: GPs could provide "a high standard of contraceptive care which, like a well-known lager, can reach the parts other services cannot" through reviewing the contraceptive needs of every woman of reproductive age.[4]

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Sometimes, the GP may be perceived as either "the father figure called on in time of trouble" who is invested "with authoritarian and disapproving attitudes" or "the successful attractive male" for whom the female patient may have "latent sexual feelings".[5] In such cases, individuals could avoid "jeopardising their relationship" with their GPs by seeking family planning services from independent agencies and dedicated family planning clinics. The case was thereby made for an integrated service with multiple entry points.

Dedicated family planning clinics were valuable for providing consultations without an appointment.[6] Staffed largely by women, those clinics provided a much-needed resource to deal with referrals from GPs. With the increasing body of knowledge, contraceptive care was becoming more specialised. It is therefore not surprising that plans were being made to start the specialty of medical gynaecology with an emphasis on linkages between hospital and community. However, worries were expressed regarding the decreasing number of women in gynaecological practice and proposals were made for changes in the career structure in order to encourage training in medical gynaecology.[7]

Contrast in reproductive cancers

With the demonstration of the value of screening mammography, close collaboration between family planning and breast screening clinics was being proposed to improve the quality of care.[8] GPs were not fully convinced of the value of regular breast examination and, furthermore, many women were less keen on breast than vaginal examination.[4]

Breast and cervical cancers are the two main reproductive cancers. Whereas cervical cancer occurs in the reproductive tract largely through the sexual transmission of certain types of the human papillomavirus (HPV), breast cancer has a strong hormonal aetiology through its association with nulliparity, late childbearing and use of sex steroids. Being a disease of affluence, breast cancer often receives much support, both financial and in the media, from affected individuals and their families. This effective advocacy leads to a most prominent visibility for breast cancer that is in sharp contrast to cervical cancer, which is associated with deprivation, the stigma of promiscuity and disadvantaged individuals.

Repositioning services

The existence of a major health problem does not necessarily mean that there is a feasible intervention for implementation. Whereas family planning, maternal health and the control of sexually transmitted infections (STIs), including HIV, continue to be the mainstay of reproductive health services, local considerations are primordial in the setting of priorities, as exemplified by the selection of interventions for the control of reproductive cancers. In resource-poor settings, it is difficult to justify the introduction of screening mammography, especially in situations with high maternal mortality, low contraceptive prevalence and the absence of interventions for the control of STIs and cervical cancer. Besides capital investment in expensive equipment that needs maintenance, screening mammography necessitates the services of highly skilled individuals with a substantial workload to maintain their proficiency in reading the films. Despite their theoretical

advantages, both breast self-examination[9] and clinical examination[10] are of extremely limited value in decreasing mortality from breast cancer when incorporated into screening programmes.

At best, services for breast cancer screening would achieve a 35% reduction in mortality from breast cancer. This effectiveness is in sharp contrast to the situation with cytology screening for the secondary prevention of cervical cancer, which has an average lead time of more than 10 years. It is widely accepted that invasive cervical cancer is largely avoidable and is due to deficiencies in service provision such as population coverage and quality of care. The imminent introduction of HPV vaccines will lead to primary prevention of cervical cancer from infection with HPV types 16 and 18. As the latter are responsible for about 70% of cases of cervical cancer, screening services will still be necessary. With HPV vaccination being most effective when administered in early adolescence, interaction between daughter and mother should be exploited for integrated reproductive health services with the simultaneous provision of cervical cancer screening. With integrated reproductive health services,[11] effective linkages should be sought through a systems perspective to consider other components, such as schools and behaviour change communication, for promoting HPV vaccination.

Prominent in 1981, the issue of population growth continues to generate much interest as reflected by the current parliamentary hearings in London on its impact on the attainment of the millennium development goals. Whilst acknowledging a lack of evidence in certain specific areas, efforts should focus on meeting reproductive health needs, including cancer control,[12] through the upscaling of proven interventions specially to reach the poor.

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News Roundup

Sperm bounce back after male contraception

Men taking hormonal contraception – likely to be available in the near future – regain their fertility in a few months, a new study suggests. A number of clinical trials have shown that taking a certain mix of hormones, including testosterone, can reliably suppress sperm production in men. But until now researchers have remained uncertain about how long it takes for men to regain fertility once treatment stops. A new study pooled data from 1549 men in 30 studies.[1] According to the analysis, once the men stopped the treatments it took about 3–4 months for their sperm counts to return to fertile levels. Male contraception is most likely to come in the form of a patch, topical gel or bimonthly injection when it first arrives, according to researchers. Making a male birth control pill remains tricky because the chemical form of orally delivered testosterone produces serious side effects, such as liver damage.

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Reported by **Henrietta Hughes**, MRCGP, DFFP
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Vaginal ignorance

Organon recently commissioned a survey of nearly 10 000 women investigating their knowledge, attitudes and perceptions about the vagina. Surprisingly, 50% of women felt it was the part of the body they knew least about. Some 50% also reported feeling uncomfortable talking to health care professionals about vaginal-related matters. In many countries, Nuvaring®, the once-monthly vaginal contraceptive ring, is becoming increasingly popular. Nuvaring will certainly increase a woman's options, especially those who find it difficult to remember a daily tablet. The survey does, however, throw up concerns over women's lack of knowledge and misconceptions, and may influence ultimately their choice of contraception. Nuvaring is licensed in the USA, Canada, Russia and many European countries, and Organon hope to gain a UK licence in 2007.

Source: www.organon.com

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Calcium and vitamin D supplements and bone fractures

A report of a women's health trial including over 35 000 healthy postmenopausal women suggests that food supplementation with calcium and vitamin D does not protect against bone fractures.[1] Women aged 50–79 years at the start of the trial were randomised to receive 500 mg calcium as calcium carbonate with 200 IU vitamin D-3 twice daily or placebo. The average follow-up was 7 years. The women taking calcium and vitamin D-3 had significantly higher bone density than controls but no difference in hip and total fractures. Women taking supplements had a higher risk of kidney stones.

Reference

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Fertility treatment abroad

Infertility Network UK is the largest support organisation for those experiencing fertility problems. Recently they have become aware of increased numbers of couples travelling abroad for treatments, which are difficult to access in the UK. Both Infertility Network UK and the Human Fertilisation and Embryology Authority are encouraging couples to think very carefully before considering treatment in foreign clinics. The high standard of care couples receive in the UK may not be replicated abroad and couples are encouraged to make an informed decision.

Source: www.infertilitynetworkuk.com

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You are young. You are in love. What now?

Young people feel the crunch of the sexual hormones. Before they reach the point of having sex, they need information about how to get pregnant, how not to get pregnant, and how to avoid sexually transmitted infections. Rotary Fellowship for Population and Development (part of Rotary International) has developed an Internet-based, short guide about adolescents' reproductive health. Available on the website are ideas and guidelines for teachers and health professionals, together with information on reproductive health for adolescents.

Source: www.rfpd.dk

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