



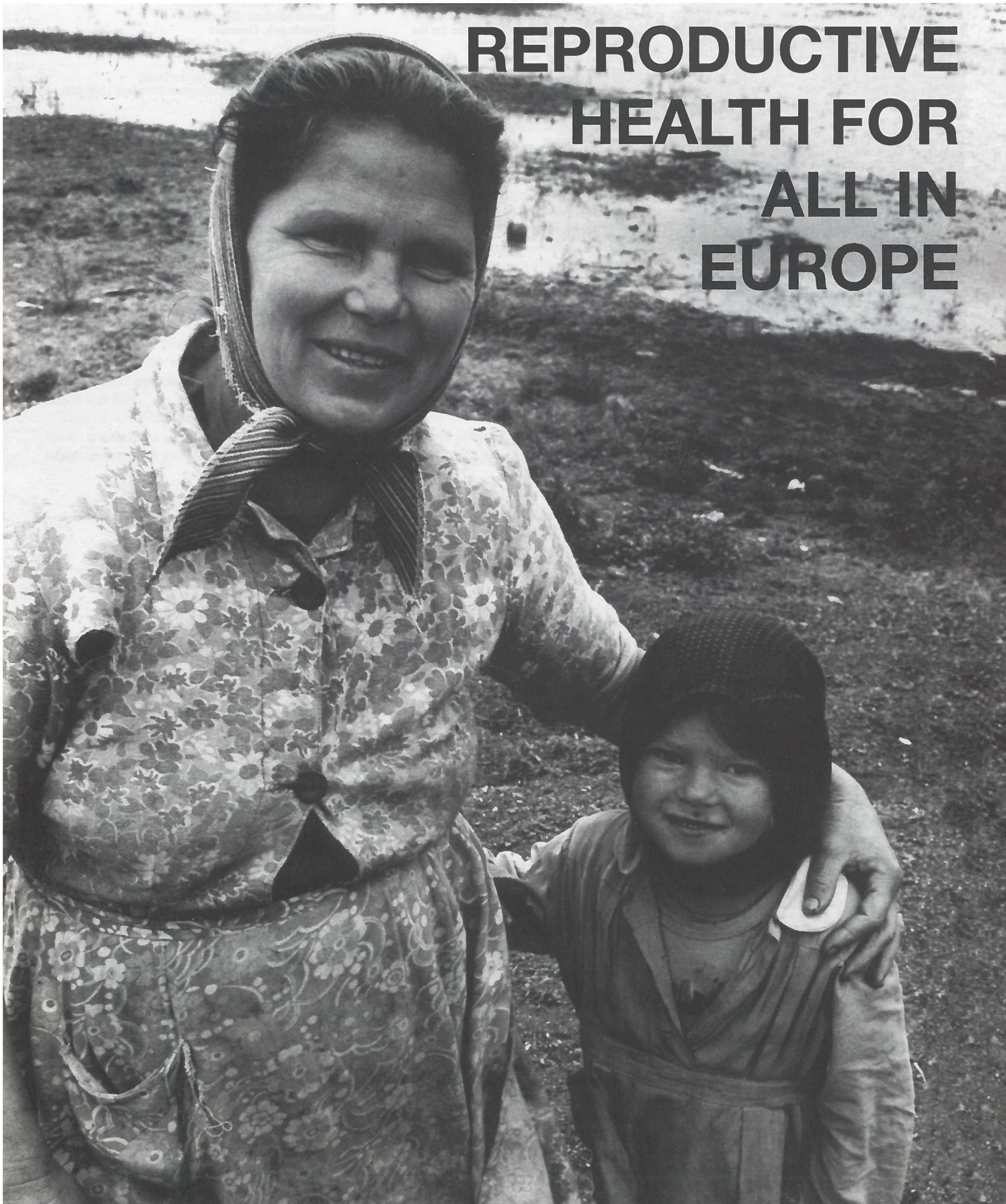
ENTRENOUS

The European Family Planning Magazine



No. 33/September 1996

REPRODUCTIVE HEALTH FOR ALL IN EUROPE



ENTRE NOUS

The European Family Planning Magazine

ENTRE NOUS is published by:
The Sexual and Family Health Unit
WHO Regional Office for Europe
Scherfigsvej 8
DK-100 Copenhagen Ø
Denmark
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Fax : 39 17 18 50

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ISSN 1014-8485

ENTRE NOUS is funded by the United Nations Population Fund (UNFPA), New York, with the assistance of the World Health Organization's Regional Office for Europe, Copenhagen.

It is produced and distributed three times a year in English and French by the Sexual and Family Health Unit of the WHO Regional Office for Europe. Present distribution figures stand at 5200 English, 2500 French, 2000 Spanish, 2000 Portuguese, 1000 Russian, 500 Hungarian.

ENTRE NOUS is produced in:
Spanish by the Instituto de la Mujer, Ministerio de Asuntos Sociales, Almagro 36, 28010 Madrid, Spain
Portuguese by the General Directorate for Health, Alameda Afonso Henriques 45, P-1056 Lisbon, Portugal
Hungarian by the Department of Obstetrics and Gynaecology, University Medical School of Debrecen, P.O. Box 37, Debrecen, Hungary
Russian by the WHO Information Centre for Health for the Central Asian Republics, Kierskaya 27, Bishkek 729495, Kyrgyzstan.

The Spanish and Portuguese issues are distributed through UNFPA representatives and WHO Regional Offices to Portuguese-speaking countries in Africa and South America.

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EDITORIAL

Reproductive Health in Europe

*In every country
- for every age group*

Europe today is comprised of some 50 very different States and 850 million people. They are geographically different: some of them, like Kazakhstan, cover enormous areas of land while others, like Luxembourg, are almost microstates. Their populations also vary: in number, in demographic characteristics and in their social and economic situations. The highly affluent and highly developed, aging populations of the North and West present a stark contrast to the relatively young, generally poor and less-developed nations of the South and East.

Thus, it scarcely comes as a surprise that health concerns in general, and reproductive health concerns in particular, should vary

widely from region to region and even from country to country in Europe. Reproductive health is a lifelong concern: within the framework of WHO's definition of health as a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity, **reproductive health addresses the reproductive processes, functions and system at all stages of life.** It implies that people should be able to have a responsible, satisfying and safe sex life; that they have access to effective, affordable and acceptable methods of fertility regulation; and that they have health care services that will enable women to go safely through pregnancy and childbirth - and have the best chance of giving birth to a

healthy infant. It also involves treatment of cancer of the reproductive organs - breast and cervical - as well as premenopausal and postmenopausal care.

These are the goals, but the route to reach them obviously depends on where we start from - and the size and type of the problems which we face.

A number of these very different paths of development and differing aspects of reproductive health in Europe are reflected in the articles of this issue: Alex Gromyko presents some new and very alarming figures on the epidemic spread of sexually trans-

mitted diseases (STDs) in the Newly Independent States of the former USSR. Cornelia Helfferich discusses the health needs of older women, especially of the very numerous older women in developed countries such as Germany. She also looks at the question of contraception as it changes throughout women's lives. Finally, Gayane Dolian shares with readers some of her insights on reproductive health in Europe, its problems and prospects.

Another thing the list of articles clearly shows: problems of reproductive health are not only women's problems, but most often it is women who suffer the most.

While maternal and child health has been advocated as one of eight basic items to be provided in primary health care in developing countries, far too little attention has been given to the reproductive and sexual health of women. In resource-poor settings around the world, reproductive tract infections (RTIs) are thought to be very common and their consequences for the health and social well-being of women and their children are frequent and potentially devastating.

There is so much truth in the statement that societies can be judged by the way they treat women. The situation of women is a revealing indicator of general social well-being: "The goal of empowerment cannot be achieved without attention to the basic circumstances of women's lives", Dr. Nafis Sadik, Executive Director of the UN Population Fund, said at the World Summit for Social Development in Copenhagen in 1995. "An essential component of empowerment is the right of all people, couples and individuals alike, to decide freely and responsibly the number and spacing of their children and to have the information and the means to do so. **The right to reproductive health is a principle of the first importance** not only for women, but for all people and all nations."



Keneva Kunz
Editor, *Entre Nous*

Reproductive Health in Europe

Different problems need different solutions



Interview with Dr Gayane Dolian, acting Regional Advisor for Sexuality and Family Planning

I like to use the image of a flower, with many petals arranged around the centre, but it could just as well be a sun, with many different rays streaming outward. The main idea is that reproductive health has many aspects, it is a multi-faceted concept."

Dr Dolian, who is serving as Regional Advisor while Dr. Assia Brandrup-Lukanow is on maternity leave, then went on to describe the various petals of this flower which represent the emphasis for work in reproductive health, including youth, reproductive rights, primary health care (PHC), education and monitoring. "In the centre I place the area which needs special emphasis in the individual country. The petals are more-or-less permanent aspects, the centre provides the focus in each case. For instance, in the Russian Federation, the key area of emphasis is moving from abortion to contraception. In Russia there is a high frequency of abortions, with the accompanying dangers of secondary infection, STDs and even infertility. So this is an area needing priority attention in the Russian Federation. In Sweden, however, reproductive health problems are of a very different nature - and obviously require work in different areas."

"The European countries also differ greatly in their demographic characteristics.

If we look at Moldova, for instance, almost 80% of persons with STDs are between age 16 and 21. For reproductive health this means that to prevent STDs and unwanted pregnancies the emphasis must be on youth and education. Materials produced for information purposes on, say birth control, have to be suitable for this age group. Whereas in western countries, for instance, with a much larger proportion of women aged 40 and over, information suited to the contraceptive needs of these women make be very much needed."

NO NEED TO REDISCOVER THE WHEEL

"At the same time it must be stressed that while reproductive health is a priority problem in every country, it is a very international problem. We need to make use of what we have learned already in developing new strategies, and then co-operate with our counterparts in the countries themselves to tailor them to their needs and to help them implement them using the experience gained from more developed countries."

New possibilities, new projects are often developed through international or multi-national agencies. The problem then

becomes one of getting the information to the people in the countries themselves, a problem of educating people at various levels. "Take the case of the abortion drug mifepristone which provides us with the possibility of performing abortions without curettage. It can be of little help if the people concerned: gynaecologists, midwives, etc., cannot be provided with the information and training that they need. This is perhaps even more important when we talk about the general public. There are a wealth of well-produced and very usable materials available on sexual education - in English, say. And here at WHO many of them have even been translated into Russian. But what if we need several hundred thousand copies, to distribute to teachers who urgently need and want them - it can prove difficult to obtain several million US\$ for such a project."

Obviously, there is much to be gained by sharing experiences, whether by forming links through international organisations or directly from one country to another. Collecting and pooling information on resources makes them more available, as has been demonstrated by recent European projects, such as the Handynet, which provides a database accessible all over Europe on national programmes and

Health care for older women

a real need

by Dr Cornelia Helfferich

Women in Germany live an average of six years longer than men (almost seven years on average in the EU). This doesn't mean that they are healthier during their lives, but rather that they suffer from different illnesses than men and are affected by other causes of death. The years that women have "gained" on men through their more extended life expectations (76.23 years in Germany, 80.21 on average in the EU, in 1992) are especially characterised by a large number of health complaints and chronic illnesses - and by difficult social and economic circumstances. For this reason it is necessary to develop suitable programmes to improve their assistance, care and social situation.

SOCIAL SITUATION

From the age of 60 years onward, the previously relatively equal age-specific ratio of men to women becomes increasingly unequal, until in the very advanced age

group (over 90 years) there is only one male to three females. The longer life expectancy of women, plus the fact that married women are on average two years younger than their husbands, results in an increasing number of widows among women above age 55. In the 75-85-year-old group they are already more than two-thirds. For older women being a widow also usually means living alone: only 1% of households include members of three or more generations under the same roof. A special problem is the social isolation of women in need of care and of women who for health reasons are no longer mobile. "Ageing is feminine", the saying goes, and it is also by and large socially isolated.

And old age is not only feminine and lonely, it is also poor; older women are comparably poorer than men of the same age. Incomes/pensions of women are clearly below those of men. The system of old-age security is designed for lifelong, full-time participation in the workforce, and

as such favours men over women. If a woman's income is below the poverty line, the difference is made up by the State in the form of social assistance. Almost double the number of women as men receive social assistance after age 60, and it is assumed that many older women do not take action to receive what is due them and thus are not included in the statistics. Poverty in old age is a phenomenon which affects women who cared for their families as housewives and mothers and unskilled women workers, lower-ranking white-collar workers. Older women are less likely than men to occupy accommodations intended for the elderly.

HEALTH SITUATION

Added to the difficult social situation is the difficult health situation. Between 50 and 70 years of age the most frequent causes of mortality among women are malignant neoplasms, the second most frequent are illnesses of the circulatory system. Breast ►

assistance for the disabled. Multinational agencies are important storehouses for information, which health workers can avail themselves of.

EVERY POPULATION NEEDS REPRODUCTIVE HEALTH

"People of reproductive age are strong and healthy; they are the productive core of every population, its best workers. When they are healthy, the country will be healthy, because so many other things depend upon reproductive health. Reproductive health is defined officially as *a state of physical, mental and social well-being*; it's not just an area to be left to gynaecologists."

"So reproductive health in itself has to be a priority for all European countries, although the situation varies from one country to another. But the problems are most urgent in the Newly Independent States (NIS) and countries torn by war and civil conflicts: Bosnia, Armenia, Azerbaijan. If we take the question of reproductive rights, and ask someone working in England, Sweden or Germany, they would perhaps reply that violence was a major concern in this area. But ask someone from Kazakhstan and they would likely say maternal and infant mortality."

If you had to single out three areas, three

petals of this reproductive blossom, that were most important, most needing of our attention here and now, what would they be?

"Number one, **information, enough of it and the right kind**. Not only for the population in general, but for doctors, nurses, midwives, social workers and others. Secondly, **primary health care services, for all areas of reproductive health**. This would include prevention measures against unwanted pregnancy and STDs, abortion services, family planning, the whole spectrum. And the third area, obviously linked to the other two, would be **emphasis on youth**. This is the best way to improve knowledge in the years to come. With sexual education programmes on preventing unwanted pregnancy, prevention of STDs. Young people will be our reproductive team for the future."

EVOLUTION OF REPRODUCTIVE HEALTH

"Reproductive health could be described as a process of evolution, which has been going on in all countries of Europe but at vastly different speeds - and occasionally in different directions - due to their differing circumstances. Development has been slow in the NIS, for example, not the least because this was an area which was completely prohibited under Stalinism. The problems were not acknowledged to exist

and thus there was no need for research or expertise in areas such as STDs, or youth sexual education. This is why the programme to replace abortions with contraceptive measures is so important now. People are very interested because a lack of information means a lack of improvement."

"For so very many reasons - primarily economic, social and political and not just scientific - many of the countries of eastern Europe have not managed to progress very far along in this developmental process. What we need to do is to help even out the progression, help them move along more quickly and easier. Make up the deficit by moving twice as fast."

"This is another reason why relations and the exchange of information between people of different countries is very important. I was working in Armenia and gaining experience in the area of reproductive health, but in 1987 I went for WHO training to England for 4 months and then to Belgium for another 2. In those 6 months I could gain specialised knowledge that would have taken me, say 5 years to acquire in Armenia."

"We are all in this together - we live in the same region and are part of this European family. If one member of your family is ill or disabled, the rest of you try to help him or her out. This of course means problems and challenges for both those giving help and those receiving it. ■

cancer is the most frequent among the malignant neoplasms of women over age 60; lung cancer, most frequent among males, is in 8th position. In actuality, the health situation of older women overall is characterised by an increasing frequency of chronic illnesses and multimorbidity with increasing age. Since women live longer than men, they are especially vulnerable. A few illnesses among those over age 64 affect women more commonly than men: twice as many women are stricken with depression and affective psychoses, and senility and rheumatism are more common. After age 60, diabetes prevalence is 20% higher among women. Women are less commonly affected by other chronic illnesses such as chronic obstructive lung illnesses, strokes or stomach and duodenal ulcers.

Not only is the frequency of chronic illnesses and complaints high among older women, their drug consumption is high as well. In 1989, 42% of women over age 70 in the States of the former Federal Republic took sleeping drugs occasionally, regularly or daily (19% of them regularly or daily), 75% took painkillers (18% of them regularly or daily), 24% mild and 9% strong tranquillisers, 14% stimulants and 10 anti-depressants.

Special attention needs to be given to the hip and thigh fractures suffered by women of advanced age, not only because they increase with age especially among women (up to an annual incidence of 1305 fractures per 100,000 persons aged 80-84 years) and among those over age 64 these represent the most common cause of accidental death. A portion of them appear to be preventable. Two-thirds of the over-75-year-olds fall in the bath- or bedroom area. Besides lowered neuromuscular control, medicines such as antidepressants, antipsychotics/neuroleptics, anxiolytic drugs, diuretics or laxatives have been linked to the cases of falling.

CARE: WOMEN ARE CARERS, BUT ARE NOT CARED FOR

Overall the system of care is extensive and specialised. Older persons basically have health insurance and thus have a right to the necessary assistance for sight, hearing and movement. In 1995 a system of care insurance was introduced which, following a certain code, covers the contributions for home care, for instance with a certain number of care units per month, or a maximum monthly state contribution for ambulatory care by a private person in the household. The prerequisite is lengthy membership in a compulsory health insurance plan and official confirmation of the need for acute care.

A wide network of ambulatory services are available for care in the home, which through health insurance are available to all. They include the provision of meals, care by

paid geriatric attendants, by young men carrying out their national service, or by unpaid home and family attendants. In addition there are residences for the aged where people live who are able to care for themselves, as well as personal care homes for the elderly needing care. The institutions are operated by charitable organisations, municipalities, and private agencies.

The problem of care is more acute for older women than for men. Despite the fact that many illnesses strike them less often than men, these illnesses can have greater consequences for their lives. The medical complications resulting from a stroke, for instance, do not necessarily require referral to a home for the elderly, only the lack of a suitable means of ambulatory or family care. In general, the possibilities of obtaining in-home care for elderly women are poorer than for elderly men, as women are more often widowed while the men can often be cared for by their wives. With increasing age the proportion of women needing care increases. But the work, which women performed during their lives for the health and well-being of others, especially the members of their families, is not repaid accordingly when they reach the age where they themselves need care, so that these women now could come to enjoy the care of individuals they trust. The general rule is: women care for their spouses and parents (or parents-in-law) more frequently than do men. When they, on the other hand, are in need of care, they receive it less often. The same applies to older women in

need of care as to younger women with chronic illness or disability: they are much more often than men referred to in-patient personal care homes or homes for the elderly. Disabled, chronically ill or very aged men remain longer in the care of their families. Of the old in-patients, 70% are women.

SUMMARY: SOMETHING NEEDS TO BE DONE FOR ELDERLY WOMEN

The proportion of elderly in the German population is steadily growing, and women make up the greater share. The system of care for the elderly is relatively good, even though the costs are being questioned ever more frequently. For some time, however, the interaction of social and economic considerations with the health and personal care problems of elderly women has been given less consideration. Improvements are necessary in many areas, in the system of pension payments, in social and housing policy, and in the structure of personal care. Ilona Kickbusch of WHO said that one could judge a society by the way it treated women. In the case of Germany, the most visible deficit is seen in the treatment of elderly women.

Dr Cornelia Helfferich
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WHO FILE

Sexually Transmitted Diseases (STDs) epidemic in eastern Europe:

a call for help!

by Dr Alexandre Gromyko

At the same time as western Europe has witnessed a significant decline in the incidence of syphilis and gonorrhoea, there has been an extremely rapid rise, of syphilis especially, in the eastern parts of Europe. During the years 1980-91 the incidence of syphilis in countries of western Europe dropped to below 2 per 100,000 persons and 20 per 100,000 for gonorrhoea. But since 1991 there has been an extremely rapid rise, particularly in the Newly Independent States, in the notification rate of syphilis. In the Russian Federation, for example, the incidence was 86 per 100,000 in 1994 and 172.1 for the year 1995, which represents a **FORTY-FOLD INCREASE FROM 1989 TO 1995** (see graphs). Generally speaking, in many countries of the former USSR, the **incidence of syphilis has increased 15-30 times**, from 5-15 per 100,000 as observed in 1990 to as high as 120-170 per 100,000 in 1995.

WHY ARE STDs NOW ON THE RISE?

Ultimately the reasons are social and economic, as in so many health situations. Tremendous social and economic upheaval throughout eastern Europe during the last 10 years have followed in the wake of the transition to a market economy system. The marked and prolonged decrease in both national and per capita incomes is reflected in growing unemployment, prostitution and drug abuse.

And such major economic downturns have very damaging social consequences; in many of these countries there is:

- a general instability of society and breakdown of social infrastructures;
- war, civilian and ethnic conflicts;
- sharp increases in migration;
- large numbers of refugees and homeless and unemployed persons.

All of these factors have very negative

effects on the incidence of "social" diseases, such as tuberculosis, STDs, scabies, psychiatric illnesses and many others. Simple economic factors are also very important: more than 30 million people in the Russian Federation now live below the poverty line. The physical and moral condition of youth, especially, has weakened significantly due to malnourishment, increase in alcohol consumption, smoking and early age of starting of sexual relations, accompanied by violence and rising child prostitution.

These social developments have had considerable repercussions on the health of the population, particularly on trends in curable sexually transmitted diseases.

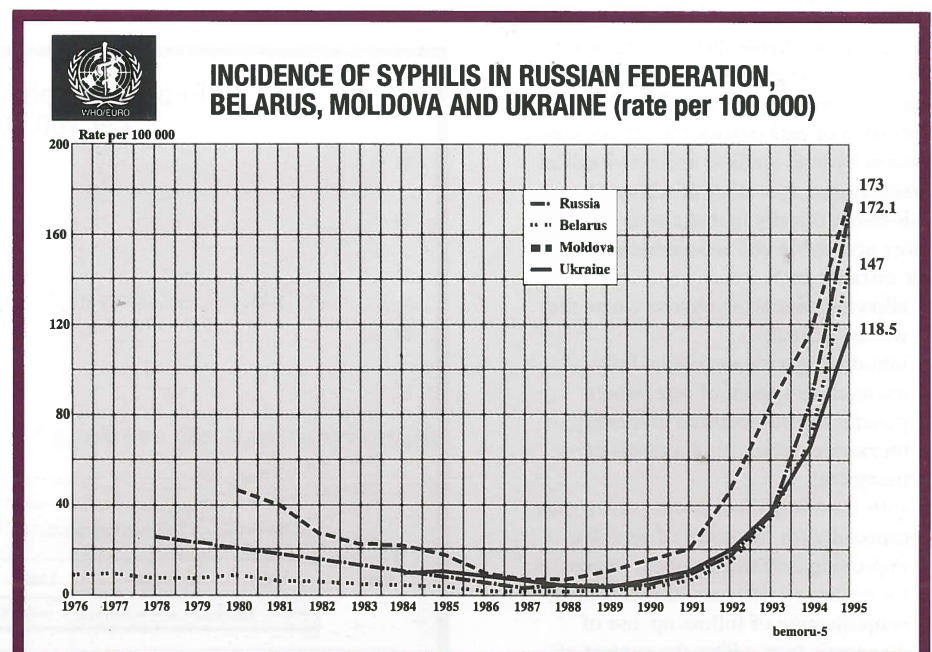
STDs are not only a concern because of the discomfort caused by the acute infection. They can have very damaging consequences, including infertility, ectopic pregnancy, urethral stricture, cervical cancer, premature mortality, congenital syphilis, foetal wastage, low birth weight,

prematurity, ophthalmia neonatorum and other complications. What's more they are **proven risk factors in the transmission of HIV, and therefore their control is a major concern in preventing the spread of HIV and AIDS.**

WHAT CAN AND NEEDS TO BE DONE?

Practically all of the NIS are experiencing major epidemics of STDs, especially syphilis, and they are affecting younger people and adolescents to a greater extent than older age groups. The origins of these epidemics can be traced not only to the social causes already mentioned, but also to the **accessibility, acceptability and effectiveness of control mechanisms and treatment.** These factors hold the key to bringing the epidemics under control.

The areas of strength and weakness of existing systems must be recognised and steps taken to improve the balance between ►



different areas of activity. Strong presentations must be made to the highest levels of government to generate awareness of the problem and to secure support for the recommended initiatives. The WHO Regional Office for Europe organised an action-oriented meeting of experts from the countries concerned with three expert advisers. They sought to exchange up-to-date information from each country on the extent of the problem, identify priority actions to control the epidemic, specify technical support and training needs, and agree on an overall plan of action.

RECOMMENDATIONS

1. Prevention of STDs and sexual health promotion

The absence of effective national co-ordination of programmes of health promotion in the area of sexual health and STD prevention is perhaps the most serious shortcoming in the existing situation.

Governments urgently need to bring together all agencies concerned to develop a strategy to rapidly implement sexual health promotion. Such a strategy would:

- integrate existing health promotion activities within dermatovenereology and HIV/AIDS programmes;
- be targeted towards youth from a young age, groups at high risk of infection, including homosexual men, prostitutes and their clients, and other socially vulnerable groups;
- use effective techniques of mass information, peer education, face-to-face counselling and involve key opinion leaders within communities.

2. Clinical services

Clinical services are faced with both increasing workloads and shrinking resources. Moreover, traditional health care practices, relying frequently on in-patient management and requiring patients to identify themselves and to accept strict legal obligations are proving unworkable. Patients are increasingly unwilling to accept such conditions and as a result there is a rapid growth in provision of care outside the official medical system by both medical and non-medical practitioners, as well as of self-treatment. It is thus a priority to make state services more accessible and acceptable to patients, for instance by:

- allowing patients to choose where they will be treated;
- introducing without delay a fully anonymous system of care, where patients are not required to identify themselves either for diagnosis or treatment;
- shift from in-patient to out-patient care, especially for treatment of syphilis;
- improving case management in general, for instance with same-day treatment, simplification of follow-up, use of diagnostic tests within the context of

- simplified case management algorithms based on clinical features of the disease, use of generic drugs where possible, and developing ways to ensure that contacts and sexual partners seek examination and treatment;
- providing affordable or free of charge services.

The general consensus was that clinical services are well provided with expertise but often sorely lack funding - a point calling for action by governments and other responsible authorities.

3. Management of STDs by non-dermatovenereologists

Since this situation is a reality, efforts should be made to try to ensure that all persons handling patients with STDs would provide high quality care, for instance by introducing a system of issuing a license to a private practitioner.

4. Training

While training of dermatovenereologists is of a high standard, in order to make clinical management more effective dermatovenereologist training could be modified to incorporate more emphasis on health promotion, positive doctor-patient relationships and patients' rights. Also, keeping point 3 in mind, dermatovenereologists and their organisations need to find ways to share their knowledge and expertise more effectively with other clinical colleagues who are likely to see patients with STDs.

5. Active case finding and screening

Since active efforts to identify individuals with STDs have proven successful, screening of pregnant women and other clinical and occupational groups under existing programmes should be maintained or extended, but with full respect for these individuals' confidentiality.

6. Surveillance

Changing epidemiological circumstances and patterns of health care require review of existing services.

- Notification of cases should be anonymous.
- Pilot sentinel surveillance schemes should be introduced and evaluated in individual dermatovenereologists clinics, in an attempt to obtain more epidemiological information.
- More general implementation of sentinel surveillance should be considered.

INFORMATION AND CO-ORDINATION OF EFFORTS ARE THE KEYS TO SUCCESS

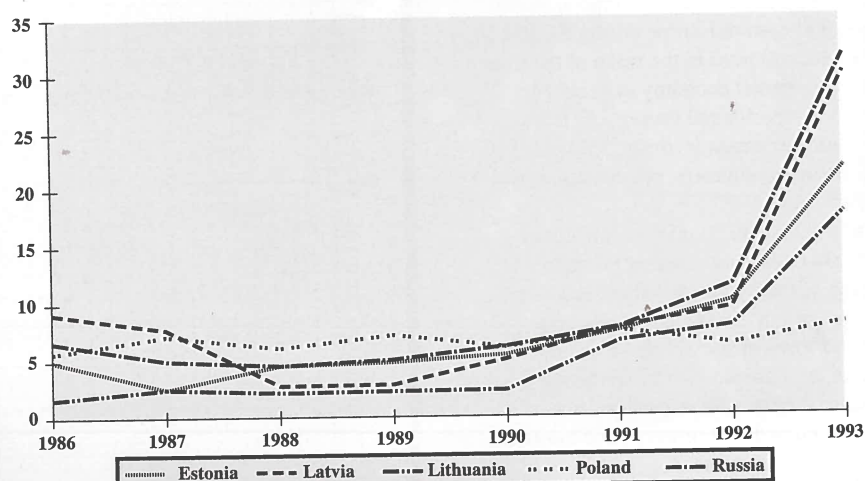
Developing better lines of communication between health professionals in various disciplines, governmental and non-governmental organisations, and the general population and high-risk groups is an urgent priority and will require innovative action.

Existing laws concerning the control of sexually transmitted diseases are by and large of little use in controlling epidemics such as the ones now developing in eastern Europe. Changes are urgently needed, both to make the law less oppressive and at the same time protect the rights of individuals who may be at risk of infection from others known to have STDs.

Finally, ways need to be found to allow countries to share their experiences of developing and implementing programmes and innovations, perhaps by creating a regional organ for STD control in eastern Europe under the auspices of international health organisations.

Dr Alexandre I. Gromyko
Regional Advisor on HIV/AIDS and STD
WHO Regional Office for Europe

Reported syphilis in eastern Europe per 100 000 inhabitants





UNFPA

ENTRE NOUS

The European Family Planning Magazine



WHO

September 1996

READER'S QUESTIONNAIRE

This year *Entre Nous* - The European Family Planning Magazine has reached its sixth year of publication as a magazine, with a present distribution figure of 5200 in English, 2500 in French, 2000 in Spanish, 2000 in Portuguese, 1000 in Russian (with a request for 2000 additional copies) and 500 in Hungarian.

The current phase of the *Entre Nous* project is coming to an end in December 1996.

At the request of the main funding agency — the United Nations Population Fund — we are carrying out a three-phase survey of *Entre Nous*. This will enable us to better assess the need for continued support to the project.

- A readers' survey, October - November 1996
- An assessment by the members of the Editorial Board - November 1996
- An in-depth evaluation - December 1996

The objectives of *Entre Nous* are to facilitate exchange of information on reproductive health/family planning and sexuality in Europe, as well as networking, to update knowledge of professionals on reproductive health issues and to promote UNFPA and WHO programmes and policies. You, our readers, are best equipped to tell us how well we succeeded. Should we go on? Kindly let us know, by taking a few minutes to complete the attached questionnaire.

Please fax or send the questionnaire to:

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Deadline: November 1996 (or as soon as possible thereafter)

Thank you for your cooperation



ENTRE NOUS

The European Family Planning Magazine

No. 28-29/May 1995



ENTRE NOUS

The European Family Planning Magazine

No. 32/May 1996



REPRODUCTIVE HEALTH: EVERY STEP OF THE WAY...



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The European Family Planning Magazine

No. 30-31/December 1995



TUNING INTO WOMEN



Special Reports

- Women and violence
- Birth: A photo-essay

The Beijing Conference: A victory for women?



ENTRE NOUS

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WORLD POPULATION 1993

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THE MEDIA AND FAMILY PLANNING

ABO

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CHALLENGES
Women and Family Planning

Family Planning World
The News magazine for Family Planning Service Providers

International Family Planning Perspective

Reproductive Health Matters
Making a difference with safe and effective family planning

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Childbearing Children

Change call: Copper-T shortage avoided

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ENTRE NOUS

The European Family Planning Magazine



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Family Planning and Lifestyles in Germany

by Dr Cornelia Helfferich

In the Federal Republic of Germany, all women are assumed to be knowledgeable about contraception. For both boys and girls, contraception is one of the themes dealt with in compulsory sex education in schools. Advisory centres, at least in the cities, offer consultation for youngsters. The Federal Act on Pregnancy and Family Care, adopted in August 1995, expressly states that every man and woman has the right "to information and advice, from advisory centres provided for this purpose, on questions of sex education, prevention and family planning." The law also provides for the establishment and financing of advisory centres and assigns to the Federal Center for Health Education the work of developing the concepts of sexual education and nationally standardised educational materials.

Women can choose from a variety of methods and means of prevention. The pill is the preferred choice of almost two-thirds of the women practicing prevention (1990: 61.6%). It requires a prescription and costs DEM 15 per month. Condoms are second in popularity, used by just under one-third (31.2%). Widely available in drug stores and pharmacies, they cost between DEM 0.80 and 1.20 a piece. Use of IUDs, diaphragms, the temperature method and coitus interruptus is only of marginal significance. While there is no charge for the medical consultation, individuals must themselves pay for the contraceptives they use - with two exceptions: for women under the age of 20 years there is no charge for prevention methods prescribed by a doctor and women receiving social assistance can obtain an IUD free of charge.

Clearly, lack of information or excessive cost no longer serve as barriers in the path of women seeking to prevent pregnancy. Nevertheless, only about two-thirds of all pregnancies are planned and we still have induced abortions: 104 per 1000 live births in the older German states (i.e. states of the pre-1990 Federal Republic) and 495 per 1000 live births in the newer German states (i.e. states which prior to 1990 formed the German Democratic Republic). What can and should be done about this?

CONTRACEPTION THROUGH THE COURSE OF LIFE: YOUNGER WOMEN MAKE GOOD USE OF PREVENTION

Young women today are highly competent and responsible in their use of contraceptives:

- Three-quarters of sexually experienced girls aged 15 to 17 years replied in 1994 that they "always took very exact precautions not to become pregnant. Two-thirds were using the pill. The investigation revealed that the girls were in other respects well-informed on questions of means and methods of prevention. The number of them who did not take precautions the first time they had sex has dropped in the last decade from 20% to only 10%.
- "Teenage-pregnancies" are rare: in 1992 only 166 girls under the age of 15 became pregnant in the older German states; 96 of these pregnancies were terminated. In the newer German states there were 224 such pregnancies and 122 induced abortions (in comparison, there were 720,794 and 88,320 live births respectively in the two regions).

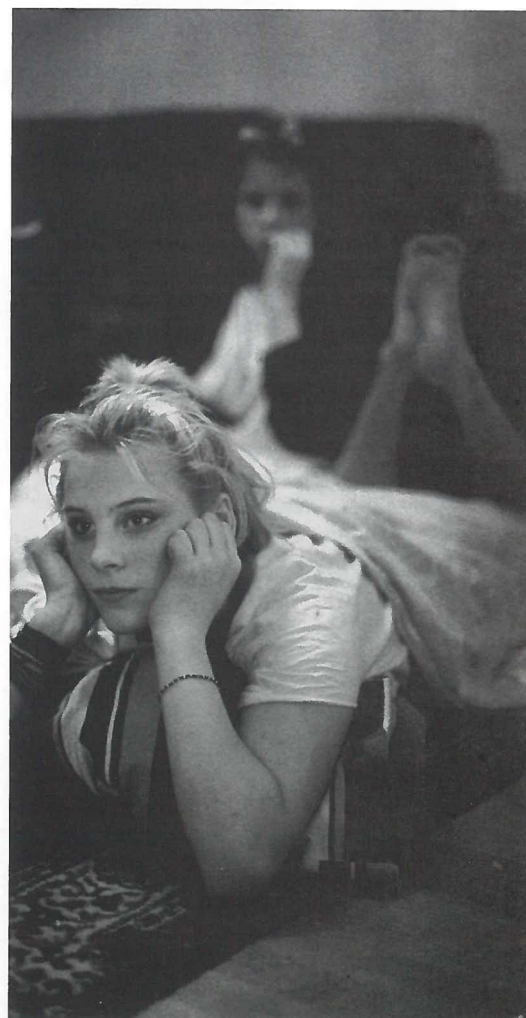
WOMEN OF CHILD-BEARING AGE WHO DO NOT USE PROTECTION: EITHER A PREGNANCY IS NOT UNWELCOME, OR THEY HAVE NO SEXUAL PARTNER

If women of child-bearing age are grouped separately according to their age, education and family status, it becomes apparent that it is especially women who have no partners, or who either plan on having a child or feel a child would not be unwelcome, who do not use prevention.

A 1994 survey showed the frequency of contraceptive use to be greatest in the 21-29-year-old group. Younger and older women use prevention less frequently, although the reasons for this differ in the

two groups. Most of those aged 20 years and younger who used no prevention did so because they lacked a sexual partner; this was less significant among the older age groups. In these groups the most important reason for not taking precautions were the wish to have a child or the decreasing fertility of older women.

The most important reason given for not using prevention was the wish for a child. Wanting a child is, in Germany as elsewhere, predominantly connected to a steady relationship with a partner, despite the fact that among women who gave birth to their first child before the age of 20 years the proportion of single mothers is high: 40.5% in the older German states, 86.9% (1991) in the newer ones. This is to say that



these women were unmarried when they became pregnant and did not get married shortly afterwards.

Three patterns of family status and life styles are discernible: almost three-quarters of those between the ages of 16 and 65 years, who lived alone without a partner, used no protection for that reason - they envisaged no risk of pregnancy. Among the group who lived alone but had a steady partner, most of them said they used some form of protection (79%; among those 29 years of age or younger at the time the figure rose to 91%). They could become pregnant and did not wish to do so. Of those women who lived with their sexual partners, half were ready to accept a pregnancy, the other half practiced contraception.

CONTRACEPTION, FAMILY PLANNING AND PLANNING A LIFETIME

A comparison of the widely different proportions of childless couples in the GDR and the Federal Republic before 1990 reveals how varied was the feeling of readiness to have a child: in the East childless couples were a tiny minority, while in the West they comprised almost one-fifth of all couples. Thus contraception should not only be discussed technically, as a possibility of protecting against unwanted pregnancies, but within the context of socially predominant life styles with and without children.

Prior to 1990 there was a great difference between East and West Germany primarily in the possibility of combining profession and family and in the availability of publicly organised day care facilities. These external circumstances combined with other factors to shape different patterns in East and West concerning the age and situation of women giving birth and the number of their children. In the GDR prior to 1990, and in the newer German states after 1990, women married at an average age two years younger than that of women in the Federal Republic and the older German states respectively. Thus the reproductive life of women in the East began earlier. In 1992 one-half of these women giving birth were younger than 25 years of age and only 15% older than 30 years; in the West only one-quarter of the mothers were younger than 25 years and one-third were older than 30. In extreme cases it happened of course that a "late mother" in the older German states had her first child at an age where a woman in the newer states became a grandmother.

In contrast to the very even distribution of family patterns in the newer states, there are within the older states very clear differences according to level of education. The general trend, to postpone the birth of the first child and to give birth to fewer children, becomes more accentuated especially where highly

educated women are concerned. Women who give birth to several children at an

In extreme cases it happened of course that a "late mother" in the older German states had her first child at an age where a woman in the newer states became a grandmother.

early age are at a disadvantage in the educational system. Single mothers especially face clear disadvantages at present.

TERMINATIONS OF PREGNANCIES DURING THE COURSE OF LIFE

The importance of external social circumstances also becomes clear if we compare the abortion situation in the socialist GDR with that of the Federal Republic prior to 1990: the results of a study in 1991 show that women students, in the West especially, had induced abortions if they became pregnant at an early age, because they felt they were too young or because they could not conceive of having children at this stage in their lives. Women completing only 10 years of compulsory school education in the West were less likely to terminate a pregnancy occurring when they were young. A family situation, into which a child could be integrated, was also of importance for the completion of the pregnancy. For women in the West, more induced abortions were linked to conflicts in relationships and the situation between the partners were of more consequence for their decision than in the East.

For women in the East it was not only a "matter of course" to have children, but even preferable to have them at an early age - even during their studies. The importance of the partner in the decision to have an abortion or complete the pregnancy was reduced in view of the natural expectation of social security and especially of support in its - widely functioning - family context. Women in the East much less often had their first pregnancy aborted than did women in the West. They did, however, have their third or fourth pregnancies terminated much more often, i.e. abortion was used primarily to limit family size in the GDR* (possible in the absence of available contraception). While women in the West already having two or three children were prepared to accept yet a third or fourth pregnancy, the women of the East felt they were too old for more children or that their accommodations were too limited. The proportion of first pregnancies terminated in rural areas of the East was only 5%, while it was 23% in the urban regions of the

West; the proportion of final pregnancies terminated in rural areas of the East amounted to 21%, in the cities of the West to 10%.

The differing abortion situation in East and West clearly shows the meaning of social patterns in the establishing of a family. In order to alter the conceptions of with whom, at what age, and under what circumstances a woman can have children, with the intent of changing a "willingness" for children, we need only to emphasize the impossibility of combining family and profession. As long as this is the reality experienced daily, the tendency, to postpone the birth of the first child - at least for professional women - will become stronger.

TO IMPROVE REPRODUCTIVE HEALTH IN GERMANY

Improvements in the area of reproductive health in Germany should enable women to a greater extent to have choices and enable them to decide for themselves. In Germany the need for information on contraceptives, their availability and reasonable cost has been widely achieved. The next step towards improving reproductive health is the provision of the material basis to make a choice possible, to facilitate the combination of profession with family, which forms the basis of the family pattern. Reducing the disadvantages which result from a decision to have children is also important as a contribution towards lessening the social inequalities among women. In developing suitable concepts and materials for sexual education and advice for women on questions of contraception and family planning it is important to address contraception as a recurrent question, throughout the course of life. Young women, who do not wish to have children yet, women of normal child-bearing age, who have to decide for or against having (more) children, and older women, who regard their reproductive phase as having ended - all of them have varying questions and wishes, and need very different sorts of advice.

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*N.B.: This is a pattern we used to see in all of Eastern Europe/Newly Independent States.

COUNTRY NEWS

Focus on Moldova

“Without information booklets on modern contraception, family planning, prevention of STD’s and unwanted pregnancies, how can one educate the population, and especially the young population?”

The question, posed by Drs Usatij and Shuman of the Rejon Hospitals in the Novie Anei and Orchej, is typical of the reproductive health situation, in Moldova as in so many other newly independent states (NIS). Information that is reliable, accessible and easy to understand, in the local language has to be a number one priority in all measures to improve family and reproductive health. Lack of information has been identified as a major factor in the alarming surge of STD’s in most of these countries (see article by A. Gromyko,

“Sexually transmitted diseases epidemic in eastern Europe: A call for help” in this issue).

Dr Gajane Dolian recently returned from a mission to Moldova on family health education, especially intended to evaluate the situation on family planning and STD education of professionals and of the population at large, at different levels. She discussed with a variety of health care officials a strategy for successful reproductive health education.

Healthcare professionals are the first target group, and the plan of action calls for a series of seminars and workshops to inform and enlist the assistance of health care personnel at all levels, from teachers of sex education, to hospital personnel, and not least the mass media. The campaign will include,

for instance, four weekly television programmes on breast-feeding, infertility, STD and reproductive health. The plan will be linked with Healthy Lifestyle initiatives in Moldova.

Together with the vital information booklets that women especially can take with them to read and refer to later, after they have left the maternity ward, abortion clinic or primary health care official.

Article prepared by Keneva Kunz, based on Dr Dolian’s report on her recent mission to Moldova.



Helping the News Media cover Family Planning

How can family planning organisations help the news media cover family planning accurately? Why are the news media important for family planning and reproductive health programs? How can organisations go about establishing an effective news media relations program?

These questions are answered in *Helping the News Media Cover Family Planning*, the latest issue of **Population Reports** from the Center for Communication Programs at the Johns Hopkins School of Public Health.

Reproductive health and family planning organisations spend a great deal of time and money planning and implementing communication campaigns to inform the public of their services, but many pay relatively little attention to the news media, according to this 28-page report. The authors argue that working with the news media should be an important part of every family planning organisation’s communica-

tion activities. And, just as in any other form of effective communication, a successful relationship is based on serving audiences: What do journalists need? When do they need it? Why do they need it? In what form do they want it?

The report discusses how to build a news media relation program, based on a well-defined strategy and using continuous monitoring of the results.

Copies of *Helping the News Media cover Family Planning* are available free of charge to readers and organisations in developing countries. In developed countries multiple copies are USD 2.00 each, from **Population Reports**, Center for Communication Programs, 111 Market Place, Suite 310, Baltimore, Maryland 21202, USA. Tel.: +1 410 659 6300, fax: +1 410 659 6266. E-mail: PopRepts@welchlink.welch.jhu.edu.

RESEARCH

Male participation and responsibility in fertility regulation

Women's health advocates have consistently called for men to take more personal responsibility for reproductive health and fertility regulation. The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction has carried out several studies on men's needs and preferences with regard to methods of fertility regulation, especially in less-developed countries.

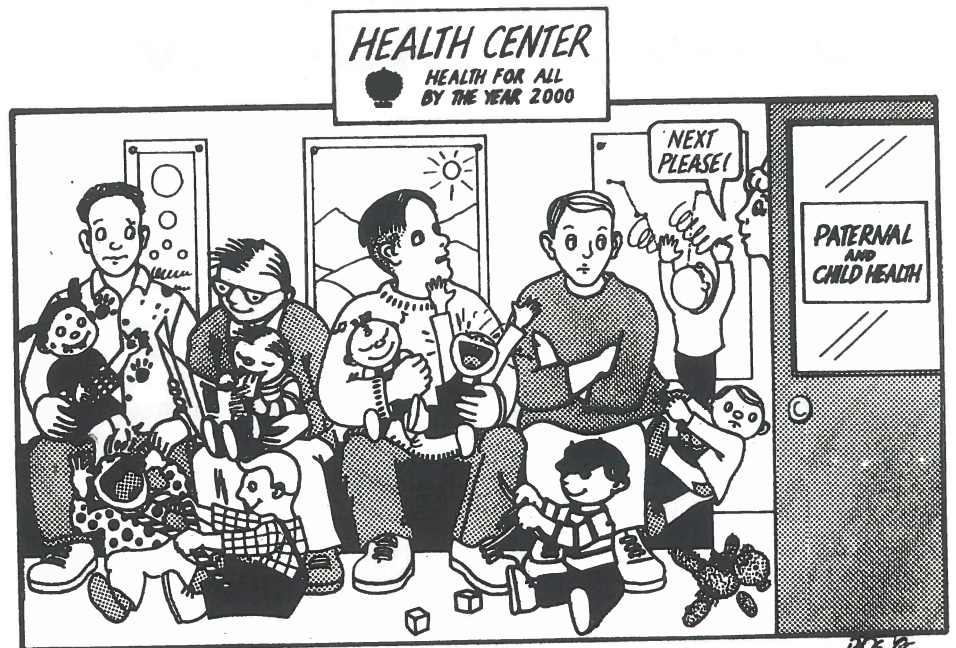
Although there were significant inter-country differences, a high percentage of men studied knew at least one method of fertility regulation, most often the condom. On average, some 75% of men approved of the use of family planning, even in developing countries, which is contrary to the commonly held notion that men in these countries are against family planning. It is not clear from the data, however, how many men approve the use of male methods, but in spite of this, the actual use of such methods was very low. Condom use was low even in the countries that are relatively more effected by the AIDS pandemic. Vasectomy use remains negligible in Africa (0.1%) and Latin America (1%), although it was used by 10% of respondents in East Asia.

THE CHIEF OBSTACLE TO THE USE OF FAMILY PLANNING METHODS BY MEN IS THE LACK OF CHOICE IN MALE METHODS

Apart from withdrawal, the options for men are limited to the condom and vasectomy. In studies carried out in 1976 men were asked about two hypothetical methods - a male pill and an injectable method for men - they said that these methods would be more acceptable than condom and vasectomy.

REPRODUCTIVE HEALTH CONFERENCE URGES WIDER USE OF EMERGENCY CONTRACEPTION

Emergency contraception should be available to all women who wish to use it, according to a recent conference of reproductive health specialists. In a consensus statement the 1995 conference, held in Bellagio, Italy,



asserted that "millions of unwanted pregnancies could be averted if emergency contraceptives were widely accessible".

Emergency contraceptives are methods that women use *after intercourse* to prevent pregnancy. Several methods are known to be safe and effective, including higher doses of regular combined ethinyl estradiol/levonorgestrel contraceptives (the Yuzpe regimen) and the IUD. Levonorgestrel may also be used and mifepristone (an antiprogestone drug that suppresses ovulation and can inhibit implantation of the fertilized ovum in the uterus wall) is currently being studied to ascertain the optimal dose.

Delegates pointed to three main reasons why emergency contraceptives are not used more widely. First, many women simply do not know of the availability of contraceptives that have the desired effect after intercourse, or even that post-coital contraception is feasible. Second, there are few products being marketed specifically for use as emergency contraceptives. Third, service providers often seem reluctant to provide emergency contraceptive methods. But because these methods must be used within a short time of unprotected intercourse, women must know about them *before* they need to use them. The conference called for "prophylactic provision of emergency contraceptives" so that women can have them on hand for use as and when needed.

(For more information see *PROGRESS in Human Reproduction Research*, No. 35. Available from: *Special Programme of Research, Development and Research Training in Human Reproduction*, WHO, 1211 Geneva 27, Switzerland.)

Advances in female sterilisation research

Some 153 million women around the world have chosen to be sterilised for contraceptive purposes, some 138 million of them in the developing countries. The most common surgical procedure today is minilaparotomy, in which the Fallopian tubes are approached from a small cut in the abdomen. The advent of fibre-optic technology was soon followed by techniques of electrocoagulation and of applying clips and rings to the Fallopian tubes to block them. There have been improvements in the design of blocking devices, but only small gains in safety and efficacy.

In July 1994 the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction convened a consultation of experts to review the situation and identify promising approaches for use in developing countries. **The ideal method of female sterilisation would be a safe, simple and effective one-time procedure for occlusion of the Fallopian tubes that costs little, involves only local anaesthesia, causes minimum damage and is both individually and culturally acceptable.** The experts stressed the need for adequate training of the personnel who perform sterilisations and also drew attention to the need for adequate counselling as one of a range of contraceptive methods so that women do not become sterilised without full information about the procedure

and thus later regret is avoided as far as possible.

(Papers presented at the consultation are reviewed in *PROGRESS in Human Reproduction Research*, No. 36. Available from WHO 1211 Geneva 27, Switzerland.)

Warnings against quinacrine

Short-term toxicity tests sponsored by Family Health International confirm that quinacrine can cause genetic damage in the in-vitro systems used, and reinforces concerns that quinacrine could be carcinogenic. Its use as a non-surgical method of female sterilisation has been the subject of controversy in recent years and even though the method is still in the experimental stage, it has been used without proper controls in a number of countries. In 1994 WHO recommended that further studies on toxicity testing should be done and possibly long-term animal carcinogenic testing before proceeding with clinical trials, and the Medical Advisory Panel of the International Planned Parenthood Foundation (IPPF) stated that the use of quinacrine pellets for female sterilisation could not be recommended until studies demonstrated its safety.

(*IPPF Medical Bulletin*, Vol. 30 No. 1, Feb. 1996.)

Contraceptive research and development

An international effort supported by the Rockefeller Foundation and other donors - Contraception 21 - is working to revitalise contraceptive research and development.

During the past decade fewer researchers have entered the field and both private- and public-sector funding has decreased, despite the fact that health advocates and policy makers have called for expanded and improved contraceptive methods for both women and men. The Contraception 21 agenda places women's concerns at the centre. In addition to an overall emphasis on improving the quality of care, three specific areas are emphasised: improved vaginal methods, particularly those that protect against sexually transmitted diseases (STDs); menses inducers (preferably a once-a-month pill); and more male methods.

Participants at the 1994 International Conference on Population and Development recommended that high priority be given to the development of new methods of fertility regulation for men. The results of development work during the past decade have led to modified condoms - made of more secure materials or with a tighter or looser fit.

Various methods of vas occlusion continue to be evaluated, including potentially reversible approaches using silicone plugs. For the past 20-30 years the main focus of research on systemic contraception for men has been administration of hormones to inhibit spermatogenesis (sperm production). But the main problem is that hormones used also regulate production of the androgen, testosterone, so methods that interfere with sperm production also affect sexual function. Another major difficulty with systemic male methods has been the delivery mechanisms. Studies have required weekly and sometimes even daily injections. Then there is the fact that methods affecting spermatogenesis have a two to three month delay between method initiation and infertility, requiring the use of another contraceptive method during the initial months of use.

(For more information see *OUTLOOK*, Vol. 13 No. 2, June 1995. Available from Program for Appropriate Technology in Health (PATH), 4 Nickerson St. Seattle, WA, 98109-1699. Tel.: +1 206 285 3500, fax: +1 206 285 6619, e-mail: info@path.org)

FROM OUR READERS

Promotion of breast feeding & relactation with refugee women

by Ruth Hope

I have just read the excellent issue *Tuning into Women: Entre Nous* 30/31 December 1995. However, I think an important issue has been omitted from the discussions of reproductive health of refugee women which I would like to raise with you.

For Kurds in Northern Iraq an later displaced persons of Bosnia Herzegovina significant numbers of mothers no longer followed traditional breast feeding practices. This resulted in diarrhoeal diseases and malnutrition caused by insanitary preparation of infant feeds and inadequate availability of infant formula. New mothers giving birth during the emergency did not have breast feeding skills nor support from experienced women relatives. Emergency workers needed promotion of breast feeding, lactation management and relactation skills. Their efforts were often thwarted in

Bosnia Herzegovina by intermittent arrival of powdered milk brought in by well-meaning, but inexperienced, "volunteers" bringing truck loads of charity donations from the UK and elsewhere.

Promotion of breast feeding and support to breast feeding mothers has additional benefits, in the form of lactational amenorrhoea, to women in emergency situations for whom contraceptive services and commodities are inadequate or not available.

I think these important issues deserve publicity and inclusion in any discussion of reproductive health for refugee women.

Ruth Hope

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WORLD HEALTH ORGANIZATION
Regional Office for Europe
Nutrition Unit
December 1995
Second revised draft - 15 December 1995

How to Breastfeed during an Emergency

A guide for mothers

by
Dr Elsebet Helsing, Regional Adviser for Nutrition
Dr Aileen Robertson, Consultant, Nutrition Unit
Ms Tine Dige Vinther, Consultant, Nutrition Unit



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Scherfigsvej 8, DK 2100 Copenhagen, Denmark
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Available from Nutrition Unit, WHO regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark
Tel.: +45 39 17 13 62, fax: +45 39 17 18 18.

RESOURCES

Books

La salud del Adolescente y del Joven, ed. Maddaleno, Munist, Serrano, Silber, Suárez Ojeda, Yunes. Publicación Científica No. 552, Organización Panamericana de la Salud (1995 - 572 p.). Large collection of essays and articles in Spanish treating various aspects of youth and adolescent health questions and problems. ISBN 92 75 31552 3. Available from WHO Regional Panamerican Office, 525 Twenty-third Street NW, Washington, DC 20037, USA.

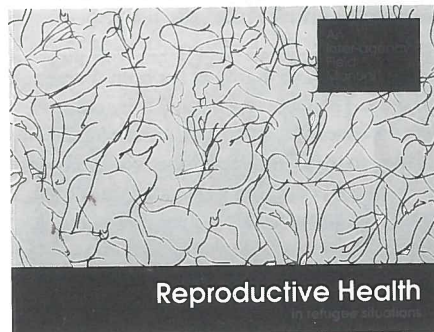


Refugee Children. Guidelines on Protection and Care. This handbook, compiled and published by the UNHCR is developed from the UNHCR Policy on Refugee Children, adopted in October 1993. The guidelines reflect the realisation that children need special care and assistance and are intended both for UNHCR staff and operational partners, whether voluntary organisations, UN agencies or governments. Available from: UNHCR Programme and Technical Support Section, Case Postale 2500, CH-1211 Geneva 2, Switzerland. E:Mail - bopandan@unhcr.ch.

Documents

Reproductive Health in refugee situations. An inter-agency manual to assist all concerned parties - governments, NGOs, academic institutions, the UN and its specialised agencies - in promoting the

integration of reproductive health services in refugee and other emergency situations. Available from: UNHCR Programme and Technical Support Section, Case Postale 2500, CH-1211 Geneva 2, Switzerland. E:Mail - bopandan@unhcr.ch.

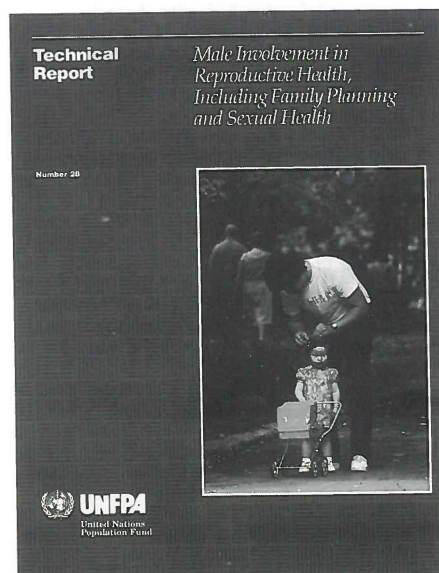


Male Involvement in Reproductive Health, Including Family Planning and Sexual Health.

Technical Report No. 28, UNFPA.

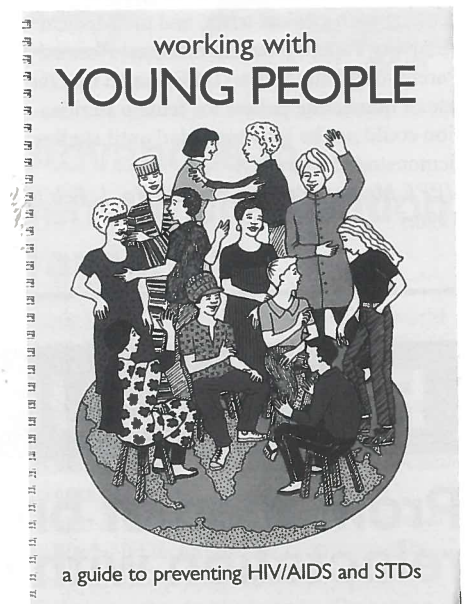
The Programme of Action of the 1994 International Conference of Population and Development (ICPD) draws attention to the importance of men for reproductive health, including family planning and sexual health, and the need for them to assume their responsibilities in the family with respect to child care and household tasks.

This paper presents a state-of-the-art review of existing knowledge regarding male involvement in reproductive health and suggests ways in which national authorities, agencies and other national organisations working in this field can further strengthen such involvement at policy, programme and individual levels. ISBN 0-89714-332-9 Available from UNFPA, 220 East 42nd Street, New York NY 10017, USA Ref. no. E/2,500/1995.



Working with Young People, a guide to preventing HIV/AIDS and STDs.

Joint publ. of Commonwealth Youth Programme/WHO. This guide is written for people who want to plan and carry out health promotion projects to prevent HIV infection and other STDs especially among out-of-school youth. Very practically based and full of useful examples and suggestions it can be used to start a new project or to integrate HIV- and STD-related prevention activities into an existing youth programme. This and a variety of other resources relating to HIV/AIDS and young people are available from AHRTAG, Farringdon Point, 29-35 Farringdon Road, London EC1M 3JB, UK. Tel: +44 171 242 0606, fax: +44 171 242 0041.



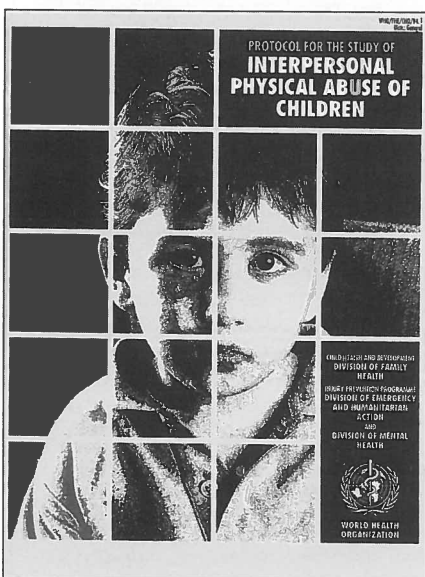
Facing the Challenges of HIV, AIDS, STDs: a gender-based response.

This is a resource pack intended to help policy-makers, programme planners and implementers, and service providers in these areas develop a gender-based approach to their work. Produced jointly by WHO Global Programme on AIDS in Geneva (CH-1211 Geneva 27, Switzerland), the Royal Tropical Institute (KIT) in the Netherlands (Mauritskade 63, 1092 AD Amsterdam) and the Southern Africa AIDS Information Dissemination Service (SAfAIDS) in Zimbabwe (17 Beveridge Road, Avondale, Harare), the pack includes tool cards and posters, which serve as guides for practical activities, plus a book explaining the gender-based approach, why it is important and how it can be implemented. Distributed free of charge by all three parties.

Teaching Modules for Basic/Continuing Education in Human Sexuality.

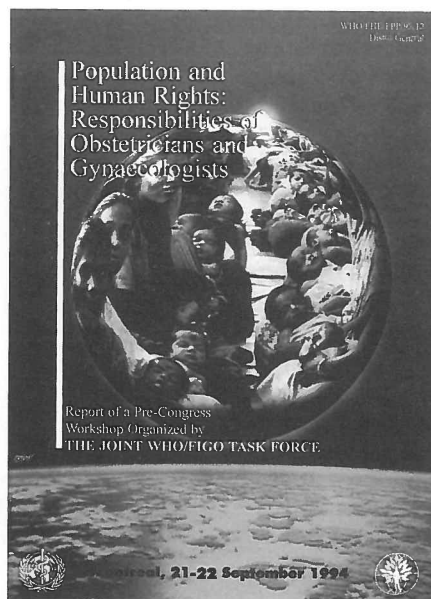
HIV/AIDS Reference Library for Nurses, Vols. 7 & 8. (1995) Nurses and other health care workers often need to deal with health problems related to sexual matters, and instructors are faced with the challenge of teaching students or other youngsters about human sexuality. These practical volumes are intended to help health care workers to deal more confidently with sensitive sexual issues, and to improve their communication and counselling skills in general. ISBN 92 9061 115 4. Available from WHO Distribution and Sales, 1211 Geneva 27, Switzerland and the Publications Unit, WHO Regional Office for the Western Pacific, P.O. Box 2932, U.N. Avenue, 1099 Manila, Philippines.

Interpersonal physical abuse of children, A protocol for study. This is a detailed handbook setting out the rationale and methodological concerns for research into Child Abuse and Neglect (CAN) in response to the initiatives of the World Summit for Children and the Convention on the Rights of the Child. It also includes appendices with examples of studies, questionnaires and protocol guidelines for researchers. WHO Distribution and Sales, 1211 Geneva 27, Switzerland. Ref.: WHO/FHE/CHD/94.1.



Health Benefits of Family Planning. Family Planning and Population, Division of Family Health, WHO (1995). This booklet summarises key findings about the health benefits of family planning and explains how offering a choice of contraceptive methods benefits both clients and programmes. It is intended for policy makers, programme managers, community leaders, teachers, health providers and others who need concise, up-to-date information about how family planning is beneficial and why it should be supported with

adequate human and financial resources at all levels. Ref.: WHO/FHE/FPP/95.11. Available from WHO Distribution and Sales, 1211 Geneva 27, Switzerland.

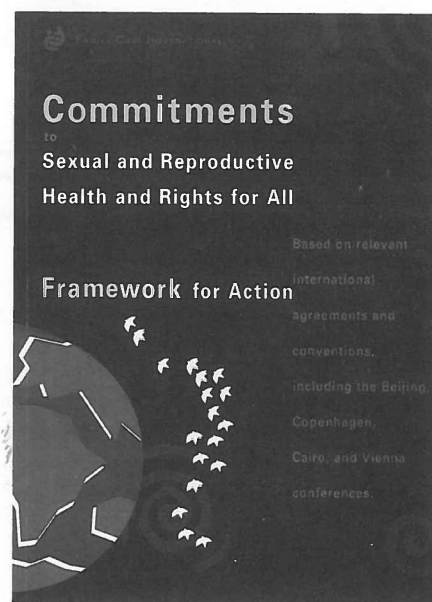


Population and Human Rights: Responsibilities of Obstetricians and Gynaecologists. Report of the pre-congress workshop of the same name held in Montreal, Canada, 21-22 September 1994, including a summary of presentations. Joint publ. of the International Federation of Gynaecology and Obstetrics (FIGO) and WHO. Ref. WHO/FHE/FPP/95.12.

A Brief Guide to Abortion. pub. by the Swedish Association for Sex Education (RFSU) (1994). Booklet in question-and-answer form designed to function as a guide to the issue of abortion. It contains a selection of facts and explanations relevant to the problems of abortion and its history; statistics are presented and controversial political and ethical questions are considered. Available from the Swedish Association for Sex Education, PO Box 12128, S-102 24 Stockholm, Sweden. Tel: +46 8 692 0700, fax: +46 8 653 08 23.

Commitments to Sexual and Reproductive Health and Rights for All: Framework for Action. This report produced by Family Care International (FCI), provides a summary of seven recent international agreements and conventions, including the Beijing, Copenhagen, Cairo and Vienna conferences. The report is a valuable reference and advocacy tool to help policy makers, governments, NGOs, parliamentarians, women's groups and the private sector strengthen strategies to improve sexual and reproductive health and rights. Each commitment carries a reference to actual paragraphs contained in the various conventions or conference document. The document includes sections on

national policy guidelines; ensuring conformity to ethical and human right standards; and providing access to sexual and reproductive health care. Specific issues such as Safe Motherhood; unsafe abortion; family planning, prevention of STD's/HIV/AIDS; the girl child; adolescent health and sexuality; violence against women; and male participation are included. The document is available in English, French and Spanish. For single copies please contact: Family Care International, 588 Broadway, Suite 503, New York, NY 10012, USA. Tel: (+1) 212 941 5300. Fax: (+1) 212 941 5563; or e-mail: fci@chelsea.ios.com. (Additional copies US\$2.00 .)



Women's Health in Norway. (1995). Report written for the Fourth International Women's Conference in Beijing 1995. Aims to contribute to international dialogue on women's health, especially reproductive health. Sections include and overview of health and social conditions of women in Norway, lessons and challenges, and a section on working towards gender sensitivity in health care. Pub. and distributed by Norwegian Board of Health, PO Box 8128 DEP, 0032 Oslo, Norway. Tel. +47 22 34 88 88.

Sexual Rights of Young Women in Denmark and Sweden. Looks at the Danish and Swedish experiences concerning young women's sexual and reproductive rights, what has been achieved and how. Pub. by and available from the Danish Family Planning Assoc., Aurehøjvej 2 DK 2900 Hellerup Denmark and the Swedish Assoc. for Sex Education, PO Box 12128, 102 24 Stockholm, Sweden.

Glasgow's health - WOMEN COUNT. Pub. by the Women's Health Working Group, Glasgow Healthy City Project, 1994. Booklet and colourful information sheets

provide information about the health situation of women in a readily accessible format, aimed primarily at those promoting and making decisions about women's health.

Developing a Policy for Women's Health.

A Discussion Document. Published by the Irish Ministry of Health (1995), this 100-page booklet maps out the issues of importance for women's health in particular, giving statistics and other information to show how women's health in the Irish Republic compares with other European nations. Ref.: PN 1701.

Available from the Government Publications Sale Office, Sun Alliance House, Molesworth Street, Dublin 2, Republic of Ireland.

Health Care of mother and baby at the health centre: a practical guide. Report of a Technical Working Group set up to define

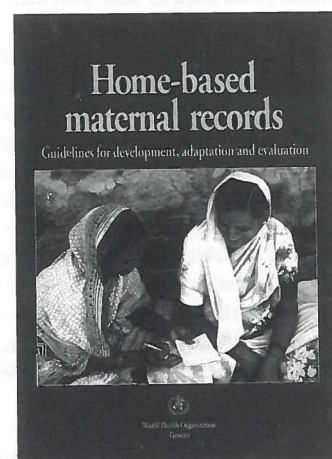
the essential obstetric care necessary at first referral level for the reduction of maternal mortality and morbidity, and to describe the staff, training, supervision, facilities, equipment and supplies needed. It presents a series of recommendations to improve access and decentralise maternal and newborn health care. Ref.: WHO/FHE/MSM/94.2. Available from WHO Distribution and Sales, 1211 Geneva 27, Switzerland.

Home-based maternal records.

Guidelines for development, adaptation and evaluation. The home-based maternal record is an example of simple, appropriate technology for mother and child health.

These guidelines, which are based on field experience, cover all aspects of the development, adaptation and evaluation of home-based maternal records. They are intended for decision makers in health services,

obstetricians, programme managers and community health service systems. Available from WHO Distribution and Sales, 1211 Geneva 27, Switzerland.



TRAINING OPPORTUNITIES IN EUROPE

The Research Center for Obstetrics, Gynaecology and Perinatology of the Russian Academy of Medical Sciences in Moscow offers over 60 different programmes for individual in-service training of specialists. The courses range in duration from 1 week to 2 months, and cover a wide variety of areas, ranging from modern methods of contraception and termination of pregnancy, to diagnosis and treatment of infertility, medico-dietetic counselling and mammography. Interested persons should contact Prof. V.I. Kulakov, Director, Research Center for Obstetrics, Gynaecology and Perinatology, 4 Oparin Street, 117513 Moscow, Russian Federation. For more information: Tel.: 7 095 438 3683. Fax 7 095 438 4965 .

Diploma in Reproductive Health in Developing Countries. A 12-week, full-time course, commencing April each year and run jointly with the Department of Obstetrics and Gynaecology of the University of Liverpool and the Royal College of Obstetricians and Gynaecologists. Although entry eligibility is, primarily a medical qualification, together with approved post-qualification experience in obstetrics and gynaecology, applications are also encouraged from non-medical health workers with an interest in reproductive health, including midwives and health services managers. The aim of the course is to provide training in skills that are required for the organisation of effective systems of reproductive health care (which include care in pregnancy and

childbirth, fertility control and infertility, gynaecological dysfunction, and sexually transmitted diseases). An appropriate understanding of background clinical problems is assumed so that learning will focus on organisational skills, and understanding of epidemiology, audit, and clinical research methods, critical evaluation of effective forms of care including systematic reviews of reproductive health interventions, information technology, and sociological and public health perspectives on relevant gender issues.

Further information from: The Course Secretary (DRH) Liverpool School of Tropical Medicine, Pembroke Place, Liverpool L3 5QA, United Kingdom. Tel: +44 151-708 9393. Fax: +44 151 708 8733.

Basic Training in Reproductive Health/Family Planning

This course gives participants the opportunity to acquire knowledge and competence for organizing RH/FP services in their own country. One third of the six-week course is devoted to lectures followed by a four-week training in different clinics of the Department, as well as in some other sites in the field.

Two courses are organised each year: the first in April-May and the second in November-December.

Postgraduate Training in Advanced Techniques for Reproductive Health/Family Planning

This course gives participants the opportunity to gain knowledge and the necessary skills for carrying out advanced techniques in their own countries.

Only 3 days of the four-week program are devoted to lectures. The rest of the course is spent with practical training.

The courses are organised each year:

the first in March-May and the second in September-December.

Application forms and further information can be obtained from:

Dr István Batár, Associate Professor and Director of Training, UNFPA Training Courses, Department of Obstetrics and Gynaecology, UMSD, Debrecen, P.O. Box 37 Hungary-4012.

Tel: +36 30 282 074 or +36 52 411 600 Ext. 5447 or +36 52 417 144 Ext 4058.

Fax: +36 52 414 577. Telex: 72 411 dote h. E-mail: ibatar@obgyn.dote.hu.

DEBRECEN, HUNGARY 1996-1999

TRAINING COURSES IN REPRODUCTIVE HEALTH/FAMILY PLANNING FOR SERVICE PROVIDERS FROM COUNTRIES WITH ECONOMIES IN TRANSITION

A joint project of the

DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY, UNIVERSITY MEDICAL SCHOOL OF DEBRECEN (WHO COLLABORATING CENTRE)

and

UNITED NATIONS FUND FOR POPULATION ACTIVITIES NEW YORK