MINUTES OF THE UPIGO GENERAL ASSEMBLY
of 25–26 October 2019 in Strasbourg.

In advance of the General Assembly, a meeting of the Bureau was held on 25 October 2019 to discuss the organisation of the General Assembly, the social programme, and the themes, dates and venue of the next General Assembly.

The General Assembly began by **introducing the participants** from Europe and Africa (see list in Annex). Thanks to the ingenuity of the mid-wives from Mali, badges were given to each participant.

The opening speech was delivered by President Chionis, who welcomed the participants from Albania, France, Greece, Mali, Central African Republic, Burkina Faso, Mauritania, Chad and Switzerland and thanked them for their participation in this General Assembly.

A presentation was given by Prof. Dr. Sibilia, Dean of the Faculty of Medicine in Strasbourg. In a brilliant speech, the Dean, who is a statutory honorary member of UPIGO, described the General Assembly as a meeting place of cultures and international professional relations between Africa and Europe. He recalled the new organisation of the health system in France with the concept of a faculty of health sciences bringing healthcare professionals together in one place: doctors, pharmacists and midwives, in a spirit of collaboration and with mutual respect for the role each has to play. He concluded with a message of kinship and generosity regarding our differences and pleaded for this collaboration to continue, as has been advocated by the WHO since its creation in 1946.

Report of the Secretary General, Moustapha Touré

He reported on UPIGO's discussions with several African countries.
The Secretary General has approached the European Union a number of times in relation to the project on basic ultrasound training for African midwives. The project will be submitted through a call for tenders, the terms of reference of which have been given to us and which will be shared and discussed with the participants at the next General Assembly.

Treasurer's report: **Guy Schlaeder**

The detailed report was presented to the plenary session. The accounts are balanced. Details of the accounts were presented to the General Assembly.

The Treasurer reported on the status of payment of subscriptions. The price of subscriptions is maintained for next year, namely, for France €2,800, Mali €400, Central African Republic €400, Greece €950, Albania €400.

Delegates' round table

This round table was an opportunity for the various delegations to introduce themselves. It emerged that the issue of insecurity due to jihadist attacks is the common denominator for all the African countries present (Mali, Mauritania, Burkina Faso, Chad, Central African Republic). Insecurity is an obstacle to people's mobility with regard to healthcare. In this respect, developing the skills of human resources will make a considerable contribution to the provision of quality care, particularly gynaecological and obstetric care.

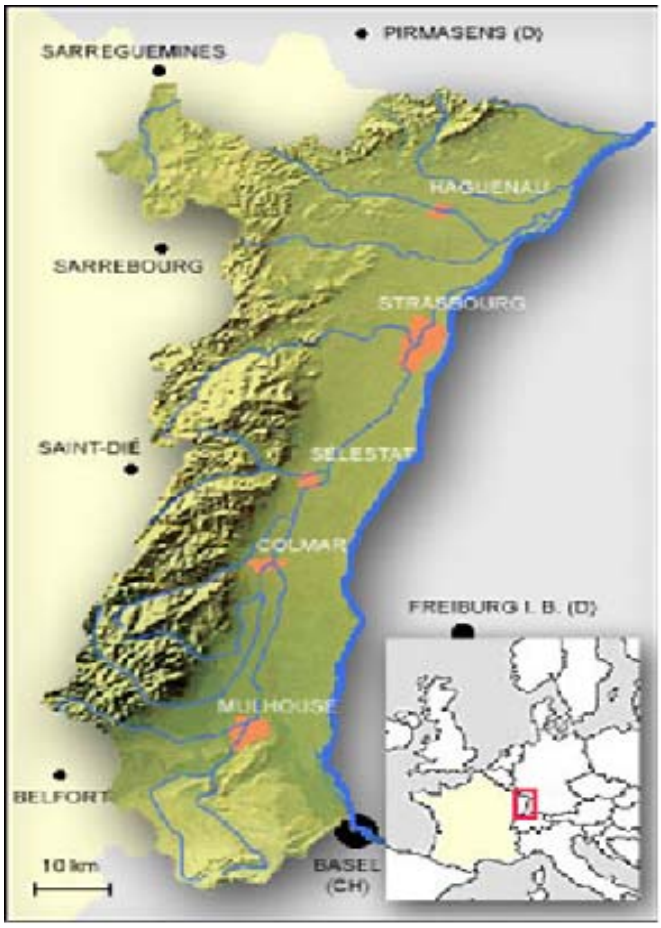
Midwives have not been trained in ultrasound in any country except Mauritania.

This justifies the main theme of basic ultrasound training for midwives in French speaking Africa. They unanimously estimate the length of training to be one month.

§ PRESENTATION OF ALSACE AND STRASBOURG by Guy SCHLAEDER (Strasbourg, France)

Strasbourg is a student town with almost 50,000 students. Our research activity is substantial, particularly in science and medicine. Our last four Nobel Prize winners are still active. Among the former Nobel Prize winners from Strasbourg, Albert Schweitzer is the best known. He was awarded the Nobel Peace Prize in 1952 and followed his university education in Strasbourg. A Protestant pastor, he decided at the age of 30 to study medicine. He created a hospital in Lambaréné in Gabon. He was also a musician and philosopher.

Strasbourg is a major communication centre and home to several European institutions: the European Parliament with 27 member states, the Council of Europe with 47 member states, and the European Court of Human Rights. There is a visible influence of German culture as evidenced by the headquarters of the Franco-German television station ARTE. Alsace was not part of France until 1648, with the signature of the Treaty of Westphalia. Alsace enjoys a very fertile landscape, situated on a plain between the Rhine and the Vosges.



.

The Vosgian foothills are covered with famous vineyards: Riesling, Gewürztraminer and Pinot Gris are the most famous and widely exported wines

The scientific session included the following themes:

Basic ultrasound for African midwives, diabetes and pregnancy, malaria and pregnancy, using coelioscopy to treat adnexal masses.

FIRST THEME: BASIC ULTRASOUND FOR MIDWIVES.

§ OUR EXPERIENCE WITH MIDWIFERY EDUCATION IN WEST AFRICA by Eduard Neuenschwander (Bern, Switzerland). This took place within the framework of the “SMW Stiftung fûr medizinisches Wissenstransfer” Foundation (foundation for the transfer of medical knowledge) ww.stiftung-smv.ch, which has the admirable motto “we only live when we also live a little for others”.

There is already a long history of training African midwives. During the West Africa project in Tanzania and Kenya, 25 ultrasound stations were rolled out and many courses were given.

What can we learn from this very rich experience? The basic ultrasound courses consisted of two 4-day modules. From a practical point of view, the aim is for the midwife to be able to determine gestational age, locate the placenta, screen for multiple pregnancies, assess the amount of amniotic fluid, foetal presentation and foetal biometry. It is about being efficient, bearing in mind that routine examinations require 20% effort for 80% results. The morphological examination for foetal malformations represents 80% of the effort for 20% of the result. Practical training takes place either in hospitals or in private practice. To obtain the first level ultrasound certificate the midwife must have performed at least 50 ultrasound examinations under supervision. Being awarded the certificate obviously implies a test of theoretical knowledge.
The smooth running of the training requires good cooperation with the local authorities and doctors. Training should be supported by local government.

It is important to write up a report after examining each parturient patient. Periodically, every month, the midwife writes a report on their ultrasound activity.

From the outset of the course, the need for midwives to keep in touch with their tutor is emphasised. They can be motivated to keep up-to-date through continuous training.

Training should be prioritised for midwives in hard-to-reach rural areas.

New ultrasound machines should be prioritised for such programmes, as there is robust, reliable and affordable equipment on the market. Due to the irregularity of the electricity supply, it is essential to equip the devices with stabilisers.

THE AIM OF THE SMW FOUNDATION IS NOT ONLY TO BRING ULTRASOUND SCANNERS TO MIDWIVES BUT ALSO TO TEACH THEM HOW TO USE THEM.

§ MIDWIFERY TRAINING IN FRANCE: by Anita Basso and Catherine Burgy, midwife teachers at the Strasbourg School of Midwifery.

- From a practical point of view, midwives learn to perform placental location, assessment of amniotic fluid quantity, diagnosis of foetal vitality, foetal biometry, diagnosis of foetal presentation, early dating before the 11th week, identification of gynaecological structures.
- Midwives may perform gynaecological ultrasound for the purposes of monitoring ovulation, provided that their experience and training has been judged sufficient by their centre’s reproductive health practitioners.

- Midwives can improve their skills through an inter-university diploma (DIU) in obstetrics and gynaecology. This diploma brings together midwives and doctors in the same course.
- Whether or not they hold an ultrasound diploma, midwives must meet the obligations of continuous training and assessment of their professional practices in order to maintain and check their knowledge.

SECOND THEME: MALARIA AND PREGNANCY

§ THE AFRICAN PERSPECTIVE ON MALARIA AND PREGNANCY by Abdoulaye Sepou (Bangui, Central African Republic)

GENERAL

Malaria is an infectious disease caused by a parasite of the genus Plasmodium.

These parasites are spread by the bites of infected mosquitoes, known as anopheles. The common manifestation is fever. Death is possible.

HISTORY

The cause of the disease was discovered on 6 November 1880 at the military hospital in Constantine, Algeria, by the French military physician, Alphonse Laveran.

In 1897, the English physician Ronald Ross proved that anopheles mosquitoes were the vectors of malaria. In 1899, the Italian Giovani Battista Grassi demonstrated that malaria can only be transmitted by anopheles via their digestive system.

EPIDEMIOLOGY

In 2017, the World Health Organization (WHO) estimated that there were 219 million cases of malaria in 87 countries, resulting in the deaths of 435,000 people.

In 2017, 92% of malaria cases and 93% of malaria deaths occurred in Africa.

Plasmodium species: Anopheles often bite at night and transmit five species of human plasmodium:

- Plasmodium Falciparum +++
- Plasmodium vivax
- Plasmodium ovale
- Plasmodium malaria
- Plasmodium knowlesi

The most common species in Africa is Plasmodium Falciparum (PF) (responsible for an estimated 99.7% of malaria cases in 2017). PF causes the severe form of malaria.

In 2017, of the 219 million cases of malaria, 200 million or 92% were recorded in the WHO African Region, 5% in the Southeast Asian Region and 2% in the Eastern Mediterranean Region

EFFECTS OF MALARIA ON PREGNANCY: in addition to the risk of maternal mortality, this parasitic disease causes anaemia in pregnant women, abortion, premature delivery, in utero growth retardation, low birth weight, and in utero or perinatal death.

PREVENTION:

Prevention by improving the living environment:

- Sweeping yards behind houses
- Proper disposal of wastewater
- Weeding around houses
- Destruction of breeding sites

- Distance from animal farms
- Daily collection of household waste

Prophylaxis focuses on:

- Intermittent preventive treatment
- Use of insecticide-treated nets
- Installation of fine screens on doors and windows
- Construction of protected latrines
- Cleaning the surrounding area
- Involving health centre staff in communication campaigns with a view to changing behaviour

MANAGEMENT:

Any clinical form of malaria in pregnant women is considered severe.

- Diagnosis is reached by thick drop or rapid test.
- The treatment protocol depends on the sensitivity of the antimalarial drugs used in each country.
- In all cases, hospitalisation is recommended for the management of malaria.

Outlooks

- Vaccination remains a possibility, but there have been huge difficulties in completing research in this area over the past 30 years.
- One vaccine, known as Mosquirix, or RTS,S, is not yet ready. However, in preliminary trials conducted from 2009 to 2015, it succeeded in reducing the number of malaria cases in children aged 17 months to 5 years by 39%.
- It is an imperfect vaccine against a complex disease
- Nevertheless, the World Health Organization remains confident in this regard.

- Three African countries, Malawi, Ghana and Kenya, are hosting the pilot programme.
- The official launch of this first malaria vaccine took place on 23 April 2019 where it was offered to children under the age of two in Malawi.
- It was extended to Ghana on 30 April 2019 and then to Kenya on 13 September 2019, reaching 360,000 children in the three countries.

§ EVALUATION OF MALARIA ASSOCIATED WITH PREGNANCY AT THE GABRIEL TOURÉ UNIVERSITY HOSPITAL by Molobaly Diallo (Bamako, Mali)

THE THIRD THEME: GESTATIONAL DIABETES

§ GESTATIONAL DIABETES by Athanasios CHIONIS and Antonios KOUTRAS (Athens,Greece)

Approximately 6% to 9% of pregnancies are complicated by diabetes that either develops during pregnancy (gestational diabetes) or was antecedent to pregnancy (pregestational diabetes mellitus).

The American Diabetes Association (ADA) defines gestational diabetes as "diabetes diagnosed in the second or third trimester of pregnancy that was not clearly overt diabetes prior to gestation. According to ADA, women diagnosed with diabetes by standard diagnostic criteria in the first trimester should be classified as having preexisting pregestational diabetes (type 2 diabetes or, very rarely, type 1 diabetes or monogenic diabetes).

In 2017: There were an estimated 204 million women (20-79 years) living with diabetes. This number is projected to increase to 308 million by 2045. 1 in 3 women with diabetes were of reproductive age. An estimated 85.1% were due to gestational diabetes. 1 in 7 births was affected by

gestational diabetes. The vast majority of cases of hyperglycaemia in pregnancy were in low- and middle-income countries, where access to maternal care is often limited.

In overweight and obese women, weight loss before pregnancy can reduce the risk of developing gestational diabetes mellitus. During pregnancy, a program of diet, exercise and smoking cessation are healthy behaviors that may be associated with reduced risk of developing gestational diabetes mellitus. If gestational diabetes mellitus is diagnosed, management involves: changes in diet, an increased frequency of prenatal visits, blood glucose monitoring, possible pharmacologic therapy, additional maternal and fetal monitoring, possibly an increased risk for induction.

Treatment of GDM is associated with significant reduction of serious newborn complications (perinatal death, shoulder dystocia, macrosomia and birth trauma),reduction in preeclampsia, reduced frequency of infants who were large for gestational age and who had a birth weight greater than 4,000 g. Based on most evidence, women in whom GDM is diagnosed would receive nutrition and exercise counselling, and when this fails, medication should be used. The goals are achieve normal blood glucose levels, prevent ketosis, provide adequate weight gain, contribute to fetal growth and development. Most women with gestational diabetes (70 to 85%) can achieve normoglycemia with nutritional therapy.

Most women with gestational diabetes mellitus are normoglycemic after delivery. However, they are at high risk for recurrent gestational diabetes mellitus, prediabetes (impaired glucose tolerance or impaired fasting glucose), overt diabetes over the subsequent five years. One-third to two-thirds of women with gestational diabetes mellitus will have gestational diabetes in a subsequent pregnancy. ACOG, ADA, the Fifth

International Workshop Conference on Gestational Diabetes recommend long-term follow-up of women with gestational diabetes mellitus.

§ GESTATIONAL DIABETES IN FRANCE by Fanny De Marcillac-Reita

OVARIAN TUMOURS THE FOURTH THEME:

§ OVARIAN TUMORS by Athanasios CHIONIS and Antonios KOUTRAS (Athens,Greece)

The ovary is composed of several tissues (epithelium, stroma, germ cells). Each of them produces different tumors (benign, malignant or borderline), with different potential malignancies, which require different surgical and pharmaceutical treatment. The histological classification of ovarian tumors is based on the cell type of origin. Due to the absence of effective screening tests, absence of typical symptoms in the majority of patients (~70%), approximately two thirds of patients with ovarian cancer have advanced disease at the time of diagnosis (III and IV). The mortality rate of this disease is the highest of all the gynecologic malignancies.

The initial work-up includes a detailed clinical examination, laboratory and imaging studies. Tumor markers (Ca 125, CEA, Ca19-9, AFP, LDH, hCG, inhibin B, human epididymal protein 4) would be useful in predicting a higher likelihood of a malignant tumor than a benign tumor.

According to 1st International Consensus Report on Adnexal Masses pelvic sonography should include the transvaginal approach with Doppler imaging as indicated. Simple ovarian cysts are not precursor lesions to malignant ovarian cancer; however, it is crucial to perform a high-quality examination to ensure the absence of any solid/papillary structures before designating a cyst as a simple cyst. The risk of progression to malignancy is extremely low; thus, a degree of follow-up is prudent. Real-time pattern recognition sonography in the hands of an experienced imager is currently

the most accurate method of characterizing an ovarian mass. Initial mass characterization could be performed either by pattern recognition or via a risk model such as the IOTA Simple Rules. When an ovarian lesion is considered benign, the patient may be followed conservatively, or if indicated, surgery can be performed by a general gynecologist. Serial sonography is a beneficial strategy, but there are limited prospective data to support an exact interval and duration. Fewer surgical interventions may well result in an increase in sonographic surveillance. When an ovarian lesion is considered indeterminate on initial sonography, and after appropriate clinical evaluation, a “second-step” evaluation may include: referral to an expert sonologist, serial sonography, application of established risk prediction models, correlation with serum biomarkers, correlation with MRI, or referral to a gynecologic oncologist for further evaluation.

§ CURRENT POSSIBILITIES OF USING COELIOSCOPY TO TREAT OVARIAN CANCER by Cherif AKLADIOS (Strasbourg, France)[2]

The presentation is richly illustrated with various video sequences.

§ NEW DEVELOPMENTS IN CERVICAL CANCER SCREENING IN FRANCE by J.J. BALDAUF (Strasbourg, France)

Abstract: The main purpose of cervical cancer screening is to diagnose precancerous lesions which, when treated, prevents progression to cancer. This screening must be part of a broader prevention policy which incorporates technological progress, including the emergence of new screening tools and, of course, HPV vaccination. The French Haute Autorité de Santé has recently recommended replacing the smear test by the HPV test for women over the age of 30. The organisation of national

screening would appear to be a prerequisite for this change in approach, which requires indispensable triage procedures.

The main purpose of cervical cancer screening is to diagnose precancerous lesions which, when treated, prevents progression to cancer. Here, we will present some current data about rolling out screening in France and replacing the smear test (the standard screening tool) with screening for the oncogenic HPV genome for women aged between 30 and 65 years old. We will also briefly analyse adapting screening modalities for women who are vaccinated against HPV infection, bearing in mind that this is a more distant prospect and, above all, largely dependent on vaccination coverage.

THE ORGANISATION OF CERVICAL CANCER SCREENING

Experts from the World Health Organization (WHO) and the International Agency for Research on Cancer (IARC) agree that the best remedy for this low participation is to establish a system of inviting women for screening. In France, the decree of 4 May 2018 provides for the nationwide roll-out of organised cervical cancer screening [1]. Its implementation is based on a system of invitations/recalls of women who have not spontaneously undergone screening in the last three years and follow-up of all women who have a positive screening test (whether they have participated spontaneously or have been invited by mail to participate in screening). 100% of the cost of the smear test is covered, i.e., it will be free of charge for the women invited. The objective of rolling out comprehensive screening on a national scale is to achieve a coverage rate of 80% in the target population, while facilitating access to screening for vulnerable populations or those furthest from the healthcare system. It should be noted that this objective was achieved in a pilot campaign conducted in Alsace [2], which reduced the number of cancers diagnosed

and deaths linked to these cancers by 16.1% and 19.5% respectively compared with individual screening, with an annual cost of €1.05 per woman to be screened, i.e., €22,700 per life-year saved [3].

REPLACING THE SMEAR TEST BY THE HPV GENOME TEST (HPV TEST)

This replacement was recommended by the HAS in July 2019 for women over the age of 30 because the sensitivity for primary screening of precancerous and cancerous cervical lesions is significantly higher, although the specificity is significantly lower. Screening for women aged 25–30 years is still based on the use of Pap smears [4] at five-year intervals. This is the most cost-effective strategy according to mathematical modelling [5].

HPV infection is the most common sexually transmitted viral infection. The main factor in HPV infection is the number of sexual partners in a lifetime and, as a corollary, the early onset of sexual activity. It is estimated that approximately 70% of sexually active women will encounter oncogenic HPV (hr HPV) in their lifetime and that 90% of these viral infections heal spontaneously within three years [6]. This viral clearance is influenced by the age of the infection, smoking, and the immune status of the subject.

The risk of developing high-grade lesions in an HPV-infected patient and the speed of progression depends on many factors related to both the HPV (type, viral load ....) and the host. For example, the risk of developing a CIN 3+ lesion at three years in the case of persistent HPV 16 infection is 30.5%, whereas it is only 6.23% in the case of persistent high-risk non-16-18 HPV [7]. The average time for cancer to develop from CIN 3 varies between five and 20 years, but faster progression is regularly reported.

In the latest HAS recommendations, the management algorithms for HPV-positive women, taking into account the lower specificity of this screening test, are based on cytological triage (at the ASC-US threshold for squamous cell atypia of undetermined significance) in order to reduce overdiagnosis and overtreatment [4]. Abnormal cytology (ASC-US+) requires a colposcopy, whereas normal cytology requires follow-up with HPV testing 12 months later. If the one-year control HPV test is positive, a colposcopy should be performed; if the one-year control HPV test is negative, a new HPV test should be offered after five years.

SELF-TESTING

HPV testing can be done on a self-sampling basis with good reliability for the detection of CIN2+ lesions. In order to involve women who are still not being screened, self-testing is an approach that overcomes two of the main obstacles: reluctance to undergo a gynaecological examination and the physical problems of accessing screening facilities (cost, medical demography, “geographical” accessibility). Patient compliance for gynaecological follow-up in case of positive results and for repeating negative tests every five years remains to be assessed [8].

THE DISTANT FUTURE IS ABOUT ADAPTING SCREENING FOR VACCINATED WOMEN

The optimal use of screening coupled with vaccination should result in a reduction in the individual risk of cervical cancer in the order of 97–99% [9]. A population-based study in Sweden showed an 88% (66%–100%) reduction in the incidence rate of cervical cancer in women aged 10–30 years who were vaccinated with gardasil® before the age of 17 [10].

The elimination of genotypes 16 and 18 through vaccination of young girls will considerably reduce the potential for lesions to develop, which will only be associated with non-vaccine HPV. Progression to cancer will be less frequent and the time to invasion will be significantly longer. Adaptation of the screening modalities with a later start and a lower frequency is proposed in countries with high vaccination coverage.

CONCLUSIONS

Organised screening provides increased safety and equity for patients, reduced costs for society, and valuable support for health professionals in the recommended management of abnormalities. This organisation is a prerequisite for screening by HPV test, which requires indispensable triage procedures. High HPV vaccination coverage would make it possible to envisage screening with a later start and a lower frequency.

NB: the French version of new developments in cervical cancer screening in France is a little more detailed and contains some additional bibliographic references.

Bibliography :

1)https://www.legifrance.gouv.fr/affichTexteArticle.do;jsessionid=0056AA0E737FC9AFDD631B3C0F24CC66.tplgfr26s_2?cidTexte=JORFTEXT000000460656&idArticle=LEGIARTI000036879733&dateTexte=20180514&categorieLien=id#LEGIARTI000036879733

2) Baldauf JJ, Fender M, Bergeron C, Marrer E, Velten M, Pradat P, Arbyn M. Cervical morbidity in Alsace, France: results from a regional organized cervical cancer screening program. Eur J Cancer Prev. 2019; 28: 33-39.

3) Levy-Bruhl D, Kudjawu Y, Dervaux B, Lehne X. Modélisation médico-économique de l'impact de l'organisation du dépistage du cancer du col utérin et de l'introduction de la vaccination contre les HPV dans le calendrier vaccinal (synthèse) Rapport INVS Mars 2007.

4) https://www.has-sante.fr/upload/docs/application/pdf/2019-07/synthese_hpv.pdf

5) Barré S, Massetti M, Leleu H, De Bels F. Organised screening for cervical cancer in France: a cost-effectiveness assessment. Which high-risk HPV assays fulfil criteria for use in primary cervical cancer screening? BMJ Open. 2017; 7: e014626.

6) Dalstein V, Riethmuller D, Pretet JL, Le Bail Carval K, Sautiere JL, Carbillet JP, et al. Persistence and load of high-risk HPV are predictors for development of high-grade cervical lesions: a longitudinal French cohort study. Int J Cancer 2003; 106: 396-403.

7) Castle PE, Rodriguez AC, Burk RD, Herrero R, Wacholder S, Alfaro M, Morales J, Guillen D, Sherman ME, Solomon D, Schiffman M. Short term persistence of human papillomavirus and risk of cervical precancer and cancer: population based cohort study. BMJ 2009; 339: b2569.

8) Aitken, C.A., van Agt, H.M.E., Siebers, A.G. et al. Introduction of primary screening using high-risk HPV DNA detection in the Dutch cervical cancer screening programme: a population-based cohort study. BMC Med 2019; 17: 228.

9) Hall MT, Simms KT, Lew JB, Smith MA, Brotherton JM, Saville M, Frazer IH, Canfell K. The projected timeframe until cervical cancer elimination in Australia: a modelling study. Lancet Public Health. 2019; 4 : e19-e27.

10) Lei J, Ploner A, Elfström KM, Wang J, Roth A, Fang F, Sundström K, Dillner J, Sparén P.Lei J, et al. HPV Vaccination and the Risk of Invasive Cervical Cancer. N Engl J Med. 2020; 383: 1340-1348.

§ PREVENTING CERVICAL CANCER IN ITALY by Pier Francesco TROPEA (Reggio di Calabria)

There are currently 2,400 new cervical cancer cases per year, the maximum frequency of which is in the 35–50 year group.

- The percentage of mortality due to cervical cancer is < 1%.
- Free cytological screening within the public health service from the ages of 25 to 64; one smear every three years.
- The best participation is in northern Italy, with 90% participation, while in southern Italy it is 60%.
- In case of positive cytology: colposcopy + biopsy. At the same time HPV testing is performed. Consequent treatment

Cervical cancer screening

- Currently in Italy, the screening provides for the performance of the Pap test only and the use of the HPV test in the presence of cellular changes often linked to the existence of HPV infection.

- However, in six Italian regions in the centre and north, the HPV test is considered as the first cervical screening examination, while the Pap test is carried out subsequently in order to detect possible cellular changes linked to the virus.

The combination of Pap test + HPV test above the age of 30 is planned, as it can reduce the false negatives of the Pap test (10%) and also detect the 98% of precancerous and cancerous lesions of the cervix.

1. American College of Obstetricians and Gynecologists (2019)
2. American Cancer Society (ACS) (2019).

IT SHOULD BE REMEMBERED THAT ...

3. The HPV virus is the second most common cancer pathogen in the world.
4. HPV infection is a necessary condition for the development of cervical cancer.
5. 1/3 of HPV infections occur in men, who are five times more likely to contract the virus than women, hence the need to extend HPV vaccination to 12-year-old boys *(F. Cognetti 2019)*

HPV infection

- There are 6,500 new cases a year as a direct consequence of infection with the papilloma virus.
- Three-quarters of women who are sexually active contract the virus during their lifetime.
- In a very high percentage of cases, HPV infection is spontaneously cured at a young age.
- Virus types 16 and 18 are responsible for 70% of cervical cancer cases.
- Virus types 6 and 11 are responsible for 90% of genital warts.

HPV infection in men is a common cause of genital warts and sometimes tumours of the anus, mouth and pharynx, hence the need to extend HPV vaccination to men.

HPV test

- The HPV test makes it possible to detect the HPV virus long before the cervical cells show any microscopic changes.
- The test therefore has great sensitivity, but low specificity compared to the Pap test, as it makes it possible to diagnose an infection that may spontaneously heal.
- A positive HPV test does not mean that cervical cancer exists.
- The use of the HPV test increases the timescale for screening to every five years as opposed to the three-year timescale required for a Pap test. *(S. Pignata 2018)*

HPV VACCINATION

- Started in Italy at the end of 2008.
- Currently, 12-year-old girls are vaccinated, the costs of which are covered by the Region. The second dose is given after one or two months and the third dose after six months.
- Vaccination is possible later on request at a moderate price.
- Seven Italian regions even vaccinate free of charge between the ages of 15 and 18.
- The region of Basilicata vaccinates girls aged 12, 15 and 18 free of charge and also, on request, women aged 25.
- The percentage of vaccinated women is higher in northern Italy (76.6%, 79.4%, 86.1%) than in southern Italy (74.3%, 62.6%).
- Lower percentages of women receive the second and third doses of the vaccine.

- In 2012 most regions had 70% of girls receiving all three doses.
- Type of vaccine: most commonly the bivalent type 16 and 18 vaccine. In some regions the quadrivalent vaccine type 16, 18, 6 and 11.
- As of 2017, the 9-valent vaccine will be available.

Research involving 60 million subjects from 14 countries showed that HPV vaccination produced a reduction in infection in 83% of girls between the ages of 15 and 19 and in 66% of women between the ages of 20 and 24, with a reduction in precancerous lesions of 15% between the ages of 15 and 19.

- It is thought that a wider roll-out of the vaccine could lead to the disappearance of cervical cancer within a few decades.
- In Norway, vaccination reduced HPV infection by 90% in vaccinated girls and by 55% in girls who had not received any vaccine due to so-called “herd immunity”.

Lancet 2019; Journal of Infectious Diseases 2018

Several HPV vaccines

- Bivalent vaccine: Type 16 and 18 (for women).
- Quadrivalent vaccine: Type 16, 18, 6, 11 (for women and men).
- 9valent vaccine: Type 6, 11, 16, 18, 31, 33, 45, 52, 58 (for women and men) (from 2017).
- Generally two doses are given between the ages of nine and 14, at time 0 and after six months.
- Three doses after the age of 14 at time 0, and at two and six months.
- HPV vaccination using the 9valent vaccine is included in the 2017–2019 Vaccination Plan provided for in Italy by the current levels of public assistance.

Comment

- No gradual increase in vaccination as expected.
- Quite marked differences between North and South.
- **ITALIAN EPIDEMIOLOGISTS AIM TO VACCINATE 95% OF 12-YEAR-OLD GIRLS IN ORDER TO ELIMINATE CERVICAL CANCER.**

ORDINARY GENERAL ASSEMBLY

- The Secretary General's report was unanimously approved.

- The Treasurer's report was unanimously approved.

- The Treasurer's call for subscription fees and the proposed rates per country were unanimously approved.

- The bureau was renewed in its entirety and is composed as follows:

President: Athanasios Chionis (Greece)

. Vice President: Pier Francesco Tropea (Italy)

Secretary General: Moustapha Touré (Mali)

- Treasurer and Past-President: Guy Schlaeder (France)

- Scientific Advisor: Jean-Jacques Baldauf (France)

The main topics of the next General Assembly are:

1) Caesarean section and current indications, how to combat the increasing Caesarean section rate by P. Deruelle.

2) haemorrhage in obstetrics coordinator A. Sepou

3) Medical and legal responsibility in conducting ultrasound in obstetrics. Coordinator PF Tropea

The next General Assembly will be held on 2–3 October 2022 in Florence (Italy).

List of participants present in Strasbourg: BURKINA FASO: Madjata KONÉ midwife/ CENTRAL AFRICAN REPUBLIC: Abdoulaye SEPOU; Régina Patricia PEPA née MAYKOUA SAMMY midwife/ GREECE: Athaniassios CHIONIS Antonios KOUTRAS/ FRANCE: Cherif AKLADIOS; Jean-Jacques BALDAUF; Anita BASSO midwife Catherine BURGY midwife; Fanny De MARCILLAC-REITA; Frédéric WAYDELICH-MANSOUR; Guy SCHLAEDER/ MALI: Mariame DIAKITÉ Moustapha TOURÉ; Molobaly DIALLO midwife Walidé SISSOKO midwife Kadiatou KONE midwife/ ITALY Pier Francesco TROPEA/ MAURITANIA: Rokhaya DIAWARA midwife/ SWITZERLAND: Eduard NEUENSCHWANDER/CHAD: Dina OUMAR midwife/ ALBANIA: Gjergji THEODHOSI (excused)

At the end of the AGM, the participants warmly thanked former President Guy Schlaeder for his kind welcome and excellent organisation.

MT/GS