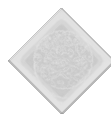


*Chapter 2*  
*Descriptive analysis of the female*  
*population on Curaçao*





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## Background

Women play an important (leading) role in the family on Curaçao culture (Ministerie BZK and UNA, 2010). In this chapter we provide information about the female population on Curaçao to try to better understand their attitude towards preventive strategies and participation in health trials in order to provide meaningful recommendations. Furthermore, a comparison is made between cervical cancer incidence on Curaçao and the response to participate with screening on Curaçao and in the Dutch Caribbean population living in the Netherlands.

## Social Demography

According to the last census (2011), the registered population of Curaçao was 150,563 inhabitants. Of the total population 81,584 (54.1%) were female. Life expectancy at birth for women was 80.4 vs. 74.2 years for men in 2011, and the main age for the first childbirth generally was 25.1. The Total Fertility Rate in 2011, was 2.1 with a mean interval between first and second child of 3.5 years. The report of the census shows an increase in the proportion of births in women who are not living together with a partner (24% in 2011) or who don't have a partner between 2001 and 2011 (18% in 2011). (ter Bals, 2011)

In today's society women tend to have a career next to their role as a housewife and mother. Most women are also in charge of the care for senior family members (Ministerie BZK and UNA, 2010). The Curaçao Bureau of Statistics also reported an increase in the percentage of women (40%) who are raising a child without a partner (ter Bals, 2011).

## 2. *Descriptive analysis of the female population on Curaçao*



*The woman on Curaçao with a view on social demography, in correlation  
with physical health information and social behavioural information*

### **2.1 Physical health information of the female population on Curaçao**

#### *2.1.1 Introduction*

Worldwide there has been a notable increase in prevalence of non-communicable diseases (NCD) among the populations, such as hypertension, diabetes mellitus, dyslipidaemias and subsequent conditions (Mendis et al., 2014).

The results of the National Health Survey (NGE) 2013 on Curaçao show that 67.3% of the women on Curaçao are overweight (Verstraeten et al., 2013). According to this study, the number of people who reported that they are known with hypertension and diabetes is higher in the female population (30.5% and 9.2%) than in the male population (21.6% and 8.7%).

A recent population study about eating habits, concluded that 24.5% of the teenagers are overweight. In spite of awareness campaigns and programmes at some schools about the importance and benefits of a healthy diet their eating habits remain unhealthy. (Dijkstra, 2015).

Obesity is an important risk factor for developing cardiovascular disease (Mendis et al., 2014) and some forms of cancer. Additionally, an obese person with one or more of the comorbidities mentioned above is at higher risk to develop complications if diagnosed in a stage of cancer that requires interventions and also at risk for lower survival. Therefore, we used the opportunity presented by the HPV trial conducted in 2015, (described in chapter 4), to collect additional data on NCD, medication use and specific habits among our research population.

### *2.1.2 Method*

The data were collected from a random selection of women (N=1,075), who participated in the HPV trial held on Curaçao in the period March-June 2015. Data were collected by two registered nurses, based on questions on a medical history form. General health data collected were: known NCD, -allergies; habits such as smoking, illicit drug and alcohol consumption; use of medication; history of trauma, -surgery, sexual transmitted disease; gynaecological history and sexual habits. A physician discussed the medical history with the participants. The dataset is representative for a studied population with equal distribution in 4 age groups between 25-65 years of age. IBM, SPSS statistics version 22 was used to analyse the data. Frequencies, chi-squares and the corresponding significance of the most commonly reported NCDs were calculated.

All participants signed an informed consent and this study was authorised by the ethical committee of Fundashon Prevencion.

### 2.1.3 Results

The number of women who reported a form of NCD was 420 (39.2%) out of 1,075 participants, which is high. (Table 2.1) The most common reported diseases were: arterial hypertension (AHT) (21.2%), diabetes mellitus (DM) (7.6%), followed by dyslipidaemia (7.3) (Table 2.1) and 36.9% of the population reported the use of medication (Table 2.1). There is a significant correlation between NCDs and the use of medications. The data in table 2.1 and 2.2 show an increase in prevalence with increasing age<sup>3</sup>.

### 2.1.4 Remarks

The National Health Survey [Nationale Gezondheidsenquête (NGE)] report published in 2013, refers to AHT (30.5%) and DM (9.7%) as the most prevalent NCDs noticed among the female population on Curaçao. Unlike the NGE, our AHT results (21.2%) was similar to the AHT of 21.6% reported in the male population who participated with the NGE and lower than the female group (30.5%). (Verstraeten, © december 2013 VIC). A possible explanation could be the difference in the sample size in each age groups which is not specifically reported in the NGE report. If the sample size of the older age groups is larger, it can influence the outcome numbers.

Although obesity is an important risk factor for serious, potentially life-threatening diseases a psychological study performed among the female population on Curaçao found that it's believed that "being fat is fine" (Dijkstra, 2015). Further research into the underlying beliefs is recommended to address this issue through specific approaches for the achievement of effective health education.

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<sup>3</sup> Source: D.J.Hooi

**Table 2.1**  
**Use of medication and count of participants with any NCD during the HPV trial followed by**  
**the four most commonly reported NCDs during the trial.**

	Total population		Age groups								$\chi^2$	df	P-value
	N=1075		25-34	35-44	45-54	55-65							
	n	%	n	%	n	%	n	%	n	%			
<b>Rx</b>	396	36.9%	32	3.0%	77	7.2%	104	9.7%	183	17.1%	147.30	3	0.00
<b>NCD</b>	420	39.2%	38	3.5%	87	8.1%	110	10.3%	185	17.3%	131.44	3	0.00
<b>DM</b>	81	7.6%	4	0.4%	11	1.0%	21	2.0%	45	4.2%	41.19	3	0.00
<b>AHT</b>	227	21.2%	6	0.6%	40	3.7%	63	5.9%	118	11.0%	120.8	3	0.00
<b>Dyslipidaemia</b>	78	7.3%	3	0.3%	7	0.7%	13	1.2%	55	5.1%	76.59	3	0.00

Source: D.J. Hooi. Statistical analysis: O. van Brummen-Girigori, A. Girigori. Rx=Medication use, NCD= Non-communicable disease, DM= Diabetes Mellitus, AHT= Arterial Hypertension



## 2.2 Some aspects about social behaviour during our study

During this study, some non-medical factors with implications in healthcare were remarkable. The most notable repeated factors are described here.

### 2.2.1 *Participation in healthcare programmes*

The reason for not responding to an invitation to participate in a Public Health Prevention Programme may be related to many non-medical factors that can be attributed to cultural, social influences (Social) or personal behavioural influences. Financial and logistical factors like lack of money for transportation i.e., or a non-efficient public transportation can lead to low participation rate. Same as behavioural factors like fear, lack of trust or communication problems.

### 2.2.2 *Communication*

Proper communication is crucial in healthcare. The capacity to transmit the message in such a way that the target group is able to interpret the exact relevance of the message is essential. It's generally assumed that the population of Curaçao doesn't really like to read. Suggesting that provision of reading material to inform the population is not the best option when implementing healthcare strategies. During our research project different ways were used to provide information namely videos, pictures and written documents such as booklets, folders and articles on social media. We noticed that booklets, folders or newspaper articles, did not capture much attention. Even the invitation letters containing relevant information were not fully read and instructions were not followed. We found that the impact of a short text written in the form of a fiction story in the local language Papiamentu was the best. It described a medical case of HPV infection among teenagers. The message was expressed in terms commonly used by local people and

specifically used a street-smart (slang) vocabulary. It was presented as if someone was sharing a personal experience on social media, illustrating some impressive photographs of HPV lesions on the penis, anus and lip and there was also a cartoon-photo picturing two people having sexual intercourse. The story was posted in 2014 and is still being shared and commented upon today.<sup>4</sup> It reached more than 100,000 people and was massively distributed through the social media page. An advice is to do research on the way in which reading is attractive to the local population on Curaçao and how people perceive and interpret the information. This was not analysed during this research project. It makes no sense that a lot of money was invested into information and population education, and that it does not help, if the way in which the information is provided does not reach the population.

### *2.2.3 Papiamentu during medical consultation to improve expression and to establish more trust*

The participants preferred a local physician speaking and fully understanding the native language, making them more comfortable to express themselves “about these topics”.

### *2.2.4 Participation and awareness*

At the start of the project in 2013, the general awareness on topics related to cervical cancer and HPV, screening and Pap smears among women on Curaçao was low. The inability to distinguish the Pap smear from other gynaecological tests, like cultures for STD in which the health practitioner follows the same procedure for sample collection, was remarkable. Table 2.2 shows an overview of the interpretations of participants to their screening history compared to the data from Palga. It is notable that 164 (15.7%) women

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<sup>4</sup> [www.facebook.com/Fundashon Prevenshon/Dialogo døkter-pashènt](http://www.facebook.com/FundashonPrevenshon/Dialogo%20dokter-pashent).

indicated that they never had a Pap smear done. In fact, this number was actually higher, namely 231 (22.2%). Table 2.2 illustrates the answer according to participants in the HPV study in 1075 women, compared with reported data in PALGA.

**Table 2.2**  
**Time interval of last Pap smear**

<b>Previous Pap smear</b>	<b>According to participant</b>		<b>According to PALGA</b>	
<3yr	486	46.6%	317	30.4%
3-5yr	140	13.4%	174	16.7%
>5yr	251	24.1%	319	30.6%
never	164	15.7%	231	22.2%
No response	1	0.1%	1	0.1%

*Source: D.J. Hooi*

A part of the project consisted of the use of a self-test device in non-responders to the screening. Unfortunately, the overall response rate was very low, and participants did not show a high interest for the self-test device: from 105 HPV positive women who participated in try-out trial (N = 253)<sup>5</sup> in 2013, only 40 women participated for follow-up with a self-test device after two years. Nine women turned out positive for HPV.

Additionally, during part of our study in 2015 a random group (N = 400) was selected out of the non-responders to participate in a self-test study. The sample population was divided into 2 groups with equal age distribution in both groups. For 200 women, the self-test was sent to their home by mail. The other 200 women received an invitation to pick up a self-test device. A total of 44 women out of 400 women responded, of whom 6 were HPV positive.

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<sup>5</sup> Source: D.J. Hooi

We assume that perhaps a different approach in raising awareness in the population would have delivered a different result in the response.

### 2.2.5 *Sexual behaviour in the local population*

When referring to a virus that is sexually transmissible and capable to cause cancer in *men* and *women*, sexual behaviour should not only be studied from a medical perspective but also from a social and psychological perspective. Different sexual habits exist which can vary per culture and may be different for each population. In general, a high number of participants in the research project mentioned a history of, or are currently, living with a promiscuous partner. Likewise, some women mentioned the practice of occasionally lending someone else's partner for her sexual needs or to fulfill her wish of having a baby. There were also cases in which the woman wanted children and she decided to have them with a man regardless of the fact that he was already in a committed relationship.

Discussions about sex topics are still sensitive, also among professionals, resulting in related issues not being comprehensively discussed. Issues such as: sexual education in schools, at what age to start, sexual education in the social media, competency to give this kind of info in specific age groups, stimulation for the use of physical barriers and so on. But also, the morals behind sexual intercourses, possible results of having multiple sex partners and possible impact of these on a family from different angles. This has an effect on important decisions that need to be made in order to protect a population against potential harms on physical (STD's) and social-psychological field (violence by jealousy but also the social and psychological effect on the youth who grow up without the father figure and with the described attitude as example to follow) (Ministerie BZK and UNA, 2010) (van Brummen-Girigori et al., 2015).

### 2.2.6 *Accepted promiscuity*

The promiscuous behaviour in the population on Curaçao has been a subject that was already analysed and described in previous dissertations (Ministerie BZK and UNA, 2010) (van Brummen-Girigori et al., 2015). There are studies that point to events that have happened during colonialism, as one of the causes for this. But, historically there has always been a constant shift in our population composition and this phenomenon can be seen throughout the Caribbean region. This may have implications on unstable family constellations which may explain this attitude in the population (van der Mark, 2003). Aforementioned attitude is in correlation with the phenomenon “kos fiá” (which stands for borrowing men in a committed relationship for sexual purposes). These behavioural patterns on the health of Curaçao’s population is an aspect that needs to be further analysed and described. It must be addressed in the context of the consequences of this attitude on the general health of the population.

### 2.2.7 *The role of the female in the local population*

The women have an accentuated role in the local population. Aspects related to our history and social factors of the past and present can explain the *matrifocal* structure of families on Curaçao (Ministerie BZK and UNA, 2010). This means the women often have a leading role in family and social life. If such a central figure loses her place in the system because of incapacity due to disease or death this will have an important effect on the environment in which she was fulfilling this role. Thus, investing in the health of the female population means investing in a healthier population in general.

## **2.3 Comparison of attendance rate and the cervical cancer incidence in the female population of Curaçao and the Dutch Caribbean population living in the Netherlands**

### *2.3.1 Background*

To underline the impact of the above mentioned (paragraph 1-2) social and culture determinants in population of Curaçao, and its impact on cervical cancer, we analysed the attendance rate of the cervical screening programme and the incidence of cervical cancer in the population of Curaçao and compared these parameters with women from the Dutch Caribbean population who emigrated to the Netherlands. Precise incidence rate for cervical cancer among specifically Curaçao female population in the Netherlands is not available as the diagnosed population from all islands from the Dutch Caribbean are merged and registered under one header: “former Netherlands Antilles and Aruba”.

### *2.3.2 Method*

*- Participation response by locals on Curaçao.*

A database was created for the registration of the participation response during the HPV trial conducted in March-June 2015. Personal information about the population was obtained from the National Registry department. All participants in this trial were selected at random and all selected participants were registered in the database per age group. We collected the following information numbers of people selected, invitations sent, confirmation on participation, cancellations, attendance, notification of incorrect address and reminders sent. In addition, we collected blood serum with the aim to store this for additional experiments if necessary. The number of selected participants and attendance on the blood serum collection was also registered. In the invitation letter, participants were asked to call and cancel if

participation was not possible. In case of no response, a different woman in the same age group was randomly selected and invited instead. The reasons for not participating were also kept in the database<sup>6</sup>.

*- Cervical cancer data collection on Curaçao.*

We obtained data on cervical cancer incidence from 1974-2016 from ADC department of Pathology. Before 1993 data from publications of incidence are available covering the 5 islands together as a whole of the former Netherlands Antilles excluding Aruba, since no electronic database of the raw data is available anymore. Because Curaçao has the largest population (estimated 75% in that period) the majority of cervical cancer cases probably occurred on Curaçao. Since 1993 registration in a CanReg (Cancer Registry software is an open source tool to input, store, check and analyse cancer registry data provided by International Agency for Registry of Cancer) database is available for Curaçao. Incidence was calculated over 5-year consecutive periods and age-standardized (ASR) using the weights of World Standard Population (WSP) until 2011. Completeness of the registration for cervical cancer is estimated at > 90%.<sup>7</sup> The trend in the incidence of cervical cancer shows a slight decrease with a peak in the 2009-2011 period. (Table 2.3)

*- Cervical cytology coverage in the total population.*

Opportunistic screening for cervical cancer with cytology (Pap smears) has been available on Curaçao since the 1970s through the general practitioners, gynaecologists, the Family Planning Foundation and the Pathology Laboratory of ADC. For normal results repeat every 3 years was largely maintained based on former Dutch guidelines. The coverage of the target age

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<sup>6</sup> Source: D.J. Hooi, Fundashon Prevensionh

<sup>7</sup> Source: C.M.D. Coronel, Pathology laboratory ADC

group of 30-60 years was estimated over the 3-year-period 2004-2006 at approximately 40%.<sup>7</sup>

**Table 2.3**  
**Cervical cancer incidence registration 1974-2016**

Source	Period	ASR 100,000	Numbers
N.A.	1974-1978	26.6	100
N.A.	1978-1982	18	73
N.A.	1982-1986	21.5	97
N.A.	1987-1991	20.4	109
CUR.	1993-1997	13.1	62
CUR.	1998-2002	11.4	59
CUR.	2003-2007	12	62
CUR.	2009-2011	16	51
CUR.	2013-2016	12	60

Source: C.M.D. Coronel, Pathology Laboratory ADC.

N.A. = Netherlands Antilles, CUR. = Curaçao

- Dutch Caribbean population in the Netherlands and cervical cancer data.

For the comparison of data between the Dutch Caribbean population residing in the Netherlands with the population living on Curaçao, we approached the Integraal Kankercentrum Nederland (IKNL) to obtain data on cervical cancer in the migrated population from Suriname and the former Dutch Antilles (Aruba, Bonaire, Curaçao, St. Martin, Saba and Statia) in the Netherlands over the period 1989-2016. 75% of the cases were recorded in the National Cancer Register with country of birth. The remaining 25% was estimated based on name algorithms common in Surinamese and Antillean names. We collected data about the relative risk of cervical cancer in relation to women born in the Netherlands: number of women with cervical cancer in the Netherlands per FIGO stage (Table 2.7), histological type<sup>8</sup> (Table 2.9).

<sup>8</sup> Source: O. Visser, Integraal Kankercentrum Nederland (IKNL)



### 2.3.3 Results

#### *- Participation response by locals on Curaçao within the scientific trial*

In 3.5 months, we collected cervical smears from 1,075 women who responded to the invitation to participate in the screening trial. As described in chapter 3, we obtained a database containing age and ID-number of all women aged 25-65 years and registered as inhabitant of the island. From each of the age strata 25-34, 35-44, 45-54 and 55-65, women were randomly selected. If a woman did not respond, after the second invitation letter, a different woman in the same age-group was selected till the sample size was reached. The response rate in general was approximately 1 in 4.5 which is 23.7% of the invited population (4,531). A larger sample size was selected in the first age group because the response to participate was the lowest in this group and the highest in the oldest age-group.<sup>9</sup>

A total of 310 out of 4,531 selected women called to cancel the appointment. The most common reasons for cancelling were: 1. no interest because of unawareness with the research project or 2. she had received the invitation but had not opened it. After having heard more about the trial from colleagues, friends or family members, they indicated that they did want to participate.<sup>10</sup>

#### *- Dutch Caribbean population in the Netherlands and cervical cancer data.*

In the Netherlands the relative risk of developing cervical cancer for women emigrated from the Antilles compared to women born in the Netherlands, is 1,4. The female population immigrating from the Dutch Antilles and Surinam has a 40-60% higher chance to develop cervical cancer compared to females who are born in the Netherlands.<sup>10</sup> The proportion of squamous cell carcinoma (SCC) in the years 1989-2016, in women from the Dutch Antilles (84%) was higher compared to the Netherlands (77%). No significant difference is

<sup>9</sup> [www.facebook.com/FundashonPrevenshon/Dialogo dòkter-pashènt](http://www.facebook.com/FundashonPrevenshon/Dialogo_dòkter-pashènt).

<sup>10</sup> Source: D.J. Hooi

noticed between the country of birth with regard to the FIGO stage in which the cancer is diagnosed.<sup>10</sup>

**Table 2.4**  
**Comparison of cervical cancer incidence and attendance to screening between population on Curaçao, Non-Western population consisting of the Dutch Caribbean population living in the Netherlands and total population in the Netherlands**

	Curaçao*		**Non-Western population in NL	**NL general
	2009-2012	2013-2016	2012-2015	2012-2015
<b>Screening attendance (30-65 y)</b>	40%	40%	49.6 % (48.5%-51.1%)	64% (36.5%-83.8%)
<b>Cervical cancer incidence 100,000 (ASR World)</b>	16	12	10.7 (10-11)	8 (4-12)

Sources: \*C.M.D. Coronel, pathologist ADC, Curaçao, NKR, Regionale Screeningsorganisaties, \*\*screening attendance and cervical cancer incidence is an average of the GGD regions adopted from volksgezondheid.info, where, according to the CBS NL (CBS NL, 2018), the highest% non-Western population is registered, including Antilleans. (NKR., 2018) NL= the Netherlands

### 2.3.4 Remarks

The same pattern as seen on Curaçao of low attendance to screening programmes and high incidence of cervical cancer is noticed in the Dutch Caribbean population living in the Netherlands. Response to screening in the Netherlands in 2015 was 58.5% (LEBA, 2016).

On the website “volksgezondheidszorg.info”, a higher incidence per 100,000 women of cervical cancer and a lower response rate to participate in cervical cancer screening programmes is noticed in cities such as: Rotterdam (11 and 49.2%), the Hague (10 and 48.5%) and Amsterdam (11 and 51.1%), that are

known to have >30% consisting of not western migrated population. Four groups (approx. 1.3 million people) form the population of non-Western background, of which the Antilleans is the smallest group (12%). Turks (31%) and Moroccans (30%) make up more than half of this population, followed by the Surinamese (27%). In the Netherlands, people from the Dutch Caribbean add up to approximately 150,000 (0.88%) of the total population (CBS NL, 2018). The total female population older than 15 years of age amounted to 59,199 in 2016, including first- and second-generation migration background with the largest population in the age-group of 15-30 years (CBS NL, 2018). The higher population in the younger age group can be explained by the number of students that migrate from the Caribbean every year to study in the Netherlands. The reason why it seems like less people from the Dutch Caribbean are responding to participate may partly be explained by the low response rate of the group of 30-35 years old women in contrast to older women who respond better to a screening invitation. Yet, this need to be further analysed.

Cervical cancer incidence on Curaçao from 2009-2011 was 16 per 100,000 women<sup>11</sup> (ASR World) while from 2013-2016 the incidence was estimated 12 per 100,000 women<sup>11</sup> (ASR World). The last reported incidence in the Netherlands is 8.0 per 100,000 women (ASR World) (NKR, 2018).

Based on the calculated relative risk (1.6), cervical cancer incidence under the previous Antillean population living in the Netherlands is approximately 9.5 (6x1.6), which is slightly lower than on Curaçao (2013-2016). Migrants often have an incidence that lies somewhere between the country of origin and the country of migration due to adaptation to the country of migration (Visser, 2006).

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<sup>11</sup> Source: D.J. Hooi

In conclusion Social factors and culture differences, may be important reason why attendance rate on Curaçao and emigrated population living in the Netherlands is low and cervical cancer figures are higher.

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## Appendices

On the following pages:

- Table 2.5 Descriptions of the response to the invitation to participate with the screening for cervical cancer trial by means of HPV detection and cytology triage.
- Table 2.6 Reasons given for cancelling the appointment.
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**Table 2.5**  
**Descriptions of the response to the invitation to participate with the screening for cervical cancer trial by means of HPV detection and cytology triage**

Age group	Total N=4554										Blood serum collection
	Selected	Invited	Confirmed	Cancelled	Attended	Incorrect address	Reminders	Attended	Cancelled	Selected n=	
<b>1</b>	1,341	1,339	206	56	253	66	964	18.89 %	4.18 %	858	40
<b>2</b>	1,166	1,154	204	45	285	41	782	24.70 %	3.90 %	675	60
<b>3</b>	958	954	183	85	236	45	588	24.74 %	8.91 %	452	69
<b>4</b>	1,089	1,084	170	124	301	28	631	27.77 %	11.44 %	587	68
<b>Count</b>	<b>4,554</b>	<b>4,531</b>	<b>763</b>	<b>310</b>	<b>1,075</b>	<b>180</b>	<b>2,965</b>	<b>23.73 %</b>	<b>6.84 %</b>	<b>2,572</b>	<b>237</b>

*Age groups: 25-34 years (1), 35-44 years (2), 45-54 years (3), 55-65 years (4)*

*Source: Hooi, Fundashon Prevenshon. (2015)*

**Table 2.6**  
**Reasons given for cancelling the appointment**

Reasons	<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	Count
	25 - 34 y	35 - 44 y	45 - 54 y	55 - 65 y	
<b>1</b> Hysterectomy	2	15	58	90	165
<b>2</b> No interest	5	8	14	11	38
<b>3</b> Pregnancy/puerperium	23	3	0	0	26
<b>4</b> Under treatment with a medical specialist	3	7	5	8	23
<b>5</b> Emigration	11	8	0	5	24
<b>6</b> No sexual intercourse	8	1	2	1	12
<b>7</b> Prefer sample taken by family doctor	2	2	3	5	12
<b>10</b> Participated in the pilot 2013	0	0	0	1	1
<b>11</b> Other	2	1	3	3	9
<b>Total</b>	<b>56</b>	<b>45</b>	<b>85</b>	<b>124</b>	<b>310</b>

*Source: Hooi, Fundashon Prevenshon. (2015)*

**Table 2.7**  
**Relative risk of cervical cancer in  
relation to women born in the Netherlands**

Period	Country of birth	
	Surinam	Dutch Caribbean
<b>1995-2001</b>	1.7	1.0
<b>2002-2008</b>	1.4	2.2
<b>2009-2015</b>	1.3	1.4
<b>Total</b>	1.4	1.6

*Source: Visser, IKNL. (2018)*

**Table 2.8**  
**Number of women with cervical cancer in**  
**the Netherlands per FIGO stage and country of birth, 1989-2016**

FIGO stage	Country of birth	
	the Netherlands	Dutch Caribbean
<b>1A</b>	4,121	32
	24%	24%
<b>1B</b>	5,646	50
	34%	37%
<b>2</b>	3,405	19
	20%	14%
<b>3</b>	1,477	11
	9%	8%
<b>4</b>	1,678	17
	10%	13%
<b>Unknown</b>	523	5
	3%	4%
<b>Total</b>	16,850	134

*The rest are classified under the population of Surinam, others and unknown.*

*Source: Visser, IKNL. (2018)*

**Table 2.9**  
**Number of women treated by the gyne-oncologist,**  
**with cervical cancer on Curaçao, per FIGO stage, 2013-2016**

FIGO stage	Year diagnosed				Total
	2013	2014	2015	2016	
<b>1A</b>	1	1			2
	8%	6%			4%
<b>1B</b>	7	6	4	6	23
	58%	38%	27%	60%	43%
<b>2</b>		4	4	1	9
		25%	27%	10%	17%
<b>3</b>	2	3	2	1	8
	17%	19%	13%	10%	15%
<b>4B</b>	2	2	5	2	11
	17%	13%	33%	20%	21%
<b>Total</b>	12	16	15	10	53

*Source: Gomes Bravio (2017)*



**Table 2.10**  
**Number of women with cervical cancer in**  
**the Netherlands according to histological type**  
**and country of birth, 1989-2016**

Histology type	Country of birth	
	The Netherlands	Dutch Caribbean
<b>SCC</b>	12,891	112
	77%	84%
<b>ADC and other</b>	3,959	22
	23%	16%
<b>Total</b>	16,850	134

*Source: Visser, IKNL. (2018)*

