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Abortion Deaths from Tetanus in Bangladesh

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1. Uzma A, Underwood P, Atkinson D et al, 1999. Postpartum health in a Dhaka slum, *Social Science & Medicine* 48:313-20.
2. Nahar S, Costello A, 1998. The hidden cost of 'free' maternity care in Dhaka, Bangladesh. *Health Policy and Planning*. 13(4):417-22.

Reproductive health services in Catholic hospitals in the USA

IN the USA, the trend among health care providers is to merge and enter into joint ventures in order to compete for managed care contracts. There are an increasing number of religiously affiliated health care providers, most of which restrict the type of reproductive health services they provide. Roman Catholic institutions are guided by the "Ethical and Religious Directives for Catholic Health Care Services". Rigid interpretation of these directives has resulted in loss of women's access to abortion, contraception, infertility treatment, AIDS prevention and condom distribution, and sometimes to emergency contraception for women who have been raped. Mergers with religious providers is the most serious and least visible threat to reproductive health services in the USA. This article suggests action that can be taken by doctors, patients and community activists to protect reproductive health services when mergers with religious institutions occur.[1]

1. Gallagher J, 1997. Religious freedom, reproductive health care, and hospital mergers. *Journal of American Medical Women's Association* Spring:65-68.

Malaria in pregnancy: India, Uganda

A survey was carried out in 1992 to 1995 to examine the relationship between malaria infection and pregnancy in central India, a region where two types of malaria are endemic. Malaria infection is higher among pregnant than non-pregnant women and leads to anaemia, miscarriage, intra-uterine fetal death, premature delivery, low birth weight and maternal death. More than 2000 pregnant women with fever who attended antenatal clinics participated in the survey and two control groups. Significantly more pregnant women were found to have malaria (17 per cent) than non-pregnant women (8 per cent). The women with malaria were significantly more anaemic than the women in the control groups. Those infected with *Plasmodium falciparum* were more anaemic than those with *P. vivax*. The mean birth weight of newborns born to infected mothers was 350g less than of babies born to non-infected mothers. Cerebral malaria was one of the common complications – there were five maternal deaths, three miscarriages and two stillbirths but because of incomplete records, this is likely to be an under-estimate. The authors recommend routine malaria chemoprophylaxis for pregnant women and educational campaigns to inform women of the need to attend hospital early in their pregnancies.[1]

Malaria in pregnancy is also a problem in Uganda. This study looked at the use of antenatal care services, the use of drugs to prevent malaria and anaemia and health-seeking behaviour regarding malaria during pregnancy. A total of 149 women were interviewed. The cost of the services was a barrier to their use as was the erratic supply of drugs. Women treated themselves for malaria with local herbs and drugs bought from shops. Not all women agreed with formal health care providers on the importance and need for regular antenatal care attendance. Since rural health units are usually understaffed, there are not enough trained staff to convey health education messages. Current health education is not particularly effective in changing behaviour.[2]

1. Singh N, Shukla MM, Sharma VP, 1999, Epidemiology of malaria in pregnancy in central India. *Bulletin of World Health Organization*. 77(7):567-71.
2. Ndyomugyenyi R, Neema S, Magnussen P, 1998, The use of formal and informal services for antenatal care and malaria treatment in rural Uganda. *Health Policy and Planning* 13(1):94-102.

Abortion deaths from tetanus in Bangladesh

ABOUT 1,000 Bangladeshi women die of pregnancy-related tetanus every year, mostly due to inserting roots and sticks in the cervix. A national survey of tetanus deaths in hospitals identified 298 women who died from pregnancy-related tetanus. This is likely to be an under-estimate as village women are less likely to be treated in hospitals.[1]

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1. Rochat R, Akhter HH, 1999. Tetanus and pregnancy-related mortality in Bangladesh [Research letter]. *Lancet* 354:565.

Medical abortion study in Vietnam

THIS trial compared medical abortion (mifepristone-misoprostol) to surgical abortion among 393 urban Vietnamese women who were given a choice of methods. Both methods had very high success rates and nearly all women were satisfied with their abortion experience, regardless of which method they had chosen. Those who used the medical method complained of more minor side effects, but women who chose this medical method who had previously had a surgical abortion were more likely to say that they preferred the medical method.[1]

1. Thi Nhu Ngoc N, Winikoff B, Clark S et al, 1999. Safety, efficacy and acceptability of mifepristone-misoprostol medical abortion in Vietnam. *International Family Planning Perspectives*. 25(1):10-14/33.

Female condoms in Zambia

EXPERIENCE with the female condom in Zambia is not encouraging. In October 1997, the Society for Family Health launched the female condom throughout Zambia, but current use is so minimal that many shopkeepers will no longer stock them.[1]

1. Chipungu J, 1999. Zambian women shun female condoms. Gender-aids@hivnet.ch, 12 August.

Computerised Pap smears

CONVENTIONAL primary screening for cervical cancer depends on manual microscopic assessment of cervical (Pap) smears. The process is time-consuming and requires highly skilled staff, most of whose time is spent looking at normal smears. A multi-centre trial compared the use of a new computer-assisted technology, called PAPNET, with conventional primary screening. 21,700 smears were analysed by both methods. The sensitivity was comparable, with false-negative results occurring with both methods. The specificity of PAPNET, however, was better in identifying abnormal smears. There was a significant difference in the time taken to do the screening, with PAPNET about three times faster than conventional screening. More investigation is needed and stringent quality control, if conventional screening is to be replaced by PAPNET.[1] An economic study found that PAPNET was more expensive than conventional screening. On the other hand, cytologists find PAPNET more comfortable and interesting to use which is an important consideration at a time when it is difficult to recruit cytologists. There are uncertainties about PAPNET's potential for routine screening although it looks promising. Unfortunately, cost considerations may limit PAPNET's future development and implementation.[2]

1. PRISMATIC Project Management Team, 1999. Assessment of automated primary screening on PAPNET of cervical smears in the PRISMATIC trial. *Lancet* 353:1381-85.
2. Kreuger FAF, van Ballegooijen M, Doornewaard H, 1999. Is PAPNET suitable for primary screening? [Commentary]. *Lancet* 353:1374-75.

Right-to-know re cervical cancer

THIS paper explores the reasons for the lack of primary prevention of cervical cancer in New Zealand, based on interviews with key people involved in New Zealand's cervical cancer prevention policy and a literature review. Two discourses were identified as key: 'protectionism' and the 'right to know'. The protectionist position has dominated New Zealand's policy; information about the sexual risk factors for cervical cancer have been suppressed in the public domain. The 'right to know' position, developed by the feminist women's health movement, argues that women are being denied the opportunity to make informed choices about their sexual behaviour which could protect them from cervical cancer. The authors question the protectionist assumption that women will be put off screening by the promotion of sexual risk information, as there is no empirical evidence to support this.[1]

1. Braun V, Gavey N, 1999. 'With the best of reasons': cervical cancer prevention policy and the suppression of sexual risk factor information. *Social Science and Medicine* 48:1463-74.

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