Wednesday, June 28, 2000

17:30 - 18:30 Gallus hall	Opening session	Reproductive Health
	Chairmen	*D. Serfaty (France)* *H. Meden-Vrtovec (Slovenia)* *G. Creatsas (Greece)*
17:30	- Reflections on the Cairo programme of action *P.F.A. Van Look (WHO, Switzerland)*	
17:45	- Reproductive health in Slovenia *L. Andolsek-Jeras (Slovenia)*	
18:00	- Freedom in reproductive choices *D. Cossey (United Kingdom)*	
18:15	- (R)evolution of the European Society of Contraception *C. Coll (Spain)*	

Reflections on the Cairo Programme of Action

Paul F.A. Van Look

Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland

Although the term "reproductive health" had been used by scientists, practitioners, and consumer groups for some years, its widespread acceptance came in 1994 with the adoption by 178 countries of the Programme of Action of the International Conference on Population and Development (ICPD), held in Cairo, Egypt. ICPD argued that it is possible to achieve the stabilization of world population growth while attending to people's health needs and respecting their rights in reproduction. This "paradigm shift" away from family planning and population control to reproductive health is generally considered as perhaps the greatest achievement of ICPD. In 1999, when a worldwide review of progress in the implementation of the ICPD Programme of Action was undertaken, it was possible to see that a number of significant changes had taken place. Many important challenges remain, however. For instance, there continues to exist a large unmet need for family planning and, with world population set to grow for several more decades, the pressure on developing country programmes to provide services to increasing numbers of clients with varying needs will intensify. Additional methods offering dual protection, i.e. protection against both pregnancy and sexually transmissible infections including HIV/AIDS, urgently must be developed, and greater attention has to be given to the sexual and reproductive health needs of adolescents. Also, intensified efforts are called for to contain the spread of the HIV/AIDS epidemic. Regrettably, investments in reproductive health by both donors and recipient countries are falling markedly short of requirements, making it unlikely that International Development Goals in areas such as maternal and infant mortality reduction and universal access to reproductive health services will be reached by the target date of 2015.

Reproductive Health in Slovenia

L. Andolsek-Jeras

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The Slovenian way of achieving present state of reproductive rights and reproductive health level started after the Second World War by introducing gradual liberalisation of abortion legislation and by integrating contraceptive counselling into primary health care services for women. In the late sixties, Slovenian women became increasingly aware of their hurnan rights. The later has together with the endavour of some gynaecolojgists lead to the most progressive legislation which culminated in Constitutional article in 1974 and in the currently still valid Law on Medical measures for the realisation of the right to free decision on the childbirth. This law covers all three aspects of fertility regulation: contraception (sterilisation included), medical termination of pregnancy and treatment of infertility. In previous decades higher accessibility of reproductive rights was manifested in changing trends of abortion rates and figures of contraceptive use, as well as in maternal and perinatal mortality rates. In the nineties, social changes occured and shaped different viewing of women's roles and reproductive rights in our society. Moreover, new health legislation was adopted, providing the basis for the reform of the health care system. The limited implementation of reproductive rights and accessibility of previously very affective health care, mainly among certain population groups of women (young, older, economically deprived) goes along with the deterioration of some reproductive health indicators. General health indicators (life expectancy, infant mortality, causes of mortality) as well as some indicators of reproductive health (early neonatal mortality rates, contraceptive figures and abortion rates) are comparable to that of Central European countries. The exceptions are maternal and perinatal mortality rates, sterilisation rates, morbidity and mortality rates of reproductive tract cancers. At present, some steps have already been undertaken to bring the infavorable indicators to the acceptable level and to improve reproductive rights and reproductive health of our population.

Freedom in Reproductive Choices

D. Cossey

International Planned Parenthood Federation European Network, London, United Kingdom

Attempt to define this concept by asking the following questions:

1. what does freedom in reproductive choices mean for the individual woman and man in 21st century in Europe? what do we want it to mean?
2. are the concepts 'a woman's right to choose' and 'every child a wanted child' still valid in today's Europe?
3. is freedom in reproductive choices balanced by responsibility in reproductive choices?
4. is there a right as well as a choice to reproduce? how can this right be reconciled with freedom?
5. how does the troika of choice, rights and health (IPPF European Network's framework) help to achieve freedom in reproductive choices?
6. are there Europe-wide initiatives and collaboration to improve freedom on reproductive choices? what are they? what could they be?
7. what aspects of the Cairo Programme of Action specifically help freedom in reproductive choices? what could be targets for Cairo + 10?

(R)evolution of the European Society of Contraception

C. Coll

Barcelona, Spain

- Abstract not available -

Thursday, June 29, 2000

08:30 - 10:00 Main Session I Progestins and anti-progestins
Gallus hall

Chairman: A. Pretnar-Darovec (Slovenia)
Co-Chairman: M. van Santen (Germany)

08:30 - 09:00 - Sex steroid receptor function
E. Baulieu (France)
09:00 - 09:30 - New progestins in contraception
S.O. Skouby (Denmark)
09:30 - 10:00 - The role of anti-progestins in contraception
R. Sitruk-Ware (USA)

Progestins and anti-progestins. Sex steroid receptor function.

E.E. Baulieu

Collège de France - INSERM u. 488, Bicêtre, France

- Abstract not available -

New Progestins in contraception

S.O. Skouby

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Progesterone exerts most of its actions through its specific receptors. However, synthetic progestins and progesterone itself may bind with other steroid receptors, thus producing a variety of effects. The 21-carbon series (pregnans) includes the corticoids and the true progestogens (e.g., medroxyprogesterone acetate). The 19-carbon series (estranes) includes all the androgen derived, among them the progestogens used in most oral contraceptives. The removal of carbon 19 from testosterone changes the major hormonal effect from androgenic to progestogenic, but these "19-nor" steroids retain varying degrees of androgenic activity. Some of the 19-nortestosterone are acting as prodrugs and some are active unchanged. The expressed androgenic effects of the original 19-nor progestins (northisterone etynodrel, levonorgestrel norgestrel), prompted the development of less androgenic compounds, and an obvious benefit of the new progestins (desogestrel, gestodene, norgestimate) is a reduction in the clinical symptoms associated with the androgenicity of the older compounds. Newer, orally active, progestins are being developed through a molecular approach to compound selection with human progesterone receptor serving as the molecular target. The expectations from thesee new progestins are no mineralocorticoid or glucocorticoid activity, and with benificial physiologic effects on hirsutism and acne. Dienogest is such a novel progestin, a hybrid progestin combining the typical qualities of 19-norprogestins with those of hydroxprogesterone derivatives. Drospironoe is another

promising progestin derived from 17 alfa spirolactone with clear antimineralocorticoid and antiandrogenic acitivities. In future combined oral contraceptives with a wider range of progestogens will enable individual and refined contraceptive possibilities and thus increase compliance through the whole fertile period ensuring optimal planning of pregnancies.

The role of antiprogestins in contraception

R. Sitruk-Ware

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The role of antiprogestins on ovulation and implantation derives from the physiological effect of progesterone on these functions. These molecules able to counteract the progesterone action at the receptor level have been shown to inhibit ovulation, delay the implantation window and prevent the secretory transformation of the endometrium. Due to the multiple actions of mifepristone the more studied of the antiprogestins, this agent has been proposed for emergency contraception, regular continuous contraception or as a menses inducer.

As an emergency contraception, doses as low as 10mg in a single dose appeared to be effective in preventing unwanted pregnancies when administered up to 5 days after an unprotected intercourse around mid-cycle. According to the time of administration, the molecule may act in delaying or blunting the LH surge, or preventing implantation.

Other modes of applying the contraceptive effect of mifepristone were tested such as weekly administration, single application two days after the LH peak or as a continuous therapy. Continuous low doses administration result in LH suppression for doses as low as 1mg but not at 0.5mg daily. Schedules associating continuous daily administration with sequential low doses of progestins have also been tested and the results look promising.

However, while several pilot studies indicated that antiprogestins and essentially mifepristone could prove useful for contraception, the exact dosage and schedule of application remains to be determined in a large number of cycles.

Friday, June 30, 2000

08:30 - 10:00 Gallus hall	Main Session II Contraception in peri-menopause *Chairman: S. Skouby (Denmark)* *Co-Chairman: S. Özalp (Turkey)*
08:30 - 09:00	- Age-dependent change in reproductive function *H. Meden-Vrtovec (Slovenia)*
09:00 - 09:30	- OC use in the peri-menopausal woman: do we still need special considerations? *I. Milsom (Sweden)*
09:30 - 10:00	- Contraceptive counselling in peri-menopause *P.G. Crosignani (Italy)*

Age-dependent changes in reproductive function

H. Meden-Vrtovec

Department of Obstetrics and Gynecology, University Medical Centre Ljubljana, Slovenia

Objective. To estimate the diagnostic value of inhibin as a marker of ovarian capacity and reserve in the process of ovarian ageing, we determined the levels of inhibin A and B, E_2, FSH and LH in women with regular menstrual cycles, in women with failed ovarian stimulation in an in vitro fertilization programme, in women with premature ovarian failure (POF) and in postmenopausal women.
Design and Methods. The first group consisted of 30 women in the reproductive age (mean 30.45 ± 3.64 years) with regular menstrual cycles; the second group of 35 women (mean 35.03 ± 4.0 years) with a failed ovarian stimulation with human menopausal gonadotropins (HMG), the third group of 21 women with premature ovarian failure (POF) (mean 28.14 ± 5.75 years) receiving no hormonal replacement therapy (HRT) for more than 6 months and the fourth group of 26 postmenopausal women (mean 54.88 ± 3.4 years) who received no HRT for more than 6 months
Results. The mean levels of inhibin A and B were within the normal range in women with regular menstrual cycles and in those with failed ovarian stimulation (71.9 ± 42.4 pg/ml and 67.5 ± 51.8 pg/ml, respectively), whereas in women with POF and in postmenopausal women they were significantly lower (41.7 ± 86.3 pg/ml and 11.3 ± 19.6 pg/ml, respectively) (p=0.001). The E2 levels were significantly higher in women with regular menstrual cycles and in those with failed ovarian stimulation (p=0.002). FSH and LH levels were significantly higher (p=0.000) in postmenopausal women and in those with POF.
Conclusions. The levels of inhibin A and B cannot predict the ovarian reserve and are not more reliable than FSH determinations.

Oc use in the perimenopausal woman
Do we still need special considerations?

I. Milsom

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Contraceptive counselling to women in the perimenopause requires special considerations. Although there is a marked decline in fertility after 40 years of age and some evidence to suggest that the frequency of sexual intercourse declines with increasing age many women who are perimenopausal still have a strong fear of an unplanned pregnancy and justifiably insist on a safe and effective form of contraception. In addition perimenopausal women may develop problems specifically related to this period in their lives such as irregular menstrual bleeding, heavy menstrual bleeding and the risk of developing troublesome climacteric symptoms.
The use of combined oral contraceptives was originally restricted in women over the age of 35 due to the belief that there was an increased risk of cardiovascular complications, such as myocardial infarction, in women over the age of 35 using the combined oral contraceptive pill. Later studies have however clearly indicated that the use of the combined oral contraceptive pill can be continued well into the perimenopausal years in healthy non-smokers. In fact the oral contraceptive pill provides in this group of women not only an effective means of contraception but also numerous additional benefits of potential importance to perimenopausal woman. Among the benefits provided are a regular menstrual cycle and the avoidance of perimenopausal bleeding irregularities, reduced menstrual blood loss, which otherwise often increases in this age group, the prevention of climacteric symptoms, protection against osteoporosis and the reduced risk of ovarian and endometrial cancer.
Perimenopausal women should however always be informed of alternative methods of contraception and the choice of contraceptive method must be individualised. The potential advantages and disadvantages of the different contraceptive methods and their ability to influence other common problems encountered during the perimenopause must be taken into account. Special considerations are necessary regarding counselling in women during the perimenopausal period but the continued use of the combined oral contraceptive pill in healthy, non-smoking perimenopausal women is today a well accepted alternative.

Contraceptive counselling in perimenopause

P.G. Crosignani

I Department of Obstetrics and Gynecology, University of Milano, Milano, Italy

Despite a physiological decline of fertility perimenopausal women still run the risk of unwanted pregnancies while ovarian aging quite often induces abnormal cycles associated with estrogen deficiency symptoms. Therefore contraceptive counselling during this transition time has to take account of the need for reliable contraception as well as the problems related to ovarian aging.
Treatment options

1. Barrier methods or IUD, with cyclic progestogen
   In a large proportion of patients cycle irregularities are initially linked to luteal phase defects. Cyclic progestogen is an effective short term treatment for women already protected by other methods against unwanted pregnancy.
2. The contraceptive pill. Users can continue taking OC to fulfill all needs. OC can be started in patients wishing to avoid cycle disturbances or estrogen deprivation symptoms and desiring contraception.
3. ERT plus medicated IUD. A combination use of unopposed estrogen and progestogenmedicated IUD similarly offers control of the cycle and reliable contraception. The approach is particularly effective in patients suffering from excessive bleeding, frequently occurring in this age group.

08:30 - 10:00 Main Session III Strategies and prevention of STD in Europe
Gallus hall

Chairman: G. Creatsas (Greece)
Co-Chairman: V.N. Prilepskaya (Russia)
E. Vrtacnik-Bokal (Slovenia)

08:30 - 09:00 - Current status
V. Unzeitig (Czech Republic)
09:00 - 09:30 - Strategies for prevention
J. Paavonen (Finland)
09:30 - 10:00 - Cost/benefit of STD prevention
J. Henry-Suchet (France)

Strategies and prevention of STD in Europe, current status

V. Unzeitig

Masaryk University, Dept. Obst & Gyn, Perinatology Unit, Brno, Czech Republic

- Abstract not available -

Strategies for Prevention of STIs in Europe

J. Paavonen

Department of Obstetrics and Gynecology, University of Helsinki, Finland

Sexually transmitted infections (STIs) are among the most common infectious diseases and most serious public health problems in Europe today. Of those infected, at least one fourth are teenagers and two thirds are younger than 25. However, significant recent progress has been made in the prevention of STIs. ***Chlamydia trachomatis*** (CT) is the most common bacterial STI, and the major cause of pelvic inflammatory disease, adverse pregnancy outcome, tubal factor infertility, and pelvic pain. Most CT infections are asymptomatic, and associated health problems are usually observed several years after the exposure. CT also facilitates transmission of other STIs including HIV, and causes perinatal infections. The overall health care costs caused by CT infections are enormous. Thus, prevention of CT infections is a major public health gole. First void urine testing, high performance nucleic acid amplification tests, and single dose therapy with azithromycin are examples of recent improvements in the diagnosis and management of CT infections. Universal CT screening programs among sexually active target populations have proven cost-effective, and should be implemented in order to prevent short-term and long-term complications associated with chlamydial infections. **Gonorrhea** rates have decreased in most developed countries in recent years. For instance, in Finland CT is more than 20 times more prevalent than gonorrhea today. During the past decade, *Neisseria gonorrhoeae* (GC) has developed resistance to penicillin and tetracycline, and quinolone resistance is emerging. Concern about this problem has led to initiation of monitoring programs of antimicrobial susceptibility of GC isolates. In recent years, there has been a significant decline in the incidence of **syphilis** in many European countries as well, due to comprehensive syphilis prevention efforts, such as antenatal screening program. Syphilis elimination efforts are critical for improving infant health, slowing the spread of HIV infection, and reducing racial disparities in health. **Human papillomavirus** (HPV) is the most common viral STI worldwide. HPVs cause a remarkable number of benign and malignant epithelial

lesions. The relationship between HPV and cervical neoplasia has been studied in greatest detail, but HPV has also been closely linked to a variable proportion of many other neoplasias. The large disease burden associated with HPV infections has stimulated interest in the development of an effective prophylactic and therapeutic HPV vaccine. Phase I/II clinical trials are currently underway to evaluate the safety and immunogenicity of monovalent or multivalent HPV VLP (virus-like particles) vaccines. Large scale efficacy trials will be initiated within the next two years. Undoubtedly, a multivalent HPV vaccine has the potential to interfere with the establishment of HPV infection in the host, and to prevent neoplastic and non-neoplastic epithelial lesions caused by HPVs. About one in five adults is infected by **herpes simplex virus type 2** (HSV-2), the organism that causes genital herpes. HSV-2 is the major cause of genital ulcer disease (GUD) worldwide, and the role of GUD in facilitating the transmission of HIV is well documented. Recurrent episodes are common among those infected. Atypical HSV episodes and intermittent asymptomatic viral shedding between episodes are difficult to detect in clinical practice, and particularly problematic among discordant couples. Identification of susceptible individuals by type-specific antibody testing needs to be thoroughly evaluated. Counselling of patients with first episode genital herpes, implementation of HSV treatment guidelines of suppressive therapy with, and increasing use of serological screening are important strategies in the prevention of acquisition of HSV infection. **Bacterial vaginosis** (BV) is a common cause of abnormal vaginal discharge in women of childbearing age. BV has been strongly linked with adverse pregnancy outcome (APO), such as preterm rupture of membranes, amniotic fluid infection, and preterm birth, all leading to increased rates of complications in both mothers and neonates. BV also increases the risk for HIV transmission. This can have an enormous impact in developing countries. Since BV is more prevalent in black women it may partially contribute to the disproportionate rates of APO and HIV in different racial groups. The heavy cost and burden of BV-related infectious complications all demand further research, particularly in the area of prevention since few prevention strategies exist so far to reduce complications associated with BV. Intervention studies of the impact of universal antenatal screening and treatment in the prevention of APO have largely been disappointing. Overall, education is a critical component in **STI prevention**. Medical school STI teaching programs, STI training programs for health care providers, and implementation of STI management guidelines in combination with STI surveillance programs have a large potential in the prevention of STIs, decreasing STI associated morbidity, and producing cost savings.

Cost/benefit of STD prevention in family planning centers

J. Henry-Suchet

CH Jean Rostand, Sevres, France

Family Planning Centers (FPC) are on first line for STD prevention, being connected to young people asking for contraceptive advice. AIDS, as threatening life, is the main STD, to prevent by education. HPV infection, usually detected by PAP test on vaginal smear in most countries, will be prevented by vaccination in a foreseeable future. B and C Hepatitis are prevented by vaccination. *Gonorrhoea* and *Chlamydia trachomatis* (CT) are primary causes of salpingitis leading to infertility and ectopic pregnancy. As opposed to gonococcal infection which greatly decreased, CT low genital tracts infection is common in young occidentals, the epidimics spreads mostly in adolescents, after the onset of sexual activity. It is strongly related to age and estimated 5-20 % (mean 10 %) in young females < 25 years and 5-10% in males. Several cost/benefit analysis show that prevention is

beneficial in each population with a prevalence > 4%. The total cost of a general screening could save twice the cost of treatment for salpingitis caused by CT and six times the total cost of CT epidemics if late sequelae are taken into account. Such prevention, applied in Scandinavian countries and USA, in FPC and Youth clinics, obtained a dramatic decrease of the epidemics in controlled populations. According to prevalence, each country has to evaluate if systematic or selected detection are beneficial.

Saturday, July 1, 2000

13:30 - 15:00 Gallus hall	Main Session IV Sexual (r)evolution
	Chairman: V. Bruni (Italy)
	Co-Chairman: A. Gomes F. (Portugal)
13:30 - 14:00	- Contraception and sexual (r)evolution
	I. Borten Krivine (France)
14:00 - 14:30	- Influence of contraceptive methods on sexual function
	J. Bancroft (USA)
14:30 - 15:00	- New research in sexual psychophysiology
	R. van Lunsen (The Netherlands)

Contraception and sexual (R) evolution

I. Borten-Krivine

Paris, France

What we asked contraception to resolve was to separate the sexuality from reproduction. Over the past thirty years we have gone from beeing able to make love without becoming pregnant to having passed from the demand to make love without an unwanted pregnancy to having medically assisted pregnancies without intercourse, for some couples. Between these two extremes, we will address :

- How women's control of their fertility has changed their sexuality. Most women enjoy their newfound freedom. Nevertheless contraception does not solve all sexual disorders. Some have been masked by the fear of pregnancy.
- How men's loss of power over contraception and reproduction has radically affected the balance between men and women within the couple, and in society.
- The *golden age* (1960-70) when the pill solved contraception, and antibiotics cured most sexually transmissible diseases. During that period the pill was considered largely responsible for changes in teenage and adults sexual behavior. As a matter of fact, the pill was more a part of this ungoing change than its driving force.
- The drastic changes required by AIDS and their consequences on sexuality.

On all these topics we shall try to show that medical skill and knowledge cannot totally control sexual issues that are so closely related to unconscious desire and emotion.

Key-words : contraception - women’s liberation- sexual revolution- sexual disorders

Influence of contraceptive methods on sexual function

J. Bancroft

Indiana University, The Kinsey Institute, Bloomington, IN, USA

In 1987, the author was commissioned by the WHO to review the literature on the effects of oral contraceptives (o.c.'s) on women's sexuality (Bancroft & Sartorius 1990). This review showed interest in this topic during the early days of high dose pills with a number of poorly

designed studies producing inconclusive results. Since the introduction of low dose o.c.'s this potential side effect has been largely ignored. Two studies, addressing this issue, will be briefly presented.
The first assesses the direct effects of oral contraceptives in women who have been sterilized, thus eliminating the complex implications of fertility control and allowing placebo control. This study was carried out in 150 women, 75 from Edinburgh, Scotland and 75 from Manila, Philippines (Graham et al 1995). Women were assessed for a baseline month and randomly assigned to a combined OC (COC), a progestogen only (POP) or placebo for four months. The COC adversely affected sexuality in 12 of the 25 Scottish women, but the effect was not apparent in the Filipino group. The possible explanations for this difference will be discussed. There were no negative effects of the POP.
The second study assesses the effects of a COC on sexuality in women starting on the COC for contraceptive purposes. Detailed assessments were made before starting the COC and each woman was followed for 12 months or until discontinuation. 97 women were studied. Negative changes in sexuality were common and were significantly associated with discontinuation, particularly during the first 3 months. Adverse effects of COC's on women's sexual well-being appear to be an important though unacknowledged factor contributing to discontinuation with these methods. These effects deserve further study as it is possible that they may be avoided or reduced by modification of the OC constituents, or by identification of those women at risk.

Bancroft J & Sartorius N (1990). The effects of oral contraceptives on well-being and sexuality. *Oxford Rev Reprod Biol*, 12:57-92
Graham CA, Ramos R, Bancroft J, Maglaya C. and Farley TMM (1995). The effects of steroidal contraceptives on the well-being and sexuality of women: A double blind, placebo controlled, two centre study of combined and progestogen only methods. *Contraception*, 52:363-369

New research in sexual psycho-physiology

R.H.W. van Lunsen (1), E. Laan (2) and W. Everaerd (2)

Dept. Sexology and Psychosomatic Ob/Gyn, Division of Ob/Gyn (1) and Dept. of Clinical Psychology (2), Academic Medical Centre, University of Amsterdam, Amsterdam, The Netherlands

Sexuality is a complicated bio-psychosocial phenomenar. In modern sexological research the sexual process leading to subjective (cognitive) and objective (genital) arousal is studied by means of psychophysiological methods that enable to monitor psychological processes and physical changes simultaneously. The female sexual response is studied by means of vaginal photoplethysmography that enables to measure changes in vaginal blood flow, a reliable marker for genital arousal and lubrication. Studies in pre- and postmenopausal women have shown that postmenopausal genital arousal is not estrogen dependent and that complaints of vaginal dryness and dyspareunie are probably more the result of an arousal disorder than of hormonal changes. Studies in men and women indicate that the initiation of the human sexual response is more or less an automatic process and that only ongoing arousal seems to be influenced by cognitive processes e.g. emotions. Sexual desire is the result of a cognitive elaboration of a perceived physical arousal resulting from sexual stimuli that "prime" the sexual system at a pre-attentive (pre-conscious) level. In this presentation several examples of research resulting in a new model of the human sexual response will be presented.

Thursday, June 29, 2000

• Session 1 Contraceptive and non-contraceptive benefits of OC

Gallus hall

Chairman: D. Serfaty (France)
Co-chairman: M. Orlean (Latvia)

10:30 - 11:00 Key-note lecture:
Non contraceptive benefits of oral contraception
M. Short (Ireland)

11:00 - 12:00 Free communications:

Breakthrough bleeding: measurement and differences among oral contraceptives
C.M. Lynch (USA)

Ovarian androgen production during oral contraceptives treatment in obese versus non-obese women with polycystic ovary syndrome
D. Cibula (Czech Republic)

Synthesis and secretion of Prolactin during menstrual cycle due to intake of combined oral contraceptives
Lj. Milasinovic (Yugoslavia)

The influence of oral contraception on the biochemical markers of bone metabolism
B. Pinter (Slovenia)

Vaginal microflora in women using oral anticonception
G.G. Donders (Belgium)

Vaginal rings for delivery of Nestorone® Progestin for contraception
T.M. Jackanicz (USA)

Non contraceptive benefits of oral contraception

M. Short

Rock Court Medical Centre, Dublin, Rep. of Ireland

The non contraceptive benefits of oral contraception can be grouped into 2 main categories: benefits that accrue when oral contraception is specifically utilised for contraceptive purposes and benefits that result from the use of oral contraceptives to treat problems and disorders.

The non contraceptive incidental benefits can be listed as follows:

Effective contraception leads to:
- Less need for therapeutic abortion
- Less need for surgical sterilisation
Less endometrial cancer
Less ovarian cancer
Less benign breast disease
Fewer ectopic pregnancies

More regular menses leads to:
- Less flow
- Less dysmenorrhea
- Less anaemia
Less salpingitis
Less rheumatoid arthritis
Increased bone density
Probably less endometriosis
Possibly protection against atherosclerosis
Possibly fewer fibroids
Possibly fewer ovarian cysts.

Protection against pelvic inflammatory disease is especially noteworthy and a major contribution to not only presenation of fertility but to lower health care costs. Also important is the prevention of ectopic pregnancies.
Prevention of benign and malignant neoplasia is an outstanding feature of oral contraception. Oral contraception use decreases the incidence of benign breast disease. Oral contraceptives are frequently utilised to manage the following problems and disorders:

Definitely beneficial:
- Dysfunctional uterine bleeding
- Dysmenorrhea
- Mittelschmerz
- Endometriosis prophylaxis
- Acne and Hirsutism
- Hormone Replacement for Hypothalamic Amenorrhea
- Prevention of menstual porphyria

Probably beneficial:
- Functional ovarian cysts
- Pre-menstrual syndrome
- Control of bleeding (Dyscrasias, Anovulation)

Oral contraceptives have been a cornerstone for the treatment of anovulatory, dysfunctional uterine bleeding. Oral contraceptives are also a good choice to provide prophylaxis against the recurrence of endometriosis in a woman who has already undergone more vigorous treatment with surgery or the GnRH analogues. To protect against endometriosis, oral contraceptives should be taken daily with no break and no withdrawal bleeding

Oral contraceptives are associated with a collection of effects which yield an overall improvement in individual health. From a public health point of view, the combined impact leads to a decrease in the cost of health care. For both the individual and the public health, these impacts are especially significant in older women. These considerations allow the clinician to present oral contraception with a very positive attitude, an approach which makes an important contribution to a patients ability to make appropriate health choices.

Breakthrough bleeding: measurement and differences among oral contraceptives

C. M. Lynch

University of South Florida College of Medicine, Tampa, FL USA

Objective: To review the issues surrounding breakthrough bleeding (BTB) that pertain to bleeding measurement and the differences in bleeding among oral contraceptives (Ocs).
Method: Relevant articles published from 1966 to 1999 were identified by searching MEDLINE. Additional sources, such as articles published before 1966 and book chapters, were located by consulting the bibliographies of the articles accessed.
Results: Breakthrough bleeding is a common cause of birth control pill discontinuation, and can result from a variety of factors, including noncompliance, underlying medical conditions, and formulation of the OC. Well-designed clinical trials that measure BTB use prospective menstrual diaries, require standard definitions for bleeding and spotting, have sufficiently long study duration (at least 4 cycles), control for new users vs previous OC users, and for compliance, and account for differences in bleeding profiles in Sunday-start vs day- 1 start regimens. A review of BTB studies reveals that many investigators fail to use standard definitions for bleeding and spotting, to control for compliance, or to control for new vs previous OC users. In addition to estrogen dose, BTB rates are influenced by the type of progestin in the OC. For example, in controlled, comparative studies, Alesse® (20 mg EE and 100 mg levonorgestrel) provided cycle control comparable to that of a triphasic OC containing 35 mg EE plus norethindrone, and better than that of a 20 mg EE OC containing norethindrone acctate (Loestrin® FE 1/20). The impact of BTB can be minimized in women by proper counseling, which should educate the patients about the possibility of BTB, and also address their fears associated with BTB.
Conclusion: Physicians prescribing OCs should consider the importance of study design for accurate measurement of BTB, the general trends in BTB rates among OCs, and the importance of patient education to decrease the likelihood of pill discontinuation due to BTB.

Ovarian androgen production during oral contracetpives treatment in obese versus non-obese women with polycystic ovary syndrome

D. Cibula (1), M. Hill (2), M. Fanta (1)

Charles University, Dept. of Obst. & Gyn. (1), Institute of Endocrinology (2), Prague, Czech Republic

Objective: Polycystic ovary syndrome (PCOS) as a proven risk factor for NIDDM and coronary artery disease is an evident indication for long-term treatment. Combined oral contraceptives (OC) are still the first choice of treatment for most PCOS women. However, differences in endocrine and metabolic parameters between obese and lean PCOS patients have been postulated. This is the first study evaluating the effect of OC treatment in obese versus non-obese PCOS patients.-Patients and methods: A total of 28 lean (BMI<23) and 15 obese (BMI>30) PCOS women were enrolled into the study. PCOS was defined as follows: (a) increased levels of at least one androgen, (b) oligo-amenorrhea, (c) anovulation. The levels of testosterone, androstenedione, DHEA, DHEAS, and SHBG were measured before and after 6 months of treatment with OC containing gestodene, desogestrel or norgestimate. Results: Anthropometric parameters (BMI, WHR) remained unaltered during the six months of therapy. There were not differences between obese and non-obese women in the changes in testosterone, androstenedione, DHEA, and DHEAS levels. The index of free testosterone (IFT) was significantly more decreased in obese women. The same proportions of both groups had normalized levels of androgens at the end of treatment. Moreover, there were no differences in the degree of hirsutism or acne score improvement between obese and non-obese PCOS patients. -
Conclusions: The positive effect of OC containing low androgenic progestins on ovarian androgen production is not negatively influenced by a higher BMI.

Synthesis and secretion of prolactin during menstrual cycle due to intake of combined oral contraceptives

Lj. Milasinovic, A. Kapamadzija, J. Vukelic, A. Djordjevic

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Objective: During menstrual cycle, concentrations of serum prolactin in women significantly changes due to menstrual cycle phase. The aim of this study was to investigate the influence of long - term usage of combined oral contraceptives (COC) on synthesis and secretion of prolactin. Study design: The level of serum prolactin in 58 healthy women with normal menstrual cycle was evaluated using enzyme immunologic essay, three times during one menstrual cycle: in early follicular phase (from 6th - 9th day of cycle), in periovulatory phase (13th - 18th day) and luteal phase (22nd - 25th day). The investigated group consisted of 31 women who had been taking COC (Levonorgestrel + ethinyl estradiol 0,25 mg + 0,05 mg) longer than 12 months. In control group there were 27 women who had never been taking COC. Results: Mean values of prolactin in investigated group were: 9,04 +- 5,23 ug \ l in follicular phase, 10,28 +- 4,93 ug \ l in periovulatory phase and 10,08 +- 4,69 ug \ l in luteal phase. The difference between serum prolactin levels in each phase of the cycle is not significantly important. Mean values of serum prolactin in control group were: 9,69 +- 5,32 ug \ l in follicular p,11,69 +- 5,64 ug \ l, in periovulatory p and 10,73 +- 5,42 ug \ l in luteal p. Serum levels of prolactin in periovulatory phase is significantly higher than in early follicular phase ($p < 0,01$). Serum levels of prolactin in periovulatory phase is significantly lower in investigated group comparing to control group ($p < 0,05$). The difference between follicular and luteal phase among both groups is not of significant importance. Conclusions: Women users of combined oral contraceptives do not have increase of serum prolactin levels in periovulatory phase of menstrual cycle. Intake of COC has no significant influence on serum prolactin levels during follicular and luteal phase of menstrual cycle.

The influence of oral contraception on the biochemical markers of bone metabolism

B. Pinter

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Objectives: The aim of the study was to evaluate the influence of combined oral contraception on the biochemical markers of bone metabolism in the women aged 20-29 years. Design and methods: In the prospective clinical study 41 women were included. Twenty-one women in the study group were given oral contraception containing 30 µg etinilestradiol and 150 µg levonorgestrel and twenty women in the study group were given non-hormonal contraceptive method. In the beginning of the study and after three months of contraceptive use biochemical markers of bone metabolism were evaluated: bone alkaline phosphatase, osteocalcin, urine calcium, pyridinoline and deoksypyridinoline. Linear regression method was used to evaluate the influence of oral contraception on the biochemical markers of bone metabolism. P values less than 0,05 were considered statistically significant. Results: The study group did not differ from the control group in the reproductive history and the life-style habits. The average age of the women in the study group was 21,2 years and in the control group 22,4 years ($p=0,015$). The average gynaecological age was 8,5 years in the study group and 9,8 years in the control group ($p=0,01$). In the beginning of the study the values of the biochemical markers in the study group did not differ from the values in the control group. At the end of the study we did not find any statistical significant changes in the values of any biochemical markers of bone metabolism after three months of use of the oral contraception comparing the study group to the control group. Conclusions: The combined oral contraception containing 30 µg etinilestradiol and 150

µg levonorgestrel did not influence the biochemical markers of bone metabolism in the women aged 20-29 years.

Vaginal microflora in women using oral anticonception

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Gasthuisberg University Hospital, Universiteit Leuven, and Laboratorium voor klinische pathologie, Antwerpen, Belgium

Introduction: A normal vaginal flora can be defined as a lactobacillus-dominant ecosystem of microorganisms that prevent endogenous cohabitants and pathogens to proliferate. Setting: Women presenting in the vulvo-vaginitis clinic, Gasthuisberg University Hospital Leuven, Belgium. Methods: Fresh vaginal fluid microscopy (lactobacillary grades), composite criteria according to Amsel (BV), vaginal pH and vaginal lactate in 113 oral anticonception OAC users versus 124 control women not using any anticonception (16 of whom had undergone tubal ligation), presenting in the vulvo-vaginitis clinic. Results: A healthier flora was seen in the OAC users. Lactobacillary grade III (grossly abnormal) was present in 24% of OAC users, versus 33% in controls. Bacterial vaginosis (BV) and aerobic vaginitis (AV) were both present in 11% of OAC users and in respectively 15.4% and 18.5% ($p = 0.058$) of the controls. Lactate concentration was not different in both groups (mean 114 mg/dl in OAC useres vs 95 mg/dl in controls). Mean pH was lower in OAC users ($p=0.05$). OAC users were younger than the controls ($p < 0.0001$). Conclusion: OAC use does not cause detoriation of the vaginal lactobacillary flora and may rather protect women against BV and AV.

Vaginal rings for delivery of Nestorone® progestin for contraception

T.M. Jackanicz

Population Council, New York, USA

A dimethylpolysiloxane ring, placed in the vagina, is an effective means to administer steroids at a continuous, relatively constant low dosage for both fertility control and replacement therapy. Several rings, 58 mm in diameter and 8.4 mm in cross section, have been developed that deliver either NESTORONE® Progestin (NES: 16-methylene-17alfa-acetoxy-19-norpregnene-3,20-dione) alone or in combination with ethinyl estradiol (EE). (1) Rings have been designed to deliver 150 to 200 µg of NES per day and 10 to 20 µg per day of EE. Within the ring steroids are incorporated into 3 mm diameter elastomer cores, whose lengths can be varied to deliver a range of steroid doses. Normally the ring remains *in situ* for three weeks and then is removed for one week to allow withdrawal bleeding; alternate approaches are a 26 days in / 4 days out regimen and a bleeding signal schedule, where a woman leaves the ring in until she begins to bleed, removes it for 4 days and then reinserts it until her next bleeding episode. Both *in vitro* and clinical data indicate that the ring is effective for one year. Results from clinical trials conducted by investigators in the Population Council's International Committee for Contraception Research indicate that this device inhibits ovulation effectively, supports excellent bleeding patterns, and elicits no major side effects. (2) A 50 µg NES only ring, used on a continuous schedule, also inhibits ovulation consistently, but the bleeding patterns are less regular than those of NES/EE ring users. This ring works well in lactating women, whose duration of amenorrhea is extended beyond that of control subjects. Since NES is metabolized rapidly, nursing mothers can use the device without adverse consequences for the infant.

Thursday, June 29, 2000

13:30 - 15:00 Parallel Sessions

Gallus hall

• Session 2 Emergency contraception

Chairman: M. van Santen (Germany)
Co-Chairman: G. Bartfai (Hungary)

Key-note lecture:

13:30 - 13:45 Emergency contraception: a decade of progress
P.F.A. Van Look (WHO, Switzerland)

13:45 - 14:00 Improving knowledge of access to emergency contraception
A. Bigrigg (UK)

14:00 - 15:00 Free communications:

Refining the Yuzpe method of emergency contraception (EC)
A.M.C. Webb (United Kingdom)

Young women requesting emergency contraception have a high frequency of new unintended pregnancies despite counselling
G. Falk (Sweden)

Repeated use of hormonal emergency contraception by younger women in the UK
S. Rowlands (United Kingdom)

Dispensation of emergency contraception in Family Planning Clinics, in the val de Marne, suburb of Paris, France
H. Christmann (France)

Can hormonal emergency contraception (EC) be available without medical prescription?
E. Aubény (France)

Progesterone receptor (PR) down-regulation and pinopodium formation in rec FSH induced cycles as compared to oral contraceptive (OC) users (Novynette, Gedeon Richter)
G. Ugocsai (Hungary)

Emergency contraception: a decade of progress

Paul F.A. Van Look

Department of Reproductive Health and Research, World Health Organization, Geneva, Switzerland

Emergency contraception, defined as “methods that women can use after intercourse to prevent pregnancy”, has the potential to prevent tens of millions of unintended pregnancies throughout the world but, until a few years ago, this potential remained largely unknown and hence untapped. A series of developments during the last 5-10 years, however, is gradually lifting the veil off the “nation’s best kept secret” in many countries around the world. Increasing efforts are being made by health and

family planning organizations to bring emergency contraception into the mainstream of reproductive health care. These efforts include, *inter alia*, the issuance, by several organizations, of revised clinical guidelines that have removed all medical contraindications to the use of emergency contraceptive pills, with the exception of pregnancy; the initiation of media campaigns in several countries to increase public awareness; the establishment of an international Consortium for Emergency Contraception dedicated to the identification, through model introductions and operations research, of "best practices" needed to broaden access to hormonal emergency contraceptives; and the testing of innovative service delivery models such as prescribing by pharmacists on behalf of physicians. The research conducted by the World Health Organization and others, that led to the discovery of two new, improved approaches to hormonal emergency contraception, namely the use of levonorgestrel or mifepristone, has been a catalyst for many of the positive developments in this field during the last decade.

Improving knowledge of access to Emergency Contraception

A. Bigrigg

Family Planning & Reproductive Health Care, Glasgow, UK

Post coital contraception will only benefit individuals if they are aware of the existence of safe effective methods, and how to access them in a timely fashion**.** This paper will review the results of successful publicity campaigns in the UK, and innovative initiatives such as computerised telephone lines to allow individuals to locate clinics supplying emergency contraception in the United States of America. The potential advantages of over the counter supply, (distributed by pharmacists) and advance prescribing will be debated. In addition, advice which could be given directly to women who have access to packets of oral contraceptives that are not specifically packaged as post coital contraception will be discussed.

Refining the Yuzpe method of emergency contraception (EC)

C. Ellertson (1),K. Blanchard (1), A.M.C. Webb (2), C. Leadbetter (2), M. Evans (2), A. Tyrer (2), A. Bigrigg (3), S. Haskell (4), H. King (5), A. Glasier (6)

Population Council, New York, USA (1); Abacus Centres for Contraception and Reproductive Health, Liverpool, UK (2); Centre for Family Planning and Sexual Health, Glasgow, UK (3), Planned Parenthood of Greater Iowa, USA (4); Sheffield, UK (5); Edinburgh, UK (6)

The Yuzpe regimen of emergency contraception is the most widely used EC method in the world, however the regimen has not been changed in over 20 years. The Population Council of New York coodinated a study which investigated three questions concerning the Yuzpe regimen 1) Will the Yuzpe regimen work up to 120 hours after unprotected intercourse? 2) Will four 50 mcg ethinylestradiol / 1 mg norethindrone pills work as well as four 50 mcg ethinylestradiol / 0.25 mg levonorgestrel tablets used in the Yuzpe method? Will this modification cause fewer side effects? 3) Is a single dose regimen consisting of only the first half of the Yuzpe regimen as effective as the standard Yuzpe regimen? Will this dose cause fewer side effects? Question one was investigated by an open study of women presenting berween 72 and 120 hours who preferred the Yuzpe regime over the standard treatment and copper intrauterine device insertion. A multicentre, randomised, double blind trial was carried out to answer questions two and three. Between October 1997 and February 2000, five centres recruited 2000 women into the randomised trial and 100 into the extended arm.

Recruitement to the latter will continue until the end of the year. Results from the randomised part of the study will be analysed and presented at the Congress.

Young women requesting emergency contraception have a high frequency of new unintended pregnancies despite counselling

G. Falk (1), L. Falk (2), U. Hanson (1) and I. Mislom (3)

Dept. of Obst. & Gyn. (1), Dept. of Dermatology and Venereology (2), Örebro Medical Centre Hospital, and Dept. of Obst. & Gyn. (3), Sahlgrenska University Hospital, Göteborg, Sweden

Since introduction in Sweden in 1994 emergency contraception has become a welcome addition to the campaign against unwanted pregnancy. Unprotected sexual intercourse also involves the risk of contracting sexually transmitted diseases (STD). The aim of this study was to assess the short- and long-term risk of unintended pregnancy and to determine the frequency of chlamydia infections in women requiring emergency contraception.
Material and Methods: Between September 1998 and February 1999 young women aged 15-25 years had the opportunity to request emergency contraception at a Youth Centre in the City of Örebro, with opening hours during Saturdays and Sundays. Emergency contraception was given with the Yuzpe regimen. A follow-up visit 3 weeks after treatment, which included contraceptive counselling, was offered to all participants. At both visits a pregnancy test and a chlamydia test were performed and the women completed a questionnaire. After the initial visit the adolescents where monitored for new pregnancies during the following 12 months.
Results: One pregnancy occurred in the 134 young women who received emergency contraception during the study period. None of the women had a positive chlamydia test. Of those requesting emergency contraception 54% did so because of unprotected intercourse, 32% because of a ruptured condom, 11% because of missed oral contraceptives (oc) and 5% had mixed reasons. At long-term follow up, one year after the initial visit, 11 of the 134 young women had experienced an unintended pregnancy which lead to legal abortion. In all cases the young women had either started and quit oc or had never commenced the prescribed oc.
Summary: Young women who request emergency contraception are despite a planned follow-up with contraceptive counselling a high risk group for new unintended pregnancies. In Sweden they do not seem to be a high risk group for STD.

Repeated use of hormonal emergency contraception by younger women in the UK

S. Rowlands (1), H. Devalia (1), R. Lawrenson (2), J. Logie (2), B. Ineichen (2)

EPIC, London (1) and European Institute of Health & medical Sciences, University of Surrey (2), UK

Objective. To ascertain whether repeated use of emergency contraception (EC) is common.
Design & Methods. A cohort of women aged 14-29 in 1993 was identified from the General Practice Research Database and followed up for a period of four years. Patient files were searched for evidence of use of EC and regular contraception (RC). Relationships between EC use and the personal characteristics of women were examined using chi-2 tests of association considering age, smoking status, evidence of prior sexual activity and records of use of RC. For women with records of use of EC, repeat use and

the numbers of EC records were examined using Mann-Whitney and Kruskal-Wallis tests where appropriate.
Results. 15,105 of 95,007 women (16%) had received EC during the study period (an average of 5% per annum). There was a small year on year increase in uptake of EC between 1994 and 1997. Only 4% of users received EC more than twice in any year. There was a positive association between use of EC and prior sexual acitivity. EC users with records of prior sexual activity also appeared more likely to be repeat users, having significantly more EC records during the full four year period. More than 70% of those who had no previous record of use of RC had used RC within one year of use of EC.
Conclusions. These results disprove the notion of widespread repeated use of EC. They show that provision of an EC service does not result in failure to initiate RC or abandonment of RC; rather they show many women using RC for the first time after use of EC.

Dispensation of Emergency Contraception in Family Planning Clinics, in the Val de Marne, Suburb of Paris, France

H. Christmann, M. Prudhomme, Y. Perriot, P. Delberghe, M.C. Leroux

Service de Protection Maternelle et Infantile, Conseil general du Val de Marne, Creteil, France

Objectives: To facilitate access to emergency contraception (EC). To allow the nurses in the family planning clinics to deliver it during the doctor's absence. Methods: For one year, 1998, 1102 women requested EC in the 38 family planning clinics participating in the study. This study evaluated the utilisers and the circumstances under which dispensation occurred. Results: The users of EC were young, 45% under 18 years and 90% under 25 years. There was a marked difference between the contraception the women declared they used and that which they actually did during their last episode of sexual intercourse. Women requested EC in case of condom breakage or slipping (49%), forgotten pill (8%), or after unprotected intercourse (43%). Nurses personnaly received 809 requests for EC, and 293 women were received by the family planning doctor. In 77% of the cases, EC was given by the nurses, and for the others after medical opinion. But only 7% had a medical <<problem>> (contraindications to estrogen-progestin, or cycle disorder). Among the 823 women for whom information was obtained, 22 unwanted pregnancies were observed, 18 of these patients decided to have an abortion. 97.3% efficacity. Conclusions: Making EC more easily available in family planning clinics with dispensation by nurses does no harm and may reduce the rate of unwanted pregnancy.

Can hormonal emergency contraception (EC) be available without medical prescription?

E. Aubeny

French Association for Contraception, Paris, France

WHO trials have demonstrated that two EC hormonal products, combined ethynilestradiol levonorgestrel product (Tetragynon®) and levonorgestrel-only product (Norlevo®), are more efficient when used earlier after an unprotected sexual intercourse. The need for a medical visit delays the use of EC and therefore decreases its efficacy. In addition, many women are reluctant to modify their daily activities to get an EC prescripıion. Combined ethynilestradiol - levonorgestrel product has only one contraindication: previous thrombo-embolic accidents. An interrogation is sufficient to detect these previous disorders. Its seems therefore possible that para-medical staff deliver this drug on medical supervision. But consulting para-medical staff will also

delay the use of EC. In several countries, levonorgestrel-only EC products are now available. Levonorgestrel has no contraindication. Besides the WHO studies have shown that they are better tolerated than Yuzpe method. Thus there seems to be no need that these products should be prescribed by medical staff. Indeed, in France a levonorgestrel-only EC pill is now available in pharmacies without medical prescription. The product can also be directly delivered for free by high-school nurses to pupils in case, for any reason, they cannot obtain the product from a pharmacy or have no possibility to get a fast appointment in a Family Planning center. These provisions should contribute to the decrease of unwanted pregnancies.

Progesterone receptor (PR) down-regulation and pinopodium formation in rec FSH induced cycles as compared to oral contraceptive (OC) users (Novynette, Gedeon Richter)

G. Ugocsai, M. Rozsa, L. Csabai

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The study aimed to investigate the parallel appearance of the biological endometrial receptivity markers PR down-regulation and surface protrusion pinopodia in ovulation induction cycles using recombinant FSH preparate and GnRH analogue as definitively ovulating controls and compared to the changes under lowdose OC influence. 5 anovulatory infertile women underwent as a diagnostic step ovulation induction to reveal the presence of some endometrial receptivity markers around the time of implantation. Rec-FSH was given to promote follicular maturation, GnRH analogue to provoke ovulation. On day LH +8 endometrial biopsy was taken for PR immunohistochemistry and pinopodium studies with scanning electron microscope. Prior to this, as control and comparison OC was taken for two months for partial pituitary down-regulation and on day 10 of the tablets the same biopsy was performed. In the induced cycles all endometria displayed simultaneous disappearance of PR expression and appearance of pinopodium formation. In the OC control cycles PR expression remained strong and no pinopodia were present. Lowdose OC proved to destroy the fine-tuned cascade of endometrial receptivity, achieving contraception by this way also.

Thursday, June 29, 2000

15:30 - 17:00	Parallel Sessions
	• Session 3 Evidence-based practice in family planning
Gallus hall	*Chairman: Ph. Hannaford (UK)* *Co-Chairman: E. Aubény (France)*
15:30 - 16:00	Key-note lecture: Evidence-based practice in Family Planning *D.A. Grimes (USA)*
16:00 - 17:00	Free communications:
	Analysis of the maternal mortality and its relation to reproductive characteristics in a university hospital of a developing country *S.S. Özalp (Turkey)*
	Family planning after ten years in Romania. Outcome and perspectives *V. Copaci (Romania)*
	Hormonal contraception without a pelvic exam: a California demonstration project *P.D. Darney (USA)*
Uterine	The long term effectiveness and acceptance of the Levonorgestrel Intra-System (LNG-IUS) for the treatment of menorrhagia in women sufferers who require contraception *M.S.A. Mansour (United Kingdom)*
	Coagulation and fibrinolysis in women taking a 24-days regimen containing 15 µg Ethinylestradiol plus 60 µg Gestodene *F. Fruzzetti (Italy)*
	CMV must be determinate in family planning services? *O. Casian-Botez (Romania)*

Evidence-based practice in Family Planning

D.A. Grimes

Family Health International and University of North Carolina School of Medicine, Durham and Chapel Hill, North Carolina, USA

Evidence-based medicine is improving family planning around the world. The process involves a determined effort to find the best available information concerning a clinical question, then filtering that evidence through the clinical skill of the clinician, while keeping in mind patient preferences. The antithesis of evidence-based medicine is autocratic or authoritarian medicine, which has governed medicine for several millennia. Misunderstandings about intrauterine contraception highlight the need for evidence-based practice in family planning. Based on flawed studies and claims of alleged authorities, many clinicians and consumers have concluded that the IUD poses serious risks of upper genital tract infection and infertility. Dispassionate examination of the evidence indicates otherwise. Current recommendations against IUD use by HIV-infected women prevent large numbers of women from using this highly effective

contraception; in contrast, cohort data from Kenya show no significant increase in risk and a reduction in viral shedding among copper IUD users. Growing evidence suggests that IUDs protect against endometrial cancer, yet few consumers or clinicians are aware of this potential benefit. The Cochrane Collaboration, an international effort to identify and synthesize randomized controlled trials in medicine, now includes fertility regulation topics. Interested clinicians and consumers are invited to join in this global collaboration designed to provide the best available evidence on family planning topics.

Analysis of the maternal mortality and its relation to reproductive characteristics in a university hospital of a developing country

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Osmangazi University Faculty of Medicine, Department of Obstetrics and Gynecology, Eskisehir, Turkey

Objective: To analyze the causes of pregnancy-related deaths and their relation to reproductive characteristics of the patients. Materials and Methods: The causes of pregnancy-related deaths and the demographic characteristics of the patients were analyzed retrospectively from the patients' files or hospital death reports in a period of 5-year between 1994 and 1999. Results: Nineteen pregnancy-related deaths were identified during the five-year period and maternal mortality ratio was calculated to be 636 per 100.000 live births. Seventeen (89.4%) of the deaths were due to direct obstetrical causes, including 7 (36.8%) toxemia, 6 (31.6%) obstetric hemorrhage, and 4 (21.1%) infection/sepsis. Indirect obstetric causes of deaths were observed in 2 (10.6%) cases, including one (5.3%) heart failure and one (5.3%) advanced stage cancer. All of the patients were referred from other hospitals and 12 (63.0%) of them had no antenatal care. Fifteen (78.9.0%) patients had no or primary school education, 15 (78.9%) had low socioeconomic levels, and 15 (78.9%) and 8 (42.1%) patients had ≥2 parity and living children, respectively, ($p<0.05$). Discussion: High maternal mortality rate, obtained in this study, was thought to be due to the referral of high risk pregnancies with complicating severe disease to the university hospital. Except one case with cancer, all of the other pregnancy-related deaths could be prevented by proper antenatal care, early diagnosis and appropriate management. However, low education and socioeconomic levels were seemed to be the barriers for getting appropriate health care. It was suggested that using effective contraceptive methods could decrease the maternal mortality rate, which increased with the number of parity and living children.

Family planning after ten years in Romania
Outcome and perspectives

V. Copaci, Gh. Budau

"Bega" University Clinic, Timisoara, Romania

The aim of our study is to asses the results of family planning since 1990, after 35 years of interdiction. We followed the evolution of the main indexes related to the production during the years and opposite to the previous period. We have observed a slow but continuous improvement of this data as a result of governmental and nongovernmental activities. The enhancement of the medical insurance could sustain this trend in the future.
Conclusion: contraception and safe abortion available to any couple is the pillar of a good reproductive health.

Hormonal contraception without a pelvic exam: A California Demonstration Project

P.D. Darney, G. Sawaya, K. Leon, J. Boggess, C. Harper

Center for Reproductive Health Research and Policy, University of California, San Francisco, USA

Purpose: More than 20 million births will occur in California in the next 25 years. Two-thirds of these will be to indigent women. To meet the need for family planning the State implemented a "public-private partnership" in 1997, including a demonstration of the efficacy and safety of providing injectable and oral contracephon without a pelvic examination.
Methods: 2400 women who did not have an examination were followed for two years and compared to 1500 similar women who were examined to estimate potential "missed morbidity", to evaluate the acceptance of more effective contraception, and to document the efficacy of referral of women judged to need an examination.
Results: Women who did not have a pelvic examination were not at higher risk of cervical neoplasia than women who did have one. Unexamined women were more likely to adopt a more effective method than examined women. 75% of women judged to require an examination kept their referral appointments.
Conclusions: Unnecessary pelvic examinations discourage women from seeking contraception and are expensive. Limiting pelvic examination to those at risk of neoplasia and infection does not increase morbidity, encourages the adoption of effective contraception, and is acceptable to women.

The long term effectiveness and acceptance of the Levonorgestrel Intra-Uterine System (LNG-IUS) for the treatment of menorrhagia in women sufferers who require contraception

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Dept. of Obst. & Gyn., Hexham General Hospital (1), Newcaste upon Tyne Contraception and Sexual Health Service (2), UK

Objective: To assess the acceptability, long-term continuance and effectiveness of the LNG-IUS as a long-term treatment for menorrhagia in women requiring contraception.
Methods: This is an ongoing, prospective, observational study (October 1995 untill now). After counselling, 129 women suffering from menorrhagia were investigated by hysteroscopy, endometrial biopsy and transvaginal ultrasound scan. Of these, 59 women who suffer from menorrhagia and use the LNG-IUS as a contraceptive for more than 6 months will be considered in this study.
Interim Results: 59 women, including 10 nulliparous, were fitted with the LNG-IUS for contraception and treatment of heavy menstrual loss. Mean age is 40.5 years. 53 (89.8%) women continued using the IUS (mean 18.5 months) as compared to 5 removals (mean 7.2 months). There was one expulsion (1.69%) in a parous woman. The overall continuation rate was estimated at 89.8%. 58 (98.3%) women

reported improvement in menorrhagia by 2 months with 36 (97.3%) of 37 women referred with menorrhagia and dysmenorrhoea reporting improvement of both symptoms. Regular but reduced menstrual loss resumed in 45 women (76.3%) after a mean of 5.8 months. 3 of the 5 discontinuing women requested removals for prolonged spotting in spite of perceived reduction in blood loss and alleviation of dysmenorrhoea. No pregnancy occurred during the study period.
Conclusion: The LNG-IUS has a dual role as an effective and acceptable long-term treatment for women complaining of menorrhagia and dysmenorrhoea in addition to being an effective and compliance-free contraceptive. This will allow more women world-wide to regulate their fertility.

Coagulation and fibrinolysis in women taking a 24-days regimen containing 15 µg Ethinylestradiol plus 60 µg Gestodene

F. Fruzzetti (1), A.R. Genazzani (1), C. Ricci (1), De Negri (2), C. Bersi (1), F. Carmassi (1)

University of Pisa, Department of Obstetrics and Gynecology (1) and Department of Internal Medicine (2), Pisa, Italy

The effects of oral contraceptives on coagulation system is estrogen-dose-related. In order to investigate the effects of an association containing 15 µg ethinylestradiol on haemostasis, prothrombin fragment 1+2 (F1+2) and thrombin-antithrombin III (TAT) complexes, fibrinogen, antithrombin III (AT III) activity, and plasma concentrations of tissue plasminogen activator (t-PA) and its inhibitor (PAI), were evaluated in tot healthy women (age 18-34). All women received a 24-days regimen containing 15 µg ethinylestradiol plus 60 µg gestodene for 12 months. At baseline the levels of the parameters tested were within the normal range. Parameters of coagulation did not increased with oral contraceptive use. No changes in plasma fibrinogen concentrations, nor in Prothrombin F1+2, nor in TAT III levels were observed after 6 and 12 months of oral contraceptive use. Parameters of anticoagulation and fibrinolysis showed a similar trend: t-PA and PAI either antigen and activity did not change during OC intake. AT III activity remained costant. These results show that very low doses of ethinylestradiol as 15 µg don't impair haemostasis in healthy females.

CMV must be determinate in family planning services?

O. Casian-Botez (1), D. Azoicai (2), L. Coca (1)

Women’s Wellness Center (1), University “Gr. T. Popa”, Epidemiological Department (2), Iasi, Romania

This study aimed to prove by serological investigation the possible abortional role for CMV. Study design: Presence of serum anti-CMV antibodies was studied in 20 women aged 18-42 years within the first day after consecutive spontaneous abortion in the first and second trimester of pregnancy (group A) and the control group, consisting of 40 apparently health subjects, 10 medical nurses with high contaminated risk and 30 blood donors (group B). The group A was investigated for abnormality of maternal reproductive organs (clinical and echo

exams), endocrine dysfunction and infection systemic disease (clinical and biochemical exams), drugs and alcohol consume and abortion maneuvers (anamnesis); these investigations were normally. Results: Both groups manifested presence of serum IgG class anti-CMV antibodies (IgG-anti-CMV), but levels of the antibodies proved higher in women following spontaneous abortions (especially in the second trimester of pregnancy) and in high-contaminated risk group. The prevalence of high-level anti-CMV antibody (IgG titers>9,2UI/µl) was 75% in the patients from group A as compared to 57,15% in the group B (but for medical nurses is 66,66%). No subject has IgM-anti-CMV, but the higher levels of the IgG in women with abortions in the second trimester pregnancy may prove a seroconversion (IgM persists only 2-3 months). Conclusions: Many couples presenting in our Center with recurrent pregnancy loss are panicked and want know everything about treatment. High incidence in general population (72%) and in high contaminated risk population (66,66%) may explain the great incidence anti-CMV antibody in women with spontaneous abortion and the CMV implication like risk factor for abortion disease. This conclusion is the reason for current anti-CMV antibody determination at pregnancy persons, especially in the pregnancy women with reccurent abortions.

Friday, June 30, 2000

10:30 - 12:00	Parallel Sessions
	• Session 4 How to optimise contraceptive services? The role of non-medical professionals
Gallus hall	*Chairman: O. Loeber (The Netherlands)* *Co-Chairman: A. Yeshaya (Israel)*
	Key-note lecture:
10:30 - 10:45	How to optimize contraceptive services? The role of non-medical professionals. *A. Webb (UK)*
10:45 - 11:00	How to optimize contraceptive services? The role of non-medical professionals. 28 years of Swedish experience as midwife in contraception *G. Lundberg (Sweden)*
11:00 - 12:00	Free communications:
	Activities of Latvian Contraceptology Association *M. Orleana (Latvia)*
	Role of non-medical professionals *M. Lamont (United Kingdom)*
University	Experiences of learning: an evaluation of the integration of Family Planning Training into the new medical undergraduate curriculum at Liverpool Medical School *J.T.McVicker (United Kingdom)*
	Forgetting to take the pill as a reason for requesting a voluntary termination of pregnancy *D. Serfaty (France)*
	Contraceptive misconceptions - The Intrauterine Device *H. Roberts (New Zealand)*
	New intrauterine contraceptive devices on ultrasound *C. Bastianelli (Italy)*

How to optimise contraceptive services? The role of non-medical professionals

A.M.C. Webb

Abacus Centres for Contraception and Reproductive Health, Liverpool, UK

To enable couples to use the contraceptive method of their choice they require to be aware that contraception exists and what choices are available. Therefore the first need is for clear information. This can be transmitted in a variety of ways be it in schools and through all types of media as well as more dedicated health promotion channels. Once information is obtained and because of the personal and private nature of sexual relationships anyone seeking advice must feel comfortable about whom they approach.

The most important feature of anyone who is going to provide contraceptive advice or services is their ability to listen to the client's needs and impart information which is factually correct as well as clear and acceptable. Because most people who require contraceptive services are fit and healthy and the risks of most contraceptive methods are minimal, the level of training required in the medical field is not extensive for most methods and clients although there must always be medical back up for clients with other medical problems. Non-medical professionals have a huge role to play in the optimisation of contraceptive services as they can have a considerable influence on the potential users whether it is by giving positive influences or misinformation whether deliberately or otherwise.

How to optimize contraceptive services? The role of non-medical professionals. 28 years of Swedish experience as midwife in contraception

G. Lundberg

Women's Clinic Hospital, Helsingborg, Sweden

In Sweden midwives specialist scope of activities in obstetrical and gynecological care include preventive measures/reproductive health care from a life-cycle perspective for parents to be, new parents and their new born babies, for youth regarding sex- life and for women of all ages, for instance in connection with gynecological health check-ups, family planning and counselling on menopausal problems. Family planning units with midwives are eqally distributed throughout the country and have been involved in maternity welfare and preventive care for a long period of time. When abortions increased in the latest part of the 1960's, especially among young girls and a more liberal abortion-law was discussed concentration on preventive measures had to increase. Education and training for midwifes started in 1972 aiming at out-patient care and more responsibility in methods for birth-control to include use of oral contraceptive pills (OC) and insertion of intra-uterine devices (IUD) and from 1974 this is in the basic education. During the 1970's special clinics for young people were opened in many parts of Sweden and have been succesful. Their main objectives were to inform, advise and help young girls and boys on topics regarding their sex-life and cohabitation, contraception, pregnancy and sexual transmitted diseases (STD). When the abortion act of 1975 came into force, which allows abortion up to the 12th week of pregnancy and after counselling up to the18th week, there were no increase in abortion rates. The midwives prescribe these days about 80% of all contraception include post-coital contraception (PCC) as well as sex-education in schools. This is unique in the world.
Key words: contraception, family planning, midwife, sex-education, Sweden.

Activities of Latvian Contraceptology Association

M. Orleana

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As a consequence of the socio-economic crisis of the transition period, the state faces the demographic crisis as well, which is characterized by following facts. Natural population growth in Latvia is the lowest in the world, namely, - 6,2. The death rate considerably exceeds the birth rate (approx. 34 000 people died and 19 000 - born in 1998). The population has become older. A high rate of abortions is observed (total abortion rate 1293 abortions on 1000 newborns). Abortions are frequently performed on the backgound of sexually transmissive diseases. The cases of sexually transmissive diseases have increased 5 - 10 times. 10 - 15 % of all maried couples in Latvia are infertile.

Only 21% of all sexually active women in Latvia use a safe and effective contraception (IUD, hormons).
On the 4th of March, 1995, Latvian Contraceptology Association (LCA) was founded. The goal of foundation and activities of LCA are aimed at improvement of the demographic situation in Latvia. The objectives of LCA are prevention of destroying of new lives and nations, protection oI family, child and woman's health, and popularization and improvement of contraception in order to diminish cases of unwanted pregnancy and abortions, thus enhancing the reproductive health.

Role of non-medical professionals

M. Lamont, A. Bigrigg, U. Bankowska, L. Hogg

Family Planning and Reproductive Health, Glasgow, Scotland, UK

Introduction: The Family Planning and Reproductive Health Directorate of the Greater Glasgow Primary Care NHS Trust has a main centre which is based in the city centre with a clinic attendance of 80,000 contacts a year of whom there are 35,000 new clients each year. The service extends to the community and clinics are based in health centres throughout the City. To use staffing efficiently and effectively there is collaboration and co-operation between health care professionals with the aim of making use of the various practitioners' skills and abilities. This allows an increasing amount of work which was traditionally carried out by doctors to be now undertaken by fully trained experienced family planning nurses.
Aim: To develop group protocols and evidence based guidelines to allow nurses to supply and administer hormonal contraception.
Method: Protocols were devised to comply with guidelines and recommendations of the Government Review on Prescribing, Supply and Administration of Medicines.
Audits were conducted to look at Client Satisfaction, Consultation Times, Staff Attitudes and Record Keeping.
Results: 77% of clients were very confident with the consultation and 99% would be happy to be seen by a nurse for future contraception.
78% felt the care received was good and adequate information on the contraceptive method was given. The consultation times were comparable with standard family planning consultations. Record keeping was good with few protocol violations.
Conclusion: Nurses, Doctors and patients can benefit from revision of practitioner roles.

Experiences of Learning: An evaluation of the integration of Family Planning Training into the new Medical Undergraduate Curriculum at Liverpool University Medical School

J.T.McVicker

Women's Health Directorate, North Mersey Community (NHS) Trust, Liverpool, England, UK

Background: The literature suggests that there is considerable variation in the quality and quantity of family planning training at undergraduate level in Medical Schools throughout the United Kingdom. In 1996, Liverpool University Medical School introduced its new undergraduate curriculum, centred on the principles of problem-based learning, and this provided the Women's Health Directorate with an opportunity to have a significant input of

family planning training based in the community. Aims: To evaluate this revised family planning training programme in terms of the learning experiences of the students involved. Methodology: A qualitative research method based on semi-structured interviews with students at the end of the programme. Analysis was based on a modified grounded theory approach. Results: The findings identified three major categories as a means of exploring the learning experience: the context, the process and the outcome of learning. A review of these categories provided evidence of the value of the training programme and highlighted areas in need of change. Conclusions: The programme provides a valuable learning experience in keeping with the recommendations of the General Medical Council for undergraduate medical education in the United Kingdom. It supports arguments for the inclusion of family planning training in an undergraduate curriculum.

Forgetting to take the pill as a reason for requesting a voluntary termination of pregnancy

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Saint Louis Hospital, Paris (1), Organon Laboratories, Puteaux (2), Corentin-Celton Hospital, Issy-Les-Moulineaux (3), Bichat Hospital, Paris (4), France

Objectives: Forgetting to take the pill is one of the reasons for an unwanted pregnancy prompting a request for a voluntary termination. The aim of this observational study was to determine how common this situation is, at which time during the cycle pills were forgotten and to produce a profile of a typical "forgetful" woman.
Design: The eight centers of the Association des centres de régulation des naissances (birth control) de l'AP took part in this 11-month study in France. All requests for an abortion were recorded but only women who had forgotten to take their combined pill at least once during the month of conception were investigated in this study (n = 276). Results: The incidence of forgotten tablet intake as a reason for a request for a termination was 5.1%. The mean number of tablets which women had forgotten to take during the cycle in which they conceived was 2.86. However, in over one-third of cases only one tablet was omitted. Overall, in one-third of cases the women had forgotten to take the pill during the first week, another one-third during the second week and the final one third over several weeks. With regard to profile, the women included in the study were mainly French (80%) with a mean age of 28 years, who had received secondary or higher education (75%), and were more likely to be single or living on their own (63.3%). Over 40% of the women in the sample had already had a voluntary abortion. In almost 60% of cases, there was a valid reason for forgetting to take the pill (geographic or psychological). Conclusions: Over 5% of requests for a voluntary abortion were due to forgotten tablet intake and in 40% of cases the women had had a voluntary termination of pregnancy in the past. Better compliance in pill-taking would help to reduce the number of requests for a voluntary abortion.

Contraceptive misconceptions - The Intrauterine Device

H. Roberts

University of Auckland School of Medicine, Dept. of Obst. & Gyn., Auckland, New Zealand

Aims: - To obtain the opinion of women in the community regarding the use of an IUD as a contraceptive method. - To obtain feedback from health professionals regarding aspects of IUD use

Background: A recent contraceptive monograph showed a 7% use of an IUD for New Zealand women between the ages of 20 and 49 who were exposed to intercourse[1]. This is a much lower use of IUDs than exists in some European countries.

A previous New Zealand study looking at contraceptive practices of women seeking termination of pregnancy (TOP) found that although 42% of women were using the pill, half of these women did not remember to take it every day[2]. There is anecdotal comment from practitioners working in the area of TOP in New Zealand that although IUD use would be an appropriate contraceptive choice for many of these women they have misconceptions about the risks of IUD use.

This study will help to clarify the opinion of both women and health practitioners in New Zealand about the suitability of the IUD as a method of contraception.

Methodology: Three hundred women in the community (urban shopping malls) were asked to fill in a questionnaire (7-10 questions) regarding their perceptions of the IUD and reasons for use or non use as a contraceptive method. Similarly 300 health professionals (doctors and nurses) were asked to fill in a short questionnaire about their knowledge of 4 specific aspects of IUD use.

The results of these questionnaires will be presented and will clarify the opinions of both women and health practitioners regarding the IUD.

These issues may need to be addressed in the future presentation of the IUD as an appropriate contraceptive choice for many women.

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New intrauterine contraceptive devices on ultrasound

C. Bastianelli, M. Farris, A. Lippa, A. Valente

I Institute of Obstetric and Gynaecology, University of Rome “La Sapienza”, Italy

Introduction: In the last year have become available in Italy two devices rather different in structure from traditional IUDs: Mirena® and GyneFIX®. In consideration of these differences, sonographic findings are characteristic and they can generate a not simple interpretation by clinicians. Objective: The aim of this study was to describe sonographic findings of these two new devices. Methods: By means of the ultrasound device Aloka SSD2000, with a 3.5 MHz Transabdominal (TA) and a 5.0 MHz transvaginal (TV) probes, two groups of healthy women who received intrauterine contraception were examinated, by the Centre of Family Planning of the University "La Sapienza" of Rome, Italy. Twenty patients had inserted the IUD GyneFIX® a non biodegradable suture thread of polypropilene, on which are threaten six copper sleeves without any plastic frame, and 21 women had inserted the Mirena a Levonorgestrel (LNG)-releasing IUD®. During follow-ups all the women underwent a sonographic examination. TA and TV was performed to verify the position of the two new IUDs inside the uterus and their aspect. Results: LNG-releasing IUD is not easily detectable as a copper IUD because it does not contain the “ultrasound positive” copper wire. The lateral arms of the T are well identifiable the vertical arm, because of dispersion and adsorbent phenomenon due to the cylinder components, appears as a series of ipo-hyperechogenic spots, on TA

scan, that project a broad shadow on the surrounding tissues on TV scan. The GyneFIX appears on the longitudinal view, TA and TV, as a series of strong hyperechogenic transversal spots on a echogenic longitudinal line. Conclusions: These new IUD are detectable by ultrasound, both TA and TV, but especially for the LNG-releasing IUD sonographic detection is not easy because of the absence of the “ultrasound positive” copper wire. Its presence in the uterus can anyway be revealed by the presence of shadows in the surrounding tissue particularly if the examination is performed transvaginally.

Friday, June 30, 2000

• Session 5 Abortion: safe, free and available

Gallus hall

Chairman: R. van Lunsen (The Netherlands)
Co-Chairman: L. Iglesias i Cortit (Spain) - A. Vogler (Slovenia)

Key-note lecture:

13:30 - 13:45 Abortion: safe, free and available
A. Verougstraete (Belgium)

13:45 - 14:00 Abortion: safe, free and available
T. Tomazevic (Slovenia)

14:00 - 15:00 Free communications:

Medical abortion with Mifepristone and Misoprostol in Austria. First results
P. Safar (Austria)

Verifying the effectiveness of medical abortion - ultrasound vs. HCG testing
C. Fiala (Austria)

Looking at the situation in France where 40% of early abortions are medical abortion
D. Hassoun (France)

Misoprostol alone in abortion up to 15 weeks gestation
J.L. Carbonell (Spain)

Abortion in the second trimester of pregnancy
A.S. van den Bergh (The Netherlands)

E1 induced midtrimester abortions
V. Vardaki (Greece)

Abortion: safe, free and available

A. Verougstraete

Sjerp-VUB, Family Planning Centre of the Vrije Universiteit Brussel and Centre Hospitalier François Rabelais (Cesar De Paepe), Brussels, Belgium

Around the world, about 46 million women have abortions each year : 26 million in countries with liberal abortion laws and 20 million in countries where abortion is illegal. The WHO estimates that of the approximately 600.000 pregnancy-related deaths occuring each year around the world, 13 % (= 78.000 women) are due to complications resulting from unsafe abortions. About one-third of women undergoing unsafe abortions experience serious complications.
Legality and safety usually coincide but some legal requirements such as permission of husband or parent, mandatory counseling, approval and waiting periods, may delay the abortion and thus increase the risk of medical complications. Difficult access to authorized centers or willing providers and long waiting lists may also cause delay.

Finally prices, even in legal conditions, may be prohibitive for poor or young women. In the following years we should focus on obtaining:

- legal abortion in countries where it is still illegal
- suppression the following legal requirements : permission of husband or parent, the necessity of being a resident (France)
- cheap abortion subsidized by health insurance
- early abortion bij improving acces en reducing waiting lists
- improvement of the European abortion network to help women find their way promptly abroad when legal limits are exceeded in their own country
- introduction of medical abortion so women have the right to choose the method they prefer
- improvement of the « awfulisation » atmosphere that still stigmatizes abortion
- easy and cheap access to emergency contraception and reliable contraceptive methods for all women, whatever their age

Abortion safe, free and available

T. Tomazevic, D. Obersnel, I. Kirar-Fazarinc, B. Pinter, A. Vogler, M. Macek

University Medical Centre, Ljubljana, Slovenia

The history of reproductive rights in Slovenia started in fifties. By stepwise liberalisation of abortion and by introducing contraceptive methods the problem of high mortality and morbidity due to illegal abortion slowly disapeared. In 1964 the Russian idea of using vacuum aspiration as a safer technique was transferred to Slovenia. In 1973 the Ljubljana abortion study confirmed its major safety. The technology of safe abortion entered the Western Europe. Thirty five years of using this technique and twenty three years after the abortion became free by law until 10 th week of gestation and available in outpatient departments of public gynecologic hospitals in Slovenia, we analysed different parameters in order to show the present and the future of this operative procedure. The Slovenian abortion rate per 1000 women aged 15-45 years is steadily decreasing: from 40 in 1980 to 17 in 1998 Due to the fact that the birth rate simultaneously decreases, the abortion birth ratio still remains 0,5. Till 1982 the mortality is 0 per 100000 abortions. Compared to some other countries the abortion rate is still too high. In some Slovenian regions the abortion rate and the abortion per birth rates are lower compared to other regions and close to the results in some western countries. In spite the fact that modern contraceptives and sterilisation after 35 years of age are easily and inexpensively available some Slovene women still rely on abortion. Probably because of its safety. Analysis of public opinion showed that the attitude toward abortion has been steadily liberalised. Despite good news regarding low morbidity and decreasing abortion rates in 2000 abortion still remaines a problem. By accepting to perform safe abortions we continue to fight consequences of illegal abortion. Thus abortion remains the necessity which in the future should be further decreased. Not by restriction, but by further developing humanistic preventive approach. Outside the health care system other social and individual measures should be taken to further diminish the number of undesired pregnancies. Responsibility of male in this respect should not be underestimated.

Medical abortion with Mifepristone and Misoprostol in Austria. First results.

P. Safar, C. Fiala

General Public Hospital, Korneuburg, Austria

Objectives: We report the first results of our experience with mifepristone and misoprostol in pregnancy termination up to 49 days of amenorrhea in our department at a general public hospital in Austria. Study Methods: Women who presented for an abortion received detailed information about the various methods, their advantages, disadvantages and contra-indications. We performed a vaginal ultrasound, determined the blood group, made a red blood count and a quantitative HCG test in all women. They took 600 mg of mifepristone. Two days later they came back to take 400 µg Misoprostol and spent about 3 hours under observation. A control visit for an ultrasound or quantitative HCG test was scheduled 6-14 days later. We treated 480 women on an outpatient basis between January 1999 and 20 December 1999. Results: All 480 women completed the treatment. Five women were lost for follow-up. The pregnancy was terminated without the need for surgical intervention in 97,3% of cases. We had to perform a vacuum aspiration for 13 women because of continued pregnancy, incomplete abortion or heavy bleeding. More than 90% of the women said they would opt for medical abortion again given the need in case of another unwanted pregnancy in the future. Conclusions: We could confirm the experiences made in France since many years and conclude that medical abortion is a good alternative to surgical abortion for many women. It is very efficient and the low rate of short-term side effects is acceptable to most of the women. It has to be underlined that detailed counselling before and good care during treatment is the basis of the high level of satisfaction.

Verifying the effectiveness of medical abortion - ultrasound vs. HCG testing

C. Fiala, P. Safar

General Public Hospital, Korneuburg, Austria

Objectives: Medical abortion with Mifepristone and Misoprostol is effective in 95-98.6% of cases. We compared ultrasound examination and HCG testing to determine the effectiveness of the treatment. Study Methods: 217 women with an unwanted pregnancy up to 49 days of amenorrhea were treated between 26 April and 10 November 1999. They received 600mg Mifepristone and 400µg Misoprostol 48 hours later. Expulsion was not verified routinely. An ultrasound examination and HCG test was performed on day one and between days 6-18. Results: The treatment was successful in 98.6 % of cases. A total of three curettages had to be performed; one for continued pregnancy, missed abortion and haemorrhage respectively. One patient had a missed abortion but expelled after hormone withdrawal. Expulsion of the sac was verified in six patients. HCG levels at the control visit dropped to 3 % in average (SD 3) ranging from 1-17 % in all cases of successful abortion, with three exeptions of 27%, 32% and 44%. The two missed abortions and the persistent pregnancy led to an HCG rate of 91%, 159 % and 7900% respectively. Endometrium measured 10 mm on average (SD 4) at the control visit in the cases of successful abortion, ranging from 1-24 mm. Diagnosis of successful treatment could be based on ultrasound examination in only 66% of cases, owing to the early stage of the pregnancy in the remaining cases. Conclusion: Measuring HCG level before and after treatment gave a reliable result in 98.5% of successful abortions, compared to 66% with ultrasound examination.

Looking at the situation in France where 40% of early abortions are medical abortion

D. Hassoun

Contraception and Abortion Centre, Delafontaine Hospital, Paris, France

We were the first in France to experiment with Mifepristone at the beginning of the eighties and to commercialise it in 1988 as a medical alternative to surgical abortion. 2 clauses of the French abortion law (Veil law) are important for medical abortion: One states that the abortion has to be in a hospital public or private, which means neither at home nor in a private office. The second one, states that in the case of all abortions, a week's reflection between the first medical consultation and the abortion is compulsory which of course delays the administration of Mifepristone.
Currently, in France, there are four approved indications

1. Medical termination of developing intra-uterine pregnancy up to 49 days of amenorrhea (7weeks since LMP)
2. Softening and dilatation of the cervix prior to surgical termination of pregnancy during the first trimester pregnancy.
3. Preparation for the action of prostaglandin in the termination of pregnancy for medical reasons (beyond the first trimester).
4. Labour induction in case of intrauterine foetal death

The protocol used for the medical abortion up to 49 days of amenorrhea is fhe following one:
At Dl after 8 days of reflection 600 mg of Mifepristone (3 tablets) is taken by the patient in the presence of a doctor or a nurse
At D3, 48 hours later, the patient comes back to the centre, takes 400mg of Misoprotol (2 tablets) and stays 3 hours under observation
At D10-14 a follow up visit is planned
In France, data show that women have a tendency to request an abortion early in their pregnancy. In 1996, 17.9% represent medical abortion out of all type of abortions despite the fact that 40% of abortion are performed before or at 7 weeks LMP.
Among patient using Mifegyne, the utilisation of this method varies slightly according to sociodemographic characteristic with only one difference: a higher percentage of younger. Even after 10 years of use, medical abortion is not proposed to women in France, as much as it could be. The use of mifepristone when a patient requests an abortion depends of 2 factors: Early awareness of pregnancy as well as a rapid response by health facility which means to set up well-adapted services organisation and to improve the acceptance and the knowledge of the method among doctors.

Misoprostol alone in abortion up to 15 weeks gestation

J.L. Carbonell

Mediterrania Medica, Clinic Fammily Plannine, Valencia, Spain

Misoprostol is synthetic analogue of PGE1, commercialized in 72 countries, for the prevention and treatment of gastroduodenal ulcers. But like all similar prostaglandins, it has strong uterocontractive abortifacient properties. A research programme with Misoprostol is performed during the last 5 years in "Eusebio Hernandez Hospital" in Havana, Cuba. More than 4.500 pregnant womens have participated in 14 clinical trials.
The sucees rate (complete abortion) obtained using doses of 800 µg misoprostol was 90%, 84% and 80% up to 9, 10-12, and 13-15 weeks gestation, respectively. The last study in adolescents (under 18 years) obtained the same succes rates. Misoprostol could be an efficacious and economical alternative to the various existing pharmacological methods: RU486, methotrexate + misoprostol. The dissemination and accessibility of

pharmacological methods will mean the saving of thousands of lives lost in unsafe abortions, especially in the Third World.

Abortion in the second trimester of pregnancy

J. van den Bergh

Preterm Kliniek, Den Haag, The Netherlands

The number of different techniques used for abortion in the second trimester diminished over the years. In general and university hospitals induction of labour is mostly accomplished by i.v. Sulprostone (Nalador®) infusion.
Private and freestanding clinics normaly use D&E (dilatation and extraction) formarly named D&C (dilatation and curettage).
For dilatation of the cervical canal ante operationem, in the USA, Canada and Australia osmotic dilators are used. In European countries this is not done. Especially after the introduction of Misoprostol for priming of the cervix, there does not seem to be any reason to use osmotic dilators anymore. Extra expenses, two or more unnecessary visits to the doctor and many hours of often painful contractions should be avoided.

E1 induced midtrimester abortions

V. Vardaki, E. Kolibianakis, S. Sifakis, G. Mikelakis, A. Zolindaki, A. Basilaki, E. Koumantakis

University Hospital of Heraklion, Dept. of Obst. & Gyn., Crete, Greece

Prostaglandin analogues are a promising alternative to the classic methods used for pregnancy termination and delivery in cases of intrauterine death, which are well known for various shortcomings. 15 women (4 primigravidae and 11 multips) with mean age 33.2 years were studied.
The mean gestational age was 23 weeks by LMP (21+3 by USS). In 12 women there was a live fetus with multiple malformations and an abnormal karyotype at amniocentesis. In addition in 2 patients there was an intrauterine death confirmed by USS and one patient requested a termination due to social reasons. A previous caesarian section had been performed in 2 patients. Misoprostol treatment was given 200μg 4hourly intravaginally until regular contractions occured (max daily dosage 1200 μg, for maximum 3 days). Treatment failure occured when the uterus did not respond to E1 treatment for three days or the patient refused to continue treatment due to personal reasons (anxiety, discomfort). A TV USS was performed following cessation of vaginal bleeding to confirm an empty uterus.
The induction to delivery interval ranged from 6 to 48 hours (nuliparas: 18 hours, multips: 15 hours). The mean dosage of cytotec given was 800 μg. All the women remained inpatient for the treatment period. Complete abortion was achieved in 14 patients whereas curettage was performed in one patient with evidence of retained products of conception. The mean hemoglobin was 11.3 g/dl and 10.8 g/dl before and after treatment. Analgesia was achieved by pethidine IM/IV. Following delivery one dosage of cephalosporin 2g was given to all patients IV. There was a treatment failure in one patient (success rate 93.3%).
The use of E1 at midtrimester pregnancy for medical termination or miscarriage of abortion seems to be a safe and succesful method.

Saturday, July 1, 2000

10:30 - 12:00 Parallel Sessions

Gallus hall

• Session 6 Sexual health in adolescence and preventive behaviour

Chairman: B. Pinter (Slovenia)
Co-Chairman: D.M. Rebelo (Portugal)

Key-note lecture:

10:30 - 10:45 Factors influencing oral contraceptive compliance in adolescent females: result of a longitudinal study
V. Bruni (Italy)

10:45 - 11:00 Sexual health in adolescence and preventive behaviour
G. Creatsas (Greece)

11:00 - 12:00 Free communications:

Taking young people seriously improving sexual and reproductive health for the next generation. Adolescent's sexual rights and health in Europe.
M.C. Dersjant-Roorda (The Netherlands)

Which women will take sexual risks? Predictors from a behavioural surveillance questionnaire in a Scottish family planning clinic
S.V. Carr (United Kingdom)

Teenager's perception of their lifestyle
B.B. Ntombela-Motapanyane (South Africa)

Teenagepregnancy in the Netherlands
W.J.J. van Enk (The Netherlands)

The project on family health peer education for out of school youth on reproductive and sexual health
H. Hassa (Turkey)

Screening, treating and contact tracing for asymptomatic Chlamydia infection in a young people's clinic (in Bootle) by outreach health advisor is both acceptable and successful
K. Jones (United Kingdom)

Factors influencing oral contraceptive compliance in adolescent females: result of a longitudinal study

M. Dei (1), P. Bettini (1), E. Buiatti (2), C. Girau (1), R. Leonetti (1), V. Bruni (3)

Adolescent Consultation Services (1), Epidemiology Unit (2) and Dept. of Gynecology- Perinatology and Human Reproduction, University of Florence (3), Italy

Oral contraceptive discontinuation, without replacing it with another reliable contraceptive method, occurred, in our experience, in about 20% of adolescent

population. A longitudinal study about clinical, physiological and social factors affecting oral contraceptive compliance in adolescents attending a ‘teen clinic’ has been planned. Thirty sexually active girls, 15-21 year aged, at their first request for hormonal contraception have been followed for 1 year. Medical and social histories have been obtained at the initial consultation, at a 4-month scheduled appointment and after 1 year. The comparison between the compliant and noncompliant group and the drop-out group highlights the fact that oral contraceptive compliance is affected more by personal life experiences and goals than by side effects or partner and parents consideration about contraceptive choice.

Sexual health in adolescence and preventive behaviour

G. Creatsas

2nd Dept of Ob/Gyn, Aretaieio Hospital, University of Athens, Greece

An increased rate of adolescent pregnancies and abortions, a high prevalence of sexually transmitted diseases and a significant number of psychosocial problems during adolescence are reported today worldwide. The improvement of adolescent sexual behavior should be one of the primary goals of the 21st century. This includes development of new contraception techniques, also providing protection from sexually transmitted diseases, improvement of contraception compliance and the correct use of mass media. As adolescents seek advice on sexual matters, it is our responsibility to provide them with accurate consultation as well as free service of Family Planning in well organized adolescent units, where they may be consulted on the prevention of undesired pregnancy, and sexually transmitted diseases. This will assist in a better fertility outcome and safe motherhood.

Taking young people seriously improving sexual and reproductive health for the next generation. Adolescent's sexual rights and health in Europe.

M.C. Dersjant-Roorada

Academic Hospital LUMC, Family Planning Dept., Leiden, The Netherlands

Taking seriously the sexual and reproductive health needs of the young must be a key objective for policy makers worldwide: the future good health and prosperity of any country depends on it. This is now more important than ever since today's world has the largest ever population of young people. There are now 1.1 billion people aged 10 to 19 and 913 million live in the less developed world.

Full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsable way with their sexuality.

A number of revolutionary changes took place in Western Europe in political, social, religious, economic, technological and professional spheres. The changes affected family planning profoundly with lasting positive effects.

Intensive work has also been carried out to elaborate a new health policy framework for the Eastern European Region. Reproductive health must be considered a part of the basic package of primary health care services.

Since the International Conference on Population and Development (ICPD) in 1994, most European population policies have shifted their emphases to that of a 'people and family centered' approach.

Policies now addresses the importance of human and family development, changing attitudes towards reproduction, and "client-centered" provision of high-quality family planning information and services.

Which women will take sexual risks? Predictors from a behavioural surveillance questionnaire in a Scottish family planning clinic.

S.V Carr

Family Planning & Sexual Health, Glasgow - Scotland, UK

Objectives: Sexual contacts outwith a steady relationship increase the risk of sexually transmitted infection and unwanted pregnancy. As these contacts may be covert, any knowledge of risk may not be revealed to the regular partner.
Aim: To predict which women may have sex with someone other than their steady sexual partner.
Methods: A sexual behaviour surveillance study has been running in the central Family Planning clinic in Glasgow. To obtain a systematic sample a sexual behaviour questionnaire was given to every 20th female coming into the clinic waiting room, the results were then analysed.
Results: Over a 3 year period 3,474 women offered a questionnaire. There was 94% response rate. There were 3131 respondents, of whom 625 (20%) were under 20 year old. 2654 answered the question about sexual partners other than steady partner. 112 (4%) had both steady and other partners. Some of the results 479 had first sexual intercourse <16 OR2.44(CI 1.59-3.73). 106 were touched sexually against their wishes > 5 times. OR2.54(CI 1.28-5.01)
Conclusions: The results show that early first intercourse, having been touched sexually on repeated occasions against ones wishes and having 2 or more terminations of pregnancy are all significant predictors for having sexual partners outwith the steady relationship. These indictors of ongoing risk behaviour could help in designing appropriate interventions.

Teenager's perception of their lifestyle

B.B. Ntombela-Motapanyane

Gauteng Department of Health, Marshalltown, Johannesburg, South Africa

Objectives: To gather information from teenagers who attend schools in the North East of Johannesburg on 1. How they perceive their lifestyle. 2. The beliefs they have about life. 3. Their attitude towards life. Design and Method: This was a descriptive study. One hundred and forty nine (149) high school girls who were between the ages 15 and 18 years of age were systematically selected from 24 schools. A self- administered questionnaire on general lifestyle was distributed to all 149 pupils. It was adapted from the Offer Self-Image Questionnaire comprising of items concerning teenagers' feelings about their world under the following factors: Psychological Self (concerns, feelings, wishes and fantasies), Social Self (interpersonal relationships, moral attitudes and vocational/educational goals), Familial Self (feelings and attitudes towards their families), Sexual Self (sexual experiences and behaviour) and Coping Self (how they cope with the world) (Offer, Ostrov, Howard and Atkinson 1988:36). Multivariate analysis using the SPSS was done. Results: Analysis of the results displayed that teenagers living in the inner-city of Johannesburg are significantly worse than the ones from the suburbs in their sexual attitudes ($p<0.015$), family relationships ($p=0.002$), mastery of their external world ($p=0,043$), psychopathology ($p=0.008$) and vocational and educational goals ($p<0.001$). All the above factors had levels

of significance, which were less than 0.05. Conclusion: Teenagers living in the inner city of Johannesburg perceive life negatively and have negative attitude towards their lives (coping, social, vocational, sexual and familial self). The study findings suggest that there is an urgent need to address coping skills, sexual experiences, family relations, as well as emotional problems of teenagers living in the inner-city of Johannesburg.

Teenage pregnancy in the Netherlands

W.J.J. van Enk and A. van Enk

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Objectives. To study the chances in the incidence and outcomes of (not by abortion terminated) teenage pregnancy in the Netherlands in the period 1990-1998 with special reference to ethnicity. Design/methods. Retrospective study of the 1990-1998 cohort in the national birth registry comprising 1.4 million deliveries of which 24719 by teenagers. Results. Teenagepregnancy has steadily declined in the total population from just over 9000 in 1971 to 2159 in 1996 but has risen slightly since then. The incidence hardly dropped in ethnic minorities till 1990. In 1990 just over half of all teenage pregnancies occurred in women of ethnic minorities and one in four of all primiparous Turkish or Moroccan women was younger than 20 years of age. Since then a sharp decline has set in. In 1998 the rate of teenage mothers in these (islamic) women had become one in eight. Among West-indian Asians (Hindustani) the rate has gone down from one in eight to one in fifteen. The fall is most pronounced in the youngest teenagers. However, no such decline is apparent in the black, predominantly Afro-caribbean, population. On the contrary, there is a slight increase in as well black primiparous as multiparous teenagers and even in the number of very young black teenagers. This explains, together with a small rise in pregnancies in ethnically Dutch teenagers, the above mentioned increase in 1997 and 1998. Perinatal death and preterm birth rate have improved in all ethnic teenage groups and are at the end ofthe nineties comparable to those in Dutch teenagers, except in black teenagers. Although these rates have also come down in black teenagers, they are still significantly higher than those in Dutch teenagers. Conclusions. 1/Teenage pregnancy is clearly on the decline in the Netherlands. The fall is especially pronounced among islamic and hindustani teenagers but there is no sign of a drop among black teenagers. 2/Outcomes of teenage pregnancy improved in all ethnic groups, but remained poor in black teenagers. 3/Campaigns to promote contraception should especially aim at black youngsters.

The project on family health peer education for out of school youth on reproductive and sexual health

H. Hassa, S.S. Özalp, S. Koral, Ü. Elgin

Family Planning Association of Turkey

Objective: The aim of the project was to provide information and counseling services on sexual and reproductive health for out of school youth and to fulfil their unmet needs. Study design: A total of 2028 out of school young person at 15-24 years of age living in a population of 35.710 (squatter area) were through the project activities implemented in the period of October 1997- 30 November 1999. “Peer Education Model” was applied in this pilot project. Results: A baseline survey to determine the existing situation was carried out before the initiation of the project (1st survey) and the evaluation survey was carried out after the completion of the project (2nd survey).

Major findings were as follows; parents' education was low. Flirtation before marriage was approved by 61.58% of the respondents and 47.78 % of them reported that they have sexual experience according to the findings of the 2nd survey. The most reported ideal age for marriage was 21– 24 years of age and 1/3 of the respondents stated that they plan to have two children in the future in both surveys' findings. Sexually active ones firstly preferred condom, secondly intrauterine device and thirdly withdrawal as a family planning method. More than half of the respondents reported that they masturbated. As a result of information given, correct answers on the sexually transmitted diseases were increased by 7% in the 2nd survey findings. Conclusion: It is expected that this pilot project on family health for out of school youth will be a model for other related public and non-governmental organizations.
The project was carried out by FPAT with the financial support of UNFPA.

Screening, treating and contact tracing for asymptomatic Chlamydia infection in a young people's clinic (in Bootle) by Outreach Health Advisor is both acceptable and successful

K. Jones (1), H. Birley (1), A. Darcy (2), A. Webb (2), H. Mallinson (3)

GUM, Royal Liverpool University Hospital (1); PACE, Abacus Centres for Contraception and Reproductive Health (2) and PHLS, Fazakerley (3), Liverpool, UK

Introduction: A study of chlamydia trachomatis [CT] undertaken in 3 young people's clinics in our region found an overall prevalence of 8.35% (in print). Screening via urinary LCR was acceptable, but returning for results and attending the Genito-Urinary Medicine [GUM] clinic 4 miles away was difficult for the young people. Out of those CT positive only 80% received their result and 64% were known to have been treated. Method: A pilot service has been set up at one of the clinics which took part in the study - PACE (Pregnancy Advice Contraception Education). Since August 1999 an Outreach Health Advisor [OHA] has been working half-time at PACE and half-time at the local GUM clinic. PACE is a clinic for those aged 25years and under located in a deprived inner city area where the prevalence of CT was found to be 10.4%. All young people attending are given written information on CT, visually reinforced by posters in the waiting room. During consultation sexually transmitted infections are discussed and screening offered. A convenient date is arranged for the client to return or contact the clinic. A contact address/telephone number is taken in the event of the CT result being positive, and the client failing to collect their result. The urine sample is also tested for gonorrhoea if CT positive. Treatment is offered at the local GUM clinic or can be issued under protocol by the OHA at PACE. Education and contact tracing are undertaken by the OHA when treatment is issued at PACE. Test of cure is performed on urine samples after treatment. Results: We have tested almost 500 clients and informing all CT positive clients is possible (60 so far). Most of the young people prefer treatment locally. Conclusions: Having an OHA facilitates treatment, allows contact tracing and is acceptable.

Friday, June 30, 2000

13:30 - 15:00 Parallel Sessions

Linhart hall

• **Special Session**
'The most recent data on contraception and thrombolic disease'

Chairman: S.O. Skouby (Denmark)
Co-Chairman: C. Coll (Spain)

- Epidemiology of thrombolic disease
  D. Lidegaard (Denmark)
- Impact of OC on haemostatsis
  U. Winkler (Germany)
- Point of view of the clinician
  C. Jamin (France)

Oral contraceptives and venous thromboembolism
A five-year nation-wide case-control study

Ø. Lidegaard, B. Edström, S. Kreiner

Department of Obstetrics & Gynaecology, Herlev Hospital, University of Copenhagen, Denmark

Objective. To assess the influence of oral contraceptives (OCs) on the risk of venous thromboembolism (VTE) in young women.
Design and setting. A five-year case-control study including all Danish hospitals.
Subjects. All women 15-44 years old suffering a first ever deep venous thrombosis or a first pulmonary embolism during the period 1.1.1994 to 31.12.1998. Controls were selected annually, 600 per year in 1994-95, 1,200 per year 1996-98.
Response rates for cases and controls were 87.2% and 89.7%, respectively. After exclusion of non-valid diagnoses, pregnant women, and women with previous VTE or AMI, 987 cases and 4,054 controls were available for analysis.
Analysis. A multivariate matched analysis was performed. Controls were matched to cases within one-year age bands. Adjustments were made for the following confounders: Age, year, BMI, length of OC use, family history of VTE, coagulopathies, diabetes, years of schooling, and previous birth.
Results. The risk of VTE among current users of OCs was primarily influenced by duration of use: (ex-use reference) never users: OR 1.8 (95% CI 1.4-2.4), <1 year; 8.1 (5.8-11.2), 1-5 years; 4.3 (3.2-5.8) and >5 years; 3.5 (2.8-4.5). Without adjustment for duration of use, current users of OCs with second- (levonorgestrel or norgestimate) and third- (desogestrel or gestodene) generation progestagens had compared with non-users ORs of VTE of 2.9 (2.2-3.9) and 4.0 (3.2-4.9) respectively. After correction for duration of use and differences in oestrogen dose, the 3rd/2nd gen. risk ratio was 1.3 (1.0-1.8). The risk decreased significantly with decreasing oestrogen dose. With 30-40µg as reference, 20 and 50µg products implied ORs of 0.6 (0.4-0.9) and 1.5 (0.8-2.6), respectively.
Conclusion OCs increase the risk of VTE significantly. The risk among current users is reduced 50% during the first five years of use. The risk increases about 150% with increasing oestrogen dose, whereas the difference in risk between users of 3rd and 2nd gen. OCs after correction for time and oestrogen dose was about 30%.

Oral contraceptives and cerebral thromboembolism
A five-year nation-wide case-control study

Ø. Lidegaard, S. Kreiner

Department of Obstetrics & Gynaecology, Herlev Hospital, University of Copenhagen, Denmark

Objective. To assess the influence of oral contraceptives (OCs) on the risk of cerebral thromboembolic attacks (CTA) including thrombotic stroke and transitory cerebral ischaemic attacks.
Design and setting. A five-year case-control study including all Danish hospitals.
Subjects. All women 15-44 years old suffering a first ever CTA during the period January 1, 1994 to December 31, 1998. Controls were selected annually, 600 per year in 1994-95, 1,200 per year 1996-98.
Response rates for cases and controls were 88% and 90%, respectively. After exclusion of non-valid diagnoses, pregnant women, and women with previous VTE, CTA or AMI, 626 cases and 4,054 controls were available for analysis.
Analysis. A multivariate matched analysis was performed. Controls were matched to cases within one-year age bands. Adjustments were made for the following confounders: Age, year, BMI, length of OC use, smoking, migraine, diabetes, and hyperlipidaemia. There were 212 and 1,207 current users of OCs among cases and controls respectively.
Results. The risk of CTA among current users of OCs was influenced by duration of use: (ex-use reference) never use: OR 1.3 (1.0-1.8), <1 year; 3.0 (1.9-4.9), 1-5 years; 2.1 (1.5-3.1) and >5 years; 1.8 (1.4-2.3). Without adjustment for duration of use, current users of OCs with second- (levonorgestrel or norgestimate) and third- (desogestrel or gestodene) generation progestagens had compared with non-users ORs of CTA of 2.3 (1.6-3.1) and 1.3 (1.0-1.8) respectively. After correction for duration of use and differences in oestrogen dose, the 3rd/2nd gen. risk ratio was 0.5 (0.4-0.8). The risk decreased significantly with decreasing oestrogen dose. With 30-40µg as reference, 20 and 50µg products implied ORs of 1.0 (0.5-2.2) and 2.3 (1.2-4.5), respectively.
Conclusion High dose OCs and OCs with 2nd generation progestagens increase the risk of CTA significantly. The risk among current users is reduced by 40% during the first five years of use. The risk increases about 130% with increasing oestrogen dose, and users of OCs with 3rd gen. progestagens have half the risk of CTA compared with users of low-dose OCs with 2nd gen. progestagens.

Oral contraceptives and myocardial infarction
A five-year nation-wide case-control study

Ø. Lidegaard, B. Edström, S. Kreiner

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Objective. To assess the influence of oral contraceptives (OCs) on the risk of acute myocardial infarction (AMI).

Design and setting. A five-year case-control study including all Danish hospitals.
Subjects. All women 15-44 years old suffering a first ever myocardial infarction during the period 1.1.1994 to 31.12.1998. Controls were selected annually, 600 per year in 1994-95, 1,200 per year 1996-98.
Response rates for cases and controls were 90% and 90%, respectively. After exclusion of non-valid diagnoses, pregnant women, and women with previous VTE, CTA or AMI, 264 cases and 4,054 controls were available for analysis.
Analysis. A multivariate matched analysis was performed. Controls were matched to cases within one-year age bands. Adjustments were made for the following confounders: Age, year, smoking, BMI, family AMI, length of OC use, diabetes, coagulation disturbances, hyperlipidaemia, and years of schooling. 61 and 1,207 were current users of OCs among cases and controls, respectively.
Results. The risk of AMI among current users of OCs was influenced only by oestrogen dose: (non-users reference) 50µg ethinylestradiol (EE): 4.7 (1.5-10.1), 30-40µg EE: 1.6 (1.0-2.4), 20µg EE: 1.2 (0.6-2.2), POP: 1.2 (0.3-5.2). Users of OCs with second- (levonorgestrel or norgestimate) and third- (desogestrel or gestodene) generation progestagens had compared with non-users ORs of AMI of 1.2 (0.6-2.2) and 1.8 (1.1-3.0) respectively. After correction for oestrogen dose, there was no difference between users of OCs with 3rd and 2nd gen progestagens, the 3rd/2nd gen. risk ratio being 1.3 (0.6-2.6). There was no consistent trend by duration of use.
Conclusion Low dose OCs do not increase the risk of AMI, whereas OCs with 50µg EE may still increase the risk significantly. There is no difference in risk according to progestagen type.

Impact of OC on haemostatsis

U.H. Winkler

Friedrich-Ebert-Krankenhaus, Dept. Obst. & Gyn., Neumünster, Germany

Thrombogenicity of OC's have been found to be related to ethinylestradiol (EE) dose in observational studies. The recent question of a possible additional effect of the gestagen-compound has prompted new interest in studies on the effect of OC's with comparable EE dose but different gestagen components. We have chosen three groups of variables of the clotting system to assess potential gestagen effects:
1. Variables reflecting established pathways of thrombogenicity
(antithrombin III, protein C, APC resistance as measured with the conventional APTT based assay, fibrinogen, factor VIII)
2. Variables reflecting known or suspected diffential effects of gestagens but with no established relationship to thrombosis (factor VII, APC resistance as measured with the novel ETP based assay, protein S)
3. Variables reflecting baseline activity of clotting and fibrinolysis (prothrombin fragment 1+2, thrombin-antithrombin III complexes, D-dimer fibrin degradation products, plasmin-antiplasmin complexes)

702 volunteers recruited in a multicenter trial were randomly allocated to a six cycle treatment with one of six study preparations allowing for a comparison of EE dose effects (50 µg, 30-35 µg, 20 µg) and gestagen effects (levonorgestrel, desogestrel, gestodene, norgestimate).
Results:
1. No differential effects of gestagens on variables reflecting established pathways of thrombogenicity (group 1).
2. Significant differential effect of levonorgestrel on variables with no established relationship to thrombosis (group 2).

3. No differential effect of levonorgestrel on variables reflecting baseline activity of clotting and fibrinolysis (group 3) with the exception
of a significant differential effect on prothrombin fragment 1+2.
Conclusions:The study confirmed comparable effects of desogestrel, gestodene and norgestimate on all variables. Levonorgestrel containing OCs have unique effects on certain variables of the haemostatic system possibly linked to differential effects on lipoproteins. However these effects do not reflect established pathways of thrombogenicity.

Point of view of the clinician

C. Jamin (France)

No abstract available

Posters

Topic 1
Contraceptive and non-contraceptive benefits of OC

P1-01 Results of the Register of complications of hormonal contraception users in the Czech Republic in 1998
M. Fanta, D. Cibula
Dept. of Obst. and Gyn. of General Faculty Hospital and 1st Medical Fac. of Charles University, Prague, Czech Republic

P1-02 Mercilon effect on blood lipid profile in women with polycystic ovary syndrome (POS)
I.B. Manukhin, M.A. Gevorkian, M.A. Tsarkova, M.D. Gorodetskaya
Medicostomatological University, Moscow, Russia

P1-03 Marvelon efficacy for treatment of polycystic ovaries
L.V. Tkachenko
Medical Academy, Volgograd, Russia

P1-04 Mercilon: the rate of side effects reported by patients in St. Petersburg
B.N. Novikov
I.P. Pavlov State Medical University, St. Petersburg, Russia

P1-05 Use of low dose OC's for correction of psychopathological manifestations of premenstrual syndrome
A.E. Volkov, A.A. Okorokov, I.O. Kryzhanovskaya
Rostov State Medical University, Rostov-on-Don, Russia

P1-06 Mercilon and Marvelon effects in adolescents with ovarian hyperandrogenia
E.A. Bogdanova, A.V. Telunts
Russian Academy of Medical Sciences, Moscow, Russia

P1-07 Estimation of clinical efficiency of Mercilon in young women
V.V. Rulev, M.I. Yarmolinskaya
Ott Institute of Obst. & Gyn., RAMS, St. Petersburg, Russia

P1-08 Exluton effects in women with polycystic ovary syndrome (POS) and hyperprolactinemia
I.B. Manukhin, M.A. Gevorkian, L.B. Studenaya, M.D. Gorodetskaya
State Medicostomatological University, Moscow, Russia

P1-09 Effect on hormonal contraceptives on breast in women with masthopathy
M.S. Gabunia, T.A. Lobova, N.M. Kipanidze
State Medical University, Moscow, Russia

P1-10 Role of low doses oral contraception in the treatment of fibromyoma and endometriosis
N.M. Pasman, M.P. Dobrova
State University, Novosibirsk, Russia

P1-11 Experience with Exluton used by women in postpartum
T.A. Lobova, M.S. Gabunia, E.N. Chepelevskaya
State Medical University, Moscow, Russia

P1-12 Marvelon effect on the progression of mastopathy
O.I. Lineva
State Medical University, Samara, Russia

P1-13 Mammotrophical effect of various combined OCs in young patients with gonadal disgenesis
E.V. Uvarova, V.A. Shavaeva, O.E. Ozerova, N.S. Martich, N.J. Baranaeva, H.A. Astachova
Research Centre of Obst., Gyn. & Perinatology, Moscow, Russia

P1-14 OC use and resistance to insulin risk
A.N. Strizhakov, N.M. Podzolkova, O.L. Glazkova, M.J. Skwortsova
Sechenov Medical Academy, Moscow, Russia

P1-15 Marvelon application for menstrual cycle regulation in patients of different age
I.K. Bogatova, E.A. Bukina, S.S. Gorbulya
Gorodkov Research Institute of Motherhood and Childhood, Family Planning Centre, Ivanovo, Russia

P1-16 Marvelon efficacy for treatment of algomenorrhoea
U.R. Khamadyanov
Bashkortostan State Medical University, Ufa, Russia

P1-17 Clinical experience with Mercilon
M.A. Repina, N.V. Kulagina, N.V. Aganezova, Z.D. Alexandrova
Medical Academy of Postgraduate Education, St. Petersburg, Russia

P1-18 Effect of low-dose oral contraceptive Mercilon on blood pressure in women above 35
N.V. Shkilyova
MMUKB Hospital N5, Marriage and family consultation service, Volgograd, Russia

P1-19 Comparative study of Marvelon and Mercilon in adolescents with cervical erosions
L.Y. Karakhalis
Kuban State Medical University, Krasnodar, Russia

P1-20 Low-dose OCs and lipid metabolism in women with insulin-dependent diabetes mellitus
S.V. Nikitine, O.E. Lantseva, V.V. Potin
Ott Institute of Obst. & Gyn., RAMS, St. Petersburg, Russia

P1-21 Results of the use of oral contraceptive Marvelon in women with mastalgy
V.N. Prilepskaya, T.T. Tagieva
Research Centre of Obst., Gyn. & Perinatology, Moscow, Russia

P1-22 Efficacy and tolerance of microdose oral contraceptive Novinet in women of reproductive age
V.N. Prilepskaya, N.M. Nazarova
Research Centre of Obst., Gyn. & Perinatology, Moscow, Russia

P1-23 Effects on body weight and body composition of a new monophasic oral contraceptive containing Gestodene and Ethinyl estradiol

F. Fruzzetti, C. Ricci, C. Bersi, A.R. Genazzani
University of Pisa, Department of Obstetrics and Gynecology, Pisa, Italy

P1-24 The effects of low dose oral contraceptive with Desogestrel in Indian women

R. Chakravorty (1), P.S. Chakravorty (2)
Infar India (1) and R.G. Kar Medical College (2), Calcutta, India

P1-25 Multicenter clinical experience with a 20 µg ethinylestradiol/150 µg desogestrel containing oral contraceptive in a central-eastern European country, Hungary

L.Zs. Horvath (1), S. Viski (2), A. Pal (2)
Medical Department, Organon Hungary, Budapest (1) and Department of Obst. & Gyn., Albert-Szent Györgyi Medical University, Szeged (2), Hungary

P1-26 Comparative study of the effects of Cerazette®, a progestogen-only pill containing desogestrel and an intrauterine device (Multiload© cu 375) in lactating women

R.I. Bjarnadóttir (1), H. Gottfredsdóttir (1), K. Sigurdardóttir (1), R.T. Geirsson (1) and T.O.M. Dieben (2)
National University Hospital, Dept. of Obst. & Gyn. Reykjavik, Iceland (1) and NV Organon, Clinical Development Dept., Oss, The Netherlands (2)

P1-27 Oral contraceptives containing low androgenic progestins do not deteriorate insulin action during treatment of women with polycystic ovary syndrome

D. Cibula (1), G. Sindelka (2), M. Fanta (1)
Charles University, Dept. of Obst. & Gyn. (1), Dept. of Internal Medicine (2), Prague, Czech Republic

P1-28 Weight differences not observed during treatment with a low-dose oral contraceptive containing Ethinyl Estradiol 20 µg vs. placebo: a randomized, double-blind clinical trial

D.D. Harrison (1), D.F. Archer (2), A. DelConte (1)
Wyeth-Ayerst Laboratories, St. Davids, PA (1) and Jones Institute for Reproductive Medicine, Norfolk, VA (2), USA

P1-29 Effects of COCs with progestagens desogestrel and norgestrel on lipid metabolism in women over 35 years old

M.A. Tarasova, V.A. Grigorieva
Dept. of Obst. & Gyn., Pavlov State Medical University, St. Petersburg, Russia

P1-30 The influence of homonally system NORPLANT on the hyperplastic processes of the endometry in women early and later reproductive age

V.N. Prilepskaya, E.V. Gogayeva
Research Center of Gynecology, Obstetrics and Perinatology (donated by V.I.Kulakov, Academician Russian Academy of Medical Sciences - RAMS), RAMS, Moscow, Russia

P1-31 Observational clinical evaluation of a desogestrel-containing combiphasic oral contraceptive in Germany

M.L. Vree
NV Organon, Oss, The Netherlands

P1-32 Comparative study on the acceptability of two modern monophasic oral contraceptives
M.L. Vree (1) and L. Zichella (2)
NV Organon, Oss, The Netherlands (1) and Clinica Ostetrica e Ginecologica, Universita degli Studi, 'La Sapienza', Roma, Italy (2)

P1-33 Effect on dysmenorrhea and cycle control following the use of a low-dose desogestrel-containing pill
M.L. Vree
NV Organon, Oss, The Netherlands

P1-34 Comparative study of the effect on acne of a new desogestrel-containing combiphasic oral contraceptive with one containing cyproterone acetate
R. Melief
NV Organon, Oss, The Netherlands

P1-35 The changes of the sexual activity with Mercilon
F. Tamási, G. Nyitray, S. Bagdány, Sz. Fejérvári
Weiss Manfred Hospital, Dept. of Obst. & Gyn., Budapest, Hungary

P1-36 Effects of a phasic desogestrel-containing oral contraceptive on seborrhea and facial acne
T.C.J. Norbart
NV Organon, Oss, The Netherlands (on behalf of the Desogestrel Study Group)

P1-37 Subjective tolerance on low-dose oral contraception
M. Havlin
Gyn. & Obst. praxis of Dr. P. Lippert, Prague, Czech Republic

P1-38 Oral contraceptives in women over 40
A. Pretnar-Darovec, L. Andolsek-Jeras
Department of Obst. and Gyn., University Medical Centre Ljubljana, Slovenia

P1-39 Contraceptive and non-contraceptive benefits of levonorgestrel-releasing intrauterine system
V.N. Prilepskaya, L.I. Ostreikova
Scientific Center of Obstetrics, Gynaecology and Perinatology Russian Academy of Medical Sciences, Moscow, Russia

Topic 2
Emergency contraception

P2-01 Experience with the GyneFix Intrauterine Device as emergency contraception
J. Dennis
Abacus Centre for Contraception and Reproductive Health, North Mersey Community NHS Trust, Liverpool, UK

P2-02 Group protocol for Community Pharmacists to provide emergency contraception. Results of a 3 months pilot study.
R. Kirkman, K. O'Brien, A. Melzack
University of Manchester/Manchester Health Authority, UK

P2-03 Condom use in clients attending for emergency contraception
P. Blencowe
Harrow Family Planning & Reproductive Health, Northwick Park Hospital, Harrow, Middlesex, UK

P2-04 The emergency contraception. The experience of Russian physicians
V.N. Prilepskaya, M.V. Oganezova, S.I. Rogovskaya
Research Centre of Obst., Gyn. and Perinatology, Russian Academy of Medical Sciences, Moscow, Russia

P2-05 No title
M.M. Lech
Fertility and Sterility Research Center, Warszawa, Poland

P2-06 Network of Centers for Emergency Contraception in Hungary
J. Bódis
Baranya County Hospital, Pécs, Hungary

P2-07 Emergency pill in Cluj-Napoca, Romania
R. Radu-Vasiu
Family Planning Central, Cluj, Romania

Topic 3
Evidence-based practice in family planning

P3-01 Reasons of the limited use of copper in IUDs in the area of Thrace
G. Galazios, K. Avgidou, P. Tsikouras, V. Liberis, K. Romanidis and P. Anastasiadis
Democritus University of Thrace, Dept. of Obst. & Gyn., Alexandroupolis, Greece

P3-02 A new advance in family planning in Europe for the Third Millennium
A. Shihata
Scripps Institution of Medicine and Science, San Diego, CA, USA

P3-03 Immunological aspects of the oviduct epithelium in IUD users
V. Sevinc Inan (1), Kenan Ertopcu (2), H. Seda Vatansever (1), Muzaffer Sanci (3), Serdar Yagceken (2), Zühtü Benli (2)
Celal Bayar University, Fac. of Medicine, Dept. of Histology & Embryology, Maniza (1), Obstetric and Gynaecology Hospital of Aegean Social Insurance, Family Planning Unit (2) and Prenatal Unit (3), Izmir, Turkey

P3-04 Predictors of placental retention following menstrual regulation
K.Ertopcu (1), S. Senol (2), S. Ozalp (3), S. Yagceken (1), O. Baskan (2), I. Ozelmas (1)
Social Security Ege Maternity Hospital (1), Ege University Department of Statistics (2), Izmir, and Osmangazi University (3), Medical Faculty, Gynaecology and Obstetrics Clinic, Eskisehir, Turkey

P3-05 An analysis of the correlation between expectations regarding reproductivity and contraceptive methods based on demographic characteristics among family planning clients

K.Ertopcu (1), S. Ozalp (2), S. Senol (3), Z. Benli (1), G. Yildirimkaya (1), F. Ozdemir (1), B. Tiras (4), I. Ozelmas (1)
SSK Ege Maternity Hospital (1), Osmangazi University (2), Ege University (3) and Gazi University (4), Turkey

P3-06 The evaluation of intervally and postabortively applied Copper (Cu)T 380 A intrauterine devices in a five year period (a total of 1731 cases)

K.Ertopcu (1), S.Senol (2), A. Donmez (1), S. Coskun (1), S. Vardar (1), S. Yetkin (1), O. Bicer (1), I. Ozelmas (1)
Social Security (SSK) Ege Maternity Hospital (1), Ege University Department of Statistics, Izmir (2), Turkey

P3-07 Clinical performance of the Levonorgestrel Intrauterine System in routine use by the Family Planning and Reproductive Health Research Network: 24 month report

M. Cox and S. Blacksell
Institute of Population Studies, University of Exeter, UK

P3-08 Clinical performance of the Nova-T®380 IUD in routine use by the Family Planning and Reproductive Health Research Network: 24 month report

M. Cox and S. Blacksell
Institute of Population Studies, University of Exeter, UK

P3-09 Effects of monthly injectable steroidal contraceptive; Mesigyna on menstrual pattern, lipid metabolism and coagulation system

M.B. Tiras (1), N. Fener (1), V. Noyan (2), P. Saygoli (1), H. Guner (1), M. Yildirim (1)
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P3-10 Natural contraception in Slovenian young males

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P3-11 Family planning practices and needs in Kosova population

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P3-12 The use of vaginal contraception

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P3-13 The impact of Copper-T and Levonorgestrel (20 mg/d) Intrauterine Devices on the uterine cervix

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P3-14 Accurate location and removal of Norplant capsule fragments: experience of a technique in a UK Fertility Control Unit

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P3-15 New perspectives in intrauterine contraception at the turn of the new millennium
I. Batar (1), D. Wildemeersch (2), E. Schacht (3), M. Thiery (3), H. Van Kets (3)
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P3-16 Chlamydia Trachomatis and IUD in family planning: is screening necessary?
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P3-17 Pelvic atinomycosis and intrauterine contraceptive device
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P3-18 The features of reproductive behaviour and contraception at the women after delivery
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P3-19 Peculiarities of pregnancy and delivery following hormonal contraception usage
N.V. Kazimirova, E.V. Bryukhina
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P3-20 The effect of oral versus vaginal Misoprostol on cervical dilatation in the first trimester abortion: a double blind randomized study
K.Ertopcu (1), A. Arici (1), S. Senol (2), Z. Ozenc (1), E. Acarlar (1), I. Ozelmas (1), A. Timocin (1)
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P3-21 The evaluation of 318 intrauterine pregnancy cases with intrauterine device
K. Ertopcu (1), S. Senol (2), E. Undar (1), G. Undar (1), I. Ozelmas (1)
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P3-22 Contraception as a method of family planning and its application in health protection of women
M. Pavlov-Mirkovic, M. Bogavac, A. Kapamadzija, Dj. Zeciri
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P3-23 The clinical appearance of PID with or without IUD use in Latvia
I. Viberga (1), G. Lazdane (1), V. Odlind (2), J. Kroica (1), M-L Nordstrom
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Topic 4
How to optimise contraceptive services

P4-01 Contraceptive practice after abortion: the importance of the consultation to prevent repeated abortions

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P4-02 Risk assessment in a contraceptive service

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P4-03 Multiload as a postpartum contraceptive

T.I. Tsybizova
Medical Academy, Volgograd, Russia

P4-04 Laparoscopic sterilization

M. Kopjar, I. Trutin, I. Maricic
General Hospital Zabok, Ob/Gyn Department, Zabok, Croatia

P4-05 Comparison of the characteristics of women to whom Intrauterine Device (IUD) had been applied in two different hospitals in the same city

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P4-06 Evaluation of Tubal Ligation (TL) cases

S.S.Özalp (1), H. Hassa (1), N. Keskintas (2), S. Korkmaz (2), I. Saraç (1)
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P4-07 The patients journey through the Clinic: a new way of ensuring quality

A. Graham, U. Bankowska, A. Bigrigg
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P4-08 Improving oral contraceptive compliance: the reminder card

M. Lachowsky (1) and R. Levy-Toledano (2)
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P4-09 Choice of contraceptive method following first experience of using Norplant in a UK Fertility Control Unit

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P4-10 Evaluation of a young person's sexual health service in a city centre pharmacy

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P4-11 Immediate postabortion insertion of levonorgestrel intrauterine device

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P4-12 A Educational Health Center - a solution for improve the contraceptive services

O. Casian-Botez, L. Coca, L. Nechita
Women's Wellness Center, Iasi, Romania

P4-13 Optimization of contraceptive services in adolescents in the environment of large industrial region in present Ukraine
Y. Paraschuk, I.A. Tuchkina, M.A. Lesovaya
Kharkiv State Medical University, Department of Obst. & Gyn. N2, Kharkiv, Ukraine

P4-14 Detection of the menopause in women using oral contraceptives
Z. Bognar
Department of Obst. & Gyn., City Hospital, Baja, Hungary

P4-15 Differences in the demographic characteristics of women to whom Tubal Ligation (TL) or Intrauterine Device (IUD) was applied
S.S. Özalp, Ö.T. Yalçin, A. Yildirim, T. Sener, I. Saraç
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P4-16 Practical experience how to optimise oral contraceptives (OC) - taking in the work of the private women consultation "Medicom"
V.B. Rymarenko
Private women consultation "Medicom", Kyiv, Ukraine

Topic 5
Abortion: safe, free and available

P5-01 Second trimester abortion in primigravidas by the method of double application of Dinoprostone gel and intramuscular administration of Carboprost Tromethamine
J. Vukelic, A. Kapamadzija, S. Milosevic, Lj. Milasinovic, Z. Drobac
Dept. of Obst. & Gyn., Clinical Centre of Novi Sad, Yugoslavia

P5-02 Evaluation of the effects of Post-Abortion Counselling on the choice of modern contraceptive methods
Ü. Kirca (1), N. Sakru (1), C. Ulman (1), S.S. Özalp (2)
Konak Maternity Hospital, Izmir (1) and Osmangazi University Faculty of Medicine, Dept. of Obst. & Gyn., Eskisehir (2), Turkey

P5-03 Introducing Mifepristone as an alternative treatment, experience from the perspective of a provider
C. Fiala and P. Safar
General Public Hospital, Korneuburg, Austria

P5-04 Counselling before and care during medical abortion with Mifepristone
B. Laschalt, L. Akinyemi, C. Fiala and P. Safar
General Public Hospital, Korneuburg, Austria

P5-05 Reproductive behavior in Kosova - from abortion to contraception
F. Kepuska, M. Kozuh Novak
Health House Prishtine, Prishtine, Kosovo

P5-06 Does vaginal administration of misoprostol improve medical abortion with mifepristone up to 49 days of amenorhea?
E. Aubény
Orthogenie center, Hôpital Broussais, Paris, France

P5-07 Reproductive health of adolescent girls after induced interruption of pregnancy
S.I. Eguina, G.A. Ushakova
Kemerovo State Medical Academy, Kemerovo, Russia

P5-08 A protocol for Dutch general practitioners in prescribing Mifepristone as a Morning-After Pill (MAP) or Menstrual Extraction Pill (MEP)
P. Wibaut
Westhoff & Wibaut, Amsterdam, The Netherlands

P5-09 Interruption of pregnancy after Karman's method
M. Sirakov, T. Chernev, St. Ivanov
University Ob. & Gyn. Hospital, Sofia, Bulgaria

Topic 6
Sexual health in adolescence and preventive behaviour

P6-01 Sexual knowledge and practice among children in elementary school
A. Kapamadzija, J. Vukelic, Lj. Milasinovic, S. Milosevic, M. Pavlov Mirkovic, A. Bjelica, V. Kopitovic
Dept. of Obst. & Gyn., Clinical Centre of Novi Sad, Yugoslavia

P6-02 Vaginal Microbicide development for the prevention of sexually transmitted diseases
A. Shihata
Scripps Institution of Medicine and Science, San Diego, CA, USA

P6-03 Delinquent adolescent girls: values, self-concept and psychosexual development problems
I.S. Savelieva (1), E.G. Dozortseva (2) , N.A. Morozova (2)
Research Centre of Obstetrics, Gynecology and Perinatology (1) and Serbsky State Research Centre for Social and Forensic Psychiatry (2), Moscow, Russia

P6-04 A department of health pilot to assess the feasibility of opportunistic screening of young women for Chlamydia Trachomatis using a urine test
S. Randall, J. Tobin
St Mary's Hospital, Portsmouth, UK

P6-05 Contraception consulting phone line Merciline: first impression of the activity in Russia
B.N. Novikov
I.P. Pavlov State Medical University, St. petersburg, Russia

P6-06 Attitude towards contraceptives as a factor in protection of young generation reproductive health
M.A. Surodeyeva

The Municipal Centre of Family Planning and Human Reproduction, Tomsk, Russia

P6-07 Training of trainers programme in sexual health education
A. Bulut (1), N. Ortayli (1), H. Nalbant (1) and M. Cokar (2)
Woman and Child Health Training and Research Unit, University of Istanbul (1) and Human Resource Development Foundation (2), Istanbul, Turkey

P6-08 Chlamydia trachomatis (CT) screening in young people in Merseyside
J. Harvey (1), A. Webb (1) and H. Mallinson (2)
Abacus, Liverpool (1) and Public Health Laboratory Services - North West (2), UK

P6-09 "They should listen to us!": what young people want from Sexual Health Services and health professionals delivering sexual health care
R. Campbell (1), E. Kay (2), M. Lyons (3)
Liverpool Hope University College (1), PACE, ABACUS Centres for Contraception and Reproductive Health (2), Liverpool, Public Health, Sefton Health Authority, Sefton, Merseyside (3), UK

P6-10 HIV/AIDS - How great is the danger for young people the case of military Conscripts in Austria?
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General Public Hospital, Korneuburg, Austria

P6-11 Teenagers hormonal contraception
K.G. Serebrennikova, E.A. Pashukova, S.P. Krivileva
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P6-12 How to optimise the teenagers health's education?
O. Casian-Botez, L. Coca, M. Ursu
Women's Wellness Center, Iasi, Romania

P6-13 Sexual behaviour and utilization of contraception in sexually active adolescents
Z. Miljkovic, M. Dokmanovic, I. Grujic
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P6-14 Enlightenment of young people on reproductive health and sexually transmitted diseases
S.S. Özalp, H. Hassa, S. Koral, N. Çakiroglu
Family Planning Association of Turkey (FPAT), Ankara, Turkey

P6-15 Role of hormonal contraception in preventing pregnancies in adolescents
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