TUNING INTO WOMEN

Special Reports
- Women and violence
- Birth: A photo-essay

The Beijing Conference: A victory for women?
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Editorial

Freedom to be yourself

By Anver Versi

In this issue we focus on women and their needs: There is a retrospective on the Beijing Conference, a disturbing report on the growing menace of violence against women, a resume of UNFPA/UNHCR’s commitment to women refugees and, to even out the balance, an inspiring photo-essay on the miracle and joy of birth.

Most of the authors whose articles appear in this issue arrive virtually at the same conclusion: that despite impressive strides forward, women today are still being victimised for being women.

The majority of women, who indeed form the majority of the world’s population, are still the poorest in virtually all societies, they are paid less than men for equal work, have little or no representation in national decision-making bodies, are still largely excluded from top professional positions and face the brunt of male physical violence in war and peace. In short, women the world over, including in progressive, liberal Europe, are still regarded as second-class citizens, whose primary purpose is in being appendages to men and bearing and rearing children. There are exceptions of course, and these visibly successful women are often held up as examples of gender equality; the truth is that these exceptions only serve to prove the rule.

The struggle for gender equality has been fought more fiercely and with greater success in the industrialised world than anywhere else but even here, the battle is still far from won. The issue at stake is not so much equality for women as real equality for women. Women are not only equal, they are becoming more than equal with men. Girls as a rule perform better than boys at school, mature more quickly, take greater responsibility and have a far larger capacity for hard work than their male counterparts. Women adapt more easily to changing working conditions and, as several tests have shown, seem to have a better natural ability to think laterally.

Men still have the edge when it comes to power as consumers. More and more manufacturers now consult women before they finalise their products, even such traditionally male products as cars. Yet only a sprinkling of women run organisations which make products that women buy. This is a glaring anomaly and it is mirrored in a number of public and international organisations.

The roots of this anomaly are embedded in traditional gender definitions and, as we all know, tradition takes a long time to change. But it is now time to give history a prod. Modern technology has virtually wiped out differences between men and women in terms of being able to do a job. What is of essence now is the creative input that goes into performing a function.

It is obvious that both male and female inputs, which contain subtle yet profound differences, are essential for a well-rounded, holistic approach. This is a departure from the early stance of the feminist movement when women took pride in being like men, even to wearing traditional male clothing and eschewing pregnancy and birth.

Now those ideas, at least in some parts of Europe, are either dead or dying. What was needed was not more women in the form of men but more women as women.

Unfortunately, the system has not been able to cope with this need. Women in the workplace are still treated as if they were men, except of course when it comes to pay, promotion and rises. Factories and offices are not designed to cope with and enhance feminine physical and psychological make-ups. Organisational structures still do not make provisions for pregnancies and child-care. Heads of departments are still horrified at the prospect of one of their executives wanting to breast-feed her baby.

And yet, everybody agrees that there is nothing more natural than a mother breast-feeding her baby and that there is nothing to stop her from writing reports, organising meetings, answering the telephone or designing a new building while she is doing so. Recently, one of the world’s biggest aircraft manufacturers had to radically re-design their seats for a new aircraft when a female designer became pregnant and discovered that the prototype seat was too uncomfortable to get in and out of and that it was virtually impossible to open the food tray if you had a bulging stomach. The result has been described as a breakthrough revolution in aircraft seat design with the manufacturers now boasting the “most comfortable and practical seat in the world” in their aircraft.

But such changes in social outlook will only happen when more and more women take over the decision making process and insist on doing so not as surrogate men but as fully-fledged women. The battle has begun but there is still a long way to go before it can be won.
THE BEIJING CONFERENCE

will it change our lives?

By Dr Assia Brandrup-Lukanow

Like most other UN Summits, the Beijing Conference on Women has been heavily criticized over the costs involved, the location chosen, the number of brackets left open in the draft Platform for Action and finally for the fact that not everyone who wanted to could participate.

Many still wonder: “Will Beijing make a difference?” Will it matter whether all countries have signed the Platform for Action or whether they have had reservations? Above all, will this Conference mean that women in the East, the West, the North, and the South will have more access to education, health and social services? Will it mean that they will be paid equally for equal work? And will it mean that they will have equal representation in their national decision-making bodies, including governments?

Many will say, as several journalists have, that for the average woman nothing will change.

I do not subscribe to this pessimistic view. First, just the unprecedented act of bringing nearly 40,000 women from all over the world together and letting them speak has disproved the doubters that women are just as vocal in their views, professional in their outlook and profound in their thinking as men.

Second, the NGO Forum and the governmental and non-governmental delegations have allowed women from minority groups, who are otherwise seldom heard from, the opportunity to make their points.

Third, women from different parts of the world, belonging to different cultures, religions and social groups, took the opportunity to exchange views, find common ground and join forces to shape a Platform for Action that can be universally valid.

Fourth, the conference gave added strength to organisations working for equal rights for women, for their equal access to health, education and inheritance, and their representation in political bodies.

However, I believe the most important aspect of Beijing lies in the simple fact that the Conference actually took place. Once participating countries had agreed to examine and analyse the situation of women in their countries, a very vital process was put into motion. Nearly all UN member countries set up special commissions to look into the political, economic and social status of women in their countries. This led to serious analyses of the educational, health, financial and material status of women. All nations that participated produced excellent background reports on the situation of women in their countries. Many of these reports were made public within the countries even before Beijing, thus focusing the national attention on women’s issues and generating stimulating debates.

In Norway, for example, the National Report on Women was presented at a forum involving thousands of women from all over Norway. In Bulgaria, the National Data Collection and Report on Women’s Health was presented at a national forum earlier this year.

The process of compiling the national reports in itself revealed sometimes embarrassing shortages of data on women. Many governments therefore decided to commit additional resources to special research and working groups who then set out to collect, compile and analyse qualitative data. In health, for example, it was clear that for most diseases, gender disaggregated data did not exist. Without information of this kind, it is almost impossible to analyse how women are specifically affected and whether they are affected in a different way from men.

Many countries were also shocked to learn that instead of moving forward to more gender equality in terms of political representation, they were moving back-wards. This drawback, as the data reveals, is particularly acute in the former communist states where women, under the old political systems, were much more strongly represented than they are now.

Miss Olga Keltochova, Minister of Labour and Social Affairs and Family of the Slovak Republic pointed out the irony when she stated: “Rejection of the quota system (for women) as a remnant of the previous totalitarian system has resulted in reducing the number of women in decisive political bodies to a minimum”.

This regressive step might be the result of a return to more traditional concepts of male and female roles in which “outspokeness” by women is considered undesirable. Having thus become alerted to the dangers posed by such attitudes, some governments have since established special ministries for women or set up monitoring bodies to ensure equal parliamentary representation for women.

Perhaps the most compelling and disturbing fact to emerge from these reports was that in one way or another, women are still under privileged, underpaid and under-represented. Perhaps the most compelling and disturbing fact to emerge from these reports was that in one way or another, women are still underprivileged, underpaid and under-represented. This is true for practically all nations, no matter how wealthy or progressive the country might be. For example, in Macedonia, while the legal framework is clear and egalitarian, its

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women in Human Rights topics taught in schools.

The Honourable Baroness Chalker of Wallacy, from the UK said it was vital to institute not only national but also regional policies on women. She referred to the ECE Regional Platform for Action which lays heavy emphasis on protecting the rights of women and the eradication of poverty. Without cooperation and solidarity between countries and regions, the goals set cannot be achieved, she warned.

Mr-Merlin Taylor, Minister of Equality and Law Reform of Ireland argued that women’s NGOs should be recognised, listened to and encouraged to flourish by governments. “NGOs have a vital role to play in agenda setting and in charting practical strategies for action in a way which complements rather than impedes on the democratic accountability of governments to parliament and the electorate.”

The Minister of Social Affairs, Head of the Delegation of Denmark, Mrs Karen Jespersen underlined the link between economic status and health. “To combat poverty, women must be healthy. Today, women suffer from malnutrition and lack of basic health care including unsafe abortions. The sexual and reproductive health and rights of women must be accepted”. In addition, she said: “Active participation in economic development includes the right for women to own land, to inherit property, and to borrow money”.

The Italian report on Women’s Status prepared for Beijing states: “In the 10 years since the Nairobi Conference, profound political changes have taken place in our country ... In the past women focused more or less exclusively on problems associated with equal opportunity employment ... Concerns have broadened to include a pursuit of a more balanced representation of women in political, economic and social decision making centres. The national policy has increasingly addressed the poverty of single-parent families headed by women and the poverty of older women without income who are now protected by social security... The introduction of family health services for maternal and infant care have the objective of giving all-round comprehensive care”.

While these are only a small sample of the views expressed by delegations, they provide a fairly representative cross-section of the very interesting reports presented by the 170 countries which participated at the Beijing Conference.

Let me close by quoting Baroness Chalker of Wallacy once more: “This Conference is much more than governments talking to each other. The inspiration for change has come from many individuals and groups working in partnership all over the world. The draft Platform for Action is largely an outcome of women’s organized voice and dialogue with governments. It is up to all of us to work together to realise that vision.”

This, I think has been the impact of Beijing. The continuing success of the Platform for Action and of this Summit will depend on how determined governments, international organizations and relevant institutions are to bring about real change, and ultimately, on the resources they allocate to the declared areas of priority.

The Beijing Conference in pictures

HE Mr Julius Nyerere, former President of Tanzania, Dr Aleya El Bindari Hammad, Leader of the WHO Delegation and Gertrud Mongella, Secretary-General of the Fourth World Conference on Women

ENTRE NOUS 30-31, December 1995
VIOLENCE AGAINST WOMEN

a crime

against humanity

By Julia Hausermann and Polly Vizard

One of the key issues on the agenda for the Fourth World Conference on Women in Beijing was the elimination of violence against women. The urgency of addressing this global problem is tragically illustrated by the treatment of women in the conflict in the former Yugoslavia, where rape and forced pregnancies are being used as instruments of war. But it is not only in times of war that women are vulnerable to abuse. Throughout the world women are suffering violence in the family, at work, in the wider community, and as an instrument of state oppression. Women everywhere remain vulnerable to threats to their lives and abuse of their physical and psychological integrity.

Although grossly under reported, violence against women is now reaching alarming proportions in developed and developing countries alike. Few countries have conducted empirical surveys to illustrate the true dimensions of violence against women.

The absence of adequate gender-disaggregated statistics make it difficult to assess the prevalence of violence against women. Even where such data is collected, cultural, social and legal barriers mean that violence against women is often perpetrated behind a shroud of secrecy. The beating, mutilation, sexual abuse, rape and burning of women is often concealed and condoned in the families and communities in which it occurs - sometimes on a day-to-day basis. Many criminologists believe that violence against women is the single most under-reported crime.

Yet even the existing data unequivocally establishes that gender based violence is a global crime of gross proportions, as the following statistics illustrate:

* In England and Wales, 18% of homicides are of wives killed by their husbands, with a quarter of all recorded violent crime blamed on domestic violence.
* In America, the number of crimes against women is rising significantly faster than any other crime. According to the latest statistics, an estimated 3-4 million women every year are battered by their husband or the man they live with. A third of female murder victims were killed by their husbands or boyfriends. One in five adult women has been raped.
* In Russia in 1993, 14,500 Russian women were murdered by their husbands. Another 56,000 were disabled or seriously injured.

Being victims of violence in their own homes.

* In Bangladesh, a retrospective study of 170 cases of murder of women between 1983 and 1985 revealed that 50% occurred within the family.
* In Thailand, 50% of married women studied in Bangkok’s biggest slum are regularly beaten by their husbands.
* In India, 11,259 dowry deaths have been recorded over the last three years.
* In Myanmar, in 1992, government troops raped women in a Rohingya Muslim village after their men had been inducted into forced labour. During the armed conflict in 1971, 200,000 civilian women and girls were the victims of rape committed by Pakistani soldiers, and in 1992, 882 women were reportedly gang raped by Indian security forces in Jammu and Kashmir.
* In Peru, 70% of all crimes reported to police are of women beaten by their husbands. The rape of women by security forces is also a common practice in the ongoing conflict in Peru.
* In Spain there were 15,888 reports of conjugal violence in 1992.
* In Denmark, 25% of divorced women point to violence as their reason for divorce.

THE CONSEQUENCES

Whilst the health impact of traditional practices such as female genital mutilation and son preference have long been recognised, less attention has been given to the health consequences of other forms of domestic violence.

But as the above examples graphically illustrate, domestic violence and rape are a significant cause of female morbidity and mortality. Domestic violence is now being recognised as a major international public health issue.
The health consequences of violence against women include psychological trauma and depression, injuries, sexually transmitted diseases and HIV, suicide and murder. In developing countries, domestic violence and rape account for about 5% of the total disease burden among women aged 15-44. In industrialised countries, where the total disease burden is much smaller, this share rises to 19%. In these countries, assaults have been reported to cause more injuries to women than vehicle accidents, rape and mugging combined. Gender-based violence is not only an obstacle to human health and well-being. It is also a violation of the human rights and fundamental freedoms of girls and women recognised in the Universal Declaration of Human Rights and subsequent legal texts.

Governments have a responsibility to ensure that domestic legislation incorporates penal and civil sanctions to condemn all forms of violence against women, to provide just and effective legal remedies, and to punish the perpetrators of such violence.

Yet all too often, Governments ignore these responsibilities. The long-standing failure to implement fully the provisions of international human rights instruments, and to protect and promote the rights and freedoms of girls and women is a matter of grave concern.

THE RESPONSE

In 1993, the UN General Assembly adopted the Declaration on the Elimination of Violence Against Women which recognises the urgent need for the universal application to women of the principles of integrity, dignity, security, liberty and equality of all human persons.

It requires states to take measures to prevent and eliminate violence against women, and to ensure that women subjected to violence have specialised assistance, including health and social services, counselling and rehabilitation.

It also requires research, data collection and the development of appropriate guidelines to assist in the implementation of the principles set forth in the Declaration.

It is recognised that, together with the police and social workers, health professionals are frequently the first to know of a case of domestic violence. A number of states are therefore now providing specific training for health professionals on the identification of domestic violence, and the manner in which assistance can best be provided to women experiencing such treatment.

The WHO Regional Office for Europe recently commissioned Rights and Humanity, an international NGO, to carry out a survey of violence against women in the European region based on data provided by the countries. This survey illustrated the paucity of data available. Many Ministries of Health responded that there were no relevant statistics, or that the only available data concerned criminal prosecutions for bodily harm.

Although some West European countries reported that they are currently undertaking a survey in preparation for the Beijing Women’s Conference, there appeared to be no surveys being undertaken in the countries of East and Central Europe. However, all of the replies indicated an awareness of the seriousness of the problem and the need for research on the extent of domestic violence.

Of the 38 countries surveyed only two - Portugal and Malta - provided material on the efforts being undertaken to address the problem. In Portugal, a study has recently been completed involving a representative sample of Portuguese women in an effort to determine the extent of domestic violence in the country. The Commission for Prosecutions concerning violence against women.

Women express many motives for failing to report acts of domestic violence or to leave a violent relationship. These range from a fear that leaving the matrimonial home might cause them to lose access to their children and/or their belongings, to fear of more violence as a reaction from their partner. Like rape victims, many women suffering domestic violence prefer not to involve the police due to the undignified and insensitive treatment they frequently suffer from law enforcement officers and courts. Even when violence against women is reported, there is often a failure to treat violence against women as a crime. The victims are left unprotected and the perpetrators unpunished.

That the issue of violence against women is now firmly on the international and many national agendas is to be welcomed. The appointment by the UN Commission of Human Rights of a Special Rapporteur on Violence Against Women and the inclusion of integrated measures for the prevention and elimination of such violence in the Beijing draft Platform for Action provide the impetus for global and national action.

The urgency of this is clear. In some countries, law reform may be necessary to ensure prohibition of marital rape and corporal mistreatment of women within the family. In virtually all countries, greater resources need to be made available to provide shelters and to assist women suffering domestic violence, and their children, and to provide them with the necessary psychological and material support.

For its part, WHO could assist ministries of health and social services by developing guidelines for national surveys, and training materials to assist health professionals in the identification of domestic violence and the appropriate response to the psychological needs of women suffering such abuse. Further, WHO and health professionals could play an important role in sensitising the police and judiciary to the full nature of this problem, so as to ensure that women suffering domestic violence and/or sexual abuse are treated with dignity and respect.

She lives with a successful businessman, loving father and respected member of the community

Last week he hospitalised her

Equality and Women’s Rights is actively involved in public awareness efforts, training of the police, medical professionals and social workers, and promoting resources for additional shelters for battered women.

Similarly, in Malta, a report has been completed this year that analyses both the legal protection of women and the extent and response to domestic violence. In 1991, an Interdepartmental Action Committee within the then Ministry for Social Policy was established, and the response to domestic violence continues to be multi-sectoral.

The necessity for a multi-sectoral approach is clear. Domestic violence is associated with the legal position concerning rape (including marital rape), incest, pornography, prostitution, and bodily harm, and with the manner in which the criminal justice system handles

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Polly Vizard is a researcher working with Rights and Humanity. She is presently undertaking her PhD research on economic, social and cultural rights at the London School of Economics.

ENTRE NOUS 30-31, December 1995
By Dr Daniel Pierotti and Dr Serge Malé

The second half of this century has seen an unprecedented number of refugees and people displaced either through wars or natural disasters. The “ethnic cleansing” drives in the former Yugoslavia and the genocidal tendencies in Rwanda have added a horrifying new dimension to the already fraught situation.

As the numbers of refugees mounted, it became abundantly clear that such emergency situations pose particular perils to women. Among the most vulnerable groups are women who are pregnant or in the process of childbirth or post-partum recovery. Women and adolescents are also exposed to greater risks of sexual exploitation, abuse and violence.

It became obvious to some of us working in the field that a new UN policy, designed to safeguard the sexual and reproductive rights of women caught up in such emergency situations was urgently needed.

In 1993, Ms Marylin Rice (IEC staff member) and myself produced a first proposal on the issue based on the right to security of the person and physical integrity of the human body as expressed in human rights documents, and the right of couples and individuals to make decisions concerning reproduction free of discrimination, coercion and violence.

The proposal did not meet with much enthusiasm - both UNFPA and UNHCR were hesitant. It was too early.

By 1994, however, the situation had changed radically. UNFPA was now committed to providing the same reproductive health services to women in refugee situations as it does to those not involved in conflicts. The opening of the UNFPA Emergency Relief Operation Office in Geneva on November 1 1994, gave teeth to the policy.

In addition, the issue had formed a major plank in the Draft Plan of Action for ICPD and it was approved unanimously during the Cairo Conference. The original proposal was updated and adopted. UNFPA and UNHCR would work in tandem and each organisation would pay its own expenses.

However, relating reproductive health issues to a refugee environment was new ground for most of us. In order to hammer out a comprehensive, practical plan of action, it was decided to bring together specialists from both the UN bodies involved and from relevant NGOs for a Symposium on Reproductive Health in Refugee Situations, to be held in Geneva in June 1995. The objectives of the Inter-Agency Symposium were quite clear: They consisted of defining minimum reproductive health activities to be implemented in refugee situations, the necessary tools to facilitate their implementation, and coordination of activities among agencies. As a lead-up to the Symposium, a number of preparatory meetings were held as follows:

The First Preparatory Meeting (14-15 December 1994 involving 13 agencies, 27 participants) was devoted to defining the main themes to be debated and setting up working groups to produce papers on each theme. Initially, nine themes were identified: Safe motherhood, Family planning, STD/

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UNFPA assistance in Emergency situations:

UNFPA is concerned that reproductive health and family planning issues are addressed with the same urgency that is devoted to other aspects of emergency relief.

Access to reproductive health care and family planning is a fundamental human right. To this end, UNFPA will work in close cooperation with other UN and non UN agencies and organisations within the overall coordination framework for operational activities set by the Inter-Agency Standing Committee under the guidance of the Emergency Relief Coordinator.

Within its mandate and resources, UNFPA is prepared to commit funding during any phase of relief operations to assist people in need, including refugees, asylum-seekers, internally displaced persons and other persons of concern, or returnees. The full extent of UNFPA’s interventions, including technical assistance, will be determined on the basis of each individual case.

UNFPA emergency assistance will focus on the provision of reproductive health and family planning (RH/FP) counselling and services within the health care mechanisms available during relief operations. Funding will be provided for equipment, supplies and drugs needed for the delivery of such services, including the prevention and treatment of reproductive tract infections, including STDs, and the prevention of HIV/AIDS. UNFPA can also extend technical assistance, training and salary support for health personnel. Provision of services must follow UNFPA principles of informed and voluntary choice. The range of contraceptives should be carefully tailored to the capabilities of the service providers and the existing infrastructure. Special consideration should be given to the needs of adolescents.

UNFPA will channel its assistance through agencies and organisations which deliver emergency relief programmes. These include United Nations organisations (e.g. UNHCR, UNICEF, WFP, WHO) government agencies and non-governmental organisations with the capacity to operate in difficult situations. Funding will be taken from the country programme resources of the countries of origin of the population concerned. The amounts involved to cover such contributions will be determined in consultations between the UNFPA Representative and Country Director and the concerned Geographical Division at Headquarters. Approval procedures will adhere to UNFPA guidelines for decentralised project approval.

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It was recommended that reproductive health interventions should always be extended to local host populations when needed and that the opinions of women and their participation should receive high priority in setting up services.

The participants agreed that a Field Manual on Reproductive Health was badly needed. Such a manual would have to take into account the needs and demands of the population, put emphasis on the participation of the country, respect national policies, insist on coordination of activities, and be confident in the feasibility of the project. There were ideas on the reorganization of the Manual and details on content. This exercise was extremely useful and practical. A draft version of the Manual was made available to all participants of the Symposium.

The Symposium itself, from 28 to 30 June 1995, in the presence of the Executive Director of UNFPA and the High Commissioner for Refugees, was a real success. The number of agencies present (50 agencies, 135 participants) and the quality of presentation, debate and outcome. The very precise conclusions and recommendations arrived at will not only facilitate the implementation of reproductive health activities, but also their coordination.

Following the Symposium, an Inter-agency working group has been established under the coordination of UNHCR. This group facilitates reproductive health issues in refugee situations and it will also develop and finalize practical tools such as the field manual, and work closely with ad hoc consultative bodies.

In conclusion, the Symposium was a useful and invigorating exercise. It allowed open debate between agencies and developed concrete ways to implement reproductive health in difficult situations. It established the willingness of UNFPA to become a vital partner in this field and has closely linked the policies and activities of UNFPA and UNHCR.

It now seems that the objective to ensure that all refugees and internally displaced persons receive the same reproductive health services as non-conflict populations before 2000 can be achieved if all humanitarian agencies include reproductive health on their agendas as part of routine health activities.

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The lessons of Bosnia and Rwanda

Despite numerous surveys conducted by many international organisations, we still lack any reliable data on the violence to which women have been subjected during the war which, for four years now, has ravaged the countries of the former Yugoslavia. For quite a long time, ethnic rapes were on the international agenda, but after a while this terrible subject was erased. Erased from the media, erased from our consciences. Nor is anyone, any longer, in a position to say with any accuracy how many women have been killed during the bloody civil war in Rwanda.

Time and time again I have gone to Bosnia to help save wounded women and children in urgent need of surgery. I have spent many months in Rwanda, some of them the most difficult moments of the civil war. I know, therefore, perhaps better than many others, how serious the situation is. However, I know neither facts nor figures. And I think that this is the most glaring evidence of the magnitude of this tragedy and of the innumerable violations of the rights of the civilian population, especially the women, perpetrated in all areas of the world where armed conflicts are raging and where, in all cases, the control exercised by humanitarian organisations is insufficient.

In his Letter to Women, dated last June 29, Pope John Paul II begged pardon, on behalf of all men, from all women for the wrongs to which they have been subjected throughout the centuries. On August 27 he encouraged them to take an active part in politics. He also appealed to Croatian, Muslim and Serbian women, as they could “ideally join hands to form a great chain of peace, which could force governments, combatants and peoples to have confidence in the sincerity of the negotiations and in the prospects for a peaceful coexistence”.

Many things have changed for us women during the course of the last decade. True equality, however, has not yet been fully achieved. Now it is precisely us, the women, who are most exposed, not only to the violence of wars, but also to that of an international justice which has not always recognised the extent of the tragedies which we experience.

Address by MARIAPIA FANFANI
(Workshop: Women Health and Violence Beijing)
TRAINING in reproductive health care

By Dr Assia Brandrup-Lukanow and Patty Owen

Over the past few years, it has become increasingly evident that there is a pressing need to improve reproductive health care in Central and Eastern Europe (CCEE) and the Newly Independent States (NIS) of the former USSR.

Training, particularly in Reproductive Health and Family Planning is a vital aspect of any effort to improve the quality of health care in the regions referred to. Indeed, many public health teaching institutions in Europe have been paying special attention to the training needs of postgraduate students and professionals from CCEE/NIS countries. Most, if not all, international agencies and bilateral donors actively support courses, workshops, and study tours. Training programmes range from the training of trainers to training service providers, journalists and even clients.

From the countries that receive this support there is a seemingly insatiable demand for fellowships at foreign institutions, medical literature and training courses through international consultants.

The underlying conviction is that knowledge, information, education and skills are the pillars on which development is built. There is little doubt that this is indeed so, but how are we to ensure that what is taught actually benefits those who are ultimately meant to profit from the skills of knowledgeable professionals? In reproductive health care, the ultimate beneficiaries are mainly women and children.

While there is no argument about the importance of training, there is some uncertainty about the most effective method of training as only a few training programmes are ever evaluated for their impact in the long run.

In addition, of course, it is difficult to say how much an improvement in health indicators is due to training activities, and how much due to other factors, such as political changes, better communications, transport, electricity and water supply and a higher standard of living.

In order to better understand these issues and coordinate training efforts, the WHO Regional Office for Europe organised a meeting on Training in Reproductive Health for CCEE/NIS is June. Course organisers from nine public health teaching institutions met in Copenhagen. Following is a summary of the workshop.

Participants at the conference included directors and/or course coordinators from:
- The London School of Hygiene and Tropical Medicine,
- the University of Exeter,
- the University of Debrecen,
- the University of Geneva,
- the University of Uppsala,
- the Baltic School of Public Health,
- the German Agency for Technical Cooperation (GTZ),
- the International Planned Parenthood Federation (IPPF).

The secretariat was composed of staff of the SFP unit, WHO-EURO, and the HRP programme, WHO-HQ.

MAIN AIMS

The main aims of the meeting were to:
- Review the training orientation, course contents and activities of the participating institutions and organisations;
- Examine aspects of reproductive health which might not be adequately covered by existing courses, address the recruitment of course participants and identify appropriate means of evaluating the impact of courses.

Presentations included:
- An overview of the current reproductive health and family planning situation in CCEE/NIS as reflected in fertility rates, contraceptive prevalence, abortion incidence and maternal mortality statistics;
- Sexually transmitted diseases as reflected in epidemiological studies, with particular attention to HIV/AIDS incidence, and training course content, orientation and activities of each of the participating institutions.

REPRODUCTIVE HEALTH

There are approximately 98 million fertile women in the European region, but the fertility rate is not high by global standards. Although this alone is no real cause for concern, closer inspection of reproductive health services and contraceptive prevalence in Europe reveals significant differences among countries.

Due to the lack of appropriate contraceptives and counselling services, abortion remains the principal means of fertility regulation in the CCEE/NIS, sometimes equaling the number of live births, and in some cases even exceeding this by two or three times.

The widespread use of abortion may have negative health consequences, as revealed in the epidemiology of maternal mortality. However, induced abortion may be responsible for more widespread chronic disability such as pelvic inflammatory disease and secondary infertility.

However, there is little data on the long term side-effects of induced abortion.

Another area of concern is the limited choice of contraceptives available in most countries of CCEE/NIS.

Priority areas of assistance to CCEE/NIS have been identified as:
- Contraceptive supplies
- Gynaecological equipment
- Training in quality of care in abortion services
- Pre and post-abortion counselling
- Information, education and communication programmes
- Data processing and analysis
- Services for adolescents

Information, education and communication priorities include: Mass media programmes; client information material, sex education curricula and training in counselling skills.
AIDS IN CCEE/NIS

Based on the latest statistics compiled by WHO’s Global Programme on AIDS, there are currently 4.5 million AIDS cases globally. Sexual transmission reportedly accounted for 70-80% of the cases of HIV infection.

In the NIS, at present, there are only approximately 2000 cases of AIDS. How-ever, there is concern that an increase in sexually transmitted diseases in the CCEE/NIS will facilitate an increase in HIV transmission in those countries. Increasing STD incidence has been noted in countries such as Belarus, the Republic of Moldova and Ukraine. A similar trend has been detected in the Baltic states with an increase in syphilis and chlamydia infection. Despite the overall increase in STDs, HIV incidence has so far remained stable in CCEE/NIS.

Given the apparently low incidence of HIV transmission in this region, it was felt that attempts to mobilise support and resources for education on HIV prevention would face difficulties as the countries involved are most unlikely to regard HIV prevention as a priority.

This had to be acknowledged and taken account of in the development and implementation of sex education and HIV/STD prevention programmes.

ROLE OF WHO

The current and future role of the WHO co-sponsored Special Programme of Research, Development & Research Training in Human Reproduction (HRP) was discussed. Global research issues are addressed through multicenter research sites and collaboration centres. The importance of scientists and working groups coordinating and designing research projects specific to their region (CCEE/NIS) was stressed.

The HRP supports these activities by promoting them, granting research fellowships and providing technical assistance. To facilitate the implementation of research projects by trainees returning to their countries, re-entry research grants are available.

CURRICULA & ORIENTATION

Reproductive health courses offered by the participating institutions varied from biomedical research and clinical training for doctors and midwives, the development and management of reproductive health services, and the training of volunteer organisations to operate NGO programmes. Although there are some similarities in courses among the various training institutions, the training programmes collectively address a variety of topics and target groups. It was noted that some professionals from CCEE/NIS had participated in several training programmes of different organisations. It was recommended that such data as a participants’ qualifications and previous course attendance be centralised in order to assist appropriate recruitment in the future.

GENERAL DISCUSSION

Following a general discussion, the plenary identified training objectives as follows:

- Upgrading technical skills (including clinical, research, counselling, management, advocacy) with attention to empathy of trainers
- Developing new approaches (participatory, improved interpersonal skills, quality of care, community based) with the aim of enhancing the application and dissemination of the skills which are acquired an ensuring equitable distribution of services.

To better focus the activities of the meeting to produce specific recommendations, two working groups were formed to look at the issues of clinical/research training needs and management training needs, respectively. The discussions were framed around the following questions:

(A) Which training needs exist?
(B) Which training needs are not yet covered?
(C) Which lessons were learnt from past experience in providing training courses?
(D) Which strategies of cooperation and coordination among training institutions are suggested for the future?

CONTRACEPTION TRAINING

The working group addressing clinical and research training areas recommended that emphasis to be placed on improving knowledge of contraceptives, especially given widespread myths and misunderstanding of methods, complications and effectiveness. Additional areas to be addressed regarding contraceptive knowledge include risk assessment and the provision of appropriate counselling services.

The working group identified ethical concerns in the area of contraceptive quality assurance, counselling, clients’, rights, politics of contraception (e.g. priority choices, target groups, prescription practice), and myths.

A focus on the economics of contraception should be provided in training programmes to take into account the cost of various reproductive health services and a concern for equity in the distribution of these services.

A particularly vulnerable group that requires appropriate reproductive health information was identified as adolescents. Training programmes for professionals in clinical/research practice should emphasise reproductive health issues of importance to adolescents such as abortion, post-coital contraception, healthy sexuality, sexual abuse and sexually transmitted diseases.

Areas particularly relevant to adult reproductive health include birth spacing, breast feeding, abortion, cervical cancer, breast cancer and hormone replacement therapy. Training should also address the differential needs of pre-menopausal and post-menopausal women.

REPRODUCTIVE SERVICES

Training related to abortion should include education of different techniques, the management of complications and methods of pre- and post-abortion counselling. Other areas important to discussions of fertility regulation include STD prevention, andrology and infertility management.

Training in general reproductive health services such as ultrasound, laparoscopy, IUD insertion, and clinic visits is essential. However, training should be appropriate to the resources available to programme participants in their country. Training that is specific to reproductive health research methods should include courses on biomedical research, psychosocial research, acceptability studies and operation research.

TARGET GROUPS

In order for training programmes to best address the specific needs of different professions, the size of target groups and the proportion of the population that would be feasible to reach should be determined. Groups of professionals that ought to be targeted by clinical reproductive health training programmes were identified as obstetricians/gynaecologists, midwives, general practitioners and pharmacists.

ASSESSMENT OF NEEDS

The working group addressing clinical and research training areas suggested that a common methodology of needs assessment that can be applied in-country be developed. This would allow countries to take initiative in assessing their own needs and as a result experience a sense of ownership in the assessment process.

MANAGEMENT TRAINING

Before the provision of appropriate management training in the area of reproductive health is possible, an assessment of training needs of individuals, and coordination of training programmes is crucial to ensure that concerns are adequately addressed by training programmes.

COURSE LOGISTICS

The length of training courses and the time commitment required of participants was discussed. Particularly with respect to individuals in leading managerial positions in health services or health administration, →
BIRTH

a photo essay by nancy durell mckenna

Canadian born Durell McKenna moved to London in 1976. Since then she has travelled extensively in Europe, Africa, the Middle and Far East as a photojournalist. Her photographic library is wide ranging and covers all aspects of life across the globe. Her work includes Bedouin existence in the Negev Desert, craft industry in the Philippines, Township life in Soweto and the Homelands and child labour and massage parlours in Thailand.

Her favourite topic however is covering the extraordinary experience of birth.

We have the pleasure of sharing with our readers some of the pictures from Nancy’s series One Aspect of Women, which is a celebration of the miraculous changes that a woman experiences when giving birth. Nancy has also produced an exciting video on the experiences of eight women as they undergo delivery in different conditions. (Details in the resources section.)
For more information, contact:
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Hampstead, London NW3 3JY
United Kingdom.
Tel: +44 171 794 9704;
Fax: +44 171 794 97
the length of courses is a crucial issue - many employees cannot remain absent from their jobs for more than two weeks. Consultancies of international experts to countries may be the most appropriate training for this target group. Another suggestion for reducing the time requirements of participants is the development of well-defined short training modules, which could be developed in cooperation between the various training institutions.

The most effective and appropriate implementation of training courses was discussed. A review of the cost-efficiency and impact of external training versus in-country training with international consultants and/or a mixture of national and international consultants was suggested. A sequence of international training of leading professionals and trainers, followed by national training provided by these with the assistance of international consultants may be the most effective way to reach large numbers of professionals.

RECRUITMENT

It was noted that university professors and sexologists have not been explicitly targeted by training courses. As both groups are influential in setting norms and standards in reproductive health and reproductive health training, these professionals ought to be reached in the recruitment's efforts.

Language was discussed as a crucial issue in determining who participates in training programmes. By providing courses only in English or French, training institutions in western Europe reach only a small group of professionals. The feasibility of conducting training courses in-country, in the local language should be examined more closely. In order to increase the availability of training to CCCEE/NIS professionals, several schools are considering offering their courses in Russian in one of the Russian-speaking countries.

On the issue of the selection of candidates for courses, it was suggested that candidates receive questionnaires requesting information on previous courses they have attended, course organizers should also try to exchange information (crosscheck) participants lists.

MATERIALS

It was concluded that there is an urgent need for training materials of international standard available in local languages. Furthermore, the local production of information, education and communication (IEC) materials should be encouraged if continuity of efforts can be assured by financial support, perhaps by donor agencies.

It was further noted that there is a particular need for short management and project development training packages, following the logical framework approach. Organizations such as GTZ or ODA have extensive experience in this type of training and are in a good position to offer it in countries.

The group identified the need for additional topics to be included in training programmes. Specifically, courses focusing on adolescent reproductive health programmes and the production of IEC materials were mentioned. Additional areas highlighted for expansion in the training programmes were interpersonal communication, especially in the training of those who train medical personnel; managerial training with emphasis on the logical framework approach; and the psychological aspects of reproductive health need to be addressed in training of trainers and service providers.

PROMOTION

The working group agreed that IPPF is in a unique position to provide advocacy training to women's groups, NGOs, professional organizations, journalists, and teachers. The participation of officials in the ministries of health of CCCEE/NIS countries in training programmes was cited as vital to raising the awareness of reproductive health issues.

CONCLUSION

More and more professionals from CCCEE/NIS are attending training courses in reproductive health and family planning offered by European schools of public health. This trend has created an urgent need for cooperation and coordination among the training institutions to ensure that the training needs of this region are adequately addressed.

It was suggested that a clearing house of training activities be established, preferably at WHO-EURO, in order to better coordinate the training programmes and maximize the impact of the training provided. The clearing house should coordinate CCCEE/NIS wide needs assessment, create a data base on training institutions and participants, and promote collaborative arrangements between Eastern and Western European organizations involved in reproductive health activities.

Re-entry grants, administered by HRP, were discussed as a means to assist trained individuals with implementing reproductive health projects in their own countries, thereby increasing the opportunities for individuals trained out of country to become 'agents of change' in-country. Increasing the awareness of reproductive health issues on the political agendas of CCCEE/NIS countries was suggested as a priority. Involving women's groups, non-governmental organizations, health institutions, universities, and individuals in the West as well as in the Eastern European countries in fundraising and education efforts may facilitate the process of prioritization.

The need for coordinated and collaborative research and training projects in the form of twinning arrangements was emphasized. The representatives of the institutions participating in the meeting agreed to explore institutional linkages between their centers and other relevant organizations in the CCCEE/NIS region for sustainable long term partnerships.

MAIN RECOMMENDATIONS

None of the objectives can be achieved, unless the countries, the international community, non-governmental organizations and individuals commit themselves to supporting and advocating reproductive health programmes and services.

1. The consultative group in reproductive health training recommends to WHO to draw the attention of governments in the countries concerned and international agencies to the urgent need for a concerted effort to provide training in reproductive health to countries of the CCCEE/NIS.

2. The training provided by various institutions has responded to felt needs by countries and sponsors, but so far in a limited and non-coordinated fashion.

3. To support the sustainability of training programmes, the group recommends to the training institutions to promote twinning arrangements between training, health, research and non-governmental organizations.

4. To establish a clearing house for the following tasks:
   * to create a data base of existing training curricula & institutions
   * to create a data base of trainers
   * to promote twinning arrangements between centres (hospitals, universities) in Eastern and Western Europe and in-country consultancies
   * to follow-up on training in countries
   * to promote training courses
   * to raise funds to cover future training needs.

5. A proposal to cover the necessary costs for this function (est. 500 000 USD for two years) to be submitted to various potential donors.

6. In order to measure the impact of training activities, appropriate training impact indicators must be defined.

7. The updating of the WHO/UNFPA document: Reproductive Health and Family Planning in CCCEE/NIS could serve as one monitoring instrument for the longer-term impact of training.

8. The next meeting to take place at the time of establishment of the clearing-house, or, should this project not receive funding earlier, in June 1996.
By Sietske Steneker

A s a follow up to the Cairo Conference, the UNFPA Arab States and Europe Division invited representatives from the countries of Central and Eastern Europe and the Newly Independent States to meet in the beautiful mountain town of Sinaia in Romania. The Workshop, hosted by the Romanian National Commission for Statistics, was attended by 30 Public Health professionals. The meeting was chaired by Mr. van Arendonk, Deputy Executive Director of UNFPA, and Ms. Mehri Hakmati, Chief of the Division for Arab States and Europe.

Coming together for the first time under the umbrella of UNFPA, participants discussed their vision of priorities in reproductive health in the Region, and developed a set of recommendations, addressed to both national governments and the international community.

GENERAL

It is recommended that:
1. information on the Cairo Programme of Action and the importance of quality reproductive health services be made available to senior decision makers, to promote health policy readjustment, resource mobilization and adequate allocations for reproductive health care.
2. the UN system promote and facilitate the establishment of national committees for the implementation of the Cairo Programme of Action.
3. UNFPA establish a regional office to serve the countries with economies in transition.
4. governments recognize the important role to be played by NGOs. It is also recommended that the international community promote and support partnerships between Governments and NGOs, and strengthen the capability of NGOs.

The latter is especially important in countries where certain aspects of reproductive health activities are opposed by groups in society, like anti-choice movements.

REPRODUCTIVE HEALTH SERVICE

It is recommended that:
1. reproductive health care programmes be closely monitored. Indicators should be both quantitative (service utilization, health statistics, etc.), and qualitative (particularly related to client satisfaction and barriers to access and utilization of services). Governments should ensure the dissemination of data collected at service level to the health care management level and the utilization of these data for service improvement. Technical assistance should be provided to strengthen these monitoring systems, taking into account the emerging private sector and the activities of NGOs.
2. support be provided, as needed, for the dissemination of technical information on health data collection methodologies and techniques used in other countries. International standards with regard to data collection should be promoted.
3. financial and technical assistance be provided to conduct research in support of reproductive health programmes. Socio-cultural, operations, and epidemiological research are suggested, as well as some clinical studies.
4. governments establish, if necessary with external assistance, quality pre- and post abortion counseling on family planning and increase client access to family planning and existing services.
5. assistance be provided, if necessary by the international community, for the provision of the following:
   a) contraceptive supplies, including post-coital contraception;
   b) (in countries where abortion is legal) equipment and other means to improve the quality and safety of abortion care, like vacuum aspiration, as well as prostaglandin, Mifepristone, and other new, safer methods.
6. health care planners work on strengthening the role of nurses and midwives in the delivery of reproductive health services in general and counselling in particular.
7. the UN system promote and facilitate the establishment of national committees for the implementation of the Cairo Programme of Action.
8. governments recognize the important role to be played by NGOs.
9. support be provided, as needed, for the dissemination of technical information on health data collection methodologies and techniques used in other countries. International standards with regard to data collection should be promoted.

COMMUNICATION

It is recommended that:
1. national IEC strategies be developed based on a systematic assessment of the needs of different target groups (including adolescents, men and minorities), their prevailing reproductive health (including family planning and sexual health) knowledge, attitudes and practices, and common media habits, as well as on an assessment of the most effective communication channels (including any existing local capacity for media research and media-materials production). This strategy could serve as a basis for planning and resource mobilization, and would ensure that the IEC messages transmitted through the mass media and community- and school-based activities are linked and up-dated regularly.
2. IEC strategies include approaches and activities that will enhance the role of journalists and their effectiveness in increasing public awareness about reproductive health issues.
3. governments introduce appropriate health and sex education programmes in the curricula of schools and other educational institutions at all levels, if necessary with external assistance, and that such education include information on reproductive health, in particular family planning and sexually transmitted diseases (including HIV infection), and on the shared responsibilities of men and women. Educators should receive training, to enable them to develop their teaching skills in these areas. NGOs should be involved in the development and implementation of these programmes.
4. technical assistance in the area of IEC focus on the development of local capabilities for the planning, implementation and evaluation of national reproductive health communication programmes, including the development and implementation of sexual education programmes that target the teenage population, and the development of supportive IEC materials for the different components of the IEC programme.
5. IEC materials and experiences be exchanged at the national and regional levels, in view of the high costs of production of materials, as well as the similarity of the issues to be addressed.

TRAINING

It is recommended that:
1. medical staff who are directly or indirectly involved in reproductive health programmes should receive training in contraceptive technology and other methods of fertility regulation, the prevention and treatment of HIV/AIDS and other sexually transmitted diseases, and quality of care (including counseling and interpersonal communications skills). Staff involved in the planning and/or management of reproductive health programmes should receive training in management techniques and monitoring, as well as reproductive health need assessments methods.
2. training materials in the national language be produced, or foreign materials be translated, and disseminated among health professionals, educators and others involved.
3. training be made available to staff involved in IEC activities on reproductive health, including teachers, curriculum developers, trainers, and the media, in the conceptualization, design, pre-testing, monitoring and impact evaluation of IEC programmes and messages.
4. pre-service training curricula be updated to include theoretical and practical training in areas of contraceptive technology, counseling and interpersonal communication, HIV/AIDS and other sexually transmitted diseases, and adequate coverage of the primary health care approach and broader conceptualization of reproductive health care.
Adolescent pregnancy on the increase

By Dr V. Prozhanova and Dr S. Tantchev

Bulgaria has undergone great social changes since 1989 when the new political and economic systems were established. Among other aspects, the processes of migration and urbanization of certain social and ethnic groups has intensified. A large number of young people from different social and economic backgrounds have concentrated in the big industrial centers. Psychological studies among young people reveal that there is a strong tendency among these youngsters to question and seek to change the moral and ethical values inherited from the past. These include attitudes to sex. A major preoccupation is the idea of “sexual freedom”. However, this concept is not underpinned by serious consideration of the consequences of free sexual intercourse but seems to be more a gesture of defiance against the old order and a yearning for the more liberal lifestyles of the West.

One result has been that larger groups of adolescent girls are getting pregnant and becoming mothers. Bulgaria is now reported to be second only to the USA in the fertility rate of adolescents. Adolescent pregnancy, abortion and delivery can be regarded as a kind of crisis for young girls. New data on the problem describes the crisis as an “acute or subacute frustration in the social adaptation of the individual”, which is caused by sociological, sociopsychological and individual factors.

Many of these new attitudes towards sexuality and their consequences are reflected in a six year study we carried out at the Department of Obstetrics and Gynecology at the Medical Institute in the city of Plovdiv. The study, which included interviews, was centered on 1088 pregnant girls between the ages of 13-16 who were treated over a period of six years (1988-1993) at the hospital. Of this number, 625 have had a delivery and 463 have chosen to have an induced abortion.

The fertility rates for adolescents in our study are shown in fig. 1 and include the total number of induced abortions, spontaneous abortions and deliveries for 1000 girls between the ages of 13-16. The distribution, according to age, is given in fig. 2, the average age being 15.39 years (Standard deviation=0.75).

Sociological and obstetric characteristics of the group:

ETHNIC BACKGROUND

The ethnic composition of the group under study was an almost even split between Bulgarian girls (52.38%) and girls from minority communities, such as Turkish and gypsies who formed 47.61%. The Bulgarian girls were twice as inclined to choose abortion as the girls from the other ethnic groups who generally preferred to give birth to their babies. This was very much in keeping with long held Turkish and Gypsy traditions and reflected the typically higher birth rates of these communities.

EDUCATION

74% of the girls had received primary education, but 17.46% of them had not completed their primary schooling. This lack of sufficient education combined with their extreme youth had compounded their ignorance, peculiar inertia or naiveté and thus predetermined their low receptivity to birth-control methods.

LIFESTYLES

The majority of them led a healthy life: none of them had used drugs; 61% did not drink alcohol at all, and the rest did it irregularly; 52% did not smoke and half of the smokers gave up smoking after conception. These positive aspects of their

Fig. 1. Pregnancies in adolescents

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<tbody>
<tr>
<td>Abortions</td>
<td>40</td>
<td>50</td>
<td>60</td>
<td>70</td>
<td>80</td>
<td>90</td>
</tr>
<tr>
<td>Spont. abort</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td>60</td>
<td>70</td>
<td>80</td>
</tr>
<tr>
<td>Births</td>
<td>30</td>
<td>40</td>
<td>50</td>
<td>60</td>
<td>70</td>
<td>80</td>
</tr>
</tbody>
</table>

Fig. 2. Distribution by age

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
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<tbody>
<tr>
<td>Distribution (number)</td>
<td>33</td>
<td>131</td>
<td>541</td>
<td>583</td>
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</table>
lifestyles guaranteed, to a great extent, the birth of a healthy child.

MARITAL STATUS

In the group of young mothers, only 29% had an official marriage contract, the rest lived with their partners. Among those who had an abortion, pregnancies in most cases occurred as a result of extramarital sex.

Interestingly, 81.9% of the adolescent mothers expected to get married to the fathers of their babies. The rest, 18.1% wanted their babies adopted or brought up in special homes.

This was probably due not only to material and situation difficulties, but also to the fact that because of their very young ages, some of the girls were not emotionally or morally mature for maternity. The situation was quite different for the girls who had entered early marriages. It seemed that the institution of marriage supported and stimulated the birth and bringing up of a child independently of the maturity of the partners.

Negative tendencies were observed in this group also but they were considerably more rare than in the group of adolescents living with their partners without a marriage contract.

RELATIONS WITH PARTNERS

Of the young mothers, 50.9% had begun relationships with their partners for up to one year prior to pregnancy. However, only 24% of girls who had abortions had relationships that had lasted for the same period. This indicates that the feeling of greater security that came with longer-lasting relationships had encouraged the young mothers to carry their pregnancies through to delivery. But relations with partners became strained after delivery for 131 (20.9%) couples and 38 couples split up immediately after delivery.

ATTITUDES TO PREGNANCY

According to 78.9% of the young mothers, their pregnancies were desired. Out of the total sample group, 63.9% had not made any attempts to interrupt their pregnancy while 35% had attempted an interruption; of these 9% had tried to abort with the help of drugs and 27% by using non-medical methods. In fact 33% of these girls had been raped.

This undoubtedly contributed to psychic disorders and a negative attitude toward the pregnancy.

OBSTETRIC RESULTS

Delivery in the group of adolescents was eutocic, with shortened duration and low operational activity (cesarean section was performed in only 6.08% of cases).

The average weight of babies (2.866g) was lower (standard deviation=566.75g).

There was a moderate correlation between the age of the mother and the development of complications in the pregnancy, the preeclampsia and eclampsia being twice as high in the group of the young mothers.

PERINATAL RESULTS

Despite the physiological evolution of pregnancy and delivery, and the good antenatal observation of adolescents, the perinatal losses in their group were generally higher (fig. 3). The perinatal mortality rate (22.4 per thousand) was 1.9 times higher than that for 20-25-year-old women (11.81 per thousand) and 1.6 times higher than the total rate for the hospital (12.54 per thousand).

CONCLUSION

The new sexual freedoms, ushered in the wake of massive political, economic and social changes have left a large number of young victims in their path. While some young girls seem to cope well with the problems of pregnancy, childbirth and motherhood, others came from socially marginalized groups making their integration into the broader society difficult. In cases of extramarital pregnancy and childbirth the State has taken upon itself the task of trying to help where it can in bringing up the children and supporting the family. The result of our study clearly shows that the only long-term solution of the problem of adolescent pregnancy lies in an urgent campaign to promote proper health and sex education for young girls on a national level.

Dr V. Prozhanova, Dr S. Tantchev
Medical University, Kliment Orhiditsky, 5800 Plevne, Bulgaria.

OBITUARY

Andrey A. Popov 1957-1995

Andrey Popov was like a comet whirling across the sky - enthusiastic, spirited and turbulent. His life touched many lives - in Russia and across the world. The people and places he touched were forever changed by his infectious energy.

He died on April 25th, 1995, having fallen to a fall while he was skiing. He was 38 years old. He was a talented and respected medical demographer and social science researcher, known for his pioneering work in quantitative research and his commitment to improving health care for all people.

Andrey was a member of the academic community in Russia and was a valued colleague and friend to many. He was a member of the PhD, the Executive Secretary of the International Congress of Social Science Research, and a member of the editorial board of the European Journal of Population. He was also a member of the editorial board of the journal "European Journal of Population" and a member of the editorial board of the journal "European Journal of Population".

In memory of Andrey, a memorial service will be held in Moscow on May 25th, 1995. The service will be open to the public and all are welcome to attend.

Henry P. David
Fertility continues to decline

By Prof Ayse Akin Dervisoglu and Dr Mehmet Ali Biliker

The 1993 Turkish Demographic and Health Survey (TDHS) is a nationwide sample survey of women of reproductive age designed to provide information on fertility levels, infant and child mortality, family planning, and maternal and child health.

The survey was conducted by the Institute of Population Studies, Hacettepe University, Ankara as part of the worldwide Demographic and Health Surveys programme. The TDHS was further intended to serve as a source of demographic data for comparison with earlier surveys conducted by the Institute of Population Studies, particularly the 1988 Turkish Population and Health Survey, the 1983 Turkish Fertility and Health Survey and the 1978 Turkish Fertility survey.

A weighted, multistage, stratified cluster sampling approach was used for the survey. Interviews were carried out in 8,619 households and with 6,519 ever married women less than 50 years old.

AGE

The age distribution of the household population in the TDHS falls into five-year age groups according to sex. The population pyramid reflects the effects of past demographic trends on the population and gives an indication of future trends. The contraction of the base of the pyramid is indicative of recent decline in fertility, whereas the narrowing at the top points to high mortality in the past. The growing concentration of the population in the 10-19 age group implies that large numbers will be entering the reproductive ages in the next decade.

The percentage of the population under 15 years of age appears to have declined between 1989 and 1993, which is an indicator of declining dependency ratio i.e. a decrease of the economic burden on persons in the productive age group.

EDUCATION

One in three women interviewed in the survey has either never attended school or has some primary education; while 51% have either completed primary school or have some secondary education and 15% are at least secondary school graduates.

BACKGROUND

About two-thirds of women in the sample live in urban areas and the rest live in rural areas. Of the ever-married women in the sample, 96% are currently married, indicating the rarity of marital dissolution in Turkey.

FERTILITY

The fertility measures are based on the retrospective reproductive histories of women aged 15-49 interviewed in the TDHS.

Fertility rates in general in Turkey are declining very dramatically. Given that fertility over the age of 40 is almost negligible, cumulations of Age Specific Fertility Rates (ASFR) up to age 40 and comparisons using this figure show that fertility declined by almost 50% during the last decade (4.4 in 1980 vs. 2.5 in 1990).

Total fertility rate for women living in rural areas is slightly over three children (3.1) and decreases to around two children (2.4) in urban areas. The national average is 2.7 children per woman. When compared with previous surveys, the urban/rural gap on total fertility rates appears to be closing. The crude birth rate, which has fallen to 22.9 per thousand indicates a low population growth rate even if the crude death rate is very low.

BIRTH INTERVAL

The median birth interval is 33.6 months, only 10 months longer than the minimum considered safe. Thirty percent of births occurred at intervals of less than 24 months, thus placing the health of the babies and mothers at risk. This percentage shows striking variations by background variables. Among women with at least a secondary-level education, the percentage of risky birth intervals is less than half of those with no education (16% and 32% respectively).

The average childbearing age in Turkey is gradually increasing. Median age at first birth has risen from 20.6 years among women aged 45-49 years to 21.8 years among aged 25-29 years. The median age at first birth for all women (aged 25-49) is almost 21 years (20.8).

FAMILY PLANNING

Use of modern contraceptive methods is highest among women in their thirties, with roughly 75% of women in this age group reporting that they have used a modern method at some time. Use of traditional methods, including withdrawal is lower than use of modern methods in every age group, with the exception of women aged 15-24.

Specific methods: Around one-third of currently married women reported using the IUD or the pill at some time while 24% have tried the condom.

The level of current use is the most widely used and valuable measurement of the success of a family planning programme as it can be used to estimate the reduction in fertility attributable to contraception.

Overall, 63% of currently married women use a contraceptive method. The majority of these women are modern...
method users (35%) but a substantial proportion (28%) use traditional methods, particularly withdrawal. Withdrawal, (26%) is in fact the most widely used of all specific methods, as it has been in previous surveys in Turkey. The IUD is most commonly used modern method (19%). The condom (7%) and the pill (5%) are the second and third most popular modern methods, respectively.

Current use of the IUD has increased markedly and that of female sterilization has increased slightly but condom and pill use have decreased compared to the 1988 TDHS.

Considering age patterns, modern method use is most prevalent in the 30-34 age group, while traditional method use peaks in the 35-39 age group. Modern methods are practiced more frequently than traditional methods in every age group except the 15-19 and 40-49 age groups.

Current use of contraception increases directly with education. Among women who have no education, the percentages currently using modern and traditional methods are almost identical. In contrast, women with primary or higher education are more likely to use modern than traditional methods, especially the IUD and condom.

Use of contraception increases rapidly with number of living children, peaking at 78% among women with two children, after which it declines slightly among women with three or more children. In many cultures, family planning is used only when children are already had as many children as they want. In Turkey, one-third of women start using contraception after they have one child.

At present, the IUD, pills, condoms and other modern methods are available free of charge in the government sector through the primary health care units and hospitals. Pharmacies and private physicians also supply contraceptive methods, but charge for their services.

The majority of users (55%) obtained their methods from government services. Looking at sources for specific methods, pharmacies are the main suppliers of pills, condoms and vaginal methods (69%, 65%, 91% respectively). The majority of female sterilization operations take place in government hospitals (83%). Provision of modern methods by NGOs in Turkey is still at insignificant levels, not exceeding 1% for any modern methods. However, NGOs play an important role in piloting new methods of distribution, or working with special target groups.

Intent to use contraception in the future provides a forecast of potential demand for services and is a convenient indicator of the disposition towards contraception among current non-users. According to the survey, among currently married non-users, 45% did not intend to use any method in the future while 31% intended to begin use in 12 months, 14% intended to use contraception later while 8% were unsure of their intent or timing.

ABORTION AND STILLBIRTHS

The total abortion rates show a slight decrease since 1990 - from 21 per 100 pregnancies in 1990 to 18 in 1992. At the time of the survey, respondents reported that 13 of 100 pregnancies ended in induced abortion, 8 pregnancies ended in spontaneous abortion and 2 pregnancies ended in stillbirths.

Sources of contraceptives (TDHS 1993)

The stillbirth incidence, between 1.1 and 1.9, did not show a trend in the five years before the survey. Total abortion rates calculated up to the time of the survey indicate that there have been 17 induced abortions per 100 live births and 52 induced abortions per 100 women, compared to 10 spontaneous abortions per 100 live births and 31 spontaneous abortions per 100 women.

Induced abortions per 100 pregnancies increase steadily by age, reaching the highest level in the 45-49 age group with 48 abortions. This pattern differs from the 1988 TDHS, where the highest abortion rate was seen in the 35-39 age group.

The effect of education is similar to that of 1988: with the abortion rate increasing with the level of education, from 14 in the least educated group to 23 in the secondary or higher educated group. On the other hand, there are more stillbirths in the group that has never attended school or did not complete primary school than in the higher educated group.

INFANT, CHILD MORTALITY

The level of infant and child mortality is an important indicator of the general standard of living in a society and of health conditions in particular. Mortality risks during infancy and childhood have been declining at a relatively fast pace in Turkey. For the two most recent periods, the rates of decline seem to have been fastest; with the exception of the child mortality rate, all rates have declined by about 35%. For the child mortality rate, the decline is even larger, i.e. about 48%. The child mortality rate has almost halved between the 1983-1988 and 1988-1993 periods.

The infant mortality rate (IMR) in the rural areas is about 1.5 times higher than in urban areas (65 versus 44 per 1,000). This difference between the IMR of rural and urban areas mainly derives from the difference on the postneonatal mortality rates. Neonatal mortality rates for urban and rural areas are very close.

Child survival chances in Turkey are closely related to the level of education of the mother. Children of mothers with no education experience over 1.6 times the level of infant and under-five mortality as children of mothers who have at least completed primary school.

CONCLUSION

Fertility in Turkey is continuing to decline. More than two thirds of currently married women say they do not want any more children. An additional 14% want to wait at least two years before having another child. Women reported an ideal family size of 2.4 children but results from the survey suggest that if all unwanted births were eliminated, the total fertility rate at the national level would be 1.8 children per woman, one child lower than the actual level of 2.7.

Virtually all women have heard about family planning methods. At the time of the TDHS, nearly two in every three women were using a family planning method. It is clear that there is a need to expand the method mix, particularly in view of the large proportions of women who desire to limit their childbearing.

Although there is a widespread acceptance of family planning in Turkey, there are a number of continuing challenges for the family planning programmes. Programme efforts must be directed towards the use of modern family planning methods and reducing the differentials in family planning use among regions and between urban and rural areas.

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

Dr Mehmet Ali Biliker is Deputy General Director of Maternal and Child Health and Family Planning (GD MCH/FP), Ministry of Health, Turkey.
In February 1994, Dr. Gaston Legrain was assigned to the post of WHO Technical Adviser for Sexuality and Family Planning, in Amman, Jordan. He is based at the UNFPA Regional Office of the Country Support Team (CST) for Arab States and Europe, and will collaborate with the UNFPA team - headed by Dr. Atef Khalifa - both in the implementation of SFP country projects in Central and Eastern Europe, and of UNFPA projects in French speaking countries of Northern Africa.

Following are brief profiles of the team:

**Mr. Atef Khalifa**
As Team Leader, Mr. Khalifa is responsible for the overall management, supervision and direction of the interdisciplinary technical support team comprising of 12 advisors, covering the Arab States and Europe.

Mr. Khalifa is a demographer with a vast working experience in the Arab Region. He has a MSc in Biostatistics and a PhD in Sociology from the University of North Carolina at Chapel Hill.

A long stint as a Professor of Biostatistics and Population at Cairo University, Cairo Demographic Center, and as a visiting professor in other universities had given him invaluable experience in teaching and research in demography, statistics and social and health sciences. He has more than 30 major publications to his credit. Mr. Khalifa has also undertaken major surveys and led research into important socio-cultural and policy oriented projects.

All advisors provide advisory and technical support for programmes and projects within their field of expertise at regional or country level. They assist countries in the formulation, appraisal, monitoring, reviewing and evaluation of projects. They participate in the Programme Review Strategy Development (PRSD) missions for UNFPA, contribute to research and provide training.

**Mr. Mahmoud Sayed Abdou Issa:** Adviser on Integrated Population and Development Planning and Policy (ILO), Mr. Issa has a MSc in Demography from London University and a PhD in Demography from the University of Pennsylvania.

**Mr. Abdul Halim Joukhadar:** Adviser on Population Education (UNESCO), Mr. Joukhadar has a Demographic Expert Diploma from the University of Paris (Sorbonne) and a PhD in Demography from the University of Paris I (Sorbonne).

**Ms. Najwa Kssiwi:** Adviser on Population and Family Welfare Education in Worksetting (ILO), Ms. Kssiwi has a BA in Sociology and BSc in Nursing from Southeastern Massachusetts University, and the MSc in Public Health from the University of North Carolina.

**Mr. Nasim Madanat:** Adviser on Population Information and Communication (UNESCO), Mr. Madanat has a BA in English from the Lebanese University and has participated in several training courses in communication, research and management in Japan, USA and elsewhere.

**Dr. Hamid Rushwan:** Adviser on Reproductive Health and Family Planning (RH/FP), Dr. Rushwan has a MB, BS. from the University of Khartoum, Sudan and had post-graduate training and qualifications in the UK in OB/GYN.

**Mr. Abdallah Khalik Sannour:** Adviser on Data Processing (ESCWA), Mr. Sannour has a Diploma in Electronic Data Processing from the University of Connecticut, USA, and received the BA in Public Administration from the American University of Beirut.

**Mr. Edward El Wardini:** Adviser on Population Education (UNESCO), Mr. El Wardini has a Higher Studies Diploma in Economics as well as a PhD in Economics from St. Joseph University (Lebanon).

**Mr. Husein Abdel-Aziz Sayed:** Adviser on Data Collection. Mr. Sayed has a BSc in Statistics and MSc in Statistics and Population from Cairo University and a PhD in Statistics and Demography from London University.

**Mr. Hafez Chekir:** Adviser on Demographic Analysis (ESCWA), Mr. Chekir has a MSc in Statistics from the University of Tunis.

**Dr. Gaston Legrain:** Adviser on Reproductive Health and Family Planning (RH/FP), Dr. Legrain has a MD in Medicine from the Catholic University of Louvain, Belgium.

**Ms. Salama Saidi:** Adviser on Gender, Population and Development (UNFPA), Ms. Saidi has a Demographic Expert Diploma from the Sorbonne University, France, and a MA in Economics from Temple University, Philadelphia, USA, as well as a MA and a PhD in Demography from the University of Pennsylvania (Philadelphia, USA).

**Dr. Leila Dabbagh:** Adviser on Socio-Cultural Research (FAO), Dr. Dabbagh has a bachelor’s degree from Purdue University (Community health and biology), a Master’s degree in Public Health (Health education) from Indiana University, a Master of Science degree from Harvard University School of Public Health (Maternal and Child Health and Aging), and a Doctor of Public Health Degree from the University of Texas School of Public Health (International Health, Nutrition and epidemiology).
As a follow up to several articles on emergency contraceptive methods presented in the last two issues of Entre Nous, we publish below the Recommendations of the Conference on Emergency Contraception held in Bellagio, Italy, in April. The conference was sponsored by South to South Cooperation in Reproductive Health, Family Health International, the International Planned Parenthood Federation, the Population Council and the World Health Organization, with support from the Rockefeller Foundation.

**RECOMMENDATIONS**

**Methods**

1. Methods of emergency contraception should be effective, safe, convenient to use and easily accessible. Among the methods now available, ethinyl estradiol/dinorgestrel combination oral contraceptives and the copper intrauterine device (IUD) best meet these requirements and should be provided. We recommend additional research, however, to improve these methods and to develop new ones responsive to women's needs. When developing contraceptive products, researchers should explore and develop any potential these products may have for emergency contraceptive use.

2. The class of compounds known as antiprogestogens appears very promising for emergency use. Antiprogestogens deserve top medical research priority.

**Policy**

3. Inter-governmental agencies, governments and non-governmental organizations (NGOs) should ensure that emergency contraceptives are included in all family planning programmes and on all national essential-drug lists.

4. Drug regulatory authorities should require explicit description of emergency use in the labeling of ethinyl estradiol/dinorgestrel oral contraceptives and for the copper IUD.

**IEC/Advocacy**

5. Advocacy and information/education/communication (IEC) activities should be developed collaboratively, and should foster community and policy support among women's groups, professional associations, health advocates, policy makers, NGOs, donors and community leaders. Potential users of emergency contraception require information on the methods before they need them. Therefore, IEC efforts should be broad-based, culturally sensitive, and locally relevant.

6. IEC strategies should consider groups with special needs, such as adolescents.

**Service delivery, monitoring, service evaluation**

7. Emergency contraception should be made available to all women who seek it, provided no contraindications are present. Women should be able to select from among available emergency contraceptive methods.

8. In order to prevent pregnancy following acts of sexual violence and coercion, emergency contraception should also be available from sexually transmitted disease clinics, rape crisis centers, police stations and hospitals.

9. Training in emergency contraception should be included in the curricula of all medical and non-medical personnel. Training should include counseling as well as method-specific service requirements, including treatment regimens, management of side-effects, and proper follow-up.

10. Women seeking emergency contraception should also be counseled and offered a choice of effective and reliable methods of contraception for regular use. When the environment is not conducive to proper counseling and/or service provision, client should be referred to an appropriate service provider for ongoing contraception.

11. In all family planning consultations, women choosing a method of contraception for which emergency contraception is an appropriate back-up (e.g. barrier methods, periodic abstinence) should be informed about and, when appropriate, provided with emergency contraceptives for future use.

12. Hormonal emergency contraception is appropriate for distribution through many channels, including clinics, over-the-counter in pharmacies, and community-based programmes. Any provider trained in IUD insertion can provide IUDs for emergency use.

13. Research should be conducted on innovative service delivery options.

14. Data should be collected on emergency contraceptive use. Questions about emergency contraception should appear in national surveys.

*The views expressed are those of the participants and do not necessarily reflect the views of the co-sponsoring organizations of the conference. (abridged version)*
RESOURCES

Books

The success of the child growth chart in reducing levels of infant morbidity and mortality has been the principal impetus to the development of the WHO prototype home-based maternal record. This record takes the form of a card, retained by the woman herself, on which information about her pregnancies, the births of her children, and her health between pregnancies can be recorded. This book is a comprehensive guide to all aspects of the development, adaptation and use of home-based maternal records in the context of primary health care. Other topics covered include the additional information that may be incorporated into records, such as health education messages and nutritional advice, and training of health personnel in using the records and evaluating the information they yield. Decision-makers at all levels from health ministries to community health programmes, should find the book of immense value whenever the introduction of these records is under consideration.
Available from: WHO, Distribution and Sales, 1211 Geneva 27, Switzerland.
Price Swf.20.00. In developing countries: Swf. 14.-.

Among the most influential findings from the World Fertility Survey were those linking fertility patterns to child survival, in particular the findings concerning the high infant and child mortality for children born after a short birth interval.
The present study has been undertaken to examine the relations between fertility and child survival in the 1980s and to formulate policy guidelines based on more recent findings.
Write to United Nations, Sales Section, New York or Geneva.

Family Planning at your fingertips.

(1993).
Available from: Irvington Publishers, Inc.,
195 McGregor St, Manchester NH 03102,
USA or from E.M.I.S., Inc. P.O. Box 1607,
Durant OK 74702-1607.

Available from: Bridging the Gap Communications, Inc. 1014 Sycamore Drive, Decatur, Georgia 30030, USA.

A clear and practical and well illustrated handbook in French covering all aspects of family planning, for physicians, nurses, midwives, teachers and trainers in developed as well as developing countries. The authors Gaston LeGrain (UNFPA), and Pierre Delvoye (Head of the Dept. of OB/GYN at the Aih Hospital in Belgium and teaching at the Universite Libre de Bruxelles) have a long experience of training in family planning in Europe and in Africa. Published with the support of UNFPA.
ISBN 2-218-2413-6
Available from Editions Hatier, 8 rue Assas, F-75006 Paris, France.
Tel. (+33) 1 49 54 49 54.
Price: FRF 90.

The abortion Law in Northern Ireland. Human rights and reproductive choice, by Ann Furedi.
Published by the Family Planning Association Northern Ireland, with support from Europe Region, International Planned Parenthood Federation (1995).
The report confirms the recent recommendation by the Standing Advisory Commission on Human Rights that the law on abortion in Northern Ireland is so uncertain that it violates standards of international rights law and is in need of clarification.
ISBN 0 86089 105 4
Copies available from FPA Northern Ireland, 113 University Street, Belfast BT7 1HP.
Price £4.95.

Published by: Van Gorcum & Comp.
In this book, practices and beliefs of traditional birth attendants (TBAs) in different countries of Africa, Asia and Latin America are compared and systematically arranged according to the common classifications in "Western" obstetrics with reference to the perinatal period. Food taboos and food recommendations of TBAs are included. Training programmes of TBAs in the three continents are described. Suggestions for a health policy with reference to the training of TBAs are presented in a final conclusion.
Intended for anyone interested in practices and beliefs of traditional midwives, especially birth attendants, obstetricians and medical anthropologists.
Available from: Van Gorcum & Comp.B.V., P.O. Box 43, 9400 AA Assen, Netherlands.
Price: Dfl.45, US$25.-.

The State of the World's Children 1995, by James P. Grant, Executive Director of the United Nations Children's Fund. Published by UNICEF by Oxford University Press. As a contribution to the Copenhagen debate at the World Summit for Social Development, this book argues that the time has come to see the issue of protecting and investing in the growing minds and bodies of children as an issue which is integral to economic and social development. It asks what practical progress has been made since the 1990 World Summit for Children and finds that a majority of the goals set for 1995 are likely to be met by a majority of the developing nations. Malnutrition has been reduced; immunization levels are being maintained or increased; large areas of the developing world have become free of polio; iodine deficiency and vitamin A deficiency are being eliminated; ORT is preventing more that a million child deaths a year; and progress in primary education is being resumed.
Available from Oxford University Press, Walton Street, Oxford, OX2 6DP, Oxfordshire; United Kingdom
Price: £ 4.95.

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Articles and documents in Russian

Available from the Sexuality and Family Planning Unit, WHO Regional Office for Europe.


Chapter 3: Contraceptive methods.


Family Planning in Europe: The WHO Perspective, by Daniel Pierotti, WHO 1993

From Abortion to Contraception - Conference Report, Tbilisi, October 1990, including The Tbilisi Declaration.


Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding, 1 August 1990, Florence, Italy.


Having a baby in Europe. World Health Organization, Regional Office for Europe, Copenhagen. (Ref. Public Health in Europe No. 26).


Skin to Skin: Kangaroo Care in Western Europe, by Gene Cranston Anderson American Journal of Nursing, May 1989.


Why promote breastfeeding in diarrhoeal disease control programmes? by Isabel de Zoesa, Marina Rea, Jose Martinez, in Health Policy and Planning.


Islam and Family Planning, by Mohammad Abbas Uddin Notes on the Integration of Family Planning into Health Care at National Level, by Bob Fenner, Department of Health, United Kingdom.

Lecture notes on the Role of Nurses, by Ann Eady, Margaret Pyke Centre Notes on the Role of the Pharmacist in Family Planning, by Roger Odd, Royal Society of Pharmacists

Update on contraceptives, by Diana Moran, Margaret Pyke Centre Quality of Care in Family Planning: Clients' Rights and Providers' Needs, by Carlos Huezo (IPPF, London) and Soledad Diaz (Family Planning Clinic, Instituto Chileno de Medicina Reproductiva, Chile).

The Russian Family Planning Association has translated into Russian documents published by the International Planned Parenthood Federation on contraceptive methods, and family planning, including pamphlets and posters. They also publish a family planning magazine.

For further information on those documents, please contact: IPPF, Regent's College, Inner Circle, Regents Park. London NW1 4NS, United Kingdom.
HIGHLIGHTS ON WOMEN'S HEALTH IN EUROPE

In the European Region, we have attempted to fill the gap of knowledge concerning Women's Health by conducting a region-wide survey on Women's Health issues.

This project began in 1993 with the collection of data in eleven pilot countries of central and eastern Europe and the Newly Independent States. In February 1994, the results of this first phase were presented at the Vienna conference "Women's Health Counts", which brought together policy makers from the whole European region. The conference recommendation that other countries should join in the initiative, was followed by further twenty-seven Member States. The results of the nation-wide surveys of nearly forty European countries are summarized in this document.

Can be ordered from:

Family Health Team
World Health Organization
Regional Office for Europe
Scherfigvej 8
2100 Copenhagen Ø
Denmark

VIDEOS

Birth - Eight Women's Stories. Award-winning stills photographer, Nancy Durrell McKenna, has turned director/camerawoman to produce an awe-inspiring film showing the diversity of the miracle of birth. So many women give birth every second that we often take the process for granted but as Nancy's film shows, each birth is a unique and wonderful experience.

Nancy follows eight different women as they go through their labour.

We see natural deliveries, deliveries at home and in hospitals. She has filmed, with great sensitivity, Caesarian births, the birth of twins and a baby born in water.

The 70 minute video is invaluable to expectant parents and will form a catalyst for discussion and information for midwives, obstetricians and other professionals as and it provides them with a wealth of insights into this labour of love.

This is the first time that such a wide variety of childbirth has been presented in one film. No attempt has been made to promote one method of childbirth over another and all births are seen as a triumph. The film gives first hand experience of this intimate and exciting moment in life.

Birth, Eight Women's Stories has won the Gold Award at the 1993 New York International Film and Television Festival and a Bronze in the 1994 by the British Medical Association. The video is available from "Birth", 45 Muswell Road, London N10 2BS. Price in Europe is £45.

The International Course in Maternal and Child Health (in French) organized by the International Children's Center in collaboration with René-Descartes University, Paris, will take place at the International Children's Center in Paris from 15 January to 15 March 1996. For further information on this course or next year's course, please contact Dr Michel Péchevis, Château de Longchamp, Bât de Boulogne, 75016 Paris, France. Tel.: (33) 1 44 43 02 00. Fax: (33) 1 45 25 73 67.

Diplôme universitaire de Contraception (University diploma in contraception) of the Faculty of Medicine at Lariboisière-Saint-Louis in Paris. This diploma course has been offered for the past 14 years. It is open to any medical doctor (French, European or other foreign national) able to write and speak French. It consists of: 1) a theoretical course covering all the aspects of contraception; 2) a practical training period at the Centre de Régulation des Naissances (Centre for Birth Control) de l'Hôpital Saint-Louis; 3) the writing of a paper on a subject connected with birth control; 4) This university diploma is awarded upon successful completion of a written examination and by an oral defence of the paper. All inquiries concerning the Diploma in Contraception should be addressed to the Centre de Régulation des Naissances (Centre for Birth Control), Dr David Serfaty, Hôpital Saint-Louis, 1 rue Claude Vellefaux, F-7475 Paris Cedex 10, France. Tel.: (33) 1 42 49 91 39.

Reproductive Health Care - a course for Eastern and Central Europe An intensive 4-week course (April 10-May 9, 1996) in Karlskrona, Sweden, for senior obstetricians, midwives/midwifery teachers and other professionals with long-term experience of reproductive health care from Estonia, Latvia, Lithuania, Poland, North-western Russia, Belarusia and the Ukraine. The objectives of this course are to transmit knowledge about modern and cost-effective methods of preventing and treating reproductive ill-health. Specifically, this includes antenatal and obstetric care, care of the newborn, prevention of unwanted pregnancy and sexually transmitted diseases including HIV/AIDS, adolescent sexual health and cervical cancer.

The course is organized jointly by the Swedish International Development Cooperation Agency (Sida) and the Baltic International School of Public Health (BHi) in Karlskrona, Sweden. Closing date for application is January 10, 1996.

For Further information, please contact: Dr Jerker Liljestrand, Head, BHi, S-371 85 Karlskrona, Sweden. Tel.: +46.455.89 252. Fax: +46.455.89 37 77.

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