Poland

Health is improving in Poland, though there are still significant differences between urban and rural areas, with healthcare being more difficult to access in the rural areas. Eurostat reports a relatively high incidence of live births in Poland in the 15-29 year age groups, though with very low incidences for under 15s.

Poland has one of the highest incidences of chlamydia of the countries reviewed.. Of all female illnesses and deaths, the highest number are due to breast cancer. Poland has a slightly higher prevalence of smoking than the EU average. Among women, this appears to have been decreasing since 1996.

In 2005 a new Department for Women, Family and Counteracting Discrimination was established, charged with coordinating activities connected to the status of women and families in society. Current moves to address women's health appear to have a strong focus on reproductive health and procreation. The 1996-2005 National Health Programme has been working to improve general health across society by addressing issues around smoking cessation, reducing alcohol use, a reduction in Road Traffic Accidents, and early diagnosis and active care for people with ischeamic heart disease.

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Women's health

- *Legal guarantees of health protection*

The *Act on Public Financing* determines the organisation and finance of the universal health insurance offered by the National Health Fund. It stipulates that all health services connected with pregnancy, child delivery and puerperium, and for children under 18, will be provided free of charge by health service institutions, irrespective of entitlement to health care under the health insurance scheme. Health services for pregnant women and children under 18 cover medicines free of charge, and are distributed according to the rules set forth in the Act.

The Council of Ministers' Directive (5 October 1993) defines the scope of social welfare and legal aid to pregnant women and mothers bringing up a child. These women are entitled to an allowance (PLN 120 in cash for each child delivered) and in-kind benefits (e.g. a layette) as defined in the Directive. Furthermore, the entitled person is reimbursed in total for all expenses incurred for treatment at public health institutions in connection with pregnancy, childbirth and

puerperium, as well as for medicines prescribed by gynecologists and obstetricians, and any necessary hygienic items.

A person bringing up a child under 18, irrespective of his/her income level, is entitled to obtain family, psychological, legal and pedagogical counselling at educational and health service institutions free of charge.

- *Demographic situation*

In 2002, for the first time, the population growth rate in Poland showed in the negative (- 5700). In 2003 the growth rate fell further, to –14,100; in 2004 it was 7,400, and in 2005 – 3,900. Life expectancy for women has increased: in 2002 it was 78.8 years (70.4 for men), in 2003 – 78.9 years (70.5 for men), in 2004 – 79.2 years (70.7 for men), and in 2005 – 79.4 years (70.8 for men). In recent years there was no significant growth in the birthrate of live children. In 2002 it was 9.3 per million, and in 2005 9.5 per million. The number of births is linked to the level of women's fertility, defined as the birthrate of live children per 1000 women. In 2002 and 2003 fertility of women between 15 and 40 years of age was 35 per million, in 2004, 36 per million, and in 2005 it increased to 37 per million.

The rate of illegitimate childbirths grew by almost 1/3 in the years 2002 – 2005. In the early 1990s there were some 6-7% of children born out of wedlock, and in recent years this has increased to 13-16%. Among them, the rate of children born to widows and divorced women is about 2% and remains constant. However, the share of unmarried mothers doubled in that period.

Since 1999, the number of newborn children left by mothers at the hospital for reasons other than health problems has been increasing. (in 1999 – 737 newborns, in 2000 – 861, in 2001 – 899, in 2002 – 1018, and in 2003 – 1090). In 2004 there was a slight decrease of the number of newborns left in hospitals, to 1072.

Demographic data for the years 2002 - 2005

Item	**2002**	**2003**	**2004**	**2005**
Number of births of live children (in thousands)	353.8`	351.1	356.1	364.4
per 1000 residents	9.3	9.2	9.3	9.5
Number of children per woman	1.249	1.222	1.227	1.242
Birth of live children to single mothers (in thousands)	51	55.5	61	67.2

Source: Central Statistical Office, Statistical Yearbook 2004

There is a tendency for women to decide to have a first child at an older age, which is a consequence of various socio-economic factors. In 2004, most women decided to have a child when they were 25-29 years old. Four years earlier they belonged to the same age group or were younger. Currently more and more mothers decide to give birth to their first child when they are even older, that is between 30-34.

- *Self-assessment of health state*

Self-assessment is used in social research monitoring the state of the population's health. The results obtained indicate that only a small percentage of people are fully satisfied with the state of their health. Less than 13% of Poles assessed their health as very good in 1996, and in 2004 about 11%.

In general, women assessed their health as worse than that of the men. Only one in nine women assessed it as very good, and one in five as bad or very bad. Among men, one in seven thought his health state was very good, and one in seven believed it to be bad. 'Good' and 'satisfying' health assessments predominated. The results of self-assessments were worse in case of people living in rural areas.

Sixty per cent of women in the 15 years or older age group assessed their health state as worse than good (rather poor, bad or very bad). In the case of men, that indicator was 49%.

Age is one of the most important factors influencing responses to questions about the state of health. In case of most people, life quality decreases with age, due to various ailments, chiefly physical. Among women in the 15-29 age group, 80% assessed their health state as good or very

good, while in case of those in age group of 60-75, there were only 6% assessmented as such. By the age of 35-39 every second woman is dissatisfied with her health and assesses it as less than good.

Health conditions are dependent on various factors. The biological process of ageing, linked to the age of a person, and congenital and genetic defects seem to be most important among them. Other factors that directly influence the state of health and its assessment include the level of education, and economic and family situations. Factors indirectly influencing health and its assessment include such factors as lifestyle, knowledge about health, prophylactic examinations, diet, and living and working conditions.

In general, those who are better educated, in a better economic situation, and who have professional work enjoy better health. A poor family financial situation increases the risk of a low health self-assessment among both women and men; the influence of poor economic conditions was stronger, however, among women.

Low health self-assessments can be justified by the frequency of various ailments and chronic diseases. Most adults in Poland suffer from chronic diseases. The only group among the interviewed population that did not suffer any such disease were in the over 15 age group (less than 38%). More than 62% of people indicated at least one out of the list of 27 diseases and chronic diseases. The amount of women suffering from chronic diseases was larger than men (68% and 55%, respectively) and gender differences were visible in every age group.

- *Health of the Polish population*

The health of the Polish population has been improving gradually since 1991. Life expectancy increased by 3.9 years for women (4.5 for men) in 1991-2004. In rural areas life expectancy for women is higher than for men, but the differences are insignificant.

As in previous years, diseases of the cardiovascular system, malignant tumours, and external causes such as injuries and intoxication are among main reasons for demise. In this respect, Poland is similar to other EU countries.

The results of the *Study of the Health of the Polish Population*, carried out by the Central Statistics Office in 2004 show that in Poland more women suffer chronic diseases than men and that is true in all age groups over 15 years old (in 2004, 57% and 44%, respectively). The share of people (mostly women) suffering chronic diseases and the number of such diseases increase as

the population gets older. Women more often than men report hypertension and coronary heart disease (without heart attack), spondylopathy or discopathy, migraine and headache, arthropaty, neuropathy and thyroid diseases. Men more often suffer chronic peptic and duodenal ulcer disease, coronary heart disease with heart attack, stroke and epilepsy.

The incidence of death caused by cardiovascular system diseases has decreased in recent years. This is especially true in regard to men and groups within the younger population. In 2002-2003, the rate of premature death under 65 years of age, caused by coronary heart disease (standardised indicator per 100000 persons) was 94.96 and 91.83, respectively. The rates for the EU-15 during the same period were 51.97 and 50.8, respectively (National Institute of Hygiene, Medical Statistic Unit, data source: HFA, WHO).

The number of hospitalised patients suffering cardiovascular system diseases in Poland is similar to other EU member states: 2915 patients per 100000 people in 2004 (the EU 15 average in the same year was 2424.48).

The implementation in 2003-2005 of the *'National Programme of Cardiovascular System Diseases Diagnostics and Treatment'* (POLKARD) proved to be very successful and its extension for the years 2006 – 2008 has been approved.

The death toll due to malignant tumours had not changed in recent years, and in case of some types of cancer, e.g. colonic carcinoma or pulmonary carcinoma in women, has even increased. Malignant tumours are the main cause of death in women. The rate of premature death, under 65, per 100000 people due to malignant tumours in Poland was 104.6 and 102.65 in 2002-2003, respectively (standardised indicator). The EU average for the same period 15 was 79.87 and 78.97 respectively (National Institute of Hygiene, Medical Statistic Unit, data source: HFA, WHO).

The highest number of illnesses and death are due to breast cancer - 11750 (20%) of new cases in 2004 and 4950 deaths (12.9%). Next are colonic carcinoma – cases affected: 5700 (9.6%), deaths: 3900 (10.1%); and pulmonary carcinoma - 7781 (8.1%) occurrences and 4700 (12,2%) deaths. At fourth and fifth place in the ranking are endometrial carcinoma and cervical carcinoma. In connection with this, in 2005 A long-term *National Programme to Combat Cancer* was introduced in 2005 to counter this disease, which will run till 2015.

The rate of death caused by external causes seems to be falling. Among the reasons for deaths in this group, death in road traffic accidents (RTAs) predominate. The 2002 – 2003 standardised rate of premature death in accidents, in persons under 65 years of age per 100000 persons, was 54.06 and 53.19 respectively. This includes respectively 13.42 and 13.03, deaths from RTAs. In the EU-15 the average was 33.12 and 33.57, with 10.4 and 9.8 f these being RTAs (National Institute of Hygiene, Medical Statistic Unit, data source: HFA, WHO).

- *Use of health services*

The use of health services, including hospitalisation, medical advice in primary medical care institutions and specialist advice is closely connected to the health condition of the population.

In 2003 almost 21 million Poles (56% of total population) used at least one kind of health service. There were more women, 12.5 mln (63%) than men, 9.1 million (48%); more residents of urban areas, 13.5 million (59%) than rural areas, 7.5 million (52%), among those who did so. In 1996 the share of people who used at least one kind of health services was similar, 57%. In 2003 47% of women (and 36% of men) used the services of primary health care (first contact or the family doctor); the services of specialists were used by 24% of women (17% of men), dentists - 18% women (13% men), and 8.7% of women (6.7% of men) were hospitalised or used other form of closed health care institution.

In all age groups, women use primary medical care services more often than men, except in the oldest group (75 or more), where the share (62%) is the same for both sexes. A total of 12,414,000 services (11,660,000 in 2003) were used in outpatient specialist, gynaecological and obstetrics clinics Of these, 909.9 were from primary medical care doctors. There are total of 582 gynaecological and maternity wards in hospitals (not including Ministry of Defence and Ministry of Internal Affairs and Administration hospitals), for 20293 patients. This includes beds for 1654 patients in University clinics, and 83 places for girls under 18.

- *Use of social welfare*

A total of 93.9 thousand persons stayed in all kinds of social welfare institutions: 50.3% of these were women, and 4.2% children under 18. In 2004, out of 1154 permanent social welfare institutions 64 (5.2%) were social welfare homes for mothers with children under 18, or for pregnant women.

- *Accessibility of health care*

The health service act ensures finance from public resources and this important legal provision has improved the accessibility of health care services.
Furthermore, on Poland's accession to the EU, under the provisions on coordination of social welfare systems, defined in Council of Europe Directives No 1408/71 (EEC) and 574/72 (EEC) and Council of Europe Directive No 859/2003 (EEC), social welfare benefits for Polish citizens who are insured and who remain in EU or EFTA territory are financed or reimbursed by the National Health Fund (according to certain conditions).

Specific health policies for women

Currently there is no separate office with responsibility for women's affairs in Poland. In 2001 the *Government Plenipotentiary for the Equal Status of Women and Men* was established. In June 2002 the Plenipotentiary's scope of duties was extended to counteract discrimination on the grounds of age, social and ethnic origin, political views and social orientation. In November 2005, the new government liquidated the position of the Government Plenipotentiary for Equal Status of Women and Men and the Secretariat. In December 2005 a new Department for Women, Family and Counteracting Discrimination was established at the Ministry of Labour and Social Policy, charged with coordinating activities connected to the status of women and families in society. It is also tasked with counteracting discrimination.

The Ministry of Health is responsible for the organisation of the health protection system, as well as for the creation and realisation of health policy. The Ministry also supervises the activity of National Heath Fund. A substantial number of governmental institutions are also very much involved in policies and activities relevant to the field, such as: Krajowe Centrum ds. AIDS (www.aids.gov.pl), Krajowe Biuro ds. Przeciwdziałania Narkomanii, (www.narkomania.gov.pl), Ośrodek Diagnostyczno – Badawczy Chorób Przenoszonych Drogą Płciową (www.std.bialystok.pl), Państwowa Agencja Rozwiązywania Problemów Alkoholowych (www.parpa.pl).

Numerous health, women and youth-oriented non-governmental organisations are very active in the area of women's health, sexual and reproductive health and family planning. The main NGOs working in the area are: Federacja na Rzecz Kobiet i Planowania Rodziny, Centrum Praw Kobiet, Towarzystwo Rozwoju Rodziny, Polskie Towarzystwo Oświaty Zdrowotnej, Polskie Towarzystwo Higieniczne, Stowarzyszenie 'Pomocna dłoń', Demokratyczna Unia Kobiet.

Women's health problems are also part of gender equality issues. Currently in Poland there are many separate institutions and structures addressing gender equality issues, including women's

health. These are, among others: Stowarzyszenie Współpracy Kobiet NEWW Polska, Ośrodek Informacji Środowiska Kobiecych OŚKa, Zieloni 2004, Fundacja Partners Polska, Koalicja KARAT (KARAT Coalition).

Gender-sensitive health policy design

The Constitution of the Republic of Poland guarantees health under Art. 68 par. 2 and ensures all citizens of both sexes, irrespectively of their financial situation, equal access to health services financed from the public funds. This includes access to specialist care for children, pregnant women, people with disabilities, and older people. Pregnant women are entitled to health care free of charge, even if they are not insured, and this covers the full scope of health services, not only those connected with their pregnancy (e.g. dental care). The cost of such services is covered under the state budget. In addition, the Act guarantees children and young people under 18, and women during pregnancy and puerperium, the right to additional health services in regard to dental care and the materials used for this purpose.

Women's health is an object of particular concern and protection by all state public institutions. A substantial number of legal procedures and specific policies have been designed to address women's health issues. Examples are seen in the legislative acts providing a special protection of women's rights and health.

According to the Act of 7 January 1993 on family planning, protection of the human embryo and the conditions governing the permissibility of abortion, the government and self-governing bodies are obliged, within their scope of responsibilities defined in special regulations, to provide all pregnant women with health, welfare and legal services, in particular through:

1. providing a pregnant woman with prenatal care and medical care,
2. providing a pregnant woman with welfare care, if she is in a difficult material situation, during pregnancy, childbirth and puerperium,
3. providing pregnant women access to detailed information about the rights, benefits and services to which the woman, or parents and their children are entitled, and to information about institutions and organisations providing psychological and social support and dealing with adoption issues.

During the years 1996-2005, the National Health Programme was implemented in Poland. The purpose of the Programme was to improve health condition of the society and was addressed to all, children and youth, women and men. However, some of the operational targets focused primarily on men. These were:

- reducing the widespread habit of tobacco smoking,
- reducing and changing of structure of alcohol drinking and reducing the damage to health caused by alcohol drinking,
- reducing the number of accidents, especially road accidents,
- improving the early diagnostics and active care over people from the ischeamic heart disease risk group.

Additionally, within the framework of the Programme to Combat Cancer launched in 2005, one of the important aims are screening, diagnostics and treatment of prostatic carcinoma in men.

Three primary issues and how they apply to women

- *Cancer*

Malignant breast cancer is the main cause of female deaths from tumours in Poland. More than 4000 women die of it annually and their number is gradually growing: in 1991, 4198 women died, and in 2003 4942. The total female death rate from breast cancer increased from 21.4 in 1991 to 25.1 in 2003 (per 100000 women). The rate of registered women dying from breast cancer increases with the age of the woman: it is 8 per 100000 women of the age group 30-44 years, and 105 per 100000 in the group of women over 75 (2003). The occurrence of deaths from breast cancer varies in the different parts of Poland and when analysed by age group (every 15 years), is seen to be higher in urban areas than in rural ones. Large variations are observed in the oldest women's groups – here the death rate of women in urban areas is almost twice that of those living in rural areas. Changes have been observed that indicate that the prognosis is more positive for women living in urban areas than in rural areas: the death rate from breast cancer decreases in all age groups among women living in towns, while among women living in rural areas it increases in the age group of over 60, though it remains at the same level for women 45-59 years old.

Many women in Poland die from cervical carcinoma: in 1990 there were 2070 cases and in 2003 1825. Deaths from cervical carcinoma in Poland feature as one of the highest in Europe and although it is dropping, the decrease is at a slower pace than in most other countries. The standardised death rate of women in Poland in the years 1990-2002 dropped from 10.4 to 8.4, while it dropped from 3.5 to 2.4 during the same time in other EU countries (5)(based on data from European Health for all database, WHO Regional Office for Europe, Copenhagen, Denmark).

- *Sexually transmitted infections*

In Poland, the risk of sexually transmitted infections is growing, as a result of the increased risk behaviour of children and young people, earlier and earlier sexual initiation and spreading prostitution. This is also true among people coming from countries where the rate of venereal diseases and HIV/AIDS infections is high. Furthermore, the number of diagnostic examinations and screenings are dropping, so that the number of registered cases may not reflect the real epidemiological situation. Because many sexually transmitted infections, including Chlamydia infections, are asymptomatic and diagnoses of these diseases are complicated, the real number of those infected is unknown.

The number of registered cases of venereal diseases dropped more than six times in the years 1990-2003, from over 10000 to 1600. The incidence of venereal disease also dropped, from 12.0 to 2.4 per 100000 women (42.7 to 6.3 for men).

In the early 1990s, the highest incidence of venereal disease was among women in the 20-24 year age group (ca. 50 per 100000 women) and in the age groups 15-19 years and 25-29 years (over 30 per 100000 women). From the mid-1990s the structure of incidence within age groups has changed and now the predominant rates are in the groups of 20-24 and 25-29, with 6-7 cases per 100000 women. A cause for concern is the incidence of syphilis among girls in the age group of 15-19, which hasn't changed for several years and is higher than among young men.

- *HIV infections, incidence and number of deaths resulting from AIDS*

It is estimated that in Poland there are some 20,000-30,000 persons infected with HIV. From the discovery of the first HIV infection in 1985 to 31 March 2006, 10,034 Polish citizens were discovered to have the virus. Out of this total, 1,757 contracted AIDS, and 822 subsequently died.

Over 1 million anti-HIV screenings are carried out in Poland each year, out of which some 90% are obligatory tests for blood donors. The greatest incidence of HIV occurs among those who take drugs by injection. Drug addicts account for at least 50% of all persons infected with HIV. The remainder are homosexuals and bisexuals, persons maintaining hazardous heterosexual relationships, and blood donors. A relatively high incidence of HIV is noted among female prostitutes – 10 out of 1,000 screenings in 2003, and – since the middle of the 1990s – among the children of mothers infected with HIV: 15 out of 1,000 screenings in 2003. For over 25% of those infected with HIV, there is no information on the probable method of transmission. Most of the persons diagnosed with AIDS are men (81% of all cases in 1986-2004). At the time of detection, women are usually younger than men; the disease is usually detected among women aged 20-29

(as opposed to 30-39 in the case of men). Almost all (92%) of the cases are urban dwellers (4) according to figures from the National Institute of Hygiene, www:pzh.gov.pl/epimed

In the 1990s, the annual number of new cases of AIDS in Poland was relatively constant, but is nevertheless growing. Thus, in 2000, 93 cases of AIDS were discovered among men, and 28 among women, whilst in 2004 there were 12 new cases among men and 37 among women. The incidence figures give a similar picture.

Women have equal access to anti-retrovirus (ARV) treatment. During pregnancy, all women receive ARV drugs, and since 2006 they can take advantage of free HIV screenings. On account of social and biological factors, women are particularly at risk of contracting HIV, which is why some preventive action, e.g. multimedia campaigns, are devoted to women. This year, women were targeted in a multimedia informative-education campaign called 'Women and HIV,' organised by the UNDP.

- *Reproductive health*

Female mortality connected with reproduction

In Poland there is a clear decrease in the number of deaths of mothers for reasons connected with reproduction (pregnancy, childbirth and puerperium). In the period 1990 – 2003, the absolute number of maternal death for obstetrical reasons fell by more than a factor of three: from 52 deaths in 1990 to 14 in 2003. During this period, the greatest number of deaths occurred among mothers aged 30 and over, and was higher than the total number of deaths for women in childbirth. On the other hand, there were fewer deaths for women in childbirth among mothers with the greatest reproductive activity, i.e. aged 20-29. The most usual cause of death among mothers are haemorrhage, infections, extra-uterine pregnancy, embolism and hypertension.

The reduction of mortality in childbirth may be proof of improvements in medical care during pregnancy and childbirth, of increased health awareness among women themselves, and of the generally good social and economic status of women. Other factors connected with the mortally of women for the above reasons is age (child-bearing women over 35 are at greater risk), the number of pregnancies (greater risk from the fourth child onwards), and short intervals periods between births.

- *Access to methods and resources encouraging conscious procreation*

An Act on family planning, protection of the human embryo and the conditions governing the permissibility of abortion is in force in Poland. Pursuant to this act, abortions are legal in only three cases:

1. when the pregnancy puts the woman's life and health at risk,
2. when pre-natal tests and other medical circumstances have revealed a major likelihood that the embryo may be irreversibility injured or its life jeopardised
3. where there is reasonable suspicion that the pregnancy was the result of a crime.

In 2004, 193 abortions were noted (174 in 2003). Of this number, 62 were dictated by risks to the life and health of the mother (59 in 2003), 128 were dictated by medical considerations regarding the embryo (1,122 in 2003), and 3 were dictated by the fact that the pregnancy was the result of a crime (3 in 2003).

Pursuant to the above mentioned Act, government administration and terrestrial self-management bodies *(?statutory services?)* are obliged, within the scope of their responsibilities, to ensure that citizens have free access to reproductive measures and resources.

At present, infertility is treated under contracts agreed between the National Health Fund and health establishments. Services for patients are financed by the Fund. Unfortunately, in vitro treatment is not covered by the Fund.

The most modern medical contraceptive resources are now registered in Poland. They are generally available if paid for in full. However, the National Health Fund *Partly-refundable Drugs List* contains drugs that are used to treat hormonal disorders and which are also contraceptive substances. One drug (Diane 35), which is registered as a dermatological drug with additional contraceptive action is 50% refundable.

In 2004 the Act was amended, whereby the age of pregnant women subject to preventive checkups was lowered. The National Health Fund has concluded contracts providing benefits under prevention and health promotion programmes, including prenatal tests. Tests are to be provided for women aged over 35 (until now, the age threshold was 40).

Non-invasive and invasive pre-natal tests are provided by health care establishments and private and group medical practices. Non-invasive pre-natal tests (e.g. ultrasound scans) are now a standard feature of medical care for pregnant women. Invasive tests (amniopunction and cardocenthesis) are performed on instructions from a gynaecologist if there is a suspected genetic disorder or fault with the development of the embryo, or if the embryo has an untreatable disease

that may endanger its life. However, the number of such tests is still unsatisfactory. In 2004, 3,420 prenatal invasive tests were performed (192 more than in 2003), as a result of which 242 embryonic disorders were noted, and 18,163 genetic consultations were provided.

In 2003 there was a case in which a doctor refused to perform a pre-natal test despite the presence of indications for performing it.

Help for pregnant schoolgirls

Pregnant schoolgirls have a particular right to receive help to continue to complete their schooling. Under the regulations in force in Poland, schools are obliged to grant leave to pregnant schoolgirls and other assistance necessary for them to complete their education, reducing as far as possible any delays in progress with their schooling. Leave is granted at their request.

The Ministry of Education maintains no statistics on pregnant schoolgirls and cannot divulge such statistics. Nevertheless, according to figures from the Central Statistical Office, in 2003, 45 children were born to mothers aged 14 and less (6 less than in 2002), and 22,570 were born to mothers aged 15-19 (1,828 les than in 2002).

Specific healthcare policies for young girls

There are no healthcare policies designed particularly for young girls. Healthcare services for young girls are provided mostly by pediatricians (up to the age of 18) and by GPs. In cases of specialised care needs young girls are referred to relevant specialist within the health insurance system.

There is no information on treatment for girls up to the age of 18, as part of standard treatment by GPs. Doctors in public health centres provide vaccinations against German measles for girls aged up to 14. In 2004, 98.4 % of these girls received this vaccination (97.8% in 2000).

As with all children, girls are under the care of their GP.

In 2004 there were 9.051 girls aged up to 18 in the maternity wards of hospitals (out of a total of 1,022,070 patients).

In 2002, there were 2 cases of girls aged 0-19 suffering from breast cancer, and 22 cases of girls suffering from a tumour in the genital organs. A total of 487 tumours were discovered among girls aged up to 19.

In regard to venereal disease, 27 new cases were discovered among girls aged 15-19 in 2004. Of these, 20 cases were syphilis, including 18 cases of early syphilis and 7 cases of gonorrhoea, representing 1.8 cases per 100,000 people (compared to 2.4 in 2004).

- *Teenaged pregnancies*

The prevention of teenaged pregnancies is a vital social task. Both social and medical considerations call for efforts in that direction. Young people are not prepared for the parenting role. A teenaged pregnancy involves more risks than that of older females. The fact that the majority of teenaged girls can become pregnant does not mean their bodies have sufficiently developed for pregnancy and childbirth to proceed properly.

Pregnancy greatly increases the nutritional requirements of a girl's still developing system. Nutritional deficiencies adversely affect both her developing system and that of the foetus, and delayed foetal development is most common amongst teenaged girls. (33% of the time in girls giving birth before the age of 16, 20.3% between the ages of 17 and 18 and 12.6% in girls who have celebrated their 18th birthday). The most common problems connected with teenaged pregnancy are toxaemia, protruding placenta, pelvic positioning of the foetus and urinary tract infections.

The experience of many countries has shown that teenaged girls rarely avail of good medical care during pregnancy in comparison with older women. That is especially disadvantageous in view of those pregnancies' higher risk factor.

An example of 'best practice' in women's health

Many health programmes and campaigns have been carried out under the National Health Programme for 1996-2005. Examples include:

- the *Initial Neural Tube Defect Prevention Programme* — The practice of supplying folic acid to women of reproductive age became widespread in order to prevent congenital defects of the neural tube in infants;
- As part of the HIV/AIDS prevention programme in schools educational leaflets have been developed and distributed. Anonymous free testing for HIV/AIDS infection has been carried out in combination with pre- and post-testing counselling;
- The State Agency to Resolve Alcohol-Related Problems has dealt with foetal damage caused by alcohol use by pregnant women and taken steps to preventing alcohol consumption by pregnant women; a brochure on Foetal Alcohol Syndrome has been published;

- The ‘Pink Ribbon’ breast-cancer-prevention programme has also been conducted in post-junior-secondary schools.
- Optimum pregnancy care is a programme to prevent premature births and underweight infants by promoting healthy behaviour;
- Elimination of sexually transmitted infections — the introduction of diagnostic and therapeutic methods to deal with infections caused by type B streptococcus bacteria in women and their children.

Additionally, many programmes aimed at detecting tumours were carried out:

- A screening programme aimed at early diagnosis of breast cancer (mammogram testing for women aged 50-59) was carried out;
- A programme for the early detection of cervical cancer (cytological tests for women aged 30-59) was conducted;
- Taxoids in the treatment of cancer of the ovaries (financial resources at the health minister’s disposal were earmarked for the purchase of taxoid-type medications used in chemotherapy);
- A programme to care for families with a history of malignant tumours — early detection and prevention of malignant tumours in families with a high genetically conditioned risk of contracting breast, ovary, colon and uterine membrane cancer.
- The *National Programme to Combat Tumours* was established on the basis of a law passed in 2005

Further gender influences on patterns of health

Gender actually has no influence on health patterns in Poland. Instead, a kind of positive discrimination towards women can be observed. Some National Health Programmes have focused on women’s health by including breast and cervical cancer screening programmes.

To summarise, the following gender-related characteristics of Polish society may be distinguished:

- *Use of medical services*

Gender is one of the basic factors differentiating people’s approach to the use of medical services. Amongst the young, middle-aged and elderly, men avail themselves of medical services less often than women. Only amongst children are there more male than female patients.

A higher incidence of TB is noted amongst men (5,873 in 2004) than women (2,818 in 2004). The number of new TB cases has been falling each year (8,791 in 2004 compared with 10,960 in 2000). At the same time, the number of people registered in mental-health clinics has increased (from 82,645 in 2000 to 127,533 in 2004).

- *Gender differences in health-related behaviour*

In the 1990s, two lifestyle-related behavioural irregularities capable of affecting people's state of health emerged. Lifestyle factors included: a low level of physical activity, obesity, tobacco smoking, the use of psycho-active substances and excessive alcohol consumption.

In general, men are more active physically than women. More men go in for intensive physical work-outs and sports as well as other activities requiring physical exertion. But in middle age (30-59), it is men who spend more time watching television than women who go for walks or ride bicycles.

Cigarette smoking is, or was, the addiction of most Polish males. Most male smokers are strongly addicted, smoking 20 or more cigarettes a day.

Men consume alcohol decidedly more often than women. The largest share of drinkers is found amongst men between the ages of 30 and 39. Younger women drink more often than older ones, and town-dwelling women are more likely to drink than those living in rural areas.

Neurological disorders have been systematically on the rise, including those related to stress, and their incidence is higher amongst women than men.

- *Life expectancy and mortality*

The life expectancy for men is relatively short, and is eight years shorter than for women. The principal causes of death have been circulatory disease and external factors.

Male mortality due to circulatory disorders is 3.5 times higher than that of women in middle age and more than twice as high for people past retirement age.
Increased mortality due to malignant tumours has been noted both amongst men and women. Tumours pose a greater death threat to males than females, particularly as regards bronchial and lung tumours. The latter are among the causes of death related to smoking.

Men and town-dwellers have a higher death rate due to cirrhosis of the liver which is linked to alcohol consumption.

Main reference documents:

1. Badanie GUS „Stan zdrowia ludności Polski' przeprowadzone w 1996 r.

2. Badanie GUS „Stan zdrowia ludności Polski' przeprowadzone w 2004 r.
3. Badanie GUS „Ochrona zdrowia w gospodarstwach domowych' w 2003 r.
4. Sprawozdanie Rady Ministrów z wykonania w roku 2003 ustawy o planowaniu rodziny, ochronie płodu ludzkiego i warunkach dopuszczalności przerywania ciąży oraz skutkach jej stosowania.
5. Sprawozdanie Rady Ministrów z wykonania w roku 2004 ustawy o planowaniu rodziny, ochronie płodu ludzkiego i warunkach dopuszczalności przerywania ciąży oraz skutkach jej stosowania.
6. Governmental documents of Ministry of Heath, Ministry of Labour and Social Policy and Chancellery of the Prime Minister prepared for Council of Ministers
7. Duży Rocznik Statystyczny 2004, GUS
8. Podstawowe dane z zakresu ochrony zdrowia.' GUS 2004
9. www.nfz.gov.pl
10. www.mz.gov.pl
11. www.federa.org.pl/
12. WWW.stat.gov.pl
13. Podstawowe informacje o rozwoju demograficznym Polski do 2004 roku
14. Romuald Dębski, Ciąża i poród u młodocianych, Wychowanie seksualne i Planowanie Rodziny w Polsce, TRR,1997
15. Finansowanie ochrony zdrowia w Polsce. Zielona księgą' Ministerstwo Zdrowia