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EDITORIAL

Over the past years Entre Nous has addressed the classic sexual and reproductive health issues including sexually transmitted infections including HIV/AIDS, emergency contraception, abortion and contraception, maternal mortality and morbidity, and rape in emergency situations. We are dedicating this issue of Entre Nous to another area of reproductive health, that of human genetics and its potential to improve the health of newborn children.

The statement of the WHO expert consultation on new developments in human genetics on pages four and five in this issue presents the general issues and priority actions of WHO, with respect for the general principles of bioethics. For example, all nations are encouraged by WHO to set up genetic centres and there is a strong need for a taskforce to be able to ensure the capacity for a global response in the face of new developments in human genetics.

One of the greatest fears of parents to be and of the medical staff taking care of them is congenital disorders, defined by WHO as “all disorders caused by environmental, genetic and unknown factors, whether they are evident at birth or become manifest later in life”. Fortunately, the diagnosis and management of congenital diseases is becoming more and more of a reality, at all social levels, through prenatal diagnosis and newborn screening. In Bulgaria, for example, there is a programme to provide families affected by hereditary diseases with a correct clinical diagnosis and genetic information as part of a follow-up and to prevent congenital anomalies in a region with about 10,000 births a year. The adequate management of patients with congenital anomalies and the counselling of families is the goal and more can be read about the initiative on page nine.

In addition to being addressed at the United Nations level, philosophers and ethicists have recently met in England to discuss assisted reproductive technologies (ART). The commercialisation of ART, regulation issues and the possibility of widespread use must take into account, moral, cultural, religious, legal and political considerations. Effy Vayena, a technical officer at WHO, was at the meeting and recounts on pages seven and eight the key issues of birth “by design”.

Other articles in this issue address violence against women, the male pill and male reproductive health, sexual health for the elderly and dual protection against unwanted pregnancies and HIV. We hope that interested readers will take direct contact to the authors should there be interest in further discussion on a particular issue.

And, as always, readers are encouraged to contact Entre Nous to propose new topics for articles or report on new initiatives and publications. Starting next issue, Entre Nous will also be published in a web version.

Assia Brandrup-Lukanow
Chief Editor

Jeffrey V. Lazarus
Editor

Entre Nous goes on the internet
We will continue to print the English version of Entre Nous.
The French version will be on the internet.
Other language versions will be printed locally.

Entre Nous would like to welcome Thoraya Obaid as the new Executive Director of UNFPA. Obaid, the first Saudi national to head a UN agency, was appointed to the position on 25 October 2000. She will replace Dr Nafis Sadik, the first woman to be appointed head of a UN agency, who retired after 14 years as the head of UNFPA.

Obaid was the director of the division of Arab states and Europe in UNFPA, a position she held from December 1998. Assisting governments to establish programmes that empower women has been the main focus of Obaid’s work both at UNFPA and at her previous position as deputy executive secretary for the Economic and Social Commission for Western Asia. While at UNFPA she has supported the continuation of Entre Nous magazine.
STATEMENT OF WHO EXPERT CONSULTATION ON NEW DEVELOPMENTS IN HUMAN GENETICS

For urgent consideration by WHO, executive board and the ACHR*

A consultation of WHO which included experts in human genetics and relevant WHO staff was held in Geneva, Switzerland, from 20 to 21 July 2000, to review recent developments in human genetics and identify challenges and priorities for WHO, and the future role of the organization in genetics. The following statement was unanimously adopted.

The advances in human genetics that have occurred during the past twenty years have revolutionised our knowledge of the role of inheritance in health and disease. The genome not only determines the cause of catastrophic single gene disorders that affect millions of persons worldwide, but also, depending on environment, puts individuals at increased risk of cardiovascular diseases, cancer, and other common diseases. This knowledge has been linked with an equivalent explosion of unparalleled rapidity in the areas of information technology and biotechnology, and a globalisation of technology change. If used appropriately, this knowledge will provide many exciting future opportunities to achieve better health for people in all countries. However, it is clear that many individuals, groups and nations have concerns about the use and exploitation of genetic data and genome technology, and concerns that non-genetic determinants of health will be neglected. Genetic advances will only be acceptable if their application is carried out ethically, with due regard to autonomy, justice, education and the beliefs and resources of each nation and community.

The role of WHO
The World Health Organisation is uniquely equipped to consider the new ethical issues that arise from developments in human genetics, by virtue of its mandate to pursue public good and to assist all nations in efforts to improve the health of their populations. It has a shrinking window of opportunity to provide leadership with regard to the key issues facing humankind in the application of genetics to health. WHO has a respected record in both developing and developed countries, and bases its activities on a strong knowledge base. It has a particular role in facilitating health in developing countries, and in narrowing the gap between the ‘haves’ and the ‘have-nots’. Its experience in quality assessment, setting enforceable international standards of care, education, and promotion of research will be invaluable in developing policies related to genetic procedures and advances in biotechnology. It has a commitment to the preservation of health, to prevention as well as treatment of disease, and to the equitable provision of health care. It has an excellent track record of collaboration with other international bodies, such as the CIOMS (Council for International Organisations of Medical Sciences), the WMA (World Medical Association) and UNESCO in dealing with relevant issues in medical ethics, and with the OECD (Organization for Economic Co-operation and Development) in quality control and standards for biotechnology. Most important, it has a long experience of handling ethical issues in the public interest. WHO has the expertise and mandate to lead on behalf of all nations and to take appropriate action in this high profile area. It has a responsibility to provide leadership in health-related ethical issues, and must offer policies on human genetics quickly and decisively.

Ethical issues arising from human genetics
The application of genetics to population health must be carried out with due regard to the general principles of bioethics. The many issues involved are covered in detail by past WHO efforts. These strong foundations, and the resulting documents (see references 1 and 2) which cover the issues in detail should be examined to ensure they are circulated and built upon.

There are many variations of experience and belief in different countries and cultures, but the principles outlined in the documents mentioned above apply to all populations. An appreciation of ethical principles in human genetics should be a part of the professional training of all health personnel, as well as educators and other decision-makers with an interest in health policy.

Legal and educational implications of new developments in human genetics
PATENTING facilitates the process of product development in genetics as in other medical fields, but patent protection must balance the provision of necessary incentives for invention with protection of public health interests. Gene patenting could impede international collaboration, especially between developed and developing nations, to the detriment of health care and biomedical research. WHO should participate in international debate on the implications of patenting and biotechnology in order to ensure that the health consequences in all countries are taken into account. It should work with key partners to develop a legal and ethical framework for gene patenting.

GENETIC KNOWLEDGE: WHO, working with other organisations, should play a major role in validating authoritative sources of information on human genetics and making these widely available. Education is a two-way process, and health care professionals have much to learn from support groups representing those with genetic disorders, and other citizens, in developing policies and strategies.

Priority actions for WHO
The group recommends that WHO:

- develop the capacity to offer a global response to the ethical, legal and social issues posed by the revolution in human genetics, and the implications of both therapeutic and non-therapeutic use. It should convene an internal task force, with urgency, to coordinate activities in this field in an imaginative way, with representation from the highest level and from all relevant departments and regions. This task force should recommend the best structure for providing leadership in formulating policies relating to advances in human genetics and disseminating these to Member States. The taskforce will assess the resources necessary to meet these challenges;

- convene a public, high level meeting, involving the director-general of WHO, to consider these issues and to stimulate global dialogue among major stakeholders. The meeting could consider whether WHO should create a standing commission or expert panel to offer a leading voice on ethical, legal and human rights issues associated with human genetics;

- ensure the establishment of a genetic resource centre. This will coordinate facilities and resources for research, standards, education and development. The resource centre could provide protocols and reference samples for simple and inexpensive gene analysis for common mutations, and develop model transferable strategies for training in clinical genetics and genetic counselling. It will coordinate and promote community education programmes in all countries to raise the level of knowledge of genetics, and help in the
organisation of regional training workshops to provide expertise in diagnostic and therapeutic approaches. Pilot studies on new scientific advances such as gene therapy or accurate sequence-based genome analysis could be initiated, assessed and, if successful, used as models. The centre will encourage collaboration between developing and developed countries. One area of particular importance is to ensure availability of genomic and bioinformatics resources in all countries to provide a mechanism for involvement in appropriate components of genome studies;

- organise a conference to examine the implications for developing countries of advances in genetics and related biotechnologies;

- encourage all nations to set up genetic services to meet immediate demand and to prepare for future needs. In so doing, the WHO will develop a template of recommended programmes and approaches to integrate basic interventions related to genetics into national health systems;

- develop international norms and standards for genetic testing and other health-related gene technologies; and

- consider the implications of use of experimental transgenic animals, possible hazards from xenotransplantation to humans, and relevant issues arising from the development of these and other genetically modified organisms.

References

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*ACHR = WHO's Advisory Committee on Health Research
The following interview is taken from a letter between two experts in reproductive health. David Griffin, a WHO scientist, provided the answers.

The term male "pill" tends to be placed in quotation marks because, although a male oral contraceptive pill is a feasible option, the first products in this area are likely to be injectable preparations which will be given by intramuscular injection at intervals of four weeks, eight weeks or perhaps eventually twelve weeks. They will be analogous, therefore, to the monthly, two-monthly and three-monthly injectable contraceptive products already available for women.

What does WHO think of the male pill? We feel it would be a valuable addition to the range of contraceptive methods currently available and under development. Indeed, it has been a major research and development objective and activity within the WHO Special Programme of Research, Development and Research Training in Human Reproduction since this Programme was first established in the early 1970s.

What do you think are its advantages/drawbacks? Its main advantage is that it would offer men and couples another option for male contraception to add to the very limited current range of male methods, namely the condom and vasectomy. One of the drawbacks that is often quoted is that women would not trust men who told them they were using the male "pill". This is analogous to the same concern expressed in the past about trusting men who claimed they had been vasectomized. The same response applies in both situations, namely, the woman should consider herself at risk and take the appropriate action. It is likely that this method will be used by couples in stable relationships. In this situation it has been claimed that women would not be able to depend on men keeping to the treatment needed to maintain contraceptive effectiveness. Ensuring and monitoring compliance of use will be much easier with an injected product than with a self-administered oral preparation, but the use of such a method will ultimately depend on mutual trust by the couple.

Why do you think it has taken so long to develop a male pill? Traditionally, contraceptive research was focused on the female as the "bearer of the child". In addition, many people felt that it would be impossible to shut off the continuous production of millions of sperm compared to preventing the release or survival of a single egg each month. Most of the emphasis of the early R&D that took place largely in the pharmaceutical industry, therefore, was on hormonal contraceptive methods for women that would either prevent ovulation or prevent implantation of a fertilized egg. Although some pioneering scientists kept the possibility of a male contraceptive alive over the past few decades with animal studies and small-scale clinical trials, it is only in the last 5-10 years that large-scale clinical studies have been carried out to show that it is not only possible to stop sperm production with a variety of different hormone preparations but that this is associated with a very high level of contraceptive efficacy and the approach used is well tolerated by the male volunteers.

What are its implications for world population control? We do not think in terms of population control but rather in terms of addressing the reproductive health needs of individuals and couples so as to enable them to have the number of children they wish, when and if they wish to have them. This involves providing them with the means to regulate their fertility in either direction, namely to avoid having children should they so wish, as well to avoid preventable infertility.

Would its widespread use be a good thing? It depends on how this is defined. We feel it would be a valuable addition in terms of meeting the family planning needs of men and couples worldwide. The important thing to remember is that the male "pill", like any other method of contraception, is not expected or intended to be a method for all men, although many men may well find it attractive should it become available; but rather it is intended for those men who want to use it. Even if the total of eventual users amounts to only 10-20% of the male population, this is still a very substantial number of men.
CHOICES AND DILEMMAS IN THE NEW REPRODUCTIVE TECHNOLOGIES

Philosophers and ethicists gathered last September at the University of Oxford to debate some of the ethical issues which emerged from modern reproductive technologies and continue to arise, especially because of scientific breakthroughs in genetics. Assisted reproductive technologies (ART) such as in vitro fertilisation, gamete intrafallopian transfer, zygote intrafallopian transfer and, lately, intracytoplasmic sperm injection have provided hope (and babies) to thousands of infertile people, but the social, psychological and ethical implications of these techniques have also invoked anxiety and confusion among the general public, scientists, ethicists, health care systems and even the law. Since 1978 when the first in vitro fertilisation baby (also called test-tube baby) was born, ART has grown to become a major component of reproductive medicine, made headlines, been argued in courts and legislated. Further, it has influenced the way we view reproduction and has challenged our ethos and morals.

Although ART is essentially infertility treatment, developments in genetics and cell biology create the possibility that ART will be used in the future to prevent disease and promote health in a much larger segment of the population. The Oxford meeting was one of several that have provided a forum for presentation and scrutiny of arguments among scholars, physicians, and policy makers as they address ethical concerns about reproductive technologies on national, international and multicultural levels.

Issues discussed in the meeting included the fate of spare embryos created for ART treatments, commercialisation of reproduction through compensation of egg or sperm donors, cost of and access to assisted reproduction, cloning for medical reasons, the welfare of the child born from ART, difficulties in framing public policy and "babies by design". Debates on such issues raise many difficult questions without necessarily giving an equal number of satisfactory answers, or the one size fits all type of answer. However, it is through such elaborate discourse and analysis of the moral and ethical complexity of the issues that the risks and benefits will be fully understood. I refer here to examples that have relevance to public health.

Whether ART should be regulated is controversial. A review of the current ART regulations in Europe shows not only the variation of legal approaches to a number of ART related issues, but also how legislation developed in the early 1990s does not cover the unanticipated developments. Research on spare embryos from ART and the purposes for which ART should be allowed, illustrate the variation. For example, some European countries forbid all embryo research, while others allow research but forbid placement of the researched embryo in the uterus. Some countries forbid the creation of embryos merely for research purposes, while others do not. Other countries illustrate an even greater variety of approaches.

The noted differences are dictated by the different moral principles, the different cultural values, religious beliefs, political and legal systems. One of the implications of such probably unavoidable variation has been the so-called phenomenon of reproductive tourism where people pursue their wish for having children with assisted reproduction beyond their national boundaries, if within these boundaries they feel restricted. The meeting noted that harmonisation of ART regulation would be as intriguing as difficult: establishing international principles could perhaps facilitate and promote better and more coherent regulations.

A new tool, preimplantation genetic diagnosis (PGD) has attracted great interest. After fertilisation of the oocyte in vitro, this method allows screening for genetic or sex-linked diseases before the embryo is placed in the uterus. Selection of healthy embryos and placement in the uterus have already resulted in hundreds of healthy babies. Lately, PGD has been used to detect chromosomal abnormalities with remarkable success. This new diagnostic method along with the development of our understanding in human genetics opens new avenues in reproductive medicine and health in general, as prevention or treatment of genetic abnormalities linked with certain diseases will become possible. However, selection of the genetically "right embryo" raises ethical questions about the extent of our biological control over the next generations.

Enhancement of the child to be born, or "babies by design" could soon become a

Do you think its use would lead to a rise in the incidence of STIs and, in particular, AIDS?

There are two separate but obviously linked issues here, namely the need to provide protection against an unplanned pregnancy and to provide protection against sexually transmitted infections including HIV/AIDS. People at risk of being infected by an STI should use an effective barrier method, such as the male condom, and this should be used correctly and consistently. Although the male condom used in this manner will also provide a degree of protection against pregnancy, individuals in this situation who desire a higher level of contraceptive protection, should use both a barrier method and an additional, more effective contraceptive.

Who do you think will more welcome its arrival, men or women?

From the clinical trials that have been carried out with experimental male contraceptive products to date, it is clear that both men and women welcome such a method: the men because it enables them to share responsibility for family planning, and the women because it relieves them of the burden of contraception.

What do you consider to be the best method of contraception? Why?

There is no such thing as a universal "best method of contraception". This will depend on the individual and his/her perception, beliefs, needs, lifestyle and situation. What is important is to increase the range of contraceptive options so that everyone will be able to find at least one method that suits them from the perspectives of safety, effectiveness, acceptability and affordability.

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possibility. Many would accept making changes in the germ line to create disease-free children and eliminate several diseases from the map of world health. Others point out that intervening in the germ line can easily take us down the slippery slope of eugenics, creating much larger problems than those the intervention attempts to solve. It will eventually be up to the particular societies and countries to deal with such issues, potentially creating a wide variety of regulations and thus a variety of possible outcomes.

Three weeks after the conference in Oxford, a case of a baby boy born “by design” in a hospital in the US, made headlines worldwide. The embryo was conceived in vitro, although there was no infertility problem, and tested with PGD in order to be a matching donor for his sister, who suffered from a type of anaemia. It was the unprecedented case of making a life (ensuring that it did not carry the disease) to save another life. The incident provoked questions about how far we can go with assisted reproduction and genetics, and at what moral and monetary costs. The questions are still pending, suggesting that we are marching into uncharted territory where reproductive liberty, individual choice and the welfare of the future child are all at stake.

The issues debated at the Oxford meeting appear in other professional meetings and the literature as well as in the lay press, indicating the increasing concern about the power of our new reproductive and genetic technologies. The recurrent theme is that despite the difficulty in finding solutions for these issues, it is an absolute imperative to continue articulating those complex aspects that will determine whether these new technologies are power for good or for ill. Understanding the depth and the complexity of the challenges in reproductive medicine and genetics could be the way to move from perplexed dilemmas to informed choices.

The UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction at WHO reviewed ART in 1992 and published a technical report (TR5 No. 820 Recent Advances in Medically Assisted Conception). In response to recent developments and challenges in this field, the Special Programme is currently reviewing the technical, ethical and social aspects of assisted reproduction.

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The first issue of Entre Nous in Bulgarian was published in Spring 2000 by the Ministry of Health under the UNFPA supported Project BUL/00/P01 “Strengthening the National Reproductive Health Programme”. The print run is 1000 copies.

Entre Nous in Bulgarian is distributed together with a supplement about Bulgaria that publishes articles concerning initiatives, studies, problems about the Sexual and Reproductive Health. The audience of Entre Nous is policy makers, health care providers, academic society, heath managers, youth specialists, teachers, young people and journalists.
The Sofia Registry of Congenital Anomalies/SoRCA/ was set up by the Bulgarian Society of Human Genetics and the Municipality of Sofia. It initiated its activities according to the recommendations of EUROCAT/European Registration of Congenital Anomalies and Twins in 1996. SoRCA is a clinically oriented programme, aimed to provide affected families with a correct clinical diagnosis and genetic information as part of a follow up and to prevent congenital anomalies (CA) in a region with about 10,000 births a year. An integral part of this complex approach is the assessment/management of psycho-emotional disturbances and prenatal diagnosis in coming pregnancies. The programme is coordinated by a working group consisting of a paediatrician, a computer engineer/statistician, a nurse and a part-time clinical geneticist and clinical psychologist, who maintain close contact with all obstetric/paediatric medical services in the region.

Three-year registration data
As of 23 July 1999, 558 families have been registered because of isolated or multiple CA in a foetus (38), stillborn (32) or live-born baby (488). 28,814 pregnancies have been followed over the same period and the overall prevalence of CA in this population accounts for 19.4%. The prevalence rate of the most common CA is shown in table 1.

Diagnosis
According to the aetiology, 7% of registered patients were shown to have chromosomal abnormalities, 10% single gene disorders, 57% multifactorial anomalies, 3% environmentally determined conditions and in 23% the multiple congenital anomalies (MCA) syndrome remained unidentified. Obviously, slightly more than one-third of the patients had MCA, which needed careful clinical/laboratory assessment. It was carried out in the genetic clinic of the Department of Paediatrics by personal examination and cytogenetic/biochemical/molecular methods. Thanks to this approach, in almost half of the MCA patients correct clinical/genetic diagnosis of chromosomal, environmental and more than 30 single gene disorders were made soon after birth. This was not the case in diseases with later onset/structural anomalies of internal organs, some metabolic disorders and skeletal dysplasias, etc. From this point of view, a longer registration period up to the end of the third year, a so-called updated registration, seems to give better results. This became our practice from the beginning of 1998.

Psychological assessment, follow-up, prevention
Personal contact was established with almost 30% of affected families. The psychological assessment by means of an oral interview and written questionnaire made it possible to reveal and deal with serious psycho-emotional problems in more than 50% of the cases. Diagnostic/genetic information has been provided during the visits to the Registry or in the Genetic Counselling Unit of the Section of Clinical Genetics. The follow-up and treatment, when possible, is carried out by the out-patient genetic clinic in close collaboration with other specialised paediatric clinics. Ultrasound follow-up with or without invasive prenatal diagnosis was already performed on pregnancies at increased genetic risk in 15 registered families.

Conclusion
The population based registration of congenital anomalies during pregnancy, the neonatal period and infancy greatly facilitates early diagnosis and has already become an integral part of a complex approach to families with increased genetic/environmental risks. The type of registry of congenital anomalies described above provides not only important epidemiological information, but also makes possible the adequate management of patients with congenital anomalies and their families.

References are available from the authors.

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Table 1.
Prevalence rate of some common congenital anomalies in Sofia population

<table>
<thead>
<tr>
<th>Congenital anomaly</th>
<th>No. of Registered families</th>
<th>Prevalence rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congenital heart disease</td>
<td>185</td>
<td>6.42</td>
</tr>
<tr>
<td>Nervous system</td>
<td>128</td>
<td>4.44</td>
</tr>
<tr>
<td>Neural tube defects</td>
<td>60</td>
<td>2.08</td>
</tr>
<tr>
<td>Digestive system</td>
<td>89</td>
<td>3.09</td>
</tr>
<tr>
<td>Musculoskeletal system</td>
<td>62</td>
<td>2.15</td>
</tr>
<tr>
<td>Urogenital system</td>
<td>51</td>
<td>1.77</td>
</tr>
<tr>
<td>Anomalies of limbs</td>
<td>47</td>
<td>1.63</td>
</tr>
<tr>
<td>Chromosomal anomalies</td>
<td>45</td>
<td>1.56</td>
</tr>
<tr>
<td>Down syndrome</td>
<td>32</td>
<td>1.11</td>
</tr>
<tr>
<td>Maternal age&gt;35</td>
<td>11</td>
<td>0.38</td>
</tr>
<tr>
<td>Cleft lip/palate</td>
<td>31</td>
<td>1.08</td>
</tr>
</tbody>
</table>
TAJIKISTAN - violence against women

Only the spiritual recovery of the nation will save Tajikistan from an escalation of violence against women

A WHO seminar on "Violence against women as a public health problem in Tajikistan: presentation of study results and a search for solutions" was held in Dushanbe on 29 and 30 March 2000. Opening the seminar, Professor Lyubomir Ivanov, head of the WHO office there, reported that in Tajikistan approximately 87% of women have suffered violence of some kind. This is related to the repercussions of the civil war, the violence present in society, the lowering of the age at which women marry, the prohibitions concerning women's work and education, and local stereotypes. Luigi de Martino, head of the office of the Swiss Agency for Cooperation and Development, emphasized that after Tajikistan gained its independence, women have lost certain rights they formerly enjoyed in the USSR - they have no access to education and health care, they have been excluded from social life, and their role has been confined to a domestic one.

The problem discussed at the seminar has roots going back many years. During the era of the USSR it was kept under cover, so as not to spoil the picture of women's equality in law under socialism. Yet many women and girls, who were subject to moral and physical violence, ended their life by suicide, choosing the most barbaric method of all: by setting themselves on fire. The statistics relating to these deaths were carefully kept secret, and other potential victims had no-one they could turn to for help. The civil war made this problem so much more acute that it was no longer possible to stop it from surfacing. In the course of the civil war, tens of thousands of women in Tajikistan were the silent victims of violence, forced to become second wives, concubines and slaves.

To this day, many prefer not to speak about their experience for fear of losing their home, their breadwinner and children, and sometimes even their life. Some of them have been drawn into criminal circles, where they are forced into drug trafficking and prostitution. That is why participants in the seminar, while in no way belittling the results of the pilot study on "Violence against women", conducted by the non-governmental organization "Otkrytaya Azlya", expressed doubts about the methodological validity of the study, and in particular about its anonymity.

Indeed, many of the respondents could well have suffered reprisals after the interviewers departed, since in small villages it would be extremely difficult to ensure anonymity and confidentiality. A study of this kind was highly topical and was badly needed in Tajikistan, bearing in mind the fact that women usually prefer to suffer in silence rather than expose themselves to the consequences of publicity. Moreover, many of the women still do not realize that, under the national constitution, they have the same rights as men. There are still no shelters and specialized centres for women who are victims of violence. The staff running such centres should of course undergo targeted specialized training, and above all they must be good psychologists.

Taking into account the specific mentality of our women, raised mostly in accordance with the teachings of Islam, it is easy to see that their escape to such a centre or shelter may well aggravate the conflict situation. The staff must therefore be trained to act as practical lawyers and psychologists. According to local customs, which are particularly strong in rural communities, girls from earliest childhood take second place in the family, while special attention is paid to small boys, who mistreat their sisters with impunity.

When they grow older, the women raise their sons in the same spirit, completing a vicious circle: the victims of violence raise the next generation of potential offenders. In the group discussion on intersectoral collaboration, in which the author of this article took part, it was therefore proposed to pay special attention to promoting a healthy moral climate within families, particularly in rural communities and in families with many children.

The participants also emphasized the need for the government to adopt robust judicial sanctions against the perpetrators of violence, making use of the votes of female members of parliament. Many non-governmental women's organizations, whose function includes the care and protection of women who have suffered violence, still duplicate their efforts. What is needed for more constructive joint action by such bodies is the establishment of a coordinating centre under the auspices of WHO. Little use is being made of the experience gained in involving religious authorities, elders and local councils, which usually have an immense influence on men, and especially on believers.

In conducting training courses for doctors and specialists concerned with this problem, it will be essential to draw on the experience of WHO experts such as Dr. Viviana Mangiantea, who read a highly authoritative analytical paper containing much necessary information useful to other participants at the seminar. Efforts directed at the moral recovery of the nation, with greater spiritual education in the family, must play an extremely important role here. The problem of violence, one of the major issues in our society, is now also being tackled at the governmental level. For instance, in the presidential programme on "The place and role of women in society", one section is devoted to the prevention of violence against women. A working group, made up of representatives of the government and NGOs, is engaged in elaborating this section.

The main emphasis in the programme is on normalizing social relations between men and women. But this is not something that can be done overnight. It will require years of slow and laborious work, changes in local traditions and mentality, and the spiritual recovery of the whole population - men as well as women. And this can be achieved only through close cooperation between local and international partners, with the support of the national government.

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SAVING MOTHERS’ LIVES:
Joint agency statement on reducing maternal mortality

The maternal death toll
In developed countries, the maternal mortality ratio averages around 27 maternal deaths per 100,000 live births, according to the statement Reduction of maternal mortality. A joint WHO/UNFPA/UNICEF/World Bank Statement. In developing countries the ratio is nearly 20 times higher, at 480 per 100,000 live births. It may be as high as 1000 per 100,000 in some regions. Where women have many pregnancies, the risk of maternal death is magnified, the international agencies say. In some developing countries one woman in 12 may die from a pregnancy-related problem compared with one in 4000 in industrialized settings.

Why women die
The medical causes of maternal deaths are similar throughout the world, the statement says. Globally, around 80% of all maternal deaths are the direct result of complications during pregnancy, delivery, or the postpartum period. The single most common cause, accounting for a quarter of all maternal deaths, is severe bleeding, especially postpartum haemorrhage. Sepsis, which often results from poor hygiene during delivery or from untreated sexually transmitted infections, accounts for some 15% of maternal deaths. Hypertensive disorders of pregnancy, particularly eclampsia (convulsions), cause approximately 12%. Prolonged or obstructed labour accounts for a further 8%. Complications of unsafe abortion are responsible for 13% of maternal deaths worldwide, though in some areas one-third or more of all maternal deaths are associated with unsafe abortions.

The agencies point to a number of factors that underlie the direct causes of maternal death. The low social status of women in some countries, for instance, limits their access to economic resources and education. This in turn limits their ability to make decisions about their health and nutrition. Some women are denied access to care either because of cultural practices of seclusion or because decision making is the responsibility of other family members. “Lack of access to, and use of, essential obstetric services is a crucial factor that contributes to high maternal mortality,” the agencies say.

Many women are helped in delivery by traditional birth attendants or by relatives. Many give birth alone. Only 53% of women in developing countries have the assistance of skilled health personnel (a midwife or doctor), the statement says, and only 40% give birth in a hospital or health centre. “Providing skilled attendants able to prevent, detect and manage the major obstetric complications, together with the equipment drugs, and other supplies essential for their effective management, is the single most important factor in preventing maternal deaths,” the agencies say.

Reduction of maternal deaths
Reducing maternal deaths requires action within families and communities, in society as a whole, in health systems, and at the level of national legislation and policy, according to the joint statement.

Legislative and policy actions
Obstacles that limit women’s access to health care such as distance from home to appropriate health facilities, lack of transport, and financial and social barriers must be removed, the agencies say. Instead, “legislation that supports women’s access to care must be formulated”. The statement urges that “statutes that restrict women’s access to family planning services should be repealed” and “policies must ensure that all couples and individuals have access to ... services that offer a wide choice of effective contraceptive methods”.

Policies and programmes should also encourage later marriage and childbirth, the statement says, as well as expansion of economic and educational opportunities for girls and women. Policies that increase women’s decision-making power, particularly in regard to their own health, are also essential, it says. The agencies recommend that all children, before they reach the age at which they become sexually active, should be taught the risks of unprotected sex and helped to develop the skills needed to protect themselves from sexual coercion.

Society and community interventions
The support of families and communities is key to reducing maternal mortality. Input from a wide range of groups and individuals is therefore essential, including community and religious leaders, women’s groups, youth groups, other local associations and healthcare professionals, the agencies say. Their statement stresses the need for community support in helping women obtain access to maternity care provided by skilled professionals. They recommend that communities help organize transport to health facilities, local insurance funds to help cover the costs of care, and the distribution of cheap and simple delivery kits to pregnant women.

Diet and general health
Women’s overall health influences their maternal health. A diet that has sufficient calories and micronutrients is essential for a pregnancy to be successfully carried to term. Various supplements can be given where there are micronutrient deficiencies but in the long term improvement in women’s nutrition is essential. Such a change can take place only at the community level and in the household, the agencies say. They express concern that “women often eat less, less often, and less nutritiously than their children and other family members.”


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STATEMENT ON DUAL PROTECTION AGAINST UNWANTED PREGNANCY AND SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV

Key points:
- Family planning associations should promote the concept and practice of dual protection
- Consistent and correct use of condoms is highly effective for the prevention of both unwanted pregnancy and STI/HIV
- Clients may choose to use condoms alone for dual protection or to use them with another method

Introduction
The right of individuals and couples to enjoy a healthy sexual life includes the prevention of unwanted pregnancy and sexually transmitted infections (STI) including HIV.

The prevalence of curable STIs such as gonorrhoea, chlamydia, and syphilis is high, and is even increasing in some countries. The HIV epidemic has reached devastating proportions, particularly in Sub-Saharan Africa, and is growing very fast in other regions such as Asia and Eastern Europe.

Definition of Dual Protection
Dual protection is defined as the simultaneous prevention of STI/HIV infection and unwanted pregnancy. This can be achieved by the consistent use of condoms alone or by the simultaneous use of two methods - one of which must be the condoms. Avoidance of penetrative sex, particularly in situations of high risk, is another means of achieving dual protection.

The Methods
Male latex condoms have proved to be the most effective method for protection against STIs/HIV when used consistently and correctly with every act of sexual intercourse (non-latex condoms are less well studied). However, when condoms are used inconsistently and incorrectly they give much less protection against both pregnancy and STI/HIV.

Female condoms have a role in dual protection, though the data are more limited: on present evidence, they are less effective than male condoms for protection against pregnancy; the degree to which they protect against infection needs has not been fully assessed.

Although condoms can be highly effective, there are factors that lessen their acceptability to some clients - including the need to use them with every act of intercourse and the perception that they reduce sexual spontaneity and enjoyment.

Injectable and implantable steroid hormones, IUDs and sterilisation do not require substantial involvement of the user to be highly effective for pregnancy prevention. These contraceptive methods, however, do not provide protection against STI/HIV. Oral contraceptives, which are highly effective for pregnancy prevention when used correctly and consistently, likewise provide no protection against STI/HIV.

Programme Implications
The concept of dual protection should be promoted. Sexual and reproductive health programmes can integrate information and education on the need for protection against STI/HIV with that on protection against unwanted pregnancy. Adolescents, who are particularly vulnerable to the risks of unsafe sex, should be given high priority in a programme’s activities on dual protection. Adolescent sexuality should be acknowledged and health care providers should be trained to counsel and support them in their decisions concerning sexual behaviour. While adolescents should be encouraged to delay penetrative sex as a means of achieving dual protection, contraception, including condoms for dual protection, should be made easily available to those who choose to engage in penetrative sex. Furthermore, efforts to reach men are essential. Their awareness of the risks of STI/HIV and unwanted pregnancy, and their participation in reducing them these risks, are critical.

Counsellors must assist family planning clients in determining their actual STI/HIV risk and help them to make the best decisions for dual protection. Risk of STI/HIV varies from region to region. Where the prevalence of STI/HIV is high, every client may be considered at high risk and the use of condoms assumes greater importance. Where the prevalence is low, risk depends mainly on an individual’s behaviour - for instance, having multiple sexual partners, having a partner known to be infected, or having a partner who has other sexual partners. Clear instructions on correct condom use are essential. To provide optimum protection against infection, condoms have to be of good quality and must be used consistently and correctly. Used in this way the condoms are also highly effective against pregnancy. Couples may wish to rely on condoms alone for dual protection. Hormonal pills for emergency contraception can be offered, to be kept as a backup in case a condom breaks or slips.

Many individuals who require maximum protection against unwanted pregnancy will prefer an even more effective method of contraception than condoms. This is particularly true of women for whom becoming pregnant or continuing a pregnancy, if it occurs, will carry a high risk, yet termination is unacceptable or safe abortion not available. The practice of dual protection for these people means use of condoms in addition to their regular contraceptive, whenever they have reason to believe there is a risk of infection.

Statement developed by the International Medical Advisory Panel (IMAP), May 2000. IMAP reserves the right to amend this Statement in the light of further developments in this field.

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COPING WITH SEXUAL HEALTH: an inductive intervention model

Sexuality is an integral part of life, from childhood to old age. Sexuality is not synonymous with the total experience of our erotic life, but includes the basic need for human affection, touch and intimacy, as consciously and unconsciously expressed through one’s feelings, thoughts and behaviour. Within the context of this comprehensive concept, one can understand how sexuality may be the origin for happiness and satisfaction on the one hand, but in cases of sexual dysfunction it may cause frustration and suffering. Therefore, sexual health promotion should be integrated into the routine health care process.

The purpose of this article is to enable physicians and other health care workers to cope easily with their client’s sexual health, even if they were not trained as sex therapists or sex counselors, by using an applicable intervention model. This inductive model is unique in its flexibility to the needs and capability of physicians and health care workers as well as those of the clients. It allows for a gradual and moderate discussion on sexual health issues.

The relationship between general health and sexual functioning

There is a dual relationship between health and sexual health. Many patients with heart disease, for example, fear they may have another myocardial infarction if they resume sexual activity, but at the same time they are anxious about their sexual functioning. Such a way of thinking may influence the cardiac patient to refrain from intimacy and provoke a decrease in self-esteem and even depression. All these changes relate to the client’s quality of life and they may have a great impact on his rehabilitation process. The Massachusetts Male Aging Study (Feldman et al 1994) reports on the connection between health and sexual health. This study found a significant statistical association between frequency of erectile dysfunction and chronic illness in a group of 1,290 men (ages 40-70). While complete impotence was found in 2.6% of the total group, the rate was 28% for diabetic men, 39% for cardiac patients and 15% for hypertensive men. Complete impotence was significantly more prevalent in men taking certain medications, including hypoglycemic agents (26%), antihypertensives (14%), vasodilators (36%) and cardiac drugs (28%).

Four factors play a major role in the connection between health and sexual health:

- Sexual dysfunction caused directly by the illness itself;
- Sexual dysfunction caused by treatment methods;
- The physical impact of a chronic illness (fatigue, exhaustion, concentration problems); and
- Psychological problems accompanying the illness (loss of control, loss of self-esteem, body image problems, difficulties due to role changes).

In spite of the solid evidence indicating the relationship between health and sexual health, and the belief that ignorance of sexual issues is one of the reasons that clients leave their therapists, many health care providers still find it difficult to address sexual issues as a neutral part of their clinic routine.

Discussing sexual health: problems and difficulties

Encouraging patient physician communication demands the recognition of the difficulties on both parties. Patients are unable to raise sexual issues due to shame, lack of knowledge, lack of experience in obtaining help for a sexual problem and limitation in using sexual language. These problems increase when patients are elderly. Physicians as well as other health care providers also have to cope with difficulties to initiate conversations on sexual health. Some feel ashamed, some fear entering an unknown domain and most of them lack proper training on sexual health communication and counseling (table 1). The following model may become a useful instrument for addressing sexual issues without causing any threat or inconvenience to the health provider or to the client.

The inductive model (based on the PLISSIT model) consists of four stages: it begins with a permission to raise sexual health problems and continues with the provision of basic information. Only when further intervention is needed, can the health provider step into the next stage, where specific suggestions will be presented to the client. The model ends by using intensive therapy to treat sexual problems by the health provider or by referring the client to another therapeutic service. The model enables physicians to stop at any stage, continue or refer the client to further treatment.

The first step of intervention consists of granting the client permission to discuss sexual issues. Since many clients believe that no one is interested in hearing...
about their sexual difficulties, the physician can encourage them to talk. It is important to listen carefully to the client's question without being judgmental or cynical. Clients must also be reassured that they have the right to be sexually ignorant, the right to hold their own beliefs and values and the right to continue their sexual behavior, even when such behaviour is not regarded as "normal" by the physician, professionally or personally, excluding of course illegal or destructive behaviour.

Permission can be granted in two modes: the indirect mode or the direct mode. Indirect permission will encourage clients to raise sexual health issues by distributing booklets, brochures and other informative material in the clinic and in the waiting areas. The material invites clients to discuss sexual issues without any need for an active intervention. The direct mode can take place within the framework of discussing medical history, by including questions regarding the sexual health of the client. For example, after asking questions regarding various aspects of an illness, the doctor can ask: "how did your illness effect your intimate life?" or "your sexual relations?"

Many clients feel at ease when the question is phrased more generally, e.g., "Some hypertensive men tell me about changes in their sexual functioning. In case you feel such changes, please don't hesitate and tell me about it" or "People who use this medication complain about some sexual problems. What would you like to know about this issue?"

The third most direct method is to discuss sexuality, without referring to any health problem: "Some clients have asked me about sexual difficulties in their life. If you wish we could also discuss it." It is important to emphasize that the permission stage includes more than merely posing a question. Quite often, the physician's attitude toward the client and reaction toward the question are more significant. Therefore, attention must be given to the client's verbal and non-verbal language. Even when permission is given, clients still have the right to retain their privacy, to reject any further intervention or refuse to change their sexual habits. When clients use rude expressions or have difficulties in articulating their sexual problems, it is an appropriate opportunity for improving the client's communication skills. All these interventions should be done modestly to create trust and confidence. By the end of the first step the client might have the permission for one or more of the following options:

1. Permission to stop having sex temporarily, until some recovery occurs;
2. Permission to continue the usual sexual behavior, in spite of the medical problem;
3. Permission to change sexual habits (timing, position, stimulation method, use of lubricants or other sexual aids);
4. Permission to ask for help on sexual issues from the doctor or the care provider; and/or
5. Permission to share the problem with a partner and improve communication skills.

The next stage, the limited information, includes the provision of information in order to improve knowledge, dispel sexual myths, alleviate anxiety and enhance confidence. Provision of information can also play a major role in the prevention of problems in the future or reduce anxiety in the present. A very common reaction of clients after listening to the physician's explanation is: "I didn't know that it is a normal reaction to this operation/procedure/medication. I thought that it only happened to me. I thought that I was the only one with such sexual problems."

Like permission, information should be shared with much sensitivity and modesty. The client should get the message that there is a huge variety of human sexual behaviors, preferences, needs and habits. Health care providers should also convey the message that there are various options for choice, when a client is facing a sexual problem. Sentences such as: "...do that, otherwise..." should be avoided. Information will be better accepted if it is simply and directly broached.

In most cases, the permission component is combined with the information component. The health care provider can tell the client that: "Many men who have had a heartattack are worried about resuming their sexual life" (a permission component), and can add: "You may resume your normal sexual activity as soon as you reach your normal level of physical activity", then end with some information component like: "The physical effort exerted during sexual activity is similar to having a shower, doing light cleaning job at home or climbing two flights of stairs" (an example taken from the Israel Heart Society position paper, 1999).

Another example for the combination of these two components: "It is important that you know, that every patient who receives this kind of treatment may feel tired and exhausted. These feelings may affect your mood and your activity. Your sexual functioning may also be affected. If you experience any changes we can discuss them". Instruction and information given to clients before an operation or a special treatment is another opportunity for the insertion of the sexual information.

"After explaining the medical procedure and its results, I would like to tell how it may affect the sexual functioning". Our clinical experience with the inductive model shows that the combination of the permission and the information components covers the needs of most clients. In some cases, when a sexual problem exists before the appearance of the health problem or when the sexual problem is complex or when clients have specific questions regarding their sexual function, then the intervention continues into the next stage: Specific Suggestions. Clients who are confident with their physician's care and those who feel that their sexual questions are responded to respectfully, will be ready to ask for further counselling. This is a point where the health care provider may decide to refer the client to specialist for intensive therapy.

**Intensive therapy** is the last stage of the intervention model. Before referring clients for further treatment, two issues should be clarified: previous experience to solve the problems and client expectations.

1. **Previous experience:** The following questions can be helpful: "How did you try to solve your problem? What treatment did you already use? How successful was the treatment? Did you use medications or over-the-counter drugs? What were the consequences?"
2. **Expectations:** The following questions can be helpful: "Who would you like to discuss your sexual problem with, your physician or a specialist? What kind of treatment did you have in your mind? Do you prefer to be referred to a female or male professional? Does your partner know about your difficulties? How would he/she react? Is there any mutual cooperation or open communication on this issue between both of you?"

Clarification of a client's expectation and previous experience are valuable for the decision on future intervention by the health care provider and essential for prevention of client's frustration or treatment failure. Referral of clients to professionals who specialize in treating sexual health problems is part of sexual health promotion. Therefore, a list of sexual health services should be prepared. This list should include services in the medical aspects of sexology (urology, gynaecology, endocrinology and neurology), mental health (psychology and psychiatry), as well as services which specialize in treating sexual abuse, couple therapy, family planning, youth counseling and sex therapy. These specialists can also serve as a counselling source for the
A Study On Men’s Reproductive Health

Most reproductive health research and family planning methods are historical focused on women. However, it is evident that men’s support and participation are essential to the success of any reproductive health initiative. Yet, despite the fact that Kazakhstan’s Policy on Female Reproductive Health Protection was accepted in 1996 and introduced as a guideline for health authorities, no such attention has been given to male reproductive health. This article will provide an overview of the preliminary findings to date of a study on the current situation of men’s reproductive health in Kazakhstan.

Men were questioned about their reproductive health, family planning matters, relationships with their sexual partners, etc. Field research was conducted in the autumn of 1999 employing a 34-point questionnaire to survey the reproductive age population. The questionnaires were distributed among students and staff of the University of Kalin in Almaty. 501 responses were received and the results are currently being processed. The main tendencies about the knowledge level of the participants and their attitudes toward reproductive health are outlined below.

Sexual Life
The question about having a permanent sexual partner was answered positively by 38.5% respondents, while 59.7% did not have one, and responded that they have occasional sex with different sexual partners. That 40% of the respondents responded negatively to the question of personal satisfaction in their sexual life did not come as a surprise. The main reason for this was defined as lack of a sexual life in general (84.4%). The amount of sexual intercourse within a one-week period varied between 1-2 in 36% of the responses and more than 2 in 25% (Figure 1). Some of the respondents admitted having problems with sexual intercourse, which they associated with a bad sexual experience in the past (12.7%). Interestingly, 14.7% of all participants reported harmful professional factors in their previous working life as causing problems in their sexual life.

Family planning and contraception
Questions designed to underline the level of knowledge of the participants have shown that 91% of the respondents are familiar with safe sex and family planning.

Responsibility for the number of children in the family was distributed equally between husband and wife: 31% preferred to use contraceptives by themselves and 29% preferred their partner to use them, while the rest did not answer the question. Condom use remained the most common method of contraception for men; 42% responded that they used condoms on a regular basis. The second most popular method of contraception was

The inductive intervention model (based on the FLISSIT model) is a controlled, gradual and moderate process to be implemented within routine health care intervention. The model is based on the use of direct and distinct language, permission to discuss sexual issues or to refrain from mentioning them, the right to be a sexual human being without receiving any judgmental or prejudicial response and, finally, information provision according to the client’s need. Each professional can apply the model according to his/her specific skills, motivation and according to the type of health care service.

Finally, although focusing on the elderly, the ideas presented in this article refer to clients of both genders, to married and non-married couples, to people of all age groups and to homosexual and heterosexual couples.

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hormonal (tablets): 27% of all partners used them. IUDs were third, 11.6%. The rest used “other” methods, but did not specify which.

One of the key questions concerned abortion as a method of contraception. A number of publications from the Republican Maternal and Child Health Centre show that abortion remains a major problem for the population, as it is the most popular contraceptive method. Abortion is still a major risk to woman’s health. However, public health education, promoted by the mass media and health authorities, appears to be showing results, and this was reflected in the questionnaire’s answers; 76.4% of all responses showed a strongly negative attitude towards abortion. However, 17.4% continue to consider abortion as a quite acceptable method of family planning. The remaining participants did not provide an answer, possibly due to a lack of knowledge on this issue.

Information needs
The majority of participants were very concerned about the subject of information availability on reproductive health and sexual life and admitted to a general need to be educated on reproductive health in particular. The first main source of information on sexual and reproductive health issues, was, according to participants, their friends (55.7%), followed by the media, cinema, school and parents, respectively. The majority of all (82%) admitted that they had a desperate need for reliable information on reproductive health. In addition, they thought that such information would be very useful and that they would prefer to have free access to it (Figure 2). The family setting does not appear to be the best place for frank discussions on the matter, as 60% of participants have never discussed any sexual questions within their families.

STIs
Questions on sexually transmitted infections (STIs) have shown a severe lack of knowledge among the participants. While most of them (91.4%) were aware of STIs, only half of the total were able to name more than two. Knowledge about HIV/AIDS was similarly lacking as almost 24% had written that AIDS could be transmitted only sexually and were unaware of other ways of becoming infected by the virus (Figure 2).

RH and the economy
As Kazakhstan is enduring a very painful transition towards a free market economy, question about the effects of changes in the economy on men’s reproductive health was included. The majority of respondents (92.5%) admitted that they felt there was a connection between the economy and reproductive health, with 14.1% not answering. 37.4% did not see any possible link between the two of them.

Lifestyle
Other questions included information on lifestyles in relation to sexual stimulation, such as using sex stimulators (reported by 0.9%) and occasionally watching pornographic films (37.5%). Information on lifestyles and habits harmful to health included smoking (30.3%), alcohol consumption (45.1%) and experimenting with drugs (10.6%).

Preliminary conclusions
Preliminary results suggest that there is a lack of sexual education among men in Kazakhstan. The need for solid, reliable information on reproductive health is evident and should become a priority for those responsible for the health of the nation. There is an urgency for this information, as a high percentage of those interviewed are very young. They have shown great interest in the subject and a willingness to cooperate, evidenced by the high response rate. Their future and possibly the future of their children could be different, more healthy, should they receive the sex education they require. The final results of the study will hopefully provide the needed information to help achieve this goal.

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RESOURCES

Guide to the Strategic Planning Process for a National Response to HIV/AIDS: Resource Mobilization (UNAIDS, 2000, pp 20) is the fourth of four modules, intended for country programmes, either at a national or decentralized level. It focuses on the necessary steps to assess what resources are currently available and how additional resources can be identified and accessed.

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The Female Condom: A Guide For Planning and Programming (UNAIDS, WHO, 2000, pp 80) is intended to assist programme managers in the design, implementation, monitoring and evaluation of activities to introduce, or expand access to, the female condom in ongoing activities for the prevention of pregnancy and STIs. The guide provides an overview of the female condom and summarizes current knowledge and programme experience with the provision of female condoms in a variety of settings.

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Reproductive health research at WHO: a new beginning. Biennial report 1998-1999 (WHO, 2000, pp 108, Price: Sw.fr 30, developing countries, Sw.fr. 15, ISBN: 92-4-156200-5), produced by The Special Programme of Research, Development and Research Training in Human Reproduction, provides a six-chapter comprehensive, global overview of all major reproductive health issues. The first chapter describes a range of studies aimed at understanding people’s RH needs. Topics covered include men’s attitudes and contraceptive preferences, the RH needs of adolescents, human rights issues and the impact of laws and regulations on RH, Fertility regulation, expanded family planning options, emergency contraception, the female condom, etc. are covered in the remaining chapters.

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Services for the Prevention and Management of Genetic Disorders and Birth Defects in Developing Countries (WHO, 1999, pp 94) was written because after two decades of enormous progress in medical genetics in the industrialised countries, there has still been little or no impact in developing countries. The current status of genetic services in the developing world was reviewed and recommendations were made for the further implementation of programmes for the management and prevention of genetic disorders and birth defects at the primary health care and community levels.

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A Systematic Review of the Health Complications of Female Genital Mutilation, including Sequelae in Childbirth (WHO, 2000, pp 180) identifies primary data on health complications of FGM, the lifecycle; identification of country specific and ethnic group specific outcome measures of FGM that can be used to provide focus to optimise health care provisions for care of complications; and identification of sites world-wide where opportunities exist for research into the health sequelae of FGM.

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Young People in Changing Societies (UNICEF, the MONNE Project, CEE/CIS/Baltics, 2000, pp 176) is the latest regional monitoring report from the UNICEF Innocenti Research Centre and includes the voices of young people gathered during focus group discussions and individual interviews in the Czech Republic, Latvia, Romania, Russia, Ukraine and Uzbekistan. Those taking part included unmarried teenage mothers, juvenile offenders in custody, early school leavers, youth volunteers and many others. RH, especially STIs among adolescents, is briefly discussed, but the report overall provides useful insight into the lives of adolescents.

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Resources on unsafe abortion (see Safe Motherhood: Issue 28 Vol. 1, 2000, for more resources on unsafe abortion [safemotherhood@who.ch]). The documents are available from: World Health Organization, 20 avenue Appia, CH-1211 Geneva 27, Switzerland.
Clinical management of abortion complications: a practical guide
(Document WHO/FIE/MSH/94.1)
This manual outlines the steps to dealing with the life-threatening complications of unsafe abortion. Information is organized according to the sequence of decisions that must be taken when women present with symptoms of abortion. The management of cases is presented in the form of decision trees with corresponding text that outlines the elements of care. The manual is organized so as to help the clinician deal with the most urgent conditions first.

Chapter 1 explains how to carry out a clinical assessment, identifying which conditions a woman is suffering from in order to determine which to treat first. Chapters 2 to 6 outline the treatment of shock, moderate to light vaginal bleeding, severe vaginal bleeding, intra-abdominal injury and sepsis (these conditions are discussed separately even though in practice it may be necessary to start treating more than one at the same time). The final chapter describes general procedures of emergency abortion care, including intravenous fluid replacement, blood transfusion, administration of antibiotics and other medication, the control of pain and the prevention of tetanus. The decision tree in each chapter begins with the presenting condition and takes the health worker through steps to rule out conditions that are not present until they lead to definitive management.

This book sets out guidelines to reduce morbidity and mortality associated with spontaneous or induced abortion. Recommendations and advice are backed by practical experience and rooted in the principle that emergency care for the complications of abortion should be available 24 hours a day. The book also establishes standards of safe abortion practice, for use in those circumstances where abortion is permitted by law. Prevention of abortion through education and family planning is likewise discussed.

The first three chapters describe the magnitude of mortality and morbidity caused by unsafe abortions, define the essential components of abortion care at each level in the health system, and discuss the ways in which legal and societal factors affect abortion behaviour and care. The remaining 11 chapters provide technical and managerial guidelines for each component of service, at each level of the health system. A chapter on patient information and counselling emphasizes the importance of providing information in a supportive manner. Other chapters offer detailed guidance on the facilities, supplies and drugs needed for abortion care, on the training and supervision of staff, and an ways to overcome obstacles that make it difficult for women in remote rural areas to receive timely care.

This document aims to help health workers answer the questions "Is there a problem of unsafe abortion?" and "If so, what can be done to deal with it?" It describes how to conduct practical, small-scale, local studies. This usually means focusing on the district or provincial hospital where most abortion care is provided, though study sites may also include schools, churches or workplaces.

This is the sixth in WHO's series of midwifery training modules. This module, which has been prepared for field-testing, explains the different types of abortion, the effect of abortion on maternal mortality and morbidity, the prevention of unwanted pregnancy, laws and regulations related to abortion, socio-cultural and religious perspectives, and the role of midwives in abortion care. It deals with the factors that contribute to abortion and, if incomplete abortion occurs, how it can be managed.

The midwifery skills dealt with in this training module include manual vacuum aspiration and post-abortion counselling about family planning and contraceptive methods. Other skills that are covered (because they may be necessary when managing post-abortion complications) are bimanual compression of the uterus, manual compression of the aorta, and repair of cervical and high vaginal tears. More general skills are: taking and recording observations, taking blood samples for analysis, setting up and monitoring intravenous infusions, monitoring blood transfusions and administering drugs.

From the Emergency Contraceptive Newsletter, Fall 2000, Vol. 5, No. 2.
For information about the International Consortium on Emergency Contraception or to receive the full newsletter with additional information and contact names, please contact the consortium coordinator, Elisa Wells (elisa@alaskafjile.net), 3224 Purdue Street, Anchorage, AK 99508, USA.
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Levonelle-2 approved in the UK, may go OTC
In February 2000, Levonelle-2, a prog-}

estin-only dedicated EC, was approved in the UK on a prescription-only basis. Before the introduction of Levonelle-2, the only other dedicated product available was the Yuzpe regimen, Schering PC4. Although PC-4 is less expensive, many EC providers throughout the country are prescribing Levonelle-2, citing reduced side effects.

Also this year, Schering Health Care Ltd. applied for the removal of the prescription-only status on Levonelle-2. The Medicines Control Agency submitted a recommendation to reclassify the product for over-the-counter (OTC) pharmacy sale to women 16 and older. A change in classification must first be approved by health ministers and ratified by the parliament. If approved by the parliament, the Medicines Control Agency could change the license on the product before the end of the year and Schering Ltd. would make the product available in stores sixteen weeks later. Although there is support for reclassification, many see a middle ground, particularly if experiments with pharmacist distribution prove to be successful and are instituted nationally. Moreover, there is concern that pharmacist sale without a prescription would lead to over use. EC advocates in the UK hope that some combination of pharmacist distribution and OTC sales will increase access to women nationwide.

EC approved for sale in Italy, Vatican backyard
In early October 2000, the Italian Health Ministry approved the sale of NorLevo. The emergency contraceptive is now available by prescription through Italian pharmacies. Monsignor Elio Sgreccia, the Vatican's leader on bioethical issues, expressed the church's disapproval of the decision. He said the decision was an appeal to women who oppose abortion but accept contraception. He added, "In reality, the fertilized egg is an embryo and an embryo is an individual human being. Therefore, blocking the implantation in the uterus is the same as suppressing it. Morally, it's the same thing as a surgical abortion".

EC available in a British airport
The Manchester Airport in Britain now offers emergency contraception to travellers through a drop-in health centre located in Terminal One. From the health centre, travellers can get advice on STIs, emergency contraception kits and condoms. The health centre is staffed by 18 nurses who are trained to treat a wide range of ailments from travel sickness to heart attacks. Patients do not need an appointment.

EC again available to through schools in France
In early October 2000, the French
National Assembly voted to allow the distribution of the emergency contraceptive brand NorLevo to minors without parental consent or a doctor’s prescription. The vote overturned an earlier ruling that prohibited school nurses from giving EC to students. NorLevo is a levonorgestrel-only product distributed by HRA Pharma.

Population Council completes multi-centre trial on modification of the Yuzpe regimen
Researchers at the Population Council have recently completed a large multi-centre trial on three modifications of the Yuzpe regimen for emergency contraception. In the main trial, nearly 2000 women in three countries were randomised to one of three study arms: standard Yuzpe control, a variant of Yuzpe that used ethinyl estradiol plus norethindrone in place of the levonorgestrel, or a single dose regimen, consisting of only one dose of the Yuzpe regimen rather that two. In a related observational protocol, researchers studied efficacy of treatment when given between 73 and 120 hours after unprotected intercourse. The failure rates for all the arms in the main study were not statistically different form one another, and comparable to those in the published Yuzpe literature. The failure rate for the day 4 and 5 arm was also relatively low suggesting that the 72 hour cut-off is too restrictive and women who present to the clinic 3 to 5 days after unprotected sex should not be turned away.

In order to remedy the situation in the Russian Federation, in June 2000 UNFPA initiated a two year project entitled “Reproductive health and the rights of youth in the Russian Federation”, to be implemented in six cities: Moscow, St. Petersburg, Tver, Tomsk, Novosibirsk and Barnaul. Its major aims are enriching adolescents with information about reproductive health and healthy lifestyles and supporting youth clinics in the project cities. UNFPA also plans to facilitate national adolescent reproductive health policies and contribute to the development of a culturally balanced public opinion in favour of reproductive health and healthy lifestyles.

Men can change behaviour and the course of the HIV/AIDS epidemic says the International Council of Nurses GENEVA, Switzerland, 30 November 2000 - The International Council of Nurses calls for countries and national nurses' associations to focus on men in their national responses to the AIDS epidemic. Over 70% of HIV infections worldwide occur through sex between men and women, and a further 10% through sex between men. Men play a central role in HIV transmission, due to their greater risk taking behaviour. Men have more sexual partners (male or female) than women, and therefore more opportunity to contract and transmit HIV. Men also have more influence over whether or not to have safer sex.

Cultural beliefs and expectations about “manhood” often encourage risky sexual and drug-taking behaviour in men. This puts them and their partners at heightened risk of HIV. Many consider their masculinity compromised by the very behaviours that limit the spread of HIV - having fewer sexual partners, using condoms or responding to the safer sex preferences of their partners.

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www.icn.ch

Editors note: ICN’s recent call for increased prevention programmes for boys and men and increased activity by nurses in light of the well-known role of men in HIV transmission can only be seen as one more attempt to wake international actors and attack the problem at its root. The lack of attention paid to men has again been addressed in this issue of Entre Nous. And “Men Make a Difference” is the theme of this year’s World AIDS Campaign.

NEWS

GENEVA, Switzerland, 10 October 2000 — Every day at least 1,600 women die from the complications of pregnancy and childbirth, more than 585,000 deaths each year. Midwives and nurses worldwide have joined forces to combat this deplorable situation and to put safe motherhood on the health agenda of all national governments. The International Confederation of Midwives (ICM) and the International Council of Nurses (ICN) are calling for a drastic increase in skilled attendance at birth, particularly in developing countries where the incidence of maternal mortality is highest.

“According to the World Health Organization and the Safe Motherhood Inter-Agency Group, the single most critical intervention for safe motherhood is to ensure that a health worker with midwifery skills is present at every birth,” stated Petra ten Hoope-Bender, ICM Secretary General. “Governments, civil society and the health professions must work to ensure that women have ready access to this most essential care.

The Safe Motherhood Inter-Agency Group includes UNFPA, UNICEF, the International Confederation of Midwives, the International Federation of Gynaecology and Obstetrics, the International Planned Parenthood Federation, the Population Council, the Regional Prevention of Maternal Mortality Network (Africa), the Safe Motherhood Network of Nepal, the World Bank and WHO. Family Care International serves as the secretariat.

White Ribbon [WRC] a large effort by men working to end men’s violence against women. Wearing a white ribbon is a personal pledge never to commit, condone nor remain silent about violence against women. Men and boys wear a ribbon for one or two weeks, starting November 25, the International Day for the Eradication of Violence Against Women.

Whiterib@idirect.com
http://www.whiteribbon.ca/

November 2000 — UNFPA promotes reproductive health and rights of youth in the Russian Federation

Like their peers in western Europe, Russian youth have also jumped on the “sexual revolution” roller-coaster. Unaware of the dangers of consequences, Russian adolescents have had to face problems that neither their parents nor society at large were ready to prevent.

All blocking mechanisms and restrictions disappeared overnight. Open access to information about sex impacted on the development of adolescents’ social and sexual behaviour. The costs of the transition period inevitably found their way to the young generation. The euphoria of freedom resulted in an unprecedented increase in sexually transmitted infections, abortions, unplanned pregnancies and thousands of abandoned children.

In the Soviet Union adolescent health was never an issue as they were considered a relatively healthy group. Therefore, the Soviet health system did not have any special services for the young, particularly in the field of reproductive health. A term like “adolescent counselling” did not exist in the medical practice. And, consequently, doctors were never trained in counselling techniques or communication skills when working with youth.
NEW DOCUMENTS FROM THE WHO REGIONAL OFFICE FOR EUROPE

Women's and Reproductive Health Programme
To obtain copies of the documents contact:
WHO Regional Office for Europe
Women's and Reproductive Health Programme
Scherigsvej 8
DK-2100 Copenhagen Ø
Denmark
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E-mail: entroues@who.dk

Family Planning and Reproductive Health in Central and Eastern Europe and the Newly Independent States (UNFPA, WHO, 2000, pp 176) reveals that women are a particularly disadvantaged group in these countries. New social and health policies need to be developed and reproductive health services is one appropriate mechanism for improving women's health. Unfortunately, the limited availability and cost of contraceptives remove them from being a viable option for many people. This document, which looks at the situation on a case-by-case basis, is the third update of reproductive health data for the Region since 1995.

Improving Reproductive Health Services and Access to Family Planning in Turkmenistan (UNFPA, WHO, Project Number TUP/P96/P02, 2000, pp 66) is a summary of the activities carried out during project implementation and includes recommendations for further improving reproductive health (RH) and family planning in Turkmenistan. Project work included RH training courses and examined the standards of clinical practice.

Improving the Accessibility of Health Services that Meet the Sexual and Reproductive Health Needs of Adolescents in Schools (Republic of Bulgaria, Ministry of Health, WHO, 2000 pp 28 + annexes) was part of an inter-regional project funded by UNAIDS and coordinated by the Programme of Child and Adolescents Health and Development in WHO, Geneva. The district of Varna, Bulgaria, was chosen as a pilot in the European Region. Key findings included the importance of school-based health services which include periodic monitoring of growth and development, routine checks for the identification of problems, the administration of vaccinations and the diagnosis and treatment of common illnesses.

Postdelivery Contraception and Women's Reproductive Health in the Russian Federation (WHO, Russian Academy of Medical Sciences and Moscow WHO Collaborating Centre on Research in Human Reproduction, 2000, pp 21) looks at the problem of induced abortions in Russia and efforts to introduce modern methods of contraception. The document reports on the effect of the family planning counselling approach at maternity hospitals, in which women were monitored during their first year after labour.

Safe Motherhood Needs Assessment in Albania (UNFPA, WHO, 2000, pp 16 + annexes) was a reaction to the high burden of mortality which maternal and infant deaths still represent in Albania. The current situation of maternal and neonatal care was assessed and the major components of a future national plan for maternal and perinatal care was identified.