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Some journalists attending the Social Summit rounded on UN Secretary-General Boutros Boutros-Ghali and asked him if Copenhagen, following on from Rio (Earth), Vienna (Human Rights) and Cairo (Population) would serve any real purpose other than to increase “summit fatigue”. Boutros-Ghali reflected for a moment and then replied: “The duty of the UN is to cope with fatigue. Fatigue means indifference and our role, our raison d’être, is to say we are all in the same boat”.

During the Summit itself however, it became patently clear that not all nations accept that “we are all in the same boat”. There was thinly veiled resistance from countries of the developed world to commit themselves, financially and politically to eradicating global poverty. For example, despite valiant championing by UNICEF, the 20-20 Formula was so watered down and hedged with so many get-out clauses that it is virtually meaningless. Attempts to persuade Western nations to write off the debts of the developing world, a debt burden that continues to condemn so many nations to eternal poverty, were sturdily resisted. Proposals to institute the Tobin Tax (James Tobin, winner of the 1981 Nobel Prize for Economics argued that a 0.5% tax on international currency transactions, which can exceed US$ 1,000,000,000,000 a day would raise US$150 billion a year to fight poverty) met with stony stares.

Yet the summit, in my view, was a success and worth the US$330m spent, largely by the Danish government, to make it happen. The issue was not really poverty, but the global consequences of poverty. Delegates however, were not spared the full, painful scale of poverty in our times: 1.3 billion poor, 13 million children under five die annually as a consequence of poverty, US$1.4 trillion owed by the poor nations to the rich. No degree of indifference can wish away these staggering statistics and no degree of wishful thinking can convince itself that the consequence of such abject poverty can forever be confined to the developing world.

Indeed the aim of the Summit was to drive home the inter-connectedness of everything. In a shrunked world operating in a globalised market, a sneeze in Singapore can result in a bout of fatal pneumonia in London - witness the shocking collapse of Barings Bank one of the oldest and most venerated institutions in Britain.

Civil conflict goes hand in hand with underdevelopment. Conflict, in Africa, Asia, Latin America and Eastern Europe has led to massive movements of people and unsustainable pools of refugees. This leads to more conflict and an ever widening circle of poverty. Poverty on this scale impacts negatively on the environment and leads to deforestation, degradation and desertification. This leads to even more conflict, more poverty. The result is a shrunked world market, which manifests itself, eventually, in recession and unemployment in industrialised countries. Such an economic environment, as history so clearly shows, is ideal breeding ground for extremist politics, terrorism and the rise of fascism.

The message from the Summit was that the problem of poverty is not exclusively that of the poor world but very really that of everybody. We are, whether we like it or not, “all in the same boat” and if it takes a major international confer-
From Cairo to Copenhagen

By Dr Nafis Sadik

In Cairo last September, the International Conference on Population and Development permanently changed the way family planning is viewed by the world community. The Conference firmly placed family planning among the totality of reproductive health needs, and recognized that meeting those needs is a pressing global responsibility.

One hundred and eighty nations overwhelmingly adopted the 20-year Cairo Programme of Action. The Programme of Action reflects a new strategy emphasizing that population and development are inseparable, and focuses on individual and human rights rather than on demographic targets.

The key to this new approach is empowering women and providing them with the choice through expanded access to health care, education, training and employment opportunities. The Programme of Action calls on countries to make family planning services universally available through their primary health care systems by 2015 or sooner, as part of a broader reproductive health package which also encompasses services for pre- and post-natal care, safe delivery, prevention of sexually transmitted diseases including HIV/AIDS, infertility, and management of the complications of abortion.

The Programme of Action also includes goals in regard to education, especially for girls, and for the further reduction of infant, child and maternal mortality levels.

The Conference’s adoption of this Programme on 13 September was an electrifying moment, the start of a new era in dealing with population and development concerns. It was the culmination of a remarkable process of consensus building which took shape over the course of several years, in regional conferences, Preparatory Committee sessions, and expert group meetings on various related issues.

The ICPD strategy grew out of more than 20 years experience with population programmes, and the global community’s growing appreciation of the importance of human development, environmental protection and the empowerment of women.

As the Preamble to the Programme of Action notes, “The 1994 Conference was explicitly given a broader mandate on development issues than previous population conferences [in 1974 and 1984], raising awareness that population, poverty, patterns of production and consumption and the environment are so closely interconnected that none of them can be considered in isolation.”

The context of the Cairo Programme of Action is a world of nearly 5.7 billion people, growing at between 85 and 88 million a year. More than one billion live in absolute poverty, and many more are only marginally better off. Infant, child and maternal mortality rates are still tragic in many countries despite the substantial progress achieved in recent decades. Throughout the world, women and girls face tremendous disadvantages in regard to health care, education, training, and employment prospects.

Around the world, basic resources on which future generations will depend are being depleted. There is a vicious circle of poverty, social and economic inequality, rapid population growth, environmental degradation, and unsustainable production and consumption patterns. Uncontrolled urban growth and a steady increase in international migration are among the consequences.

Strongest statement on women

The ICPD approach recognizes that these problems must be confronted simultaneously. To improve people’s quality of life and health, developing countries must have sustained economic growth within a framework of sustainable development; they must invest in health and education, especially for girls; and women must be empowered so that their social, political, economic and health status matches that of men.

In one of the strongest statements on women ever to be included in a UN document, the ICPD Programme of Action stresses that women must be full and equal participants in all aspects of development planning and programming; this is both a matter of basic human rights and a prerequisite of sustainable development. It also stresses that inequalities between men and women must be ended to meet the goal of better reproductive health.

The Programme of Action affirms “the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice.”

It further calls on countries to ensure that adolescents have access to appropriate services and information to address such issues as teenage pregnancy, sexually transmitted diseases and sexual abuse.

Implementing this holistic approach, based on the principle of free, informed choice, will have the effect of promoting smaller, healthier families. Lower birth rates will lead to a better balance between population growth and resources.

At the same time, nothing in the Cairo consensus weakens the power of nations to make their own decisions regarding population and development. The Programme of Action emphasizes that implementation is “the sovereign right of each country, consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized international human rights.”

A large and diverse group of non-governmental organizations (NGOs) were involved in an unprecedented degree in the ICPD process and in shaping the Programme of Action. The Programme of Action stresses the need for broad and effective partnership between Governments and NGOs in formulating, implementing and monitoring population and development programmes.

The international community now faces the challenge of translating the ICPD approach and commitments into action. This will require both significant policy changes and a sizeable increase in national and international resources committed to reproductive health programmes.

In developing countries and those with economies in transition, the Programme of Action estimates that comprehensive reproductive health and family planning services would cost US$17 billion per year in the year 2000, about three times what is being spent today, and US$21.7 billion in 2015. It is anticipated that developing countries will be able to provide two thirds of the necessary funds through domestic sources; the remaining one third, or about US$5.7 billion in 2000 and US$7.2 billion in 2015, will have to come from donors.

Since the Conference, various national
activities have got under way to disseminate the Programme of Action and to develop implementation plans. More than a dozen countries have already begun to review their population programmes to ensure consistency with the Programme of Action, including its approach to reproductive health. Mexico, for example, has decided to merge its family planning and maternal and child health programmes under a Directorate of Reproductive Health. Brazil is establishing a Council on Population and Development which will facilitate participation by NGOs and community groups.

At the United Nations Population Fund (UNFPA), a top priority is to ensure that policies and practice fully reflect and promote the ICPD Programme of Action. As part of a post-Cairo review of its policy guidelines, UNFPA in December hosted an expert consultation to seek guidance in developing new guidelines on reproductive health. Participants included international reproductive health experts, programme managers, representatives of women's health advocacy groups, and representatives of WHO and other international and bilateral agencies.

**New guidelines on reproductive health**

These new guidelines will focus on operational aspects of reproductive health and specifically on the following components: family planning information and services; maternal care; prevention of abortion; reproductive tract infections; infertility; women's reproductive health conditions; and harmful practices including female genital mutilation.

Among the many useful recommendations were calls for increased emphasis on sexual health and rights, male responsibility, and adolescent reproductive health.

UNFPA's financial assistance will focus on the reproductive health package outline of the Programme of Action. The greatest emphasis will be on those countries that have the farthest to go to meet the ICPD goals for the year 2015. The Fund intends to increase support for activities to prevent sexually transmitted diseases and infertility and reduce mortality and morbidity, and for advocacy work to eliminate female genital mutilation.

Greater attention will be given to information, education and communication with regard to reproductive health (including that of adolescents), gender concerns and education of girls. Additionally, the Fund plans to assist women's groups to better participate in monitoring implementation of the ICPD Programme, and to provide technical support for other organizations' and agencies' programmes to empower women and improve their status.

In recent weeks, the Fund has conducted four regional consultations, involving government officials, parliamentarians, NGO representatives and health experts from the public and private sectors in discussions on how to speed implementation of the Programme of Action. A similar workshop for the Europe region will take place from 3-5 May in Bucharest. A Task Force on ICPD Implementation has been set up to plan and support follow-up activities, in cooperation with UNFPA's geographical, technical and information/external relations divisions. UNFPA is also working to ensure that the programmes of the World Summit for Social Development and the Fourth World Conference on Women build on the agreement reached in Cairo.

Our task now, both collectively and individually, is to ensure that the optimism which has emerged from the ICPD process and which the Programme of Action reflects is turned into tangible benefits for people everywhere.

Sufficiently funded and properly carried out, the actions defined in the ICPD Programme will:
- **bring women into the mainstream of development; protect their health, promote their education, and encourage and reward their economic contribution**;
- **ensure that every pregnancy is intended, and every child is a wanted child**;
- **protect women from the results of unsafe abortion**;
- **protect the health of adolescents, and encourage responsible behaviour**;
- **combat HIV/AIDS**;
- **promote education for all and close the gender gap in education; and**
- **protect and promote the integrity of the family**.

Energetic implementation of the Programme adopted in Cairo will as a result contribute to slower and more balanced population growth; to the ending of poverty; and to economic development compatible with the demands of sustainability.

The following is excerpted from the address delivered by Dr Nafis Sadiq, before the plenary of the World Summit for Social Development.

**Copenhagen:** One of the major successes of the ICPD was consensus on a Programme of Action with a very strong emphasis on gender and equality. I am delighted to see that in Commitment 5 and in the draft Programme of Action generally, this Summit has incorporated many of the goals and elements from the ICPD Programme of Action.

It is important that this progress be maintained. Investing in people, in broadening their opportunities and enabling them to realize their potential as human beings - that is the key to sustained economic growth and sustainable development, as well as to balanced, sustainable population growth. Both the ICPD Programme of Action and the draft Programme of Action for this Summit recognize the absolute necessity and urgency of empowering women as an important end in itself, as well as a key to improving the quality of life for everyone. Without the full and equal participation of women in all its aspects, there can be no sustainable human development.

I would like to emphasize however that the goal of empowerment cannot be achieved without attention to the basic circumstances of women's lives. 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 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. I urge the nations present at this Summit to endorse in this area the language you agreed to in Cairo, as an essential contribution to social development.

The new international community reached agreement on significant new investments in the areas of reproductive health and family planning services. Many countries have already indicated that they will increase their support for population and development programmes in the near future.

These resources will be complemented by funding a wide variety of measures aimed at meeting the educational and health goals set at earlier conferences. It would be heartening to see progress at this Summit towards the 20/20 vision for commitment of resources to meet social development goals. Together with commitment to implementing Agenda 21, this would make a coherent statement of the international community's willingness and determination to end poverty, build social justice, and work towards a sustainable future.

At Cairo, the nations threw down a historic challenge in the field of social development. I hope this Summit will take up the gauntlet, not merely in the words of the Programme of Action, but in the hearts of everyone attending this meeting, and in your deeds in the future. Then we may all be proud to say that we were here on this International Women's Day.
Turkey

Women’s health tops the agenda

by Prof Ayşe Akin and Dr Arzu Köseli

The International Conference on Population and Development (ICPD) was explicitly given a broader mandate on development issues than previous population conferences, reflecting the growing awareness that population, poverty, patterns of production and consumption and the environment are so closely interconnected that none of them can be considered in isolation.

Turkey participated both during the preparatory phase of ICPD and also sent a 15 strong delegation, led by State Minister Mrs Onay Alpago, to Cairo. The delegation was made up of representatives from the technical departments of the Ministry of Health: General Directorate (GD) MCH/FP, the State Statistical Institute, the Hacettepe University Institute of Population Studies, the GD Women’s Affairs and policy makers from the State Planning Organization, the Ministry of Foreign Affairs and national NGOs.

Although the entire ICPD Plan of Action is relevant, our Ministry of Health is giving priority to: Reproductive Health, the Status of Women in our country and to Mortality and Morbidity.

Our strategy to implement the ICPD Plan of Action will involve:
(1) Publicizing the goals of ICPD,
(2) Sharing responsibilities and coordinating our activities with other sectors and
(3) Following-up and monitoring both achievements and failures.

After the preparatory phase, which was carried out in collaboration with UNFPA-Turkey, we organized a wide-ranging panel discussion for a large number of participants from various sectors. Delegates who had attended ICPD provided valuable information about the Conference and the Plan of Action to representatives of technical departments. We also discussed our targets and strategies to implement the Conference recommendations.

We took the opportunity presented by a two-day conference, organized by the Ministry of Health to declare the results of the 1993 Turkish Demographic Health Survey, to brief the scientific community about the Conference and the ICPD Plan of Action. Members of the Cairo Delegation were thus able to discuss issues and recommendations raised by ICPD with both scientists and policy makers. As a result, a number of verbal commitments were made.

The message was propagated further when, Professor Ayşe Akin, General Director of MCH/FP gave a comprehensive presentation on ICPD during a meeting to honour the late Professor Nusret Fıșek. Professor Fıșek, the founder of the Primary Health Care system in Turkey, also managed to change what was then a national pronatalist population policy into an antinatalist one some 30 years ago.

Professor Akin’s clear exposition of ICPD drew considerable interest during the commemorative meeting organized by the Turkish Medical Association. Members of the audience requested that the Plan of Action be published in Turkish. As a result, the GD MCH/FP has translated, printed and distributed chapters relating to reproductive health, status of women and mortality and morbidity. Efforts are also being made to translate the entire document.

An important step was taken when a plethora of Government Ministries and NGOs attended the Population Planning Advisory Committee’s (PPAC) annual meeting on January 24. Participants included the Ministries of Health, National Education, National Defense, The Interior, Foreign Affairs, and Transportation. Other organizations that attended this important meeting included The Women Health Advisory Board (established in 1993 under the PPAC), the State Planning Organization, the State Statistical Institute, Hacettepe University Institute of Population Studies, the Higher Education Council, and national and international NGOs.

The Plan of Action was discussed in detail, the roles of each sector were identified and every department made a commitment to take responsibility for implementing the Plan. Follow up mechanisms were also established at the meeting.

Recommendations and guidelines from ICPD documents have also been incorporated into the Seventh National 5-Year Development Plan. In January this year, the State Planning Organization reviewed national Reproductive Health, Population and Family Planning policies. In addition, the Prime Minister, Professor Tansu Çiller has initiated a special study aimed at developing an accelerate programme on population and family planning issues.

Using ICPD recommendations as guidelines, the current situation on population, reproductive health and family planning in Turkey can be summarized as follows:

* Population is a priority area. Detailed goals and targets have been laid down in the Seventh National 5-Year Development Plan.
* Improvement in the Status of Women is considered to be of special signifi-
The ICPD was an excellent international forum in which to draw attention to some of the most neglected areas in health and development. It also effectively emphasized the relationship between population and sustainable development. More significantly perhaps, the Conference has enabled countries to re-evaluate their priorities and has stimulated the desire to implement the Plan of Action.

In addition, improved services both in quality and method (surgical contraception, Norplant, injectable) is provided. Pregnancy termination is legal up to the 10th week of pregnancy and certified general practitioners have been authorized to terminate pregnancy by MR procedure since 1983.

As a result of these approaches, the mortality due to induced abortions is almost nil at present and termination services are available in all public health institutions. The use of modern FP methods is higher than the use of traditional methods. The unmet need is decreasing, while the abortion rate has levelled off and is beginning to decline.

Additional support services include the distribution of the National Family Planning Guideline to all health institutions, and an improvement in IEC material for both health personnel as well as the public. A sourcebook, Population-Health-Environment-Development which illustrates the relationship between these topics, was prepared, printed and distributed to decision makers and community leaders at all levels in the country. The recommendations of the ICPD have been taken into account in preparing the National Women’s Health Strategic Plan, which is scheduled to be completed this year. There is now a sufficient data-base to prepare the national plans of action.

Follow up mechanisms vital
However, while there is political support of FP activities, the financial commitment is not yet sufficient to meet the need.

In conclusion, the ICPD was an excellent international forum in which to draw attention to some of the most neglected areas in health and development. It also effectively emphasized the relationship between population and sustainable development. More significantly perhaps, the Conference has enabled countries to re-evaluate their priorities and has stimulated the desire to implement the Plan of Action.

However, it is vital to establish follow up mechanisms at both national and international levels so that countries can monitor their progresses, or lack of it, and also share in each other’s experiences.

Professor Dr Ayşe Akin is General Director of Maternal and Child Health and Family Planning (GD MCH/FP), Ministry of Health, Turkey.

Dr Arzu Köseli is a staff member of the GD MCH/FP, Ministry of Health, Turkey.

Moldova

Historic regional conference
by Dr Veaceslav Moșhin

Soon after the ICPD, a historic regional conference organized by the Directorate of Maternal and Child Health and the Family Planning Association of Moldova, was held in Chisinau, Moldova on 18-19 October, 1994. The conference, entitled Problems of Family Planning in Eastern Europe, was attended by about 400 Moldovan delegates representing different governmental and non-governmental organizations, and 25 delegates from Romania, Russia, Belarus, the Ukraine and Georgia. The conference, which received the approval of the President of Moldova and the Ministry of Public Health of Moldova, became a reality because of the support of UNFPA, WHO and IPPF.

The main objectives of the conference were to inform the public about the recommendations of ICPD, analyse the status of women’s reproductive health and family planning in Eastern Europe and find ways to implement the ICPD Plan of Action.

During discussions, the major population-related problems in Eastern Europe were identified as follows: (1) social and economic problems facing most families, (2) the high rate of morbidity and mortality of the population, (3) a slump in the birth rate, (4) increasing recourse to abortions, (5) rising incidence of venereal diseases, and (6) the absence of an effective family planning system.

There was general agreement that in order to resolve this crisis, it was essential for both Governments and NGO to cooperate closely in fashioning out national population programmes in each country. In order to improve women’s reproductive health in this region, participants felt that the following steps have to be taken urgently: (1) To provide populations with sufficient contraceptives; (2) Actively promote family planning concepts through the mass media, (3) Train specialists and open FP offices and centres; (4) Introduce sex education in the curricula of Pedagogical Institutes; (5) Create national and regional statistical and sociological data-bases on population issues.

The conference in Chisinau was one of the most significant ever held on the subject because it brought together people of different ages, creeds, political affiliations and from different professions together to discuss vital issues concerning family planning.

Dr Veaceslav Moșhin is the President of the Family Planning Association of Moldova.
Implementing the ICPD Plan of Action in Central Asian Republics and Kazakhstan (CARAK)

Over the next few pages, we concentrate on the efforts of Central Asian Republics to implement wide ranging reforms in MCH care systems. Most of the articles are edited excerpts from presentations made during an International meeting on MCH and Family Planning in the Central Asian Republics which was held in Tashkent, Uzbekistan from November 30 to December 2, 1994.

Uzbekistan

Squaring up to a demographic crisis

Presentation by Dr Shafkat Karimov, Minister of Health, Uzbekistan

The ancient land of Uzbekistan, which has given birth to some of the world’s greatest thinkers, scientists, and military leaders, people such as Ahoresni, Abouhaimelech, Alifaghani, Ali Farabi, Ulukbeck, Nabbrir, Navoi and many others, is also the soil that produced the brilliant physician of old times, Abou Ali ben Sina and visionary architects whose works adorn cities like Samarkand, Bukhara and Herve. Uzbekistan is rich in natural resources and endowed with fertile land and massive rivers, but today, this republic of 20 million people is in the throes of a demographic crisis. Addressing the international meeting on Strengthening Maternal and Child Health and Family Planning in the Central Asian Republics, Dr Shafkat Karimov, Uzbekistan’s Health Minister, warned of the demographic problems the country will have to face in the near future.

“Over the past ten years,” said the Minister, “the birth rate has been stable at around 30 per 1000 of population, and this has led to an annual population increase of 2.5%. If this growth rate stays the same, the population of Uzbekistan will have increased by 50% by the year 2015 to some 35 million people,” a huge leap for any nation.

Scientific population policy

Given the significance of these figures - the serious influence rapid demographic change can have on the social, economic and political fabric of nations, he said that the both he and the Government “have become aware of the importance of a balanced, scientifically-based population policy, which will include measures to regulate the population growth.”

Uzbekistan is already showing the signs of a demographic crisis today, characterized by a rising level of infant and maternal mortality, a worsening of the general health status of the population and a shorter life expectancy. The crisis is being played out against an already difficult social and ecological background. The drying up of the Aral sea is but one factor in the steady decline of both the quality and standard of living in the country.

Indeed in his book, Uzbekistan, Individual model of the transition to market economy, the President of the Republic, I.A. Karimov highlights the demographic problem when he writes: “The economic problems in the context of the demographic situation bring to light the need for clear solutions to social problems. In Uzbekistan, we have today one of the lowest standards of living. In 1990, 70% of the population of Uzbekistan lived below the poverty line, whereas in Russia and Ukraine, only 30% of the population found themselves in the same predicament”.

The Health Minister Dr Karimov warned: “If we do not take measures to control negative factors, we will have an increase in maternal and infant mortality of between 50 and 100%.” But proving just how serious the Government is in tackling the problem, Dr Karimov was able to give a detailed analysis of the issues at stake, and how Uzbekistan’s medical service had been able to respond to them.

Dr Karimov blamed the low health index of women of reproductive age and the spread of various extra-genital diseases as the main causes of the crisis. He said that frequent births by women suffering from extra-genital diseases, short child spacing, and giving birth at either too early or too advanced an age had all led to high infant morbidity and mortality. Not only does it endanger the health of the women, he said, but “the material and moral state of the family and the economy of the society as a whole.”

“We know that birth by women under 20 and above 35 is accompanied by a higher risk of perinatal mortality and can lead to chromosomal and other abnormalities in the offspring” he said. From this, “it becomes clear that children should be born during the optimal period for a woman, i.e. between the ages of 20 and 29. Today, we have many women who give birth under the age of 20 and who only stop reproducing after the age of 35.”

Discouraging early marriage

In Uzbekistan, according to sociological research, 45% of married women under the age of 20 and the first child is usually born in the first year of marriage. The interval between marriage and the first child is therefore often very short. Some 37.4% of married women under 20 have children, 20.3% have one child, 15.7% have two and 14.4% have three children before they are 20 years old.

Dr Karimov argued that marriage age not only influences population growth but also the nation’s economy “since a woman between the ages of 18 and 25 who is not preoccupied by her family and children, has a higher productivity for society.”

The Minister pointed out that measures to discourage early marriages could only be successful if they were designed with social, economic, psychological and medical characteristics in mind. “We must develop the desire among our young people to achieve certain social and economic goals before getting married. We have to increase the value of independence, autonomy, education, position in society, and career development in their eyes, especially among girls, and we, the Government, have to invest in education.

We must develop the desire among our young people to achieve certain social and economic goals before getting married. We have to increase the value of independence, autonomy, education, position in society, and career development in their eyes, especially among girls, and we, the Government, have to invest in education.
Food is now given to pregnant women, to women with many children and to poor families free of charge. All pregnant women are given vitamin tablets and the free treatment of anaemia in pregnant women, and women suffering from extra-genital diseases has been established.

Tablets, and the free treatment of anaemia in pregnant women, and women suffering from extra-genital diseases have been established.

"Through the integration of our internal medicine, obstetrics, gynaecology and pediatric services into a single center," said Dr Karimov, "we have managed to improve antenatal care. We have also introduced a rooming-in policy in the obstetric wards, as well as early breastfeeding, instead of artificial milk."

Dr Karimov said that his ministry was now using a computer system to carry out our maternal mortality. This system can give us daily information on the maternal mortality situation, and thus allows us to take appropriate measures. The system of monitoring women of reproductive age, especially of the high-risk groups has been functioning better and better, said Dr Karimov. "As a result, we have managed to decrease maternal mortality from 73.2 per 100,000 live births in 1990 to 42.4 in 1993. This means the lives of 192 women were saved."

"Apart from this, we have observed a decrease in the number of births, younger age at first contraceptive use, and a decrease in abortions by 2.5% compared to 1993."

Dr Karimov says that the bulk of preparatory work has now been done to enable an enlargement of the family planning programme, and the population, he believes, has been sensitized to the importance of family planning.

His Ministry will continue and even reinforce its work in educating and informing all groups of the population, especially young people, on how to adequately prepare for family life, the optimal age of marriage, and the importance of judiciously spacing births.

In order to raise the public consciousness towards health, said Dr Karimov, "we are using television and radio programmes as well as producing booklets, posters, and brochures, popular scientific books and other literature."

Since it is essential to inform every adolescent of risks which can influence the health, especially of future mothers, Dr Karimov said it was necessary to carry out medical and gynaecological examinations of all schoolgirls at least twice a year.

He stated that his Government was constantly working on contraceptive methods in cooperation with WHO as well as pharmaceutical companies like Schering, Upjohn, and Organon. Uzbekistan is even on the verge of producing its own oral hormonal contraceptives.

Concluding his address, Dr Karimov invited other delegates to try and find ways and means of involving Central Asian men more actively in family planning. "How can we induce the so-called stronger half of humanity to carry the burden of family planning equally with women?" he asked.
Kazakhstan

Looming shadow of ecological disaster

by Dr Aman Dujsekeev and Prof Nina Kajupova

The Republic of Kazakhstan is a vast area stretching from the shores of the Caspian Sea to China. The population of some 16 800 000 is widely scattered although the majority live in urban areas. Like many of the Central Asian republics, Kazakhstan is an ecological disaster area. The Aral sea, once the source of massive irrigation projects, has contracted to such an extent that it could disappear in the not too distant future. The coastal zone, which once provided a good living from the sea has been severely degraded and denuded. The country has also been a nuclear test site and radiation activity in some areas, combined with chemically harmful fertilisers have been a major health hazard. In addition to all this, is the poor state of the economy and a general running down of social services. Since the health of the nation depends so heavily on the health of the most vulnerable groups, women and children, the new Republic of Kazakhstan has extended a protective umbrella over them. By legislation, "Family, maternity, paternity and childhood are under the protection of society and the state."

Legal status of women

The legal status of women is considered from three positions: The role of women in society as a whole, in working collectives, and as part of a family. In the national economy, women form a very important segment: they constitute 62% of specialists with higher and secondary specialized education. Since their contribution to the national economy is so critical, policies to protect their social, economic and health status are vital. However, women's social and economic positions are inseparably linked to the quality of their reproductive health. This in turn, often influences their health during their entire life span.

Although the rate of maternal mortality is relatively high, there has been an overall decline over the past four years.

The most prevalent causes of maternal mortality in Kazakhstan are complications arising out of pregnancy and labour and during the postpartum period. Over the last few years however, the proportion of deaths from these causes has declined from 40% in 1991 to 31.1% in 1993. A similar reduction has occurred in deaths arising from abortion complications (which is the second highest cause of maternal deaths) from 23% in 1991 to 21.4% in 1993; deaths from obstetric hemorrhage (the third highest cause of death) has declined from 13.5% in 1991 to 16.3% in 1993.

From our research, we have come to the conclusion that interdependent factors which influence the maternal mortality rate include the general state of women's health, reproductive function and the quality of health service.

The age of the mother and the number of times she undergoes labour are the main determinants of maternal mortality. Among the women, who have died from these causes, multipara make up 60.0%, including 28.0% of grand multipara. The probability of obstetric complications is higher in primipara over the age of 30 and in women reaching the age limit of fertility.

Multiple labours pose universal risks. Studies show that at birth intervals of up to two years, pregnancy complications occur in 46.7% of women but when the interval is 3-5 years, the risk of complications is reduced by 25%.

Unwanted pregnancy remains one of the prime causes of maternal death. Although the number of abortions as a cause of maternal death is declining, the problem of unwanted pregnancies remains a difficult one. It is clear that reducing the number of abortions would reduce maternal mortality rates.

As early as 1978, the Alma-Ata Declaration stressed that primary health care involved: "Women and children's health, including family planning". We consider family planning as a system aimed at preventing and reducing abortions so that women would only very seldom have to resort to this mutilating operation and never have to die in full bloom.

In order to reduce the number of abortions, we have to give families the opportunity to make deliberate choices and use a wide range of effective methods. But concepts of family planning and the reproductive system are still shrouded by ignorance. We therefore use the mass media, including radio and television broadcasts, newspapers and magazines to disseminate information on reproductive health. We realize that such a sensitive issue as family planning has to be handled by competent specialists with due regard for traditions, religion and customs. Educating and training students, physicians and midwives, is a priority as a result.

Following the joint WHO and UNICEF Declaration on Protection, Encouragement and Support of Breast-feeding a special programme has been developed jointly by the Research Centre for Regional Nutrition Problems, the Republican Research Centre for Maternity and Child Health Care, the Centre of Pediatrics and Children's Surgery, and Almaty Institute of Advance Medical Studies.

Although breast-feeding has been a long-held tradition in Kazakhstan, previous health systems built hospitals with separate wards for mothers and newborns. To rebuild the maternity homes to accommodate both mothers and newborns will take many years. But, in the meantime, we have set out to popularize breast-feeding everywhere.

"Active work by WHO specialists in this field is helping us to successfully carry out the campaign. At present, according to our data, 51.1% of mothers breast-feed for up to six months. Our current annual target, employing the programmes mentioned above, is: (1) To reduce maternal mortality by 18.0% (2) To reduce the number of abortions by 14.0% and (3) to reduce mortality from acute respiratory infections by 0.9%.

UN Secretary-General Boutros Boutros Ghali at the world Summit for Social Development, Copenhagen.

The problems faced by women everywhere lie at the heart of the global agenda. Until the rights and full potential of women are achieved, enduring solutions to the world's most serious social, economic and political problems cannot be achieved."

Prof Nina Kajupova is Chief Obstetrician-Gynecologist of the Ministry of Health, and Director of the Republican Research Centre for Maternity and Child Health Care.

Dr Aman Dujsekeev is the First Deputy Minister of Health of the Republic of Kazakhstan.
Tajikistan
Succeeding against the odds
by Dr Valentina Alexeejvna Matseva

Tajikistan lies in the Central Asian region and is bordered by Afghanistan, China, Uzbekistan and Kyrgyzstan. This republic is the smallest in the region, with a population of 5.7 million living on some 143 000 sq.km. Tajikistan differs from other Central Asian republics in that the majority of its population is rural. In fact the rural population has grown from 67% in 1989 to 71.3% in 1993. Tajikistan has an astonishing number of nationalities (80), although the most numerous are Tajiks, 65.8%, followed by Uzbeks (24.4%) and Russians (22.3%).

Traditionally all families are large. Some 60% of women give birth to five or more children; 25% of them with birth intervals intervals of 1.5-2 years.

The high mortality rates for pregnant women, in childbirth, in parturient periods and for infants are the result not only of a severe socio-economic situation, but also the consequence of the civil war, which broke out in 1992. Damage caused to health care alone as a result of the war is estimated to be around USD 20 million.

Currently, the quality and quantity of Mother and Child Health services have declined substantially. The main reasons are the exodus of trained personnel, the severe shortage of medical drugs, the lack of facilities and poor management and monitoring.

The main causes of death for pregnant women, in childbirth and puerperium remain, as before, bleeding, toxemia and extra-genital diseases. The main causes of death for infants are still infectious diseases (incl. diarrhoea), respiratory diseases and pathological perinatal conditions. Following the International Year of the Child in 1979, the Government of Tajikistan instituted a number of programmes, including those of a medical nature, aimed at improving Maternal and Child Health. In some instances, the difference has been spectacular: Infant mortality, for example has been reduced from 93.6 per thousand in 1979 to 40.8 per thousand in 1990.

Priority on survival
In 1991, the Ministry of Health, in conjunction with 27 other Ministries and departments, produced a State Programme on Maternal and Child Health. The draft programme was submitted for consideration to the government, but because of a large deficit in the country’s budget, it could not be adopted.

The Civil War of 1992 not only ruined the economy, it also retarded the country’s development by 10 years. The political instability dominated people’s thoughts and their sole priority was on how to survive.

At present however, field programmes on immunization, and against the spread of diarrhoeal and acute respiratory infections have been worked out and are proved. Assistance towards breast-feeding and family planning programmes is also being provided.

The programmes, based on recommendations by WHO, UNICEF and other international organizations also take into account the country’s demographic situation, Woman and Child Health indicators and the current state of health care services. Within the framework of these programmes, training courses have been carried out, and material for health care personnel as well as for public educational work has been prepared.

However, although the full range of action on Women’s Health in the European Region, as stipulated in the Vienna Conference of October 1994, cannot be carried out at present, the MOH is making efforts to improve health care in the country by reforming the sector. The main thrust of the reforms will be directed towards increasing accessibility, and improving the quality and effectiveness of medical care.

At this juncture, it is vitally important to revise the approach towards the structure of medical care for women and children. Greater emphasis has to be placed on care before labour, and modern methods of delivery have to be introduced. Changes have to be made in the training of obstetricians in order to develop practical skills and abilities; and specialists in various fields have to be produced. It is equally important to enlist and train volunteers to work with women and children. In addition, there is an urgent need to produce publications and other educational material on training and methodology.

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Kyrgyzstan
Breast-feeding is best
by Dr Anisa Kushbakeeva

One among the many unpleasant consequences of the socio-economic problems, which began in 1990, has been the dire impact on the general health of the people of Kyrgyzstan. A major decline in income, poor living standards, and social insecurity are all reflected in many negative demographic indicators, such as low fertility rate, high maternal and infant mortality rate, and shorter life expectancy.

These indicators, which highlight the poor state of mother and child health care, also point to the dangers posed to society as a whole. Many social diseases, such as tuberculosis, viral hepatitis, anaemia, hyperthyroid, and rachitis have become very common among young children.

In an effort to arrest the situation, breast-feeding has been promoted so vigorously that it has gained the importance of a National Programme. Breast-feeding is in fact, thelynch-pin in the Government’s campaign to safeguard and improve the nation’s health.

There are many unresolved issues which have to be tackled if any improvement to Mother and Child Health is to be brought about. Among these is the high neonatal mortality rate.

It is not really possible to develop perinatal services, without first taking care of the health of pregnant women. The maternal mortality rate has been increasing fairly steeply; it was 76.4 per 100 000 live births in 1991, and now it is 84.2 per 100 000.

Since 1989, there has been a functioning family planning service and a system of “social patronage” in Kyrgyzstan. The “social patronage” system involves a social worker taking charge of families which are considered to be “at risk”. At present, one worker on average, looked after 30 such family groups.

Over the past year, international organizations have been a big help. The financial problem has been partially solved by The International Planned Parenthood Federation (IPPF) which has financed 698 social patronage workers for one year. International organizations have also supported the supply of contraceptives mainly through humanitarian assistance. As a result of this, the number of women accepting family planning is rising and a trend towards decreasing fertility rate (from 28.2 per 1000 in 1991 to 26.9 in 1993) can be detected.

Dr Anisa Kushbakeeva
is Senior Flediatrician of the Kyrgyzstan Republic.
Turkmenistan

Abortion rate declines

by Dr Khangeldi Mamedov

Turkmenistan, situated in the western part of Central Asia, extends over 1100 km from east to west and over 650 km from north to south. On the north, it borders with Kazakhstan, on the east-north-east with Uzbekistan, on the south with Iran and on the south-east with Afghanistan. On the east, the country is washed by the Caspian Sea. The northern and central parts of the country consist of the sandy deserts of the Turanian Plain and the Karakum, which make up some 80% of the total area of Turkmenistan. To the south the sandy deserts give way to the foothills of the Koppe Dagh, and to the south-east to those of the Paropamis. The rivers Amu Darya, Murgab, Teshen, Atrek and others flow through the country. The main water artery is the Karakumskim: a man-made canal.

Turkmenistan has a population of 4,361,300. Turkmen make up 72% of the population, Russians 9.5%, Uzbeks 9%, Kazakhs 2.5% and others 7%. The majority of the population is Muslim. The national language is Turkmen, while Russian is the language of international communication.

The annual rate of increase of the population is 3% with a high birth rate (33.1 per 1000) and a natural growth rate of 25.2 per 1000.

The maternal mortality rate in Turkmenistan is high, 105.3 per 100,000 live births. The main cause of maternal mortality, obstetrical hemorrhage, accounts for one third of deaths.

The perinatal mortality rate is 23.8 per 1000 live births (stillbirths: 14.5, neonatal mortality: 9.3). Preterm infants accounted for 42.2% of perinatal mortality.

A family planning service has existed in the country since 1989. Of the family planning methods used by the population, intruterine contraception has proved to be the most popular with some 41,666 intrauterine coils inserted in 1993. Hormonal contraception was received by 0.2% or 1610 women.

In the last five years, the rate of abortions per 1000 women of childbearing age has declined by 27.2%.

The most promising approach to family planning in Turkmenistan, appears to be the widespread revival of the traditional practice of exclusive breast-feeding. A level of up to 98% natural contraceptive protection can be achieved as a result of lactation amenorrhoea until the infant is 6 months old, with a corresponding level of 90-92% up to the age of 12 months.

Year by year, Turkmenistan is expanding its network of establishments delivering outpatient, polyclinic and inpatient care to women and children in particular.

Dr Khangeldi Mamedov

is Deputy Minister of Health of Turkmenistan.

Azerbaijan

Urgent need for family Planning

by Dr Valida Jafarova

Given the serious health problems in our country, especially those affecting women and children, it is very important for newly independent states like Azerbaijan to participate in international conferences like the IPCD.

As a result of war, the situation has become dire. More than one million people have fled the country, and huge numbers have been wounded. There has been a dramatic increase in the number of patients, especially children with infectious diseases. Because of the economic and ecological crisis, cases of genetic diseases have multiplied as has the number of patients with congenital anomalies. Over the last year, the maternal mortality rate increased substantially.

In 1990, as reflected in government statistics, there were only 9.3 gynaecologists for 100,000 women. Baku City had the highest maternal mortality rate while the lowest is in the rural areas. Death was common among women who delivered many children, had unwanted pregnancies or abortions. Analysis of maternal mortality showed that death due to late toxocosis (15.4% in 1992, 27.2% in 1993) was the highest cause of maternal mortality. Other causes include postpartum hemorrhage, DIC syndrome (23.6%), peritonitis after Cesarean section (5.1% in 1992 and 8.4% in 1993), and sepsis 8.6%.

Over the three year period, 1990-1993, the national maternal mortality rate rose by 23.0 to 28.20%; in some regions the rate even increased by 80%. Mortality rate due to respiratory tract diseases was 57.2%, perinatal pathology 13.3%, diarrhoeal diseases 10.2%, congenital anomaly 5.8%, sepsis 2.5%, still births 0.9%, perinatal death 14.3%, early neonatal death 5.2%; some 48% of women suffered preterm labour.

A recently formed committee to promote breast-feeding, encourages exclusive breast-feeding for at least four months after birth. Our long-term goal is to persuade women to breast-feed infants for two years.

Until now Azerbaijan had no family planning policy. In 1992, there was an attempt to set up family planning programmes but the good intentions came to nothing. Instead, there has been a serious increase in the number of abortions and abortion-related complications.

In 1993, there were 2,259 per 100,000 induced abortions; and the proportion of abortions among first-time pregnant women went up to 4.2% of the total. The statistics do not reveal the true picture because the majority of abortions are not registered at health institutions. Particularly worrying is the increase in the number of abortions among teenagers.

In the same way, the decrease in time interval between births by multiparous women and women suffering from severe anaemia also present a serious problem.

A well orchestrated Family Planning programme would obviously solve many of these problems, but at the moment, the supply of contraceptive devices in Azerbaijan is hopelessly inadequate. Only 1.4% of women of childbearing age use IUDs; 0.6% use oral contraceptives and condoms are generally unpopular. FP devices that are not designed for mass use can be found in some pharmacies but they are extremely expensive in a country where the average monthly salary is US$2.

At present, in Azerbaijan, there is one centre which deals with all aspects of reproductive health such as genetics, sex education and family planning. In order to solve the multitude of problems we have in Azerbaijan, we hope to receive cooperation and help from all friendly countries and also from the UN and WHO.

Dr Valida Jafarova

is Director of the Center for Reproductive Health, Azerbaijan.
Almaty, Kazakhstan
by Dr Tamara Djusubalieva and Dr G. B. Umurzina

During the last five years, figures coming from the medical services of Almaty, the capital of Kazakhstan, have revealed a very serious state of social distress in the city and its environs. The female population has become increasingly unhealthy and at the same time has come to rely on abortion to resolve the problems of unwanted pregnancies rather than use preventative contraceptive measures.

The abortion rate is staggering - an average of five abortions per woman - and has meant a widespread increase in the number of women with gynaecological problems.

Infertility is increasing, as is the figure for women who are healthy decreases every year. Today, it stands at only 30%. Indeed 70% of all registered pregnant women have one kind of disease or another, the most frequent being anaemia, which has increased four-fold during the last four years.

Diseases of the urinogenital system have doubled over the same time period, and the number of premature deliveries is growing annually - currently at 8% of all deliveries.

Realizing the severity of the situation, the City Health Care Department declared a state of emergency for gynaecological and obstetrical services.

Monumental task
On 12 February 1994, Order 33 approved the Family Planning Programme. The order required all medical institutions both to provide, and to massively expand family planning services for the monumental task of decreasing the number of abortions by half, and decreasing maternal and perinatal mortality.

The Programme covered the integration of obstetrical and gynaecological services with medical services in order to boost cohesion and access to both patients and services. It also defined the duties of obstetricians, gynaecologists, general practitioners, pediatricians, and other medical experts.

1993 saw the institution of 25 family planning rooms to deal with the crisis. They are coordinated by the City Human Reproductive Centre, which serves as the city's Family Planning Centre.

The primary focus of activity is the District Family Planning Room, one in each of the eight health districts' women's consultation centres.

Each district family planning room is responsible for the effectiveness of the programme in its district, and it is here that vacuum aspirations (mini-abortions) are carried out on an out-patient basis for women whose menstruation is delayed for no more than 18 days.

There are then family planning rooms in all the territorial women's consultation centres, and family planning rooms have also been set up in every territorial polyclinic serving the adult population. Services are provided by nurses who have been trained at the City Family Planning Centre. While their role is primarily to provide advice to women in their reproductive years, one of the most effective ways of ensuring that the concept of family planning is put across to the population at large has been to make it compulsory for any woman attending a clinic, whatever the cause of her visit, to discuss contraception at the family planning room.

Following a consultation, which includes a physical and gynaecological examination, the nurse will recommend a contraceptive method. Oral contraceptives are available at the facility. Pediatricians provide sex education to teenagers, and advise breast-feeding women on appropriate means of contraception.

Under the Programme, general practitioners identify women who have contraindications to pregnancy and offer them family planning advice or direct them to the family planning rooms.

Each family planning room submits the information it has acquired over the course of a month to the District family planning room, which in turn sends a special monthly report form to the City Family Planning Centre in order to monitor the effectiveness of their activities, and provide an invaluable picture of the health and reproductive patterns of the city's women.

Almaty Factfile
Almaty, the capital of Kazakhstan, has a population of 1,824,400 people with a female population breakdown of 3,533,333 women aged between 10 and 15 years old, 52,770 women between 15 and 19, and 340,000 between 15 and 49.

Deliveries are provided in seven maternal houses throughout the city. There are 7.8 midwifery beds per 10,000 population and 5.2 gynaecological beds per 10,000 population.

The level of medical services as measured by medical beds and providers per population is higher in the city than in the Republic as a whole.

Invaluable information
These reports provide a wide variety of information, including such data as the number of abortions carried out in the district; the number of abortions among children, teenagers, and first pregnancies; the number of mini-abortions, the number of insertions IUDs, and the number of women registered for IUDs or oral contraceptives; numbers of women using contraceptives, women with genital complications, numbers of sexually

Photo: Dr Marc Danzon ©
active teenagers, breast-feeding women, women with many deliveries, and frequent users of abortion services. This whole network of family planning rooms was modelled on British systems which we studied during a training tour to London organized by the International Planned Parenthood Federation.

Family planning rooms have also been established in two special institutions, one serving women with mental disorders, and one serving women with drug and alcohol problems. These rooms are charged with providing maximum contraceptive coverage to these women. But the programme does not stop there. Pharmacies which sell contraceptives have been established in all the medical institutions and industrial enterprises. Indeed many large industrial enterprises provide free contraceptives to employees, and students are given free contraceptives as well.

A further method of tackling the problem has come from the gynaecological departments, all of whom have started to insert IUDs immediately after abortions. In 1993, 25% of women accepted IUDs immediately after abortion.

**Oral contraceptives popular**

Oral contraceptives are also becoming more popular at least in part as a result of their increasing promotion. In 1993 alone 14 500 women began taking oral contraceptives and 17 000 IUDs were inserted. Although oral pills were not used in previous years, the 1993 oral pill prevalence rate made a firm start at 4.2%. In 1993 IUD prevalence was 31%, and total contraceptive coverage in 1993 increased from 27% in 1992 to 35%. Contraceptive coverage of high risk women has increased from 30% to 58%.

Following the USAID-funded October 1993 Conference on surgical sterilization conducted by the representatives of the Association on Voluntary Surgical Contraception, 32 surgical sterilizations were conducted using the mini-laparotomy method.

And the whole gamut of medical years of age, from 0.7 to 0.9 per 1000. Abortions also increased among teenagers between 15 and 18 years of age, from 28.8 to 35.3 per 1000. Among first pregnancies abortions increased from 7.9 to 8.2 per 1000.

A review of quarterly indicators of abortions and contraceptive coverage indicates a decreasing abortion rate (in comparison with the first quarter by 30%), increase in contraceptive coverage by 23.2%, and coverage with surgical contraceptives by means of laparotomy by 0.1%.

*New SFP Adviser in Romania*

Dr Katy Shroff was assigned to the post of WHO Technical Adviser for Sexuality and Family Planning in Bucharest, Romania, in October 1994. Katy Shroff is a Bachelor of Science, a Medical Bachelor and a Bachelor of Surgery. She also has a thorough grounding in family planning (Certificate of Competence, Instructing Doctor, and Regional Assessor+MFFP, Royal College of OB/GYN, London). Her last assignment was as Associate Director of Services for Women, Parkside Health NHS Trust, London.

In Romania, Dr Shroff is working closely with the Ministry of Health, Directorate of Maternal and Child Health on the National Family Planning Programme. We are happy that Katy has joined us.

*Erratum*

Reference is made to the article “Albania: Breaking the chains of the past”, Entre Nous 26-27, p. 17. The Authors of the article and the Ministry of Health have the following comments on the graph on infant mortality:

1. The source was not the Ministry of Health, but the National Institute of Statistics.
2. There was a contradiction between the text and the graph on infant mortality.
3. Also, before 1991, infant mortality was underestimated, due to different definition of infant mortality which did not include neonates from 500-1000gr born after 22nd week and omission of infant deaths in the first week at the civil register - due to this omission, the level of infant mortality was underestimated by one third. Also there was a repression of reporting on infant deaths.
SFP INTERCOUNTRY ACTIVITIES
Promoting the health of women

The "Women's Health Counts" initiative.

In 1993, the WHO Regional Office for Europe launched the Investing in Women's Health initiative. In its first phase, the Initiative focused on the status of women's health in the countries of Central and Eastern Europe (CCEE) and the Newly Independent States (NIS) of the former USSR. In its second phase, the Initiative is expanding its focus to include all of the Member States of the Europe Region.

To increase the understanding of the issue pertaining to the health of women in the European Region, the Regional Office has embarked on collecting and analyzing information to assess the top health priorities and provide the basis for programmes to improve women's health in all the Member States of the European Region. The key components of the WHO Investing In Women's Health initiative consists of:

1. Establishing a European Women's Health Network;
2. Producing Women's Health Profiles for each of the Member States;
3. Gathering Women's Health Profiles from each country into a comparative analysis;
4. Conducting regular meetings of women and health counterparts; and meetings of the Women's Health Forum which will bring together leaders in politics, international affairs and policy analysis to serve as advisers to the WHO Regional Director for Europe.

Nearly all European Member States have contributed national data on women's health. These will be compiled and published as a series, Country Highlights on Women's Health and distributed at the Women's Conference in Beijing.

Family planning and reproductive health in CCEE/NIS
by Dr Assia Brandrup-Lukanow and Ms Dorte Jepsen

In November 1994 UNFPA requested the WHO-EURO SFP unit to produce a background document for policy makers, decision makers and bilateral donors to identify main needs in family planning in the CCEE and NIS.

A draft document by Dorte Jepsen and Assia Brandrup-Lukanow, containing 22 short country reports on family planning and reproductive health in the CCEE and NIS was distributed in December. The draft also included data on the outline of the current situation, recommendation for action and international activities. The project is now being extended to include all CEE and NIS countries (27 countries in all) and the full report (120 pages) will be published in June. Both the draft document and the report can be requested from the SFP unit. Excerpts from the document are reproduced below.

Women's health
Infant and child health indicators are used as yardsticks of reproductive health, because children's health is strongly tied to their mothers' health, reflecting among other factors, conditions during pregnancy and at birth. Healthy mothers have an increased chance of having healthy newborns and children; while a woman's ill health affects not only her own opportunities and potential, but those of her children as well. Women's health is therefore an issue that crosses borders, political systems and cultural differences. It is an excellent investment as it guarantees an improvement in the health of the next generation.

Chronic illness and disability associated to some extent, with their longer survival.

As a prerequisite for health, women's economic situation is generally less favourable than that of men. The most fundamental and universal difference between households headed by women and those headed by men is the relative poverty of female-headed households in all countries. Poverty is a general indicator for ill health. For old women living alone, poverty often reaches extreme levels that threaten survival.

Food shortages and economic difficulties prevent many people from eating healthy diets. Malnutrition is a growing problem in many countries in the Region. Furthermore the prevalence of anaemia among young women is reaching levels of up to 40 to 50% in the Central Asian Republics, and 17%...
among pregnant women in Europe in general. The issue of security and women's health and safety in the home, the workplace and the community, applies to women world-wide. Although violence against women often goes unnoticed and undocumented, there are indications that domestic violence and rape are increasing, and the health consequences of this can be seen both physically and psychologically. There is a need to increase services for women who have become victims of violence.

The growing health problems, and particularly the widening gap between women's health in Western and Eastern Europe, require the re-thinking of social and health policies, and also the increased participation of women in making policy decisions over their health and future.

Family planning
With limited resources available, family planning services are increasingly being viewed as an appropriate mechanism for improving women's reproductive health. Some key reasons for providing a broader array of reproductive health services include:

(1) The incidence of induced abortions is integrally linked to access and availability of safe and effective contraception. Furthermore, women who visit family planning clinics seek abortion counselling, treatment of abortion complications and post-abortion family planning advice.

(2) Family planning services that provide pregnancy testing, prenatal and delivery care are often integrally linked to provision of appropriate care for pregnant, postpartum and breast-feeding women.

(3) Appropriate provision of contraception based on a woman's risk category and reproductive goals. Contraceptive prevalence rates range from 60 to 70% in some countries of Western Europe, to less than 1% in some countries of Eastern Europe. In many countries, the financial resources or the political will is lacking to make the necessary changes. Non-governmental organizations concerned with women's reproductive health are becoming increasingly successful in bringing about changes in their countries. The growing social respect for these organizations was reflected by the fact that many women belonging to family planning or other women's health organizations were members of national delegations attending the recent International Conference on Population and Development in Cairo. Thus, they directly influenced the decision-making process on women's health globally.

Although there is a growing interest in contraceptives in most countries of the CCEE and NIS, their limited availability and high costs do not make them a viable option for many people. In a situation where abortion is very cheap or free while contraceptives can cost as much as one third of one's salary, choice is effectively denied.

In some countries, the lack of sex education in the presence of changing social and moral values has led to an increase in teenage pregnancies, which vary widely between countries, with the UK reporting one of the highest, and the Netherlands the lowest rates in Europe. Also, many countries report increasing rates of sexually transmitted diseases, including HIV infection. The dire economic situation in many Eastern European countries has lead to an increase in prostitution/sex work. Though the number of AIDS cases is still generally low, there is an increase in female cases, not only due to sexual transmission, but also to intravenous drug use.

Two major problems in integrating reproductive health care within family planning programmes are:

1) The difficulty of providing Sexually Transmitted Disease (STD) diagnosis and therapy. Many STDs can be asymptomatic in women and this complicates clinical management. Implementing limited STD screening and/or management services can require significant commitment of human, laboratory and drug resources.

2) The fear that the reputation and credibility of family planning programmes may be tarnished if HIV/AIDS prevention and services are offered.

Therefore, the level of reproductive health services to be provided should be determined on a case-by-case basis, taking into account the client needs and programme capabilities. At the minimum, family planning programmes should provide a broad range of contraceptive choices, STD prevention and linkages with safe birth and abortion care.

In particular, family planning programmes are one element of health services throughout the life-span of women. They will only be successful, therefore, if embedded into a comprehensive system of health care which also addresses the problems highlighted earlier.

The abortion issue
Due to the lack of appropriate contraceptives and counselling services, abortion was and still remains the principal means of fertility regulation in the CCEE/NIS, sometimes equaling the number of livebirths, and sometimes even exceeding this by two or three times. As a possible result of the economic difficulties that these countries are encountering in their transition period, some are facing rapid fertility declines to levels below replacement.

Since most women who terminate an unwanted pregnancy intend to have a child later, it is extremely important to identify possible adverse effects of induced abortion on subsequent reproductive function. Cervical trauma, cervical and uterine adhesions, pelvic infections, to mention only a few, are complications which could adversely affect future pregnancy.

A review of available information concerning the long-term impact of induced abortion and subsequent reproductive outcome shows no consensus because some studies were conducted in countries where abortion was illegal, while others did not adequately control for confounding factors. However, it is generally agreed that vacuum aspiration in the first trimester, performed by an experienced and skilled specialist, is a safe procedure with few, if any, long-term adverse effects, i.e. secondary infertility, ectopic pregnancy, preterm delivery etc.

There are also several safety issues (abortion in nulliparous women, multiple pregnancy terminations, second trimester abortion) which have not been addressed adequately and need special attention, not to mention the psychosocial effects of multiple abortions and possible secondary infertility.

When designing family planning and reproductive health programmes, all the above factors should be taken into account. Above all, these services must be embedded as one element of health services provided during a woman's life-span.

Interagency meeting
In spring 1994, the SFP unit organized an inter-agency meeting to discuss technical and financial assistance to the Maternal and Child Health and Family Planning sector in Eastern Europe and the NIS. The meeting was attended by representatives from 28 multinational, bilateral and non-governmental agencies working in the field. A further 25 agencies who could not participate sent background documents and information material.

The purpose of the meeting was to exchange information on and coordinate programmes, projects and activities, and to identify geographical or technical areas in which assistance was necessary, but had not yet been provided, as well as areas in which activities were being duplicated.

The background papers, contributions of participants, and the report on the meeting are available from SFP together with the report.
GLOBAL PROGRAMME ON AIDS

REGIONAL OFFICE FOR EUROPE

UN to pool resources in battle against AIDS

by Johannes Hallauer and Alex Gromyko

A new initiative by the United Nations will pool the resources of its various agencies in Europe in the fight against HIV/AIDS. The UN Joint and Co-sponsored Programme on AIDS (UNJCP), the new umbrella programme, will involve UNDP, UNICEF, UNESCO, UNFPA, WHO and the World Bank in the urgent fight to halt the march of the disease. The programme, which will replace the WHO’s Global Programme on AIDS (GPA) is scheduled to begin in 1996.

The vast (WHO) European Region, home of some 850 million people, stretches from Greenland in the north-west to the Mediterranean countries in the south; and then cuts a vast swath across the heart of Europe to the Pacific coast of the Russian Federation. Massive political and social changes that have swept through the European Region from 1990 have seen the splintering of old empires and an upsurge of nationalism. One result is that the number of Member States has shot up from about 30 pre-1990 to 50 today.

An estimated 500 000 people in the Region are infected with HIV. As of September 1994, the cumulative number of AIDS cases reported for the Region was 138 901. The highest concentration of cases is in Western Europe. By December 1994, the highest rates recorded were in Spain, Switzerland, France and in Italy. Although these countries represent only 19% of the population of the European Region, they accounted for 72% of all diagnosed AIDS cases.

The countries of Central and Eastern Europe, on the other hand, accounted for less than 4% of all diagnosed cases, although they comprise 50% of the population of the WHO European Region. However these countries are undergoing traumatic political and social changes. The breaking up of once impenetrable borders, for example, has led to a sharp growth in mobility and has thus increased contacts with areas with higher prevalence of HIV. This, accompanied by changes in lifestyles, may vastly increase the potential for a rapid rise in HIV transmission rates. The large number of drug users infected in Poland, almost 2 800 paediatric AIDS in Romania, increasing numbers of STDs ‘Europe-wide’ and a more pronounced trend towards using injectable drugs indicate a real risk that HIV will spread rapidly unless immediate and appropriate action is taken.

The UNJCP is one response to this potential epidemic. The main aim of the new programme is to strengthen the efforts of each country in the prevention of HIV/AIDS by providing technical and financial assistance to the national programmes.

When the programme is fully functional, a UNJCP adviser will be assigned to each of the 28 countries of Central and Eastern Europe and the Newly Independent States, and will coordinate the efforts of UN agencies like WHO, UNICEF with those of NGOs and national organizations, to plan out and implement a programme specially tailored to the needs of the country in question. Working in collaboration with co-sponsoring agencies, a UNJCP adviser in any country will assist the national AIDS Coordinator in planning, administration, implementation, monitoring and evaluation of the national AIDS prevention programme, and hopefully bring the knowledge, expertise, experience and competence accumulated by the agencies constituting the joint programme to the country concerned.

Using WHO experience

It seems unrealistic however, to assume that sufficient funding for one UNJCP adviser per country will be available in the immediate future. In the interim, the programme will have to rely on inter-country advisers covering a group of countries.

The WHO/GPA/EURO programme, which ceases at the end of 1995, has been employing a similar structure and it would make sense to put the vast experience of WHO EURO staff at the disposal of the UNJCP. WHO EURO has already established firm foundations in the health sector of the Region through a variety of programmes, such as Sexuality and Family Planning, Drug Abuse Prevention, Communicable Diseases, Health Promotion. It would be logical for other UN agencies to link up with the existing WHO structure and create a regional body.

As it is, in 1994/95 WHO/GPA/EURO provided external assistance to all countries of Central and Eastern Europe, the Newly Independent States and the Baltics for the first time. A network of five posts for Inter-country Advisers on AIDS was established by the Global Programme on AIDS across the Region. Each post is responsible for the following countries:

Almaty: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan
Copenhagen: Albania, Bosnia and

ENTRE NOUS 28-29, May 1995

Thousands

ANNUAL INCIDENCE OF AIDS CASES IN EUROPE


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AIDS cases
Infertility treatment: a woman's perspective

Much unfavourable press has been written about the "high price of infertility treatments: how costly they are, their discouraging success rates, etc. Marcel Vekeman's article Is the treatment of infertility a luxury in a world in the middle of a population expansion? is no exception to this trend (Entre Nous, No 25, May 1994, page 5). Although Vekeman's article raises valid points, there are some that I wish to contest as a woman who has benefitted from infertility treatment.

He states that infertility is largely the result of inappropriate sexual behaviour ("up to 85% of the cases"). This needs correcting. One should always be wary of statistics for which no references are given, especially those construed to further an individual, often biased, point. Indeed, infertility is not as simple as Dr Vekeman would lead us to believe.

Many practicing infertility clinics encounter a significant minority of cases for which there is no defined cause. Possible causes of infertility include: insufficient hormonal production, environmental pollution and other factors, the stress engendered by modern lifestyle, and nutritional deficiencies. Dr Vekeman writes that sterility is "not just an accident", but in some cases, may well be an accident of nature or society.

Dr Vekeman thinks that society believes that sterility is a social disgrace, that society considers the "sterile individual" as a "useless element" of society". This statement is more than once in the article to any mention about what part of the world he refers to. I have met scores of women and men from Europe, North and South Americans, Africans - with fertility problems. These people come from all social and economic classes and contribute to society in their own special ways using their unique talents, like anybody else.

They are not different. Moreover, not one person has ever mentioned that he or she feels any form of "social disgrace" for not being able to procreate. Along the same line, one very important point that Dr Vekeman missed entirely is that the desire to have a child comes from within, both men and women feel it; and is not usually a society-driven force. Thus a "worldwide, educational campaign to eradicate the idea of sterility as a disgrace" would undoubtedly be a waste of precious public health resources.

Thirdly, the notion that treatment should be limited to women up to the age of 35 is pure discrimination. Is not Dr Vekeman aware that many couples are married several years before ascertaining and investigating infertility problems? That they give "Mother Nature" a chance before resorting to medical intervention? Many women seeking assistance tend to believe in stable marital relationships, many for 10 years and upwards, falling into the age bracket of 35 to 40. Some are even older. And, many of them succeed in making their dreams come true. I was one of them.

On what basis then should a couple be denied the chance for parental happiness because the woman is over 35 years of age? Would a cardiologist consider withholding by-pass surgery because the patient is "too old"? One should recall that the World Health Organization's definition of health is one of a state of physical, mental and social well-being and not just the absence of disease or infirmity. Based on this definition, infertility treatment should not be denied automatically to a pre-menopausal, or even menopausal, woman.

The issue of costs incurred during a pregnancy resulting from infertility treatment was not presented with all the facts. Again, I should like to draw upon my personal experiences and my contacts with many infertile couples. Most of the women I have met who succeeded with treatment (i.e., simple hormone stimulation to the more demanding IVF, GIFT, ET, etc.) went on to have very normal pregnancies, given their age category. They continue working, doing exercise, travelling, in short, leading very normal lives. However, because of the exceptional circumstances surrounding the conception of the baby, obstetricians seem to opt for a cesarean delivery as a precautionary measure and not necessarily because of a difficult pregnancy. I for one found pregnancy to be a wonderful experience, suffered absolutely no inconvenience, was physically very active walking and biking up to the day the baby was born, and had a perfectly normal delivery. My daughter, a bouncing full-term 3.7 kilo baby, was born two months before my 36th birthday.

In ending his article, Dr Vekeman writes that "Then, and only then, will dealing with sterility become more than a useless luxury". I would agree that certain forms of treating infertility are costly, just as is the care for cardiovascular disease, surgical or other forms of "hi-tech" medical intervention. Are these other forms also considered "luxury", in particular "useless luxury"?

One may try to argue that these other forms are deemed life-threatening intervention. Infertility treatment could also be deemed "life-threatening" from a mental (psychological) point of view and treatment is fully justified if it helps a woman, or a couple, come to terms with an infertility problem, and maybe, just maybe, have that very special feeling of "happiness". It would be socially and medically wrong to deny infertility treatment to those who need it.

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*[Note: the views expressed are those of the author and may not necessarily reflect those of the Special Programme and the World Health Organization.]
TECHNOLOGY

IMAP on Emergency Contraception

Statement developed by the International Medical Advisory Panel to IPPF (IMAP), 1994.

Despite the availability of highly effective methods of contraception, many pregnancies are unplanned and/or unwanted. These pregnancies carry a higher risk of morbidity and mortality, often due to unsafe abortion. The risk of pregnancy with one unprotected act of intercourse can be as high as one in four, depending on the cycle day of exposure in relation to ovulation. For the woman exposed to unprotected sexual intercourse, emergency contraception (also known as postcoital contraception) can be used to avoid an unwanted pregnancy.

Since the mid-1960s, the postcoital use of certain orally administered steroid hormones has been shown to be highly effective in preventing pregnancy. However, this should only be considered as an emergency procedure since data on efficacy and safety of long-term use is not available.

Copper-releasing IUDs have also been used effectively for emergency contraception. The precise mode of action of emergency contraceptive methods is uncertain. It is thought that they inhibit ovum transport, ovulation and implantation.

Established methods

Combined oral contraceptives

Combined oral contraceptives containing ethinyl oestradiol and levonorgestrel, or comparable formulations, can be taken in a regimen known as the ‘Yuzpe method’.

When the 50 μg ethinyl oestradiol/250 μg levonorgestrel Pill is available, two tablets should be taken as soon as possible and no later than 72 hours after unprotected intercourse, followed by two more tablets after 12 hours.

When Pils containing 30 μg ethinyl oestradiol/150 μg levonorgestrel are the only Pils available, these lower dose Pils can be used, taking four tablets followed by another four after 12 hours.

The Yuzpe method has a failure rate of up to 2%.

Indications for use

This method is indicated in women exposed to unprotected sexual intercourse, eg lack of contraceptive use, condom breakage, missed Pills, or in the case of rape.

Contra-indications

There are no known contra-indications to the use of hormonal emergency contraception.

Side-effects

Approximately half of the women will experience nausea. If vomiting occurs within one hour, the dose should be repeated and the use of an anti-emetic is advisable. Irregular uterine bleeding and breast tenderness also commonly occur.

Follow-up

Ideally, all clients should be followed up as soon as possible for contraceptive counselling. Most women will have their menstrual period early. Clients should be advised to visit a clinic if they experience a delay of their period in order to exclude the possibility of failure of the method with consequent pregnancy.

In the event of a pregnancy, the woman should be counselled. She should be made aware of the available options and her decision should be respected and supported. If she chooses to continue with the pregnancy, she should be reassured that there is no evidence that this method of emergency contraception has any teratogenic effect, nor that it increases the risk of ectopic pregnancy.

The use of hormonal emergency contraception has no impact on future fertility.

The use of copper-releasing IUDs

Emergency contraception can also be achieved by the insertion of a copper-releasing IUD within five days of unexpected and/or unprotected sexual intercourse. This method has been reported to be highly effective with a failure rate below 1%.

The copper-releasing IUD may be particularly useful when the client is considering use for long-term contraception and/or when the woman no longer qualifies for the Yuzpe regimen because more than 72 hours have elapsed. When using an IUD for emergency contraception, the same contra-indications should apply as for regular use.

Counselling

Whenever possible, the woman should be counselled at the time of obtaining emergency contraception. Counselling should include discussion of the correct use of the emergency contraceptive method; possible side-effects and their management; and her requirements for continuous contraception. If the environment is not conducive to proper counselling, the client should be advised to visit a family planning or health care facility where she can obtain contraceptive counselling and services.

Methods under investigation

Experience with the use of levonorgestrel alone suggests that it is an effective method of emergency contraception. One controlled clinical trial showed levels of efficacy similar to that of the Yuzpe method, with fewer side-effects. The regimen used was two doses of 750 μg levonorgestrel administered 12 hours apart, the first starting within 48 hours of unprotected intercourse.

Anti-progestagens have also been tested for use as emergency contraceptives. Mifepristone (RU486) has been found to be highly effective at a single dose of 600 mg, also with fewer side-effects than the Yuzpe method. However, its use is restricted because of its limited availability. The minimum effective dose and the time period in which it can be used effectively still have to be defined.

Access to emergency contraception

Family Planning Associations should advocate the availability of emergency contraception and, where this is available, they should advertise it widely so that health care providers and the public will know in advance that it is an option for avoiding pregnancy. Easy access to emergency contraception should be provided through the most practical delivery systems so that people in need of this method can obtain it without delay. The important issues of privacy and confidentiality should be taken into account when developing systems for making emergency contraception available.

(This replaces the Statement on Postcoital Contraception which was adopted by Central Council in November 1981 and amended in November 1982 and November 1983.)

This Statement is valid for the currently available methods for emergency contraception. IMAP reserves the right to amend this Statement in the light of further developments in this field, when sufficient scientific information becomes available.

Published in the IPPF Medical Bulletin, (28), 6, December 1994.

ENTRE NOUS 28-29, May 1995
TRAINING IN EUROPE

Course on Population and Development. An intensive two-week course (17-28 July 1995) in Cambridge for professionals working in the field(s) of health, development/family planning. The course was designed to give an overview of the relationships between population, development and sexual and reproductive health; and to explore the elements needed to develop appropriate programme strategies. The course is organized jointly by the International Planned Parenthood Federation (IPPF) and the German Agency for Technical Cooperation (GTZ). For further details, please contact: Programme Department, International Planned Parenthood Federation, Regents College, Inner Circle, Regents Park, London NW1 4NS, United Kingdom. Tel.: (44) 171-4860741, Fax: (44) 171-4877950.

5th post-graduate course for training in Reproductive Medicine and Biology. This course is organized by the Clinic of infertility and Gynaecological Endocrinology, Faculty of Medicine, University of Geneva to provide postgraduate training in reproductive health, to educate graduates in current research on Family Planning and Infertility and to acquaint trainees with the most recent advances in the technology of these areas of research.

The course programme provides a broad international orientation including neuro-endocrinology, andrology, various clinical aspects of contraception and infertility, psycho-social factors and epidemiology of reproduction. The course will be given by the teaching staff of the Departments of the Faculty of Medicine of Geneva and by advisors and staff members of the WHO Special Programme of Research, Development and Training in Human Reproduction.

The post-graduate course will lead to a Certificate in Reproductive Medicine and Biology and a diploma. The certificate can be obtained after two months intensive course followed by written examination. A limited number of students who have been awarded a certificate will be accepted for the diploma. The official language of the course is English. The next course will take place from 1st September to 13 October 1995. For details, please contact: Mrs M.C. Robert, Administrative Officer, Clinique de Stéritéet d’Endocrinologie gynécologique, HCUG, CH-1211 Geneva 14, Switzerland. Tel.: (41) 22-3824322. Fax: (41) 22-3824313.


Four organizations in the Netherlands have jointly taken the initiative to organize courses on Family Planning, Sexual and Reproductive Health (3weeks), that are specifically addressing the training needs in family planning, sexual and reproductive health of health workers in Central and Eastern Europe. These organizations are: The Netherlands School of Public Health; the Netherlands Institute of Social Sexual Research, the Netherlands Family Planning Organization (Rutgers Stichting) and the World Population Foundation. The 1995 course took place last February. For further information please contact The Netherlands School of Public Health (NSPH) Attn: Dr Evert Ketting, Course Coordinator FP/SRH, Maliebaan 94, 3581 cx Utrecht, The Netherlands. Tel.: (31) 30 333 755. Fax: (31) 30 334 184.

Training Courses in Family Planning are organized by the Irish Family Planning Association (IFPA). For further details, please write to the Irish Family Planning Association, Halfpenny Court, 36-37 Lr. Ormon Quay, Dublin 1, Ireland. Tel.: (353) 1 872 253 66.

Courses in Family Planning and Women’s Health are organized by the Margaret Pyke Centre in conjunction with the Faculty of Family Planning and Reproductive Health Care. Basic courses (1/2 June 95, 21/22 September 95 & 23/24 November 95) Advanced courses on Sex Hormones in General Practice (31 March 95 & 1 December 95). All courses are accredited for the Post-Graduate Education Allowance for GPs. For more details please write to: Heather Goodman, Training Administrator, Margaret Pyke Centre, 15 Bateman’s Buildings, Soho Square, London WIV 6JB, United Kingdom. Tel.: (44) 171 734 9351.

Human Reproduction and Public Health: Fertility, Contraception, Sexuality (19-30 June 1995) is an international two-week course in French, providing participants with minimal competencies in public health and epidemiology. For further details please contact: Dr Patrick Thonneau, Deputy Director, Epidemiology and Public Health Summer School, INSERM U292, Hôpital de Bicêtre, 78, rue du Général Lecerc, Le Kremlin-Bicêtre Cedex, France. Tel.: (33) 145-212337. Fax: (33) 145-212075.

Theoretical and Practical Demonstration and Training Course on Reproductive Health Care. This 7-day course is organized on request, in English or German, by the International Research Institute for Reproduction (IRIR). Participants should become competent in clinical investigation of antenatal and postnatal care, IUD insertion and follow-up, contraceptive choice, etc. If laparoscopy is included, the course length is up to 4 weeks. For further details please contact the Director, International Research Institute for Reproduction, Kaiser Wilhelm Ring 22, 4000 Düsseldorf, Germany. Tel.: (49) 211 58 82 88. Fax: (49) 211 55 4832.

Diploma in Reproductive Health in Developing Countries is a new course offered jointly by the Royal College of Obstetricians and Gynaecologists and the Liverpool School of Tropical Medicine. The course will be run in Liverpool for 10 weeks, from May to July each year. The focus of the course will be on reducing reproductive mortality and morbidity through an integrated community oriented approach, appropriate to developing countries. The course is divided into units: Health Economics, Principles of Epidemiology and Computing Skills, Management and Training Concepts, Appropriate Research Methodologies, Family Planning and Abortion, Infection and STDs, Antenatal Care, Labour, Special Topics including Adolescents and Neonatal Care. For further information contact: Course Secretary (DRH), Liverpool School of Tropical Medicine, Pembroke Place, Liverpool L3 5QA, United Kingdom. Tel.: (44) 517 089 393. Fax: (44) 517088 733.

Short course in Reproductive Health Research. The Centre for Population Studies at the London School of Hygiene and Tropical Medicine will offer a 5-week short course in Reproductive Health Research. The course will introduce participants to the principles and methods of effective social and demographic research in this field, and will concentrate on the design of policy-oriented research and methods of evaluating the impact of programmes.
The course, which will start on 26 June and end on 28 July 1995, will be suitable for those with research interests in this field, and for managers and others who wish to commission or use research results. Enquiries to The Short Courses Office, London School of Hygiene and Tropical Medicine, Keppel Street (Gower Street), London WC1E 7HT, United Kingdom. Tel.: (44) 171 927 2074. Fax: (44) 171 323 0638.

The National School of Public Health in Rennes organizes courses in the Population and Family Planning fields (Population Education, Family Planning). How to design a programme. Project Management, etc. Participants should apply for a fellowship from organizations willing to finance the training of project managers (UNFPA, UNESCO, WHO, IPPF, USAID, Ministry of Cooperation, etc.). For further details please contact: The Director, Ecole Nationale de la Santé Publique (ENSP), Avenue du Pr. Leon Bernard. 35043 Rennes Cedex, France. Tel.: (33) 99 28 28 55 or 57. Fax: (33) 99 28 28 28.

International Course (French or English) in Statistical, Epidemiological, and Operational methods applied in medicine and Public Health. A four-month intensive programme given from 1 February to 31 May each year. Further information may be obtained at the Secretariat Office, Ecole de Santé Publique, Université Libre de Bruxelles (ULB), Campus Erasme –CP 590/1, Route de Lennik 808, B-1070 Brussels, Belgium. Tel.: (32) 2 56840 19.

Nancy University offers a Diploma in Public Health and Community Health for health professionals. The training can take place over one or two years. For details on the programme, please write to: Fr Jean-Pierre Deschamps, Faculté de Médecine, Département de la Santé Publique, BP 194.5405 Vandelouvre-lès-Nancy Cedex, France.

Sir David Owen Population Center has established a Master's Degree in Population Policies and Programmes (one year postgraduate course from early October each year); a Diploma in Population Growth Studies (a nine-month postgraduate course running from early October to end of June): short courses (12 weeks). Population Dynamics and Development (October-December 1995) Population Programme Management (January-March 1995). For further details write to: Sir David Owen Population Centre, University of Wales. College of Cardiff, PO Box 924, Cardiff Drive, Cardiff CF1 3UY, United Kingdom. Tel.: (44) 222 874 833. Fax: (44) 222 874 419.

Population and Development. This three-month course runs annually from January to March, it is aimed at development planner, policy makers, researchers and population specialists in government, NGOs, and research institutions. Applications and enquiries to: The Admissions Secretary, Center for Development Studies, University of Wales, Swansea, Singleton Park, Swansea SA2 8PP, United Kingdom. Tel.: (44) 792 295332. Fax: (44) 792 295682.

The London School of Economics offers a one year full time M.Sc. in Population and Development within the framework of the new M.Sc. in Development Studies. For an application form write to: Graduate Admissions Office, London School of Economics (LSE), Houghton Street, London WC2A 2AE, United Kingdom. Tel.: (44) 171 955 7159. Fax: (44) 171 831 1684.

Population and Environment: Policy, Planning and Implementation (18 September - 8 December 1995). The aims of the course are to help participants assess population and environment interactions in different cultural and socio-economic contexts so that they can be integrated into development policy, planning and implementation; improve skills in preparing and implementing practical action plans to address the issues involved in the context of participants' own work and region; Develop skills in the process of Environmental Impacts Assessment in a policy context and assist the planning and management of projects that involve population and environment, for example resettlement. For application form write to: The Course Director, Population and Environment, Development & Project Planning Centre, University of Bradford, Bradford, BD7 1DP, United Kingdom. Tel.: (44) 1274 385267. Fax: (44) 1274385280.

International Course in Maternal and Child Health. This 12 weeks course (in French) is organized by the International Children’s Centre, (CIE/ICC) and takes place each year during the first trimester. The purpose of the course is to help health professionals to identify problems, needs and demands in MCH/FP and to learn about the development, implementation, and evaluation of integrated MCH programs. Applications for the 1996 course must be sent before mid-September to: Centre International de l’Enfance, Dr Michel Péchevis, Château de Longchamp. Bois de Boulogne, 75016 Paris, France. Tel.: (33) 1 44 30 20 00. Fax: (33) 45 25 73 67.

International Course in Health Development. A 9-month course given alternatively in French and in English at the Institut de Médecine Tropicale Prince Léopold. The 1996 course will be in English. The course covers subjects like Health Services Planning/Management, Operations Research and Planning, Demography, Epidemiology and Biostatistics, Education and Communication Methodology. For further information please contact: Prof. Luc Eyckmans, Director, Institut de Médecine Tropicale Prince Léopold, Nationalstraat 155, B-2000 Antwerpen, Belgium. Tel.: (32) 3 247 6666. Fax: (32) 3 216 1431.

International course on Management Skills for Project Leaders in Developing Countries (1 week & 2 weeks versions: 13-24 March 1995 & 25-29 September 1995). For further details please write to: The Short Courses Officer, Institute of Child Health (I.C.H.), University of London, 30 Guilford Street, London, United Kingdom. Tel.: (44) 71 829 8692. Fax: (44) 71 831 0488.

Women, Men and Development is a 12-week course organized by the Institute of Development Studies (IDS) for all those concerned with gender equality within social change: 31 May-19 August 1994. Further information on IDS courses is available from: The Chairman, Teach. Area, Institute of Development Studies at the University of Sussex, Brighton BN1 9RE, United Kingdom. Tel.: (44) 273 606261. Fax: (44) 273 621202.

WE SHALL BE HAPPY TO COMPLETE THIS LIST IN THE COMING ISSUES WITH YOUR INPUTS.


This Directory contains a total of 121 organizations worldwide offering some 273 courses in the field of family planning and reproductive health.

In the near future, UNFPA will have an on-line data entry system where all changes in the training courses can be entered as they become available, and will provide read-only on-line access to the Training Directory for interested persons, training institutions and other agencies.
RESOURCES

Books

Health worker's manual on Family Planning Options. Western Pacific Education in Action Series No 7. WHO Regional Office the Western Pacific, Manila (1994).

This excellent publication is divided in two parts: A manual provides an overview of each of the available fertility regulation methods, explains how they work and suggests which one is best for specific groups of people. The quick reference booklet, which accompanies the manual, can be used by health workers for counselling and information during their daily activities. The manual and the booklet will be of interest to all health care providers in centres which provide health services.


Further information can be obtained from Distribution and Sales, World Health Organization, 1211 Geneva 27, Switzerland and the Publication Unit, WHO Regional Office for the Western Pacific, P.O.Box 2932, U.N. Avenue, 1099 Manila, Philippines.

Price: Sw.fr.7.00/US$5.50. Price in developing countries: Sw.fr. 5.00/US$ 3.50.


A detailed guide to the organization and management of high quality services for female sterilization. While noting that sterilization is a highly effective methods of contraception, the book concentrates on the many issues and practical details that must be considered in order to ensure that services are voluntary, medically wise and effective, appropriate to the health care system, well-managed, efficient, and acceptable to clients. Because the procedure involves surgery and is intended to be permanent, the book gives particular attention to the information and individualized counselling needed to ensure that each woman's decision is voluntary, fully informed, and free from inducements.


Available from: WHO, Distribution and Sales, 1211 Geneva 27, Switzerland.

Price Sw.fr. 41.-. In developing countries: Sw.fr. 28.70.


The guidelines given here contain detailed information on all currently available contraceptive methods, as well as covering client education and counselling, training and supervision of service providers, introduction of new methods, and programme evaluation. They are intended for use and adaptation by family planning programme managers, administrators, and policy-makers, in developing a method mix that meets the needs of clients and responds to the specific conditions of the programme.


Available from: WHO, Distribution and Sales, 1211 Geneva 27, Switzerland.

Price Sw.fr. 32.-. In developing countries: Sw.fr. 22,40.

Research and compilation by the Terminology Office of the Council of Europe. It is designed to serve as a straightforward, precise and convenient tool for demographers, translators, teachers and research workers. It also covers statistical and migration terms connected with demography and includes an appendix listing the organizations, conferences, texts and acronyms most commonly encountered in this field.

Copies may be ordered from: Council of Europe, Publishing and Documentation Service, F-67075 Strasbourg Cedex, France.

Published by the Council of Europe. 498 pages.


Price: FF198 or US$40.

The International Donor Directory. This directory contains over 2000 entries of private donor organizations in 23 countries, which provide aid to developing countries, along with sections on government aid programs, and on how to design and present projects to potential donors.

Published by the International Partnership for Human Development, 12020 Sunrise Valley Drive, Suite 160, Reston, Virginia 22091, USA.

Price US$125 plus shipping and handling: Europe: $33.00.

Three new publications from the Department for Economic and Social Information and Policy Analysis, United Nations:


AIDS and the Demography of Africa, United Nations, New York (1994). The demographic impact is considered for 15 countries of sub-Saharan Africa whose human immunodeficiency virus (HIV) seroprevalence was estimated to surpass 1 per cent for the adult population in 1990. It also reviews the epidemiology of the HIV/AIDS epidemic and considers its likely social and economic impacts in sub-Saharan Africa.


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Documents


Vasectomy. What health workers need to know. Family Planning and Population, Division of Family Health. World Health Organization, Geneva (1994). This booklet provides answers to the most common questions about vasectomy. It offers an overview of the major points about vasectomy that health workers need to know: What vasectomy is and how it works, what are the various techniques, what are the advantages and disadvantages, what are the risks and benefits, and how to help men make well-considered choices. (Ref: WHO/FPP/94.3 Rev.1)

Female Sterilization. What health workers need to know. Family Planning and Population, Division of Family Health. World Health Organization, Geneva (1994). This booklet offers an overview of the following major points about female sterilization that health workers need to know: What female sterilization is and how it works, its advantages and disadvantages, its risks and benefits and how to help women make well-considered choices. (Ref: WHO/FPP/94.2 Rev.1)

Expanding Family Planning Options. Contraceptive Introduction Reconsidered: A Review and Conceptual Framework. By Joanne Spiechandler and Ruth Simmons on behalf of the Task Force on Research on the Introduction and Transfer of Technologies for Fertility Regulation. World Health Organization, Geneva (1994). Dr Benagiano, Director of the Special Programme of Research, Development and Research Training in Human Reproduction explains that the Task Force has addressed the lessons learned by public sector agencies in introducing contraceptive technologies into family-planning programmes. A new three stage framework has been developed by the Task Force to assist programmes in developing countries with decision-making on whether and how to introduce new methods. In addition, it proposes that the same framework can be applied to the introduction, and improved utilization, of currently available methods. This document is the first of a series from the Task Force, and will be followed by reports on assessments of the need for contraceptive introduction in various countries, as well as on other topics pertinent to this issue, such as the management of contraceptive products. (Ref: WHO/HRP/ITT/94.1)

An annotated bibliography of documents produced by the Division of Family Health. World Health Organization, Geneva (1994). This document is available, upon request, from the Division of Family Health, World Health Organization, 1211 Geneva 27, Switzerland.

Annotated Bibliography of documents relating to Safe Motherhood. Safe Motherhood Initiative, World Health Organization, Geneva (1994). The aim in compiling this Annotated Bibliography is to increase awareness of the problems of maternal mortality and morbidity and to disseminate information about possible solutions to these problems. It represents a selection of the most relevant contributions from the United Nations Development Programme (UNDP), the United Nations Children’s Fund (UNICEF), the United Nations Population Fund (UNFPA), the World Bank, the World Health Organization (WHO), the International Planned Parenthood Federation (IPPF), the Population Council, who are the co-sponsors of the Safe Motherhood Initiative.

Women’s Lives and Experiences. A decade of research finding from the Demographic and Health Surveys Program (DHS), (1994). This report summarizes 10 years of survey research on women’s well-being in more than 40 developing countries. During this period, the DHS program interviewed over 360,000 women. The report includes information on different dimensions of women’s lives, including education, relationships, childbearing, children and home life. Further information from: Macro International Inc. DHS Program, 11785 Beltsville Drive, Suite 300, Calverton, MD 20705 USA. Tel (301) 572-0200. Fax: (301) 572-0999.

Magazines

IPPF Medical Bulletin appears every two months in English, French and Spanish. It covers advances in contraception and related matters and carries review articles (See extracts from the December issue under “Technology” p 19). Available free of charge from: International Planned Parenthood Federation, Regents College, Inner Circle, Regents Park, London NW14NS, United Kingdom.

ENTRE NOUS 28-29, May 1995
Choosing a Contraceptive: Considerations for Youth.
This chart presents in a very clear ways all contraceptive methods available, the advantages related to adolescent use, the disadvantages and recommended practices.

Global Migration: People on the Move.
Financing the Future: Meeting the Demand for Family Planning.
Those three charts are available from:
Population Action International,
1120 19th Street, N.W., Suite 550,
Washington, D.C. 20036 USA.

Both wall charts are available from the Population Division of the
Department for Economic and Social
Information and Policy Analysis, United Nations,
New York, NY 10017, USA.

Investing in Women’s Health: Central and Eastern Europe
This book is one of the first fruits of the Investing in Women’s health Initiative. Coordinators from 11 pilot countries and 1 pilot city in the eastern half of the WHO European Region gathered data for the first-ever “country profiles” on women’s health and the factors that influence it. This book makes a comparative analysis of the profiles. It takes a broad view of women’s health, extending beyond the traditional focus on reproductive issues to embrace the whole life cycle. It describes not only health status and health care services but also women’s position in society and the influences of daily life on the environment on their health. It concludes by indicating the directions for future action, which should include improving the amount and quality of the data on women.

This book makes gripping and vital reading for anyone interested in women’s health, health in the CCEE and NIS, equity, healthy policy or the opportunities for beneficial change in the eastern countries of the European Region.

ISBN 92 890 1319 2
Price: Swfr. 11.-
It can be ordered from:
Distribution and Sales
World Health Organization
CH-1211 Geneva 27
Switzerland.

The 1994 Revision of the official United Nations world population estimates and projections is now available on diskette for IBM-compatible microcomputers (Annual Population 1950-2050 Price: $75, Demographic Indicators 1950-2050 Price: $150, Age patterns of Fertility 1990-1995 Price $75, etc.) and on magnetic tape for mainframe computers (World Population 1950-2050 Price: $900). These population estimates and projections provide the standard and consistent set of population figures which are used throughout the United Nations system as the basis for activities requiring population information as an input. Persons interested in further information about this database should write to the Chief, Estimates and Projection Section, Population Division (DC2-1918), United Nations,
New York, NY 10017, USA.