

cancer, so the additional risk in well-screened users is more like 2 per 10 000. By contrast, the increased lifetime risk from 10 years of use for a woman from sub-Saharan Africa with seven children, for example, would be substantial—perhaps 40 per 10 000. From a public-health perspective, one should also consider the effect of parity on cervical cancer.¹² If combined oral contraceptives were used to reduce parity (as opposed to being used as an alternative to other forms of contraception or to control the timing of pregnancies) then the protection from reduced parity could easily outweigh the risk from the hormones per se.

This thorough meta-analysis³ of the association between hormonal contraceptives and cervical cancer should both lead scientists to a better understanding of the cofactors affecting HPV infection and cervical neoplasia, and reassure women that fear of cervical cancer should not be a reason to avoid use of oral contraception.

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I am the co-chief investigator for the POET trial; Bayer-Schering provide free drugs for that trial. Cancer Research UK funds my research.

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A clarion call for greater investment in global sanitation

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There were 236 896 cholera cases with 6311 deaths notified from 52 countries to WHO in 2006.¹ This represents a 79% increase in cases compared with 2005; a level last seen in the 1990s. These sobering statistics expose a global tragedy, because the occurrence of cholera is a sensitive indicator of inequity.² Communities which depend on a water supply that is potentially contaminated with human faeces remain very vulnerable to this faeco-orally transmitted infectious disease.

Vibrio cholerae is only one of many infectious agents that thrive in contaminated water supplies, and which are a source of misery, driving poverty in many communities in developing countries. Diarrhoeal disease continues to be a leading cause of death in these countries, particularly affecting children in the first 5 years of life.³ The hindrance on global development

resulting from inadequate sanitation is recognised in the Millennium Development Goals (MDGs), and an aspirational target to halve the proportion of people without access to basic sanitation by 2015 has been established. Accomplishment of this target would profoundly reduce the risk of cholera and other epidemic-prone diarrhoeal diseases. Although global sanitation coverage increased from 49% to 59% between 1990 and 2004, on the basis of current performance the shortfall will be almost 600 million people by the target date in 2015.⁴

The vigour with which other MDGs have been approached has not yet been mirrored in tackling the sanitation shortfall. Indeed, in sub-Saharan Africa the number of people with unsafe sanitation is increasing.⁴ There seems to be political reluctance to invest in the safe disposal of human faeces, with this function

often delegated to the lowest level of governance (ie, struggling municipalities). Surprisingly, a meagre evidence base supports the health benefits of improved sanitation in populations.⁵ Rigorous science is a valuable method for persuasive advocacy.

Against this backdrop, Mauricio Barreto and colleagues' study, in today's *Lancet*, of the effect of a large-scale urban sanitation programme in north east Brazil provides remarkable supportive evidence for increasing access to this basic health right.⁶ This study bolsters the public-health evidence for a neglected intervention, transcending the gulf between small-scale efficacy or limited observational studies and population-level evidence. The authors report the results of two large population-based observational studies on occurrence of diarrhoea with or without a sanitation intervention.

Although the design was not randomised, and the challenging research environment introduced some imprecision so that the possibility of confounding cannot be absolutely excluded, these points do not detract from the convincing finding that the sanitation intervention reduced longitudinal diarrhoeal prevalence in children younger than 3 years by a noteworthy 22% (95% CI 19–26).

An estimated 1.6 billion people will need access to improved sanitation over the period 2005–15 to meet the MDG target, and the UN General Assembly⁷ has declared 2008 an International Year of Sanitation. The obvious benefits to poor people of increased provision of sewerage facilities should serve as the mandate for greater investment by all levels of government and civil society in tackling one of the greatest scourges to communities in developing countries—infected diarrhoea due to poor sanitation.

The printed journal includes an image merely for illustration

Rio das Pedras slum, Rio de Janeiro, Brazil, 2007
River used as open sewer.

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I declare that I have no conflict of interest.

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Reduction of maternal depression: much remains to be done

In today's *Lancet*, Graciela Rojas and colleagues report a randomised trial in primary care for the reduction of maternal depression in low-income women in Santiago, Chile.¹ The intervention tested had several components: training of primary-care physicians in the management of depression followed by weekly psychiatric supervision lasting an hour; psychoeducational groups for mothers; pharmacotherapy if needed; and support from trained non-medical staff to boost adherence. 230 women

participated in the trial, 114 of those were allocated to the multi component intervention. At 3 months the mean difference in depression scores favoured women in the intervention group, but the difference was much reduced by 6 months.

This trial comes 20 years after the 1987 publication of Cox and colleagues' seminal paper on the development of the Edinburgh Postnatal Depression Scale (EPDS).² The EPDS revolutionised the study of maternal

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