REPRODUCTIVE HEALTH: EVERY STEP OF THE WAY...
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Dr Eltan F. Sabatteło passed away in Jerusalem on October 5, 1995. On behalf of the Editorial Board we would like to convey our deepest sympathy to Eltan Sabatteło’s family and friends. Dr Eltan Sabatteło’s warm personality and his outstanding knowledge in the field of population will not be forgotten.

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From Family Planning to Reproductive Health

What does it mean?

Reproductive health does not start out from a list of diseases or problems, such as sexually transmitted diseases and maternal mortality, nor from a list of programmes, such as maternal and child health care, safe motherhood, and family planning. Instead, reproductive health must be understood in the context of human relationships, including the fulfilment of individual potential, minimising of risks, and ensuring the opportunity to have a desired child or to avoid unwanted or unsafe pregnancy. Reproductive health is a premise for physical and psychosocial comfort, emotional closeness, and personal and social maturation, while poor reproductive health is frequently associated with disease, abuse, exploitation, unwanted pregnancy and even death.

In his address to the “Meeting of Focal Points on Women and Child Health and Family Planning” held at WHO Regional Office in Copenhagen in December of 1995, Dr. Mark Belsey of WHO Geneva emphasised the close interrelationship of social and physical factors contributing to – or eroding – reproductive health. Maternal and child health had evolved, he reminded us, with the advent of the second Industrial Revolution and the high infant mortality rates arising from the poverty and crowded conditions in the new urban centres. And the credit for lowering both infant and maternal mortality rates was due more to the improved living conditions than to advances in medicine.

The family, whatever form it takes, is a key contributor to providing developmental and reproductive health care: health, nutrition, shelter, physical and emotional caring, and opportunities for physical and emotional development. When the important basic conditions of life worsened, the results were not long in appearing, especially at the particularly vulnerable points such as infant and maternal mortality. The causes can be tangible physical ones, like nutrition: we know that micronutrients and essential fatty acids are essential factors for periconceptual nutrition. But they can also be psychosocial: the simple factor of unwantedness is associated with a doubling of infant mortality. In Croatia, during the upheaval caused by recent armed conflict, the number of pre-term deliveries doubled. Nor is this sort of vulnerability restricted to infants: in England during World War II, for instance, there was a striking increase in the number of autistic children, thought to result in part from the large numbers of small children evacuated from cities and thus removed from parental care and contact. And recent studies indicate that the social and gender consciousness established in childhood through positive bonding and attachment to both parents is a major factor in inhibiting violent behaviour later in life.

Families. A changing pattern today, with the main trends toward increasing nuclearisation, migration, urbanisation. More instability, divorce and dislocation for children; more single parents and cohabiting couples. All of these are aspects which must be considered in planning reproductive health programmes.

As the lifespan graph indicates there is almost a continuum of vulnerability to be addressed in reproductive health measures: from birth through early childhood and adolescence, the reproducitively important adult years and the ever-lengthening years of post-fertility. All along the way are the windows of vulnerability, as Dr Belsey called them, which are no less windows of opportunity for reproductive health interventions. These may include, for example, prioritising the education of girls and women, promoting responsible sex among teenagers, providing family planning information and services that involve both sexes, offering training in parenting skills, developing child care programmes that involve men and the elderly to a far greater extent, and providing home health visiting...
Women and AIDS:

a growing threat

Isabel Yordi

Only a decade ago, AIDS was considered a male epidemic; less than 10% of persons with AIDS were women. Today the situation has changed drastically: In many countries 60% of all new HIV infections (the virus that can lead to AIDS) are among 15-24-year-olds, with a female-to-male ratio of two to one. The age-group hardest hit by AIDS, both among males and females, is youth. WHO estimates that half of all infections to date have been in the 15-24-year-old age group, but in nearly all parts of the world the peak age of infection is lower in girls than boys.

In Europe, the people predominantly affected up to now have been practising homosexuals and injecting drug users (IDUs). The transmission of HIV through heterosexual intercourse, however, increased during the latter half of the 1980s and the early 1990s, with especially noticeable increases in urban populations with high rates of injecting drug use or sexually transmitted diseases (STDs).

WHO now estimates that seven to eight million women of childbearing age have been infected with HIV. Almost half of all newly infected adults worldwide are women (in some places more than half), mainly adolescents and young women. The number of HIV-infected women worldwide is expected to reach 15 million by the year 2000.

As the number of women infected rises, so does the number of infections amongst the infants born to them. About 1.5 million children have been infected, of whom more than one-half million have already developed AIDS. Overall, about one in three babies born to HIV-infected mothers become infected themselves. Mother-to-child transmission accounts for 85% of all paediatric aids cases. Children who are lucky enough to escape may well end up as orphans: by the year 2000 as many as 5-10 million children may have lost their mother or both parents to AIDS.

WHY WOMEN?
In the vast majority of cases, the route of transmission to women is through heterosexual intercourse. Women's vulnerability to HIV and AIDS is, on the other hand, biologically and, on the other hand, socially, culturally and economically based.

The biological factors are almost all related to the female reproductive or genital organs.

- Male to female transmission appears to be two to four times as efficient as is female to male transmission. A possible explanation is that, as the recipient partner, women have a larger mucosal surface exposed during sexual intercourse. Semen also contains a far higher concentration of HIV than vaginal fluid.

- Young girls are particularly vulnerable: their immature cervix and relatively low vaginal mucus production present less of a barrier to HIV, making them biologically more vulnerable to infection than older premenopausal women.

- Untreated STDs facilitate sexual transmission of HIV. Most STDs can be cured if treated early, but half of all women with STDs don't go for treatment because often they have no symptoms at all. Poor women are especially likely to neglect their own health needs. And women are unlikely to go for treatment because of the stigma attached to going to an STD clinic where they may be recognized.

- Finally, women are disproportionately often the recipients of blood transfusions and other blood products (e.g. for anaemia or child birth complications). In the absence of adequate blood screening, women's vulnerability to blood-borne HIV transmission increases.

Sexual, cultural and economic factors also play a key role in the infection of women with HIV.

- The female sexual role is often a passive one; in some cultures women do not have the permission to talk about sex with men or to negotiate safer sexual practices.

- None of the most common preventive actions to prevent the spread of HIV is under the exclusive control of the woman, i.e. male condom use, reduction of the number of sexual partners and mutual fidelity.

- Violence has been described as one of the major public health issues of the 21st century. Violence against women is present in all cultures, although often hidden and undocumented. Women are vulnerable to coerced sex, including rape and sexual services. The list is by no means exhaustive.

Following a similar line of thinking, the WHO Global Commission on Women's Health held an extraordinary meeting on 8 September 1995 in Beijing, to discuss future actions in the light of the outcomes of the Fourth World Conference on Women. To this end the Commission adopted specific goals and targets for the year 2000 (the timeframe for the Beijing Platform for Action), which it encourages governments to adopt as the basis for policies and programmes to improve women's reproductive health.

And many of these aspects of reproductive health are the focuses of the articles in this issue: Isabel Yordi discusses the latest research findings on AIDS and how it is affecting women, Laurence Chenet presents revealing statistics on teenage pregnancies in the EU and Dia Timmermans looks at ways to involve men in family planning to a greater extent. The article on men taking action against violence, although conceived in the Icelandic context, could describe efforts in many developed countries.

In its report the WHO Global Commission specifically states: "Violence against women and girls has gained increasing recognition as both a human rights and a public health issue, and is extensively addressed in the Beijing Platform for Action. The WHO Colloquium on Women and Health Security in Beijing emphasized that violence against women has to be seen in its broadest context, referring not only to the physical and mental abuse to which women are subjected but also to the hidden violence that women face when they suffer from discrimination or are denied the basic human rights of food, medical care, education and a safe environment. A task force on Violence and Health is being set up in WHO and a plan of action for the health consequences of violence against women is being prepared. A database on violence against women is being set up to bring together quantitative and other data from both published sources and grey literature. Work in this area will focus on increasing the knowledge of the magnitude of the problem and its health consequences and improving the capacity of the health sector in prevention and management of the health consequences of violence against women and girls."
abuse, in and outside the family, and forced sex work. Any non-consensual penetrative sex can carry an increased risk of transmission of HIV and other STIDs, particularly as men who rape are not likely to use condoms. In many countries domestic violence is not even recognised as an offence. It is difficult to say how much these practises affect the spread of HIV, but studies of HIV-infected women attending antenatal clinics find that many are monogamous and have been infected by their one partner - their husband.

- In virtually every society, women face discrimination in education, employment and social status, resulting in economic vulnerability to HIV and AIDS. Especially in times of crisis, women are the most negatively affected, as is clearly shown in the “Investing in Women’s Health” report. In some countries women comprise 80% of all the newly unemployed. Households headed by women are much more likely to be financially poor than those in which there is a working male resident. Economic dependence reduces women’s chances of negotiating safer sex.

- Economic subordination is increasingly driving many women to rely on sex work for economic survival. Economic subordination makes women more vulnerable to coerced sex, rape and sexual abuse.

- Women who are migrant workers, refugees or returnees are often more vulnerable to sexual harassment, receiving financial support from men with whom they have sex or engaging in formal prostitution.

By the year 2000, as many as 5-10 million children may havelost their mother or both parents to AIDS.

Because of women’s vulnerability to HIV and AIDS, increasing numbers are being infected and those infected are often blamed and stigmatised. Women are accused of having transmitted the disease to their male partners and their offspring. This is not only unjust and harmful to the women,

- it fails to focus on men’s equal responsibility to prevent HIV,
- it prevents programmes from developing services to meet the needs of women,
- and undermine some research and intervention strategies which have been designed more to protect men from women than to enable women to protect themselves. Research for vaccines and treatment has been basically focused on the male body.

WHAT MUST BE DONE?

Fortunately, much has been learned through the efforts of the past decade. And although changing behaviour, especially sexual behaviour, has proven to be an uphill struggle, we do have some clear indications of what works and what does not. There are a number of positive signs:

- Female sex workers who can and do insist on condom use have been shown to have lower levels of infection.
- Men are being encouraged to use condoms and women taught negotiating skills to achieve it.
- A female condom has been developed, with a good level of acceptability from both males and females, but is still expensive.
- STDs detected and treated early can be cured in most cases. Diagnosis has been simplified, based on a syndromic approach, and STD services are being integrated with MCH and other services of primary health care clinics.
- Allies are being found in men’s groups to work with women to challenge community norms and values which place women at a disproportionate risk of HIV.
- Recent promising research has shown that mother-to-child transmission of HIV can be reduced by two-thirds with administration of AZT to HIV-positive mothers several weeks before and after delivery. More research is still required, however, and problems with testing and price still have to be resolved. None of these intervention strategies, however, are being developed fast enough. At least one of the reasons for this is that the impact of HIV and AIDS in women has received insufficient attention in both developing and developed countries.

CRUCIAL CHALLENGES

The Agenda for Action on Women and AIDS has identified the following ten crucial areas of need:

1. STD services for women integrated with MCH services;
   women living with the virus must be identified and provided with appropriate treatment and care.

2. Ensuring that national programmes target young people - specifically with regard to sex education.

3. Partnerships with women’s groups defending women’s rights or living with HIV must be established.

4. Programmes aimed at men must and encourage them to accept their responsibility in caring for their female partners and children.

5. Ensuring that research protocols target women.

6. Developing and providing female-controlled methods to prevent sexual transmission of HIV; essentially this involves microbicides and female condoms.

7. Encouraging socio-behavioural research aimed at analyzing cultural and socio-economic factors which condition women’s vulnerability and developing appropriate interventions.

8. Promoting research and intervention to prevent perinatal transmission.

9. Establishing a multiagency approach to address the multiple dimensions of women and AIDS, involving in particular Ministries of Education.

10. Establishing national mechanisms to support the female empowerment process.

And, finally, there is still a wide gap between the attention which women’s vulnerability to AIDS is gaining at the international political level and at the level of local implementation - the one which will make the decisive difference for women.
Taking action against violence

Being male doesn’t have to mean being violent - Men in Iceland organise a week-long campaign against violence

Keneva Kunz

One of the issues prioritised by the Fourth World Conference on Women in Beijing in 1995 was elimination of violence against women.

The urgency of addressing this global problem is tragically illustrated by the treatment of women in recent armed conflicts, where rape and forced pregnancies were used as instruments of war. But it is not only in wartimes that women are vulnerable to abuse; they are subjected to violence in the family, at work, in the wider community, even as an instrument of state oppression. Women everywhere remain vulnerable to threats to their lives and abuse of their physical and psychological integrity.

"The best-kept secret of any violent person," says Sæunn Kjartansdóttir, nurse and psychoanalytical psychotherapist at the Reykjavik Hospital, "is his own feeling of impotence. On the surface, he appears confident and pleased with himself, especially with his own toughness; he looks down on the needs, weaknesses and emotions of women, for instance. But when you look closer, it’s all only a front. What he has to hide - from himself and others - is this feeling of impotence, of a need for care, that erupts for instance when he experiences the independence, or even rejection, of women."

Like many small societies, Iceland has traditionally had a crime rate far below that of neighbouring countries at a comparable level of social development. But in recent years significant increases in violent crimes especially and violence in general - have been a cause for growing concern. Television by itself appears to be a major factor in the increase of violence in modern society.

Surveys have shown that 10-15 years after television broadcasting commences in a given society, the incidence of violent crime can be expected to double. And the nature of violence changes: while the number of people treated at the emergency ward of Reykjavik Hospital after being attacked has doubled in the last decade, the number of facial injuries has decreased significantly during the same period and internal injuries to the abdomen and injuries to the genitals increased proportionally. And police data show that the number of attacks without apparent cause has also increased.

In 9 of 10 instances the attackers were men.

No society has to accept violence as a natural law, and in many countries men have formed organisations to oppose the use of violence, the first in Canada in 1989, after an assailant armed with a machine gun charged into a women’s university residence. His flood of bullets was accompanied by a tirade of sexual abuse directed at feminists especially. Other groups in Norway and Sweden, for instance, have also taken up the challenge of opposing violence. This winter the Mens’ Committee of the Icelandic Equal Rights Council organised a week-long information and education campaign under the heading “Men Against Violence”. It included a number of events: an art exhibit on the theme organised by the Society of Icelandic Graphic Artists, domestic and foreign speakers discussing the problems of violence in families and treatment sought by those inclined to resort to violence, and a media campaign to raise public awareness. An information booklet was at the same time distributed among students in secondary schools.

WHY MEN?

"We know that the overwhelming majority of people arrested for violent crime are men," said Ómar Smári Armansson, assistant Chief of Police in Reykjavik, "despite the far-reaching changes in gender roles which have taken place during recent decades, our figures show hardly any change in this respect. We also know that official statistics indicate that a very high proportion of violent crimes are committed by fairly young people, most of them in their late tens or early twenties. And, unfortunately, we also know that the official statistics underrecord the amount of domestic violence, where men are the offenders in almost 95% of the cases.”

Swedish social worker Göran Wimmerström, who was visiting Iceland as part of the campaign, described therapeutic and prophylactic efforts to help men avoid the use of violence. “Statistics show that one woman in four in Sweden suffers physical violence from her partner. I see little reason to suppose that the situation is much different here in Iceland.” Data collected at Stigamót, the emergency reception centre for victims of rape and sexual violence in Iceland, shows that 98.7% of the attackers were male.

This is by no means to maintain that all women are good and kindly and all men bad and violent, far from it. The question is rather: how do violent men differ from others who do not resort to violence? and how can we emphasize the positive aspects of masculinity instead of its negative ones?

NOT BLAME BUT TREATMENT

In a public lecture held as part of the campaign, Ingólfur Gislason of the Men’s Committee discussed a group therapy programme which began five years ago at Manscentrum in Stockholm. Two therapists work with a group of up to ten men, which is constantly changing as new arrivals join and others leave after completing their therapy.

"Newcomers are often worried about joining the group, thinking ‘We’ll be sitting there, the nine of ‘em, all real Hells Angels types, and me, just your run-of-the-mill office block’... And then he enters the room to find nine other ‘office blocks’.”

Men seeking help are screened first, as not everyone can be helped by such treatment: those with a very low level of intelligence, psychopaths and some suffering from minor brain damage are referred elsewhere. After concluding that the applicant could benefit from the treatment, the center asks him to sign an agreement: he promises to attend 10 consecutive meetings, arrive on time and sober, and take part in the entire session. If he fails to keep up his end of the bargain, for instance, drops into the pub on his way to the meeting or arrives five minutes late, he has to begin again from the beginning.

In addition, every applicant has to promise not to lay his hand on anyone during the course of the therapy. Or commit suicide.

"The men generally have to say to begin with," Gislason continued, "but eventually they begin to open up - and go on the defensive: ‘My wife is always bitching about somethin’, drives me around the bend, so I have to give her a shake now and again’. The reply: ‘And does she stop nagging you then?’ ‘No-o.’ Or they externalize the problem. It isn’t them, actually, who is committing the action, something else takes over, alcohol, or a black-out, or loss of
control. It isn’t true, of course; the attackers know only too well what they are doing. One therapist reported that doctors who used violence were careful to strike those areas of the woman’s body where it would hurt but be the least visible. Another common excuse is one’s youth: my dad was a drunk, my mom hysterical, we were so poor, etc. ‘And do you feel better about your youth after bashing up someone you care about?’

DANGEROUS ‘LIAISONS’

Without treatment or therapy, the pattern of violence tends to repeat itself. "Most people who have experienced a violent relationship intend to make sure they never end up in another. The man is determined to find an understanding woman next time, and the woman dreams of a "gentle" man,” continued Sæunn Kjartansdóttir. “But before long any new woman will end up disappointing the man and his former partner discovers that “gentler” men don’t appeal to her. They’re not exciting enough and she won’t be long in finding herself another of the very same type.”

Which makes it important to get to the root of the problem. By the time the excuses have been dealt with, somewhere around the fifth session of therapy, participants often go into a depression. It isn’t easy to face reality the fact that there is no excuse for violence. “Participants often fail to show up for the next session or two, maybe even think about putting an end to it all. But so far Manscentrum hasn’t lost anyone. And only after having faced up to the reality of being a user of violence can men receive treatment. They learn simple methods of self-control, of redirecting anger, of taking time to cool down - and that they really have it in them to be better men.”

The treatment offered at Manscentrum has been in operation for over four years now. As of 1995, 250 males had begun treatment, two of them left without completing the sessions, but the remainder have made an end of their violent behaviour. The centre contacts them (and their partners) twice annually, and the result is confirmed: they don’t strike out any more. Which is not to say that everything is coming up roses, but that physical violence has been eliminated. If the high success rate seems hardly credible, mention could be made of a recent report from the UN on violence, which confirmed a high success rate of therapy against the use of violence: six months to a year after completing treatment 60 to 84% of men have not physically abused their partners. * Obviously, there’s much to be gained.

THE CHILD IS FATHER TO THE MAN

As in all health issues, preventive measures are always preferable to therapy, no matter how effective. Which brings us back to the question of how violent men differ from others and how can we encourage in boys the positive aspects of masculinity instead of its negative ones. Here two aspects have been repeatedly discussed: the role of the father and the need for a positive male model. Both of them, it is suggested, are connected to the way children are now raised in most western countries (and elsewhere, as well).

In a nutshell: men are involved far too little in the raising of their children. Young children are cared for by their mothers far more than by their fathers, not the least due to discriminatory legislation on "maternity" leave (rather than "birth leave") in many countries. Male pre-school teachers are a very rare phenomenon, and male primary school teachers far outnumbered by their female colleagues (in Iceland 75% of primary and lower secondary school teachers are women). With the result that young boys have to draw their own conclusions about how males should be and act, with the help of television, comic books or simply adopting behaviour completely opposite to the way mom acts.

The media do their best to provide a caricature of the male role: men hang about unshaven, cigarettes dangling from their lips, practically never doing anything at all useful, and in such an emotional knot that they can hardly utter a complete sentence, and usually let a few words plus a grunt or two suffice. Acting on the supposition that violence can be attributed, at least in part, to the lack of a positive male image among boys (and girls), a Nordic Men’s Conference held in Sweden last April urged that action be taken to involve men more extensively in the raising of children. Firstly, by ensuring that they are given the same opportunity as women to care for their infants. Secondly, by promoting a positive, male version of domesticity. Far too often, complain men, they are welcome to do their share at home - if they do it "properly". Fold the wash in the accepted manner, do a decent job of the cleaning, dress the children in suitable clothes and refrain from playing boisterous games that over-excite them. Demands which they, not surprisingly, usually find unacceptable. Once again, an interesting example can be found in Stockholm, where the director of the police academy rewards policemen who choose to take “birth leave”. He regards this as an increase in their competence. The men heading homewards even take a computer, fax machine and telephone with them - to make their return to work easier.

Compiled by Kevina Kunz, on the basis of articles by Inglöfur V. Geislon, staff worker at the Equal Rights Office in Iceland and secretary of the Men’s Committe of the Icelandic Equal Rights’ Council, and Sæunn Kjartansdóttir, psychoanalytical psychotherapist at Reykjavik Hospital, Iceland.

* Preliminary report submitted by the Special Rapporteur on violence against women, its causes and consequences, Ms Radhika Coomaraswamy, in accordance with Commission on Human Rights Resolution 1994/45 
Men’s role in reproductive health:

Family planning is a family affair.

Dia Timmermans

“In the spirit of primary health care, it is inconceivable that the responsibility for family planning should be left entirely to the woman. Primary health care tries indeed to engage a joint dialogue with the man and the woman together in order to solve what is often a problem for the woman, facing very strong male resistance, or male indifference to the idea of planning the family. The point is that family planning is a family affair. It is unthinkable that women should be left to shoulder this responsibility alone”. (Halfdan Mahler 1984)

To date not much is known about how men view their reproductive function and their sexual lives and there is little in the way of research or programme experience aimed at helping us to learn more. What limited evidence is available, however, suggests that men are highly motivated with respect to ensuring effective and satisfying sexual functioning and concerning the treatment of sexually transmitted diseases. We know less about what moves men to be concerned about an unwanted pregnancy.

A combination of male attitudes and provider bias has resulted in men being both a neglected and poorly prepared constituency for family planning and reproductive health care. Often, the negative attitude of men to family planning is attributed to their lack of knowledge about contraception as well as to cultural, social, economic and religious factors. In most of the literature on reproductive health, and even more on family planning, men only come into the picture as the point where male methods for family planning programmes are involved.

In this article I will take a closer look at the role of men and women in the field of Reproductive Health (RH), first reviewing its history, then discussing specific fields of interest and, especially, innovative approaches.

Traditionally, Maternal Child Health/Family Planning (MCH/FP) has been oriented towards women. Women, and even more specifically married women, have been the target group for preventive activities, under which health education was included.

When Primary Health Care was introduced in 1978 in Alma Ata, Mother and Child Health/Family Planning became part of the package. In general, male PHC workers dealt with curative activities and female PHC workers (often the traditional birth attendant of a village) with preventive MCH activities.

In 1987 an international conference was launched to introduce: “Safe Motherhood”, with the objective of placing more emphasis on reducing maternal mortality. Interventions on all levels, from the community to the district hospital, had to be strengthened. Both in literature and during discussions, the primary focus was on the technological aspects of the problem (the hospital: equipment, training of specialists, etc.) and very little emphasis was put on the community: what could be done at this level to improve the maternal health situation.

Not only did the new approach fail to include the community, but even more importantly, it neglected the family and, more specifically, the husband.

The introduction of Reproductive Health into the agenda of the International Conference on Population and Development in Cairo (1994) gave policy makers and programme planners the opportunity to integrate all components of RH in the package and even more important to broaden the target group. The conclusion was that attention had to be directed not only to married women, but also to men, and other women of all ages. Information and services in the field of RH should be made accessible for all members of the society. And relations between men and women (role- and gender-specific) should be discussed during all stages of the programme cycles.

Often, the consequences of failing to involve men at all levels of FP/RH programmes can spell failure, or even disaster. In Mali, where I was asked to integrate “Gender and Reproductive Health” in a District Health Programme in a village where a Community-Based Distribution (CBD) programme had been launched, confusion reigned overall. Women had been
given the message to use pills in order not to get pregnant and men (their husbands) were told to use condoms. One female community health worker had been sent away by her husband because of her participation in the CBD programme without his consent. Several weeks before my visit a woman had died during labour because of transportation problems in getting her to a hospital.

Conversely, in the newly elected management committee of the health centre, women were not included, although they take care of the family health in case of illness and prepare the food. In case of an emergency during labour, men were only sought when it was already too late, not the least because private transportation to the far away district hospital was very expensive. During a discussion with the committee on the referral problem, the men's first reaction was: "We are never informed, we are not involved".

WHAT IS MALE INVOLVEMENT?

Philip Meredith of IPPF has formulated a working definition of "Male involvement" in RH:

The wide variety of socio-cultural conditions demands that "male involvement" be understood in a much broader sense than male contraception. At the same time, it is necessary to distinguish it as a discrete programme area. Consequently the definition of "male involvement" should be used to cover organizational activities aimed at men as discrete group and which has the objective of increasing the acceptability and relevance of the practice of family planning by either sex.

Direct activities are those aimed at the male partner himself. They will seek to alter his attitudes and behaviour. This may take the form of increasing his own willingness or ability to use contraceptives rather than his partner's use of them. Alternatively, it may involve a form of education specially tailored to his appreciation of his partner's family planning needs. Indirect male involvement activities aim at changing the attitudes or behaviour of males who, in turn, exert strong influence over other males in communities (e.g. religious leaders, military officers, actory managers). Taking into account societal resistance, one variant of this is to use males as family planning delivery agents.

In the new concept of Reproductive health "male involvement" should go beyond this definition, as the man is one of two people involved in the sexual relationship and should be included in all preventive and promotional reproductive health activities.

Reproductive Health services have tended to focus on married women, who because of their biological function of childbearing, are more vulnerable in terms of their reproductive health. In many countries the family planning programmes concentrate on convincing married women of the need for community leaders, etc. We have to realize that the impact of mass media is important. What can be observed in many countries is that commercial films and videos which are available deal with the negative side of sexuality: in which violence and glamour compete for the leading role. Good programmes (even in soap opera form) about sexuality, sexual relations, etc. would have a major impact on the sexual behaviour of (especially young) people. Where TV is not available radio feuilletons are a desirable medium.

But IEC through mass media should always be accompanied by group discussions. First, in homogeneous groups (young girls, young boys, married women, married men, and a group of leaders), and later in heterogeneous groups, if possible. People need to talk about sexuality, too many questions cannot be answered by reading, listening or watching. A good illustration of this is given in: "Hearing Ourselves Talk" (1995). Men Acting for Change (MAC) have organized discussion groups for men to discuss sexuality: in a safe yet challenging environment men and women: DT can explore their ideas, experiences, and fears in a way that encourages self-reflection and change. We have learned that there is no homogeneous male-rather, men have a range of questions, concerns, backgrounds, lifestyles, and needs.

In countries where maternal mortality is still very high, discussions with men should never focus only on family planning and AIDS, as responsibility for reproductive health includes also the care of the woman who is pregnant. As soon as men get really involved in the practical care for pregnancy and childbirth, there is a real chance to reduce maternal mortality.

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References:
WHO, Why did Mrs. X die?
Meredith, P: Male involvement in planned parenthood, 1989, IPPF, London
Teenage fertility, or the number of babies born to women under the age of 20 years, varies greatly among the countries of the European Union. In the UK, for instance, it is 32 live births per thousand women aged 15-19 in the United Kingdom, by far the highest rate, while only 4 live births per thousand women aged 15-19 in the Netherlands. Within the general context of delayed child bearing apparent in all the countries of the Union, including the UK, the observed increase in teenage fertility in recent years in the Kingdom is striking and unique in the EU.

Teenage Fertility is seen as a problem by many for a number of different reasons:

1) The high rate of unwanted pregnancies.
In this age group the ratio of abortions to live births is one of the highest, which indicates a higher rate of unwanted pregnancies. While safe abortion is now available in all countries of the Union, with the noticeable exception of the Irish Republic, it remains a psychologically traumatic life event, and one which in our societies often still carries a moral judgement. In the case of young women in their teens, their coping skills might even be less developed and harsh judgement, for instance by school peers, can be very damaging. If, for some reason, an unwanted pregnancy is carried to term, the outcome for both mother and child can indeed be dreadful.

2) The adverse outcome of teenage pregnancies.
Pregnancy in adolescence is associated with an excess risk of premature and low-weight births. Moreover, infant mortality is significantly higher in babies with a low birth weight. Because teenage pregnancies occur more frequently among young women of lower social background, it has often been argued that the poorer outcomes of those pregnancies were due to socio-demographic characteristics rather than to the intrinsic factor of the young age of the mother. However, recent studies aimed at disentangling the different factors behind the adverse outcome of teenage pregnancies have indicated the independently negative impact of young maternal age.

3) The high opportunity cost.
The opportunity cost of childbearing that women have to meet is even higher for teenagers. They have often not finished their studies and will find it difficult to remain in the education system. The rate of school dropout among teenage mothers is high. Their employment prospects are also impaired, especially in those countries (like the UK) where child care facilities are scarce.

In its white paper, the Health of the Nation, the British government set itself an ambitious target: to reduce by 50% the conception rate among girls under sixteen years of age by the year 2000. A more holistic approach to family planning services, improved communication with teenagers and more appropriate sex education programmes will be needed to reverse the increasing trend that prevailed in the UK during the eighties. An active policy to fight socio-economic deprivation at the local level should also have a positive impact on teenage fertility.

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RESEARCH

Long-term use of three-monthly injectable contraceptive DMPA not linked to breast cancer

Women using the injectable contraceptive DMPA are not at increased overall risk of breast cancer compared to women who have never used it, according to a new WHO study published in the Journal of the American Medical Association (JAMA) on 8 March 1995. The study also concludes that the use of DMPA should not be restricted on the grounds of breast cancer risk. DMPA, short for depomedroxyprogesterone acetate, is a three-month injectable hormonal method of contraception, also known as Depo-Provera.

The study was conducted by the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, in collaboration with the University of Otago Medical School, Dunedin, New Zealand, and the Fred Hutchinson Cancer Research Center, Seattle, WA, USA. It involved a secondary analysis of combined data on breast cancer and DMPA which had been collected in two studies previously conducted by the three organizations in Kenya, Mexico, New Zealand, and Thailand. Those studies had involved 1,768 women with breast cancer - most of whom were under 55 years of age - and 13,905 women who did not have the disease.

DMPA is administered by injection every three months and is among the most effective reversible contraceptive methods available today. It was developed in the mid-1960s with the aim of providing women with reliable, reversible contraception which did not require taking a pill every day. Although DMPA has been widely used throughout the world, its acceptance has been influenced by concerns that it might be associated with an increased risk of breast cancer. It is estimated that DMPA is currently being used by about nine million women in more than 90 countries.

While the results published in JAMA confirm the findings from previous studies, they also provide reassurance that women who have used DMPA for long periods in the past are not at an increased risk of cancer of the breast. However, women who started using DMPA within the previous five years appear to be at some increased risk of breast cancer (corresponding to a relative risk estimate of 2.0). But this risk was confined only to the five-year period, and women who had used DMPA more than five years previously did not show an increase in risk, even if they had used DMPA for extended periods in the past.

The reason for the increased risk of breast cancer observed in recent (or current) users could be due to enhanced detection of breast tumours in women using DMPA, or to the acceleration of the growth of pre-existing tumours.

The analysis also reconfirmed the known association of increased risks of breast cancer with early menarche, being single, a late age at birth of first child, not having any children, family history of breast cancer, and history of benign breast disease.

According to the authors of the study, DMPA should not be restricted on the grounds of breast cancer risk, but women taking it should be informed of the possibility that the contraceptive might accelerate the growth of small, existing but undetected tumours. This possibility should be considered in relation to the risks and benefits of DMPA and of other contraceptive methods.

“These results are similar to those from many studies on combined oral contraceptives and risk of breast cancer” said Dr Olav Meirik, Chief of WHO Unit for Epidemiological Research in Reproductive Health. “For women and couples who wish to practice medium- or long-term contraception, DMPA is one of the alternatives to choose from. The possibility of a slight increase in risk of breast cancer is one among many factors to be considered when a choice is made to use a hormonal contraceptive method.”

DMPA provides high protection against unwanted pregnancy and has not been found to lead to the slight changes of blood clotting factors associated with the use of combined oral contraceptives. DMPA exerts a strong protective effect against endometrial cancer (cancer of the lining of the uterus).

The drawbacks of DMPA are that it can cause an irregular bleeding pattern, which is not always acceptable to the woman; it is provide-dependent and not immediately reversible; and fertility is restored relatively slowly after the method is stopped.

For further information please contact UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization, 1211 Geneva 27, Switzerland.

Research in brief

Management of common genital infections

An article in the IPPF Medical Bulletin, Vol 28, No. 5, of October 1994, discusses “The management of common genital infections”, as an essential service to be delivered by family planning providers. According to the article, lack of training for health care workers in diagnosing, treating and counselling contraceptive users on genital infections makes it difficult for them to implement these services in many less developed countries (LDCs). The absence of basic laboratory facilities and limited financial resources often add to the difficulties for LDCs, where vaginal infections and their consequences are major public health concerns.

The article focuses on the most common genital infections, including vaginitis, cervical and urethral infections, genital ulcers and warts, and other infections. It discusses diagnosis and treatment, emphasizing reliable procedures that can be performed in most LDCs.

Children by choice = advantaged children

Recent investigations into the “Consequences for Children of their Birth Planning Status” are described in this article in Family Planning Perspectives, Vol. 27, No. 6, November/December 1995. The article documents research on over 1300 children younger than two years of age in 1986 whose mothers were participants in the US National Longitudinal Survey of Youth. 61% were “wanted”, i.e. the pregnancy was either planned by the mother or desired, even though unplanned, 34% “mistimed” (a pregnancy that occurred at a time the woman would rather have postponed childbearing, regardless of whether she was practicing contraception) and 5% were unwanted, i.e. the woman would have preferred not to have the child at any time. The result, documented by a wide variety of indicators at various ages and developmental stages: planning status is highly associated with the level of developmental resources the child receives at home.

Contraceptive use by women over 40

In an article entitled “Contraception for women over 40”, published in its first 1956 Newsletter, the International Health Foundation provides a summary of discussion on the subject from the 3rd Congress of the European Society of Contraception (Proceedings edited by G. Create, D. Serrate, S. Schoolboy, Athens: SEC, 1994: 31-36). It emphasizes the need to pay attention to the specific contraception
Research in brief

Continued from page 11

problems of older women, and points out that in many countries the group aged 40-44 years has the highest rate of abortions, expressed as a percentage of the total number of conceptions (over 40%), higher even than 13-19 year-olds. Practitioners, the article concludes, must be aware of the problems and needs of this age group and not least of the misconceptions that might play a role in their contraceptive decisions.

Oral contraceptives and risk of venous thromboembolism (VTE)

Two WHO papers in the 16 December 1995 issue of The Lancet examine the risk of VTE, i.e. the formation of blood clots in veins, in women using combined oral contraceptives (pills that contain both an estrogen and a progestogen). The principal findings are as follows:

- The overall risk of VTE associated with oral contraceptives is in the lower range of the risk levels reported in previous studies.
- Women with a high body weight or those with a history of high blood pressure in pregnancy are at a slightly higher risk of VTE compared with women who do not have these problems. In the WHO study history of hypertension or smoking habit did not alter the risk.
- Users of combined pills that contain the newer progestogens, desogestrel or gestodene, may be at double the risk of VTE compared with users of pills that contain the older progestogens, levonorgestrel and norethindrone. This finding was quite unexpected, as the two newer progestogens were thought to be safer than the older progestogens in this regard.
- It was estimated that in the UK 3-4 cases of VTE could be expected per year among 100 000 apparently healthy women of reproductive age who do not use oral contraceptives. Among women using pills containing levonorgestrel or norethindrone about 10 cases of VTE would be expected per 100 000 per year, whereas 20 cases of VTE would occur among those who are using pills containing desogestrel or gestodene.

"Even though the use of oral contraceptive pills increases the risk of deep venous thromboembolism by some 3-4 times, the condition remains a rare event affecting only a very small number of women taking the pill. In fact, pregnancy, prolonged bed rest or immobilization, and recent surgery carry a greater risk of VTE than oral contraceptive use," said Dr Neil Poulter of University College, London Medical School, who coordinated the study.

RESOURCES

Books

Cutting the rose, Female genital mutilation, the practice and its prevention, by Efua Dorkenoo. Efua Dorkenoo addresses questions on the African practice of female genital mutilation (FGM) and its impact on the psychological and physical health of women, based on her own research and practical experience. Dorkenoo is the Director of FORWARD International, a London-based organization to promote the good health of African women and children, and a consultant to WHO in Geneva. Available from Minority Rights Group, 379 Brixton Road, London SW9 7DE, UK. Fax: +44 (0)171 738 6265.

Health workers’ manual on Counselling for Maternal and Child Health.
An attractively produced and practical handbook for health workers, No. 9 in the Education in Action Series from WHO Regional Office for the Western Pacific in Manila, divided into two sections, one on counselling techniques and the other on the information to be presented. Available from Distribution and Sales, WHO, 1211 Geneva 27, Switzerland and the Publications Unit, WHO Regional Office for the Western Pacific, PO Box 2932, 1099 Manila, Philippines.

Female sterilization. A guide to provision of services, now available in Russian. Published by WHO Geneva (1992), available from WHO Distribution and Sales, 1211 Geneva 27, Switzerland.

Männer: Fertilität und Familienplanung [Men: Fertility and Family Planning], by Jürgen Heinrichs. Eberhard Verlag München. A book which attempts to present an overview of the involvement and responsibility of men in family planning activities in various areas of the world. The author, who has worked on national and international family planning projects for almost three decades, is a social scientist at the Starnberger Institute for Research on Global Structures, Development and Crises.


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ENTRE NOUS 32, May 1996
Breast-feeding and fertility. Edited by Dr Ghada Hafez and Dr Kalyan Bagchi, Maternal and Child Health and Family Health, WHO Regional Office for the Eastern Mediterranean series, No. 13. This publication examines the relationship between breast-feeding and its role in contraception, evaluates its effectiveness if certain guidelines are followed and provides reasons for its failure. It also describes the results of a multicentric research study on breast-feeding, lactation, anemia and fertility. ISBN 92-9021-171-7. Price US$ 3.

Documents


This background document should help policy makers, decision makers and bilateral donors to identify main needs in family planning in countries of the central and eastern Europe (CCEE) and in the newly independent states (NIS). It contains short country reports on family planning and reproductive health in all CEE and NIS countries. (27 countries in all). Excerpts from the document were presented in the last issue of Entre Nous No. 28-29 pp. 15-16. Available from the Sexuality and Family Planning Unit, WHO Regional Office for Europe.


This document is intended to provide guidance to non-specialist doctors providing obstetric and contraceptive surgery and the necessary anaesthetic services, in small hospitals that are subject to constraints on personnel, equipment and drugs, and where access to specialist services is limited. The document describes obstetric procedures considered essential for treating the major complications of pregnancy and childbirth and for preventing maternal death. It also describes procedures for female sterilization and insertion and removal of intrauterine devices. The section on anaesthesia describes the anaesthetic techniques that should be used during pregnancy and delivery.


Summary:
The fourth World Conference on Women is taking place at a time when women are increasingly becoming infected with HIV, the virus that causes AIDS. From being almost absent from the AIDS epidemic in the 1980s, women infected with HIV now
number more than seven million - with another one million women becoming infected this year. By the year 2000, over 14 million women will have been infected and four million of them will have died. Women worldwide are asking why a virus that infects both men and women is increasingly affecting women in a disproportionate manner.

The bleak reality is that the sexual and economic subordination of women fuels the HIV/AIDS pandemic. In order to break the cycle of neglect which affects women across their life span and across generations, it is essential to undertake actions which will allow women to make informed choices and enable them to improve the quality of their lives. Women must empower themselves by networking, forming alliances, and advocating for change. Top-level political commitment is needed to reduce the social vulnerability of women to HIV infection by improving their health, education, legal and economic prospects. Effective HIV/AIDS prevention and care efforts along with sound policies and programmes targeting women affected by HIV/AIDS need to be developed and integrated into existing national structures, particularly at the community and family level. Because such social vulnerability cannot be effectively challenged by women as individuals alone, or even as groups, building effective alliances between women and men based on mutual respect, remain the greatest challenge, but also the best hope, for the lives of tomorrow.

**Psychosocial and Mental Health Aspects of Women's Health.** Division of Family Health & Division of Mental Health, World Health Organization, Geneva (1994) (Ref: WHO/FHE/MNH/93.1 (1993). This is the first issue of a series of publications dealing with women and mental health. The aim of the series is to create a forum to debate issues related to women's mental health and to their contribution to mental health care. This debate will contribute to the general reappraisal of women's health problems, giving long overdue recognition to their strength and steadfastness in coping with the myriad problems that assail them, and pointing out future directions for research and action to address women's needs. The second issue will present the bibliography of publications dealing with women and mental health. A third issue will present the situation concerning mental health and women in Spain.

Turkey, Demographic and Health Survey (TDHS) 1993. This report summarizes the findings of the 1993 Turkish Demographic and Health Survey (TDHS) conducted by the Institute of Population Studies, Hacettepe University, under the auspices of the Ministry of Health's General Directorate of Mother and Child Health/Family Planning. The United States Agency for International Development (USAID) funded the survey, while Macro International Inc. provided technical assistance. The TDHS is part of the worldwide Demographic and Health Survey (DHS) program, which is designed to collect, analyze and disseminate demographic data on fertility, family planning, and maternal and child health. A bilingual summary (English/Turkish) is available, as well as a very comprehensive report in English. Additional information on the TDHS can be obtained from the General Directorate of Mother and Child Health and Family Planning, Ministry of Health, Sihhiye, Ankara, Turkey (Tel: 312-4314871; Fax: 312-4314872), or from Hacettepe University, Institute of Population Studies, 06100 Ankara, Turkey (Tel: 312-3107906; Fax: 312-3181411).

**Population Issues - Health, Development and Environmental Perspectives - in the World and in Turkey (1994).** Prepared by: Dr. Günsen Ermencu Balkan, Edited by: Prof. Dr. Ayse Akin Dervisoglu. This document is published jointly by the General Directorate of Maternal and Child Health and Family Planning, in Ankara, Turkey and UNFPA. (80 pages) (Also available in Turkish)

**The Evolution of Reproductive Health in Finland. How We Did It. Published by Väestöliitto, The Family Federation of Finland. ISBN 952-9605-06-4.**

The purpose of this booklet is to introduce the evolution of Finland's efficient reproductive health care system. It concentrates on the key phases of development and focuses on social trends. It also describes the factors which have contributed to the positive development of reproductive health, without forgetting the shortcomings of the present system. It was produced with the support of FINNIDA. Available from: Väestöliitto, The Family Federation of Finland, Kalevankatu 16, 00100 Helsinki, Finland. Tel.: +358-0-640 235. Fax: +358-0-612 1211.

**Wall-charts**

**Reproductive Risk: A Worldwide Assessment of Women's Sexual and Maternal Health.** A wall-chart from Population Action International which graphically presents the maternal health situation throughout the world, with respect to such aspects as contraceptive prevalence, anemia, national abortion policies. Available from Population Action International, 1120 19th St. NW, Suite 550, Washington DC, 20036-3605.
Videos

1. Three half-hour videos focusing on the empowerment of women, produced and distributed by People and the Planet. Available in Afrocari-ibbean English, Asian English, Afrocari-ibbean French and Spanish.

Victory for Women - Summarizes the positive messages from the Cairo Conference on Population and Development, and looks at these from the perspective of families in Egypt and Columbia.

Learning for Life - Looks at successful examples of extending education to women and girls and how it can liberate their lives, with special focus on Senegal and Bangladesh.

Calling the Shots - Tells how women are finding new ways of communicating, with film from India and Jamaica.

All three are available from TVE, The Centre for Environmental Communications, Prince Albert Road, London NW1 4RZ, UK. Tel. +44 (0)171 586 5526, Fax. 586 4866, e-mail tve-uk@geo2-geonet.de.

2. In-clinic videos in Spanish for women in clinic waiting rooms, produced as part of a Bolivian campaign to reduce maternal and perinatal mortality. De Mujer a Mujer (From Woman to Woman), three half-hour mini dramas cover reproductive choices and family planning methods, breastfeeding, spousal communication and STDs. Can be obtained from the Johns Hopkins Population Communication Services, which assisted in the campaign. Address is 111 Market Place, Suite 310, Baltimore, MD 21202 USA.

TRAINING OPPORTUNITIES IN EUROPE

Reproductive Health and Family Planning, 12 weeks certificate course, held January-March annually, intended to provide participants with a clear understanding of the nature and scope of reproductive health in relation to population dynamics, its relationship to fertility rates and gender planning in development programmes. Masters Programme in Reproductive Health and Family Planning, 12 month taught course plus dissertation, commencing September 1996. General aims are to critically analyse social, cultural and biological determinants of poor reproductive health and provide knowledge, skills and practical solutions to improve the health of women. Furthermore, to train participants in the principles of quality of care through appropriate management and communication strategies in order to improve the reproductive health of women.

Sir David Owen Population Centre, University of Wales, PO Box 915, Cardiff CF1 3TL, UK. Fax: +44 (0)1222 874372, Tel.: +44 (0)1222 874794.

6th Postgraduate course for training in Reproductive Medicine and Reproductive Biology. The Clinic of Infertility and Gynaecological Endocrinology, Faculty of Medicine, University of Geneva is accepting applications for the above post-graduate course, intended to provide post graduate training in reproductive health. To educate graduates in current research on Family Planning and Infertility, and to acquaint trainees with the most recent advances in technology in these areas of research.

The course provides a broad international orientation covering neuroendocrinology, andrology, various clinical aspects of contraception and infertility, psychosocial factors and the epidemiology of reproduction. The course, comprising lectures and practical work, will be given by the teaching staff of the Departments of the Faculty of medicine of the University, with additional lectures given by advisors and staff members of the WHO Special Programme of Research, Development and Research Training in Human Reproduction.

The course leads to a certificate in Reproductive Medicine and Reproductive Biology and a diploma in Reproductive Medicine (alt. Reproductive Biology). The certificate can be obtained after a 2 months intensive course followed by oral and written exams. This intensive course is compulsory for all students accepted for post-graduate training. A limited number of students who have been awarded a certificate will be accepted to undertake diploma research work. The duration of the diploma course will be 22 months.

The language of the course is English. The next course will be given from September 2 to October 18. For details and application forms, please contact: Mrs. M.C. Robert, Administrative Officer, Post-graduate course, Clinique de Stérilité et d'Endocrinologie gynécologique, H.U.G., CH-1211 GENEVA 14, Switzerland. Fax: +41 22 383 43 13. Email: mary-claude robert@diogenes.hcuge.ch

Short Course in Reproductive Health Research.

The Centre for Population Studies at the London School of Hygiene and Tropical Medicine will offer a 5-week short course in Reproductive Health Research. The course will introduce participants to the principles and methods of effective social and demographic research in this field and will concentrate on the design of policy-oriented research and methods of evaluating the impact of programmes. The course, which will start on 26 June and end on 28 July 1996, will be suitable for those with research interests in this field, and for managers and others who wish to commission or use research results. Enquiries should be sent to The Short Courses Office, London School of Hygiene and Tropical Medicine, Keppel Street (Gower Street), London WCE 7HT, UK. Tel.: +44 (0)171 388 3071, Fax: +44 (0)171 388 3076.

Postgraduate training course on Women's Health, Institut für Sozial- und Präventivmedizin of the University of Basel. The one-week course is aimed at enhancing epidemiological knowledge and the examining the application of epidemiological methods to women's health questions, both for purposes of etiological research and health promotion interventions. The target group includes people from different professions interested in doing research or health promotion interventions in the areas of women's health. The course, in English, includes lectures, interactive lectures, group discussions, reviewing and critiquing articles, especially on topics such as mortality and morbidity, reproductive epidemiology, cancer epidemiology, social factors as determinants of women's health, and health promotion intervention programmes. Participants will develop a study proposal. Emphasis is on research methods, study design and methodology for etiological research and health promotion interventions. Information from and applications to: Dr. med. Elisabeth Zemp Stutz, Institut für Sozial- und Präventivmedizin der Universität Basel, Steingraben 49, CH-4051 Basel. Tel.: +41 (0)61 267 6066, Fax: +41 (0)61 267 6190.
DIARY

2nd Congress of Latvian Association of Gynaecologists and Obstetricians (LAGO). Riga, 7-8 June 1996. Latvian Obstetricians and gynaecologists will be very pleased to meet their foreign colleagues. The Congress will be held in Latvian and in English. For further information please write to: Congress of Latvian Association of Gynaecologists and Obstetricians, Dept. of OB/GYN, Medical Academy of Latvia, 16 Dzirciema Str., LV-1007 Riga, Latvia.


For further information please contact: Viajes el Corte Ingles, Sra. Mayte Lagares Gonzales, Av. Diagonal 327, Entlo.1, E-08009 Barcelona, Spain.
Tel.: (+34) 3 4590870 or (+34) 3 4593690.
Fax: (+34) 3 4592090.


User-friendly guide to HEALTH ISSUES in the
Beijing Declaration and Platform for Action
(Fourth World Conference on Women
4-15 September 1995)

The goal of this guide is to bring together a cogent, systematic overview of the issue pertaining to the health of girls and women as presented in the Beijing Platform of Action adopted at the Fourth World Conference on Women. In addition to the issues raised in the health section, there are numerous other related matters that have a profound effect on women's health. This guide attempts to highlight the most important areas for action for the health care sector and provides references to all relevant paragraphs in the original document. It is aimed predominantly at international and intergovernmental organizations working in collaboration with NGOs.


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