Adolescence is not typically connected with health problems in our minds. We think of young people as physically strong, ready for a challenge on the sports field or in the computer room. And so they should be, if properly looked after. But as we recognize more and more the key importance of social and behavioural issues for health - that what people do makes a great difference to their own well-being - we turn to the core behaviour patterns influencing both health and longevity that originate in adolescence.

Young people, between 10 and 24 years of age, comprise about a quarter of the world’s population and 85% of them live in developing countries - countries undergoing rapid changes, where it is almost always difficult to fit yesterday’s values on tomorrow’s realities. This is the case in many countries of Europe, where young people are flooded with new problems and temptations, while lacking the resources to make the dreams with which they are presented become reality.

Concern for the health of adolescents is reflected in the presentations from the various countries delivered at a Meeting on Youth and Reproductive Health in the Countries of Central and Eastern Europe (CCEE) and the Newly Independent States (NIS), held in Copenhagen 23-25 June 1997, many of which are excerpted here. Reproductive health is and must be central among these concerns, since sexuality is universal and the risks that uninfomed and unprotected sexual relations present to health can be devastating. And because they are neither children nor adults, adolescents need health programmes that are designed to meet their special needs.

Above all adolescents need to be involved - in planning, designing, implementing and evaluating measures to improve adolescent health. To give greater voice to youth, last year UNFPA organized an essay contest under the theme "Promoting Responsible Reproductive Health Behaviour: the Youth Perspective" in support of the World Youth Forum of the UN System which took place in Vienna, Austria. The thousands of entries all spoke openly, asking for timely information on reproductive health and sex education in an appropriate manner. We have included an excerpt from one of the essays which raises important issues with a fresh voice. Another initiative, the Generation 97 survey, is also described and quotes from young people are scattered throughout this issue in our attempt to give voice to their views and in support of youth involvement in all work in this area.

In her closing statement to African Youth Forum in Ethiopia in January, Executive Director Dr. Nadis Sadik emphasized that "young people, through their own organizations, can network and form alliances to articulate their needs, mobilize resources, to advocate for action, and to implement grassroots activities." Hopefully, the articles, surveys and resources featured in this issue of Entre Nous will serve to open discussion, give some suggestions and indicate where help can be found.

Keneva Kunz
Editor, Entre Nous

What is adolescence?
Adolescence, according to WHO’s definition is the period between 10 and 19 years. WHO uses the term “youth” to refer to people aged 15-24 years. “Young people” is used for both adolescents and youth (i.e. anyone in the age range 10-24 years).

What is special about adolescence? Adolescence involves:
- rapid physical growth and development;
- physical, social and psychological maturity, but not all at the same time;
- sexual maturity and the start of sexual activity;
- trying out experiences for the first time;
- a frequent lack of knowledge and skills to make healthy choices;
- patterns of thinking in which immediate needs tend to have priority over long-term implications;
- the start of behaviours that may become lifetime habits that result in diseases many years later.

Unsafe sexual activity may be just one aspect of risky behaviour. In order to address it, health services need a holistic approach, coordinating efforts so that when one problem is dealt with others are not missed. In dealing with risky behaviour, adolescents should be seen not as a problems but as a resource for building a healthier future.
Launching a new phase of Entre Nous

While welcoming our readers with this, the first issue of a new phase of Entre Nous, which will bring us up to the end of year 2000, we would like to thank all of you who took the time to reply to our questionnaire. We intend to do our utmost to take your opinions and concerns, as revealed by the survey, into account in the coming issues. These include broadening the pool of authors and publishing articles targeting issues arising in the daily settings of reproductive health services. Some new features have been added, other sections adjusted to try and respond to wishes expressed by the readers.

We are also very grateful to all the member of the Editorial Board for the invaluable contribution they have made during the evaluation process as well as for their support during the last 6 years. To the members of our new Editorial Board we extend a warm welcome and look forward to their guidance for the next three years of Entre Nous.

This issue takes a special look at adolescent health. Adolescence is a time of growth, a time of apparently unlimited energy and great potential. It is a time when young people are trying to define their place in society, discarding the trappings of childhood to assume roles of growing importance in the world of adults. In that world, at least up until now, they have had to follow the instructions of adults, some of whom they trust, while rebelling against others. To a growing extent the decisions made will now be theirs.

It is a time of growing strength, but also a time of insecurity; for facing basic questions like who am I, and who do I want to become? For expanding one’s limits, experiencing new worlds, and taking risks, both consciously and unconsciously. This process may include drinking, smoking, illicit drugs and sex. Stable families and social institutions offering care and concern during this period are an important haven for youngsters. Not least for this reason, the young people of Eastern and Central Europe deserve our special concern.

They were born into a system based on a philosophy of equality, on the one hand, and extreme control, on the other, a system in which education and health services were free and basic commodities such as housing, amenities and basic foods were affordable. Unemployment was practically unknown and social security, as well as child care, was provided on a large scale. The price, however, was not cheap: closed borders, extensive social and intellectual control and immediate enforcement of sanctions against deviations from the norm. A situation which created an atmosphere of fear, eventually led to the dissatisfaction and protest by large sections of the population, and finally disintegrated.

The young people living in these countries today are direct witnesses, actors or victims of these sudden changes which led to the collapse of the value systems they and their parents had been taught to abide by. And their parents position in this society has also drastically changed in the face of unemployment, lack of resources to make ends meet, shortages of food, electricity, etc.

If the columns on which society is built are swaying, finding your place today doesn’t guarantee that you will still have it tomorrow.

It is against this background that adolescent health in Central and Eastern Europe today has to be seen.

The decisions made and the courses chosen by adolescents today what they do and how they live are of great significance for their health both today and tomorrow. Many key behaviour patterns that influence health and longevity originate in adolescence, making it a focal time for health initiatives. This issue investigates some of the problems and possibilities of adolescent reproductive health.

Coming issues already in the planning stages will focus on minorities in Europe, emergency contraception, and partnerships in reproductive health between East and West.

We welcome contributions on the above issues.

Dr Assia Brandroid-Lukanow

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Adolescent girls are vulnerable both biologically and socially. The adolescent girl who gets pregnant before she is 18 may be up to 5 times more likely to die than a pregnant woman aged 20-25. Girls are more prone to infection with sexually transmitted diseases than boys are, they are often pressured into having sex (in many cases by older men), and they have to bear most of the social consequences of an unwanted pregnancy.

Risky sexual behaviour

For most people sexual activity starts in adolescence. In some cultures women marry very young and are expected to prove their fertility at an early age. In other societies, the age at which couples marry is going up, so the period during which premarital sex can take place is getting longer. At the same time, the age of menarche (the start of menstruation) is generally falling.

At the time of first sexual contact, adolescents often lack knowledge about sexuality and reproduction. Indeed, first sex is often experimentation and those involved usually do not prepare for it by obtaining contraceptives, even if they know where to get them. Adolescent girls may lack the power, confidence and skills to refuse to have sex. The gender roles of the submissive female and dominant male make it more difficult for the girl to say no. Some adolescents are subject to sexual abuse of varying degrees, including incest or rape.

Researchers report “clustering” of risk-taking behaviour in adolescents. This means that as adolescents take one risk, they are also more likely to take others. Drinking alcohol or using illicit drugs, for instance, often takes place in combination with unsafe sexual activity, compounding the problems that adolescents - and the services that aim to help them - are liable to face.

If contraceptives, and particularly condoms, are not available, not accessible or not used, adolescents of both sexes risk sexually transmitted diseases and the girls risk unwanted pregnancy too. Each year at least one in every 20 adolescents contracts a curable sexually transmitted disease. Indeed, adolescents and young people are more at risk of these diseases that older age groups. Women are more vulnerable to sexually transmitted diseases, including HIV, than men are because of the larger mucosal surface exposed during sexual intercourse. Young women are more vulnerable than older women because of the immature linking of the cervix. More than half of all new HIV infections are among 15-24-year-olds. Many young women do not even know they have contracted a sexually transmitted disease because they have no symptoms or because they are unaware of them. Undiagnosed and untreated, the disease continues to plague them into adult life and may lead to pelvic inflammatory disease, ectopic pregnancy and eventually infertility, as well

facing the challenge

One in every five people is an adolescent, and 85 in every 100 adolescents live in developing countries. Worldwide, some 15 million babies (more than one-tenth of all births) are born to adolescent mothers. In the least developed countries, the proportion of births to adolescents is over 17%, and in at least one area - Middle Africa - it is almost 24% of the total. In developed countries too, adolescent pregnancy is a major concern since young unmarried mothers are disadvantaged and so are their children.
as damaging the eyesight and general health of any children they may have.

Another disease of women - cervical cancer - shows itself only in later life but research shows that a woman’s risk of this disease if doubled if her first sexual activity was in early adolescence.

**Health risks to the mother**

Many adolescents have healthy pregnancies and healthy babies. They give birth without complications and enjoy their role as mothers. But all too many do not. Although their bodies may be mature enough to become pregnant, some adolescents are not sufficiently physically developed to have a safe pregnancy and delivery.

Pregnant adolescents are more likely to suffer eclampsia and obstructed labour than women who become pregnant in their early twenties. In the early adolescent years, a girl is still growing and her pelvis has not reached its full adult size. Pregnancy increases the body's nutritional needs and can slow down the girl's growth. Obstructed labour is far more likely if her pelvis is not full size when it is time for the baby to be born.

A particularly devastating complication of obstructed labour is obstetric fistula, a hole between the vagina and the bladder or rectum. The woman constantly leaks urine or faeces, smells offensive and is often ostracized both by her husband and by the community. Studies in Africa and Asia show that adolescents having their first baby are much more likely to suffer obstetric fistula than older women giving birth for the first time.

Girls who become pregnant in their teens are less likely to seek prenatal care than older women are. Yet pregnant adolescents are more likely to have health problems than women over 20. Studies in several countries have shown that the risk of death during childbirth is higher among adolescents than among older women.

Even if a pregnant adolescent is physically developed, she may lack the social and emotional maturity to cope with the experience of becoming a mother and the changes it means to her life. Her male partner, if he is an adolescent, is also not likely to be ready to shoulder the responsibilities of fatherhood.

**Abortion**

In cultures where early marriage is common, adolescent pregnancy is generally welcomed by the family, if not always by the adolescent girl. If the pregnancy occurs outside marriage, social sanctions may be severe and induced abortion often seems to be the only way of avoiding public shame and rejection. Adolescents account for a very high proportion of abortion complications, primarily because they are likely to obtain clandestine illegal abortions, or delay seeking abortion until late in the pregnancy.

**Health risk to the baby**

Babies born to young adolescent mothers also face more health risk than the babies of older women. Babies of adolescent mothers are more likely to have low birth weight, run a higher risk of being premature and have a higher rate of perinatal mortality. A major problem arises from "children having children". A young adolescent mother, barely out of childhood herself and certainly not an adult, may not have the parenting skills needed to bring up a physically and mentally healthy child.

**Social costs of pregnancy**

Unmarried pregnant young women run the risk of being rejected by family and community. One problem is often linked with others. Adolescents who have babies are often unable to continue their schooling. A young woman with a baby often has less chance of finding employment, and if she has not completed her education she will be at an added disadvantage. Her income is likely to be low in comparison to most others. Poverty and poor health often go hand in hand, rendering the mother even less able to cope and setting the child back in its development.

**The cost to the community**

Early pregnancy has negative consequences not only for the mother and baby but also for the community. The poor unmarried mother with little education is not only unable to contribute to the development of the community, but she and her family may become a burden on it. It is in the community's interest for all families - whether two-parent or single-parent - to be economically viable, and early pregnancy certainly does not help that to happen. Early childbirth means a shorter interval between generations and a higher proportion of children in the population at any given time.

**Promoting safe motherhood in adolescents**

Since early pregnancy is more than just a medical problem, it must be dealt with from more than just a medical perspective. To find out the extent and nature of the problem, countries can carry out a rapid situation analysis that shows how adolescents view sex and sexuality, what their: needs and priorities are, and how they can best be met. However this is done, it is essential that adolescents are involved so that the data really does reflect their views and health services can be adjusted to meet their needs.

Interviews with influential people in the community will be a help too - especially to work out general agreement about the goals for adolescent reproductive health. To find out how far the health services are meeting young people's needs, the attitudes of young clients can be compared with what health care workers think they are.

Both care and prevention are needed - care for adolescents who contract sexually transmitted diseases or who face the consequences of an unwanted pregnancy, and prevention of these problems in the future.

**A safe and supportive environment**

Policies and laws may hinder adolescent health, especially if they stop adolescents from receiving information and services. Sometimes laws may conflict, as when the legal age for marriage is actually lower than the legal age for sexual intercourse. Laws need to be widely known, so that adolescents understand what services they are entitled to in order to protect their health.

A national adolescent health policy helps to establish a comprehensive supportive environment. This might include, for instance, encouraging girls to stay longer in school. Or girls who become pregnant could be helped to continue their studies. Positive policies can encourage schools and clinics to provide information and services to adolescents. And families should be helped to discuss reproductive health concerns more openly with their adolescents.

A national policy could also include educating the community about the need for young women to be healthy and well nourished. Girls should receive at least the same nutritional intake as boys (which in many societies is not the case) and first births should be postponed until women are sufficiently physically developed to minimize the chance of complications. The media can be a powerful tool for promoting healthier social practices and providing positive role models.

Nongovernmental organizations and youth groups are often able to provide young people with recreation and skills training. These groups can promote healthy relationships and supply information about reproductive health. They are often willing to arrange health-related activities for their members (such as a visit by a health specialist, for instance).

**Information**

Information helps adolescents understand how their bodies work and what the consequences of their actions are likely to be. It dispels myths and corrects inaccuracies. Information should stress the need to use contraception and, for instance, explain how to use condoms. It should also include details of the services that are available, the opening times, the fees and the fact that these services are confidential.
There has to be a readiness to answer the questions that adolescents ask. Hiding information from them will not make them less interested in sex. Schools can encourage adolescents to use health services. Teachers and parents should have an understanding of adolescent development so that they can respond to adolescents' questions confidently.

Skills

Adolescents need the skills that will enable them to negotiate safe sex or say no to sex with confidence. Girls' self-esteem must be enhanced so that they understand that their bodies are their own and that they have the right to self-determination. The decision to have sex should be a shared decision by both partners, taken with full knowledge of the risks and consequences. Adolescents also need to be taught certain physical skills such as how to use condoms and other contraceptives.

Counselling

There is in many cases a need for a better understanding between adults and adolescents. Adolescents, like adults, usually respond better to explanations than they do to orders. Their development and behaviour is influenced much more readily by helping them to recognize what they are doing well rather than by punishing them for their mistakes. The role of the counsellor is to help adolescents make informed choices, giving them more confidence and helping them feel more in control of their own lives and more successful. When adolescents come for emergency care, counselling skills are important for providing support in what may be a delicate situation.

Youth-friendly health services

Pregnant adolescents are the least likely women to attend prenatal care clinics, and the chance of attendance is even less probable among adolescents who are not married. Young men also seem unlikely to seek reproductive health services such as contraceptive advice. Young people cite reasons such as lack of knowledge that such services exist, fear that the services are not confidential or that health workers will react negatively, ignorance that their concerns need professional attention, lack of money to pay the fees, and the feeling that health services are more for adults than for young people.

In most countries, reproductive health services are normally provided by family planning clinics, sexually transmitted disease clinics, and maternal and child health clinics. These places are not planned for adolescent use and adolescents often do not like to use them. Often there is little coordination between these places, which makes it difficult to meet the variety of adolescents' health needs.

Adolescents are neither children nor adults, though they share some of the characteristics of both groups. The need is for effective health information and services geared specifically towards adolescents at particular stages of development. The assessment of adolescents’ views will help design services that are "youth-friendly". Opening times should be convenient for adolescents - in the afternoon after school finishes, for instance. Prices should be affordable. The health staff should not be judgmental towards pregnant adolescents or those who have a sexually transmitted disease; the staff are there to help solve the problem, not make it worse. Consultations and treatment must be confidential and the young clients should be able to rely on this. Maybe once a week the health centre can have an adolescents' clinic when a range of youth services, including those related to reproduction, can be provided. Training of health staff should include skills for dealing with adolescents (be receptive, learn to listen, don't pass judgement) and should include information on sexuality so they can answer adolescents' questions.

Adolescent health services cannot be fully effective if they focus only on particular physical needs or medical problems. Health care workers should concentrate on attending to the young person's needs. This means taking, physical, psychological and social perspectives into consideration. A health service should be able to offer referral to other services that adolescent may need.

As adolescents undergo physical, psychological and social change and development, the aim of adolescent health services must be to enable them to undergo those changes in safety, with confidence, and with the best prospect for a healthy and productive adulthood.

Safe Motherhood Newsletter, Issue 22 - 1996 (?)
Adolescent sexual and reproductive health

Sexual relations and the prevention of reproductive health problems

- For the vast majority sexual relations begin in adolescence, in or outside marriage
- Unprotected sexual relations increase risk of unwanted pregnancy, induced abortions and sexually transmitted diseases (STD), including HIV resulting in AIDS
- Adolescents practice contraception least in the least developed countries
- The risk of cervical cancer is increased tenfold for women with six or more sexual partners or when sexual activity starts before the age of 15; smoking is also a risk

Pregnancy and childbirth

- About 1 in 10 of all births worldwide are to adolescent women
- The majority of first births in Sub-Saharan Africa are to adolescent women
- In developing countries, a pregnant adolescent below 16 is 5-7 times more likely to die of maternal causes than a woman aged 20-24. From 16-19 the risks are twice as high. The main causes are toxaemia, septic abortion and obstructed labour
- Pregnancy and childbirth-related problems are the most important cause of death for adolescent women in most developing countries
- Low birth weight is more common in babies born to adolescents than adults

Induced abortion

- Lack of knowledge, lack of access to contraception and vulnerability to abuse puts adolescents at highest risk of unwanted pregnancies
- The younger the adolescent with unwanted pregnancy the more likely to seek abortion
- Adolescent abortions estimated between 1 and 4.4 million per year are probably more
- The vast majority of adolescent abortions are unsafe since most are illegal and performed under hazardous circumstances

Sexually Transmitted Diseases

- Each year >1 of 20 adolescents contract a curable STD, excluding viral infection
- Of the estimated 315 million STDs that occur in the world every year, about 150 million are in young people aged under 25, and 100 million below the age of 20
- The highest rates of STDs are reported in young people aged 15-24
- Young female adolescents are biologically & psychosocially more vulnerable to STD
- STDs are often undiagnosed and untreated, especially in female adolescents
- STDs cause reproductive health complications & sequelae including infertility
- STDs increase vulnerability to HIV infection significantly

HIV/AIDS

- HIV infection results in AIDS and causes premature death
- Globally, more than half of all new HIV infections are among 15-24 year olds

WHO's Adolescent Health Programme has designed a method for learning about young people's sexual behaviour in order to better design programmes to meet their needs. Knowledgeable young people make up a story about how an unwanted pregnancy typically happens in their community. They use role play to develop each step in the story which usually includes a young couple's first meeting, an eventual sexual encounter, discovery of the pregnancy, and how it is dealt with by adolescents and their families. The story is then incorporated in a questionnaire and a youth organization uses this to take a much larger sample of opinion from the community. The results can be very revealing, showing how young people's first sexual encounters take place, whether or not the young people do anything to prevent pregnancy or sexually transmitted disease, how they react and whether or not abortion is considered, and how the families deal with the pregnancy. This information can provide valuable insight for programming purposes.

The narrative research method: studying behaviour patterns of young people - by young people.
A guide to its use.
(Document WHO/ADH/93.4, available from Adolescent Health Programme, WHO, 1211 Geneva 27, Switzerland.)
Sincere words to Mom from your teenage boy

They say time flies, but do we notice this in our everyday lives? We get up in the morning, have breakfast, hurry off to work and school, you or our teachers occasionally remark on something, we dream about making a lot of money, eat our supper, go to bed, and next morning ... I'm sorry if you find my description too boring. But isn't this typical of how we live? Do we teenagers really lead such a carefree life? Of course not. We don't feel like sitting around. We want to do something big. We want to escape our teenage years and grow up right now. Your opinions interest us, you interest us as individuals. But you withdraw into yourself without showing or explaining anything to us, and this makes you even more interesting. You do all this so quickly and incomprehensively. In this way a little path forms between us and separates us two generations.

We don't look at your little path. Keep your problems to yourself. When we look at some of you, we really feel like urging you to do something or forcing you not to do something. But we don't because you behave as if you were the finest grown-ups in the whole wide world.

Our problems, on the other hand, are just exaggerations. Let's take a tragic example: in today's transitional period life has become more demanding and we have to work a lot. We know you will be happy if we turn out to be educated and wealthy people. This simply doesn't happen, but we often dream that it will and we try to make that dream come true. Two of our friends sacrificed themselves for this dream. They went off to work in a foreign country, because everyone nowadays says you can make a bundle over there. But they chose the wrong route and died without realizing their mistake.

Out deepest sympathies go to our friends' families.

School is the only topic we can talk to you about without embarrassment. Even though we sometimes have to lie to you about our grades, we aren't afraid to talk to you about school.

We know that you are good to us. But great food and clothes are nothing compared to you. I am being influenced all the time by the people I hang around with, my friends, my teachers and others. But I need you, Mom. You are the dearest person in the whole world. Why can I open my heart to strangers but not to you? Don't I trust you? Or do I think you won't understand me? No, of course you are the only person in the world who can understand me. But you are always afraid to talk to me about this topic.

As citizens of the 21st century, and despite our relative youth, we receive information from various sources. You only imagine that we know what you were forbidden to know. I don't mean to say that you are forbidden times. I can't avoid all this necessary and unnecessary information. If I reassure myself by thinking that you didn't know this at my age, I won't be able to keep pace with my peers.

Let's take a simple example. Please you haven't been smoking for the past two years. You will never be able to accept this, of course. But the way things are at the moment, if I don't smoke, everyone will think I am a mom's boy, and even my girl will laugh at me. And I'm not talking about just any cigarettes. The more expensive they are, the better.

If I smoke cheap, shabby my friends will think I'm poor, so I have to smoke Salem, Dunhill, Rothmans, Marlboro, Winston, Camel or Kent. This is where the money you give me every morning goes. To scrape together enough money for my cigarettes, I walk to school.

Right now I've got a problem which is hard to talk about but even harder to keep to myself. Your son will be finishing school soon and going on to university, believe me, Mom. But meanwhile, I've been going with my girl for a month now. We still need time to figure out what's happening to us, but now the doctor says she's pregnant. So your son is already a father. Which means you will soon have a grandson. Calm down, Mom. I understand how you feel. What kind of father will I be, a 17-year-old who hasn't finished school yet? But this has happened to us so quickly, and what's done can't be undone. I mean to keep my family and I'll finish school. She suggested having an abortion, but I said no. Did the right thing, didn't I, Mom? Everyone says it's dangerous. I don't want her to go through that, and I'll put up with anything for her sake.

Things can look worse than they are, and I intend to teach my child about this topic as early as possible. Otherwise, I may well become a grandfather in my thirties, just as I am becoming a father when I am 17. I won't be able to avoid it. I just hope my child finds a decent partner. As for me and Naska, I don't think there will be any serious problems. She's so clever and affectionate. Please don't offend her, Mom. I expect we'll have a few problems to start with, because we weren't prepared for this. But were looking at things in a positive light. Right now, she's suffering, the poor thing, since she doesn't; and never will, have the courage to tell her parents. You won't believe it, but she was so frightened that she suggested we should die together. But it would be terrible to leave you forever on account of my unborn child. Right now I am her only support, and I'm ready to do anything for her. Her father is strict. If he refuses to accept us or into his family, I'll bring her home with me. That's alright, isn't it, Mom?

We need you right now. Of course, it's hard for you to absorb all this so quickly: your grandson, my wife, and an inexperienced Dad. But it's better to have your children and control them if necessary than to lose sight of them and simply worry, isn't it? She was due to go off abroad straight after school. I didn't want her to. Everyone is telling horror stories about AIDS. Who knows, maybe we ... Oh God, what am I thinking? If all family relations are harmonious, I don't think we can be affected by any symptoms. Isn't that right, Mom?

Well, I've said all I have to say. Just let me add that I love you all.
Young people in Europe

Speaking at the UNFPA Meeting on YOUTH AND REPRODUCTIVE-HEALTH in the CCEE and NIS held 23-25 June of this year, Dr Brandrup-Lukanow summarized the situation of the young people who were the focus of concern:

Born between 1978 and 1987, these young people are direct witnesses, actors or victims of the sudden changes which led to the collapse of the value systems they and their parents had been taught to abide by. Their parents’ position in society changed - many, particularly mothers, suddenly became unemployed, mothers and fathers were and are struggling to make ends meet through lack of resources, food shortages, electricity, heating and water cuts. With family tensions increasing, fathers and sometimes mothers are taking to more heavy alcohol consumption, increasing the risk of violence in the family. School curricula have changed to promote new national and new national heroes. Youth groups of para-political nature and work brigades which, apart from their normative function, also brought young people together, have disappeared without adequate replacement by groups which make it possible for young people to meet under some adult guidance.

“Adolescence is a time of intellectual activity, of idealism, of criticism and of search for one’s place in society. If the columns on which society is built are swaying, finding one’s place today doesn’t guarantee that you will still have it tomorrow.”

The need to know

Almost everywhere, youngsters expressed a need to know more. What information they have is gained primarily from friends and the mass media - and is often incorrect or at least incomplete.

“STDs are only a problem for homosexuals, sex workers and drug addicts - it is scientifically proven.”

In Albania, for instance, a survey conducted of more than 700 youth by the Students’ Organization for the Propagation of Sexual Education revealed that more than 60% had taken their information about sex from their friends and TV; 38% from newspapers and magazines. Only 1.75% had been informed by their parents. Health authorities in Belarus point out that while public policy statements on youth have avoided mention of reproductive health, extra-curricular pilot projects to teach school children about sexual and reproductive health have met with great interest on the part of the youngsters.

“AIDS can also get normal people. A person may not know that the other person had AIDS. The other person doesn’t tell that he has it and then ... Maybe he doesn’t know it himself.”

(20, M, Latvia)

Lack of suitable education and prejudice, says the Director of the Youth for Youth Federation in Romania, has meant that although the national health care system is able to provide suitable treatment for STDs, many infected people only seek medical care when the disease has reached an advanced phase, or only after trying “cures” advised by friends - this is particularly true of adolescents. Several studies in Bulgaria, one as part of an EU-PHARE Family Planning Project, show that the age at which youngsters first become sexually active is dropping: for one in six women and almost one in three males, before reaching 16 years of age. Only 18% of the adolescents surveyed used condoms during intercourse as a prevention against STD or unwanted pregnancy.

What do you think about parenthood at an early age?

“I have friends who are parents. I’m glad I’m not in their shoes, though. One would have to be responsible. I don’t think I’m ready for that kind of a commitment.”

(19, F, UK)

Since media coverage of sexual and reproductive issues is generally low - and in Bulgaria was practically nil (0.5% of coverage in print and electronic media), steps were taken to encourage the active cooperation of the media including: a national programme for STD and AIDS prevention with a series of articles in women’s magazines and special TV and radio spots, supported by EU-PHARE. Other publications included: 5 booklets by the Bulgarian Family Planning Association on sex education issues, including AIDS prevention (13,000 copies), one family planning leaflet on contraceptive methods (200,000 copies), and a training manual on sex education for teachers. Two informational workshops were held for journalists and public relations experts with the aim of expanding their knowledge on sexual and reproductive issues.

In Turkey a special “Information-Training-Communicating” project was launched in 26 cities and towns aimed at improving and extending family planning services by using as many different channels of communication as possible. Special efforts were made to enlist the support of health services personnel in producing the materials used, and a training programme offered to both nurses and doctors on inserting IUDs. Emphasis was placed on motivating men to learn about and use modern contraceptives.

“My mother told me that when she was young she didn’t use contraceptives. They were too expensive or she couldn’t get them so they practised withdrawal where the boy had to go out before ejaculation; well, I am the result of that.”

(16, F, Netherlands)

In the Russian Federation, a resurgence of the authority of the Orthodox church, which issued a statement that abortion is murder
If you think sex
education is dangerous

Try ignorance!

and contraception use was sinful, is just one
more obstacle in ensuring a legal policy
basis upon which to implement reproductive
rights. A Presidential Decree of 1994 pre-
scribing extensive activities aimed at ensur-
ing wanted and healthy children and matern-
ity and infant care, was implemented
through all government structures and by
the Russian Family Planning Association.
Funds from the Federal budget were used
for purchasing hormonal contraceptives for
adolescents and women from needy target
groups. Although it rapidly brought a size-
able reduction in the number of abortions (a
decrease of 21.2% in 1995 as compared
with 1992), a sharp cut in programme fund-
ing in 1997 will mean reducing work with
adolescents this year. And a draft law
on reproductive rights has stalled in the
Duma.

Prioritising means funding

"A lot of work has been performed by non-
governmental organisations: providing a hot
line for teenagers in Latvia’s Association
for Family Planning and Sexual Health, a
special leaflet on contraception for school
children, lectures in schools and actions in
town. However, there is a need for greater
pressure on the political decision makers to
elevate the significance of the reproductive
health of adolescents and solve future
demographic problems,” states a report from
that country. It urges “Increasing the num-
ber of youth health centres that provide up-
to-date information on health, sexual
relations and contraception” - at present
there is only one, for a population of 2.5
million, 13.5% of whom are adolescents.

In Estonia, a recent summary states,
young people can get good counselling in
different institutions - women’s counselling
centres, family doctors, school nurses and
doctors and, most importantly, there are 14
existing youth-clinics in Estonia, in all larg-
er urban centres and also smaller towns.
Here specially trained gynaecologists, mid-
wives and psychologists offer counselling
and medical services in the field of sexual
and reproductive health for young people -
free of charge everywhere. A wide choice of

hormonal contraceptives, IUDs, condoms
and spermicides is available but the relative-
ly high cost of contraceptives prevents
young people from using them.

“Lack of a systematic approach to family
planning issues has resulted in a situation
where abortion has become the primary
method of birth control,” affirms a report
from the Ukraine. The Ukrainian abortion
index per 100 live births is among the high-
est in Europe, although exceeded in Roma-
nia, and one in five Ukrainian women
under 20 who undergo an abortion suffers
from genital malfunction or even subse-
quent infertility; 30% have serious inflam-
atory diseases of the reproductive tract.

Responsibility for the future

In many former Soviet republics and coun-
tries of Central and Eastern Europe the
severe socio-economic situation encourages
mass emigration and is clearly a deterrent to
childbearing: in Romania, for example, the
demographic growth rate fell from +5.3% in
1989 to -2.4% in 1996; it is even lower in
Estonia, -4.6% (1996), the Ukraine, -5.8% (1995),
and in Latvia, -5.9% in 1996, to
name but a few examples. At the same time
many of these countries have experienced a
general rise in infant and under 5 mortality
and a drop in life expectancy. In Belarus,
the fertility rate is only 1.5 per woman.
Abortions among young girls comprise 33-
34.4% of the total number, and over one-
quarter of young girls surveyed in a recent
study (32% in rural areas) knew nothing of
contraception.

A report on the situation in the Republic
of Belarus, delivered at the recent Copen-
hagen meeting, states: "A young pregnant
woman meets many problems: censure from
her family and society and the lack of
opportunity for her to support herself and
her child independently. There is no system
of support for pregnant adolescents. The
benefit payment on the birth of a child and
the subsequent single mother’s allowance
are not large and far from reach minimal
subsistence level. In practical terms, if a
young mother cannot get any help from
relatives or from a partner then she is not in
a position to look after her child and is
forced to legally disown it while still in the
maternity ward.”

"If I’m pregnant I will still go
to my parents. They will
“kill” me. There will be
drama at home and a lot of
screeing and shouting.
Then they may say,
“We shall work it out.”

(18, F, Malaysia)

The demographic trends are critical for sev-
eral reasons: firstly, they result in a decrease
in the vitality of the population - emigration
and a drop in the birth rate mean fewer

ENTRE NOUS 36-37, December 1997
young, healthy people. In the long-term this could completely destroy the mechanism for social reproduction.

From policy to implementation

National policy, or lack of it, can be instrumental in determining RH trends. In Romania, for instance, a limited amount of low-price oral contraceptives are available to students but not to youth in general. While surveys revealed high levels of knowledge of modern contraceptive methods among youth, their use is low (see Figure Access to modern contraceptive methods on page 20). The abortion rate in Romania is still the highest in Europe: two for each live birth.

Special columns appear in weekly and monthly magazines as part of "The Stop AIDS Information Exchange", but for economic reasons periodicals reach a limited audience. In Minsk, in Belarus, a hot-line was organised but workers were not trained in the specialised skills required. The Russian Family Planning Association operates youth clubs which often serve as centres of youth communication. Adolescents themselves are the hosts and educate their peers, for instance through the action "Adolescent to Adolescent" AIDS prevention campaign. In Bulgaria, youth clubs established by the Bulgarian Family Planning Association and the Government Committee for Youth are active in promoting sexual and reproductive health, but cannot satisfy the demand of the young people in the country.

Emergencies call for special assistance

While unrest and rising criminality drain the society of the resources necessary for social progress, outbreaks of violence and civil conflicts threaten the very existence of any and all long-term health measures. In at least seven countries of Europe armed conflict has torn apart people's lives and with it practically all the infrastructure for health services.

As part of extensive efforts to help in Bosnia and Herzegovina, UNFPA launched a Reproductive Health Project under the auspices of the European Regional Office. "In its initial stage the project itself faced many obstacles." In spite of the problems, first assessments were made in 1995 and the operational part of the Reproductive Health Project started in Bosnia in March 1996.

"From April to July 1996 cantonal teams organised workshops, thus making it possible for about 500 persons to further spread the ideas and objectives of the project. The last, but perhaps most objective was educational work with youth, which was realised by gathering youth in primary and secondary schools and giving them practical and understandable lectures on sexual health, hygiene and contraception. A second step in this organisational work was organising radio and TV broadcasts, while hundreds of young people themselves from within the Bosnia and Herzegovina Federation were brought together for Round Table discussions."

Support for initiatives, encouragement for more action

Almost all of the reports referred to above from European countries revealed significant, well-thought out attempts to improve the Reproductive Health situation. Following a few basic guidelines can help make good ideas work better and make it easier to introduce new actions. In its Conclusions and Recommendations the Youth and Reproductive Meeting in Copenhagen in June 1997 suggested the following Strategies for Action:

* Youth involvement in planning, implementation, monitoring and evaluation of youth-related projects and programmes.
* Young people need not only knowledge, but skills development to enhance their capacities to communicate and make health-promoting decisions and to plan their lives.
* Improve accessibility of services and the development of a youth-friendly reproductive health care system.
* Train service providers, teachers, parents and the media and reach out to them and the policy makers.
* Develop culturally and socially sensitive sex-education programmes for in- and out-of-school youth.
* Use innovative and popular channels for communication. Undertake qualitative research to assure appropriate and effective interventions.
* Strengthen the linkages between governmental, non-governmental, private and media sectors and the necessary consensus building in society on the need for adolescent reproductive health information and services.

Helping young people to avoid HIV

More than 18.5 million HIV infections have occurred in the past decade and a half, according to WHO. The current WHO projection for the year 2000 is a cumulative total of 30-40 million HIV infection. About half of all the people becoming infected with HIV are aged 15-24 years. In developing countries the proportion is more like six out of 10.

Sexually transmitted diseases (STDs) are also a major problem in young people. The age group in which STDs are commonest is 20-24-year-olds. The group with the next highest STD rate is those aged 15-19 years.

Various programmes for preventing HIV/AIDS and STDs have been tried among young people; some have been more successful than others. Now WHO have teamed up with UNICEF and the Commonwealth Youth Programme to produce a guide to the kind of information and approaches that work best with young people. Working with young people: a guide to preventing HIV/AIDS and STDs describes how to identify target groups, how to define project goals and objectives, how to decide what young people need to know, how to communicate with young people through different means, and how to implement and evaluate the project. The guide also explains what health and support services (such as the provision of condoms, HIV testing, and counselling) are needed.

Available from: Commonwealth Youth Programme, Commonwealth Secretariat, Marlborough House, Pall Mall, London SW1 Y 5HX, United Kingdom.
A pilot survey on abortions among young Armenian women

by Gajane Dolian

The last fifteen years have witnessed a marked worsening of the social and political conditions in Armenia. This, in turn, has led to a decline in the birth-rate and also to an increase in the overall mortality rate, including the number of deaths after abortions. And just as tragically for the Armenian nation, during the last decades the incidence of infertility has sharply increased, including secondary infertility resulting from complications following an abortion.

The earthquake in Armenia in December of 1988 ended tens of thousands of lives in a single moment. The catastrophe touched all generations. Within the course of only a few minutes the lives of young and old, including many young women who stood on the threshold of motherhood ended. Moreover, the everyday existences of hundreds of thousands of people deteriorated drastically. A sharp drop in the natural growth of the population resulted - a drop which will be felt for many years to come.

The difficult socio-political conditions have also led to the massive emigration of young families especially from Armenia. Both permanent emigration, as well as the temporary emigration, of those who would normally be the source of natural increase of the population aggravate still more what is already a serious demographic trend in Armenia.

The complicated social and financial situation in many Armenian families has led to the postponing of marriages and of the first baby’s birth for several years in young families although this used to be very unusual in Armenian society.

To make matters even more serious, many Armenian young women are even now still using abortions as a method of fertility regulation. Many of them have become infertile because of complications following abortions.

It was the objective of our present study to find out the main reasons why women were using abortions as a method of fertility regulation and to develop a comprehensive policy for the prevention of abortions, unwanted pregnancies, complications resulting from abortions and secondary infertility because of abortions.

Seventy-five young Armenian women (from 15 to 25 years of age) who had used abortion as a method of fertility regulation were interviewed according to the specially prepared questionnaire. 91.1% of them were married, the remaining 8.9% were single.

In 93.8% of cases the woman's pregnancy was unplanned and in 94.6% of them it was unwanted. Most women (86.6%) had not been using any means of contraception during the month of conception. The average frequency of induced abortions in the age group 15-20 years was 2.3 and in the age group 21-25 years was 2.4. These figures reveal that even very young women had already had a few abortions, most of them did not use modern contraception, and most of them did not plan or want their present pregnancies. Thus if no changes were introduced to their situation it is only to be expected that they will have more abortions during their reproductive lives.

The reasons given by the women for terminating pregnancy are shown in Fig. 1.

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**Figure 1: Reasons for terminating pregnancies**

- Fetal malformation: 3%
- Health reason: 7%
- Don’t want children: 38%
- No answer: 12%
- Can’t afford children: 37%

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**Figure 2: Reasons for not using contraceptives**

- Opposition of husband: 7%
- Afraid of side effect: 9%
- Thought to be infertile: 3%
- Lack of contraceptive education: 38%
- Contraceptives not available: 24%
According to the data (Fig. 1), at least 37% of young families decided to terminate the pregnancy because they could not afford children. At the same time 38% of women do not want to have children because of their difficult and complicated social and economical circumstances. It should be kept in mind that the age group surveyed is the sector of the population which could have a positive influence on the natural growth rate in the country.

The reasons for using induced abortions as a method of fertility regulation are shown in Table 1.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Reason for using abortion</th>
<th>Frequency as a method of fertility regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of information about contraceptives</td>
<td>46.7%</td>
<td></td>
</tr>
<tr>
<td>Everybody does</td>
<td>30.7%</td>
<td></td>
</tr>
<tr>
<td>No knowledge of another contraceptive method</td>
<td>13.3%</td>
<td></td>
</tr>
<tr>
<td>Reluctance to use any contraceptive</td>
<td>1.3%</td>
<td></td>
</tr>
<tr>
<td>No money for contraceptives</td>
<td>5.3%</td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td>2.7%</td>
<td></td>
</tr>
</tbody>
</table>

As Table 1 indicates, most of the young women (92.7%) are still using abortions for fertility regulation because of the widespread lack of information on modern contraception and family planning. The traditional attitude of having an abortion because everybody does (30.7%) should be prevented and changed as soon as possible.

The reasons for not using contraceptives are shown in Fig. 2. According to Fig. 2, 57% of the young women said they had received very poor education in contraceptive methods, 24% of those interviewed said that contraceptives were not available or were expensive. Only 9% of the women were afraid of various side effects of contraceptives. 7% of women admitted that they could not change the mentality of their husbands who were opposed to contraception.

According to our data most of the young women did not receive any sexual and family planning education: 96.0% did not receive contraceptive counselling before marriage, 97.3% did not have post-delivery contraceptive counselling, 93.3% did not have a post-abortion contraceptive counselling.

The information concerning the sources of information on prevention of unwanted pregnancies is shown in Table 2.

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Source of information</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical doctor</td>
<td>37.5%</td>
<td></td>
</tr>
<tr>
<td>Mass media</td>
<td>29.3%</td>
<td></td>
</tr>
<tr>
<td>Husband</td>
<td>10.7%</td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td>12.0%</td>
<td></td>
</tr>
<tr>
<td>Teacher</td>
<td>4.0%</td>
<td></td>
</tr>
<tr>
<td>Partner</td>
<td>5.3%</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>1.3%</td>
<td></td>
</tr>
</tbody>
</table>

It is clear that in Armenia the young population does not receive adequate sexual and family planning education, either in school nor from their parents, and not enough education is provided by medical doctors or the mass media. According to this survey, 96.0% of interviewed needed and wanted to have more information about modern contraceptives.

At the same time 72.0% of the young women mentioned that each time they had intercourse they were afraid of getting pregnant a situation which could create a lot of sexual and psychological problems in their future sexual life.

According to our survey 44.0% of women reported that immediately after performance of the abortion procedure they had decided they would never again have an abortion, 22.7% were ready to have an abortion the next time they became pregnant, 18.6% could not answer and 14.7% mentioned that after this abortion they were going to use contraceptives.

The data collected in this pilot survey makes it is clear that young Armenians urgently need a project aimed at reducing the frequency of abortions via IEC campaigns, sexual education, distribution of family planning education materials and pilot distribution of safe contraceptives. The need for such a project is becoming ever more urgent because of the dramatic increase of STDs and AIDS/HIV in the country.

Dr Gajane Dolian
WHO Consultant on Reproductive Health

WOMEN AND CHILDREN IN THE SHADOW OF WAR: the medical situation in rural Montenegro

by Snezana Crnogorac

Just under half of the female population of the small country of Montenegro, formerly part of Yugoslavia, live in rural areas. For these 127,000 women and children primary health care is provided by GP's, with referral to specialists in hospitals and other medical institutions within a 50km radius.

Special attention is paid to the health of children and to reproductive health: pre-school and school-age children, as well as high-school students receive free medical care, as do women during pregnancy and the post-partum period. Fee and compulsory vaccination for pre-school and school children against communicable diseases such as tuberculosis, poliomyelitis, diphtheria and tetanus reached 95% of the population in 1995.

Even women in rural areas have access to hospitals to give birth - in 1995 96.8% of deliveries were carried out in institutions. Newborn death rate was 24.2 per 1000 live births.

An important problem in providing medical care to women, especially in the countryside, is ensuring the early discovery and treatment of neoplasms. In Montenegro as elsewhere, malignant neoplasms of the breasts, uterus and ovary have been increasing. As they now account for almost half of the new cases of cancers, it is very important to discover them in time and ensure adequate treatment. Unfortunately, modern screening methods are very difficult to introduce, partly because of lack of equipment and funding, but also because of inaccessibility of mostly mountainous regions. At present there are no consistent screening procedures throughout the Republic, but this is one of the goals to be achieved in the near future.

Dr Snezana Crnogorac is a Member of the Commission of the FRY Government for the Improvement of Women’s Status, Karadjordjeva 16, 81000 Podgorica.Tel./fax: +381 81 51 524, e-mail snbomami@EUnet.yu
WHO approves three-year integrated plan of action on violence prevention and health.

Studies worldwide reveal that 20-50% of women, at some time in their lives, are victims of physical violence by men they know, and that 50-60% of these women are also sexually abused. The consequences for their health include injuries ranging from bruises to broken bones to death; unwanted pregnancies and sexually transmitted diseases, including HIV/AIDS; and depression, post-traumatic stress disorders and other mental health problems.

In many countries, especially those suffering severe economic downturns, there is also evidence that, more and more often, young girls and children are becoming the victims. The violence can be personal - in the form of child sexual abuse - or "institutional" - in the form of increasing child trafficking and prostitution.

At its 50th World Health Assembly, WHO welcomed a full report by the Director-General on prevention of violence and asserted once more the responsibility of WHO to provide leadership and guidance to Member States in preventing both self-inflicted violence and violence against others. "Realising the complexity of the issue, and that violence does not only affect health in many cases is the outcome of practices detrimental to health, such as alcohol and drug abuse, as well as of various socio-economic factors," it endorsed the Organization’s three-year integrated plan of action on violence prevention and health.

**Equipping health services to help victims of violence**

As part of WHO’s efforts in addressing the problem it convened a workshop at the WHO Regional Office for Europe in Copenhagen July 30-31, 1997 aimed at improving the capacity of health professionals to deal with the situation.

"We believe that the health sector is ideally placed to identify and help the victims of violence," noted Dr. T. Türmen, Executive Director, Family and Reproductive Health at WHO Geneva. "For many women health workers are the main and often the only point of contact. But many professionals don’t know how to deal with this issue, which they perceive as overwhelming and beyond their competencies. So they turn their backs and pretend it isn’t there."

Participants in the workshop, a joint effort of WHO and the International Federation of Gynaecology and Obstetrics (FIGO), included obstetricians, gynaecologists and other health workers. Discussion focused on identifying, treating, supporting and advising women who experience physical or psychological violence, including sexual assault. A report on the workshop was subsequently presented to the 7000 participants attending FIGO’s 15th World Congress of Gynaecology and Obstetrics in Copenhagen in August.

"By being the abused women’s advocates in society, we can urge the authorities and our communities to improve the total service for abused women", concluded Dr Mahmoud Fathalla, President of FIGO. "By saying no to violence we can contribute to the long-term goal to end violence against women and truly move from our present focus on gynaecology to women’s health."

**CONTACT:** Dr Claudia Garcia Moreno, Director, Women’s Health and Development or Dr Carol Djeddah, Women’s Health, WHO Geneva, tel. +42 22 791 3499, fax +41 22 791 4189.

WHO Europe has an Internet home page: http://www.who.dk.

Women and girls are most at risk of violence from men they know.
HIV - STDs

Making integration work

Bulgarian Clinics combine obstetrics/gynaecological consultations with STD services and even family therapy.

In its clinic in the Bulgarian capital Sofia and ten FP units around the country the Bulgarian Family Planning and Sexual Health Association (BFPA) has adopted a holistic approach in promoting reproductive health. The clinics provide STD counselling and examinations as part of their services, and figures indicate they have been welcomed by women:

In the Sofia clinic:
- Total visits more than doubled in a single year, rising from 2,892 in 1995 to 5,880 in 1996.
- New to BFPA clients comprise 43% of the total number.

In the country as a whole:
- Total visits for 1996 were 6,921.
- Contraceptive consultations were 2,100 in 1995 to 2,611 in 1996.
- Clients using other services increased as follows:

<table>
<thead>
<tr>
<th></th>
<th>Number of visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1995</td>
</tr>
<tr>
<td>OB/GYN services</td>
<td>824</td>
</tr>
<tr>
<td>STD services</td>
<td>90</td>
</tr>
<tr>
<td>Sexual counselling</td>
<td>30</td>
</tr>
<tr>
<td>Psychiatric counselling</td>
<td>90</td>
</tr>
</tbody>
</table>

Integration of STD prevention into other reproductive health activities is only part of BFPA's IEC activities. For the past three years they have arranged sex education sessions in schools for youth. STD and AIDS prevention is a major aspect of the information provided, in the form of brochures, leaflets, etc. BFPA's promotions in printed media and on radio and television also make STD prevention a central focus.

MAKE A CONNECTION!: This article is a condensed version of information provided by Dr. Radosveta Stamenkova, Executive Director, Bulgarian Family Planning Association, 67 Dondukov bvd, Sofia, Bulgaria
Children Living in a World with AIDS

How can they be helped?

Any efforts to significantly reduce the vulnerability of infants to HIV infection will thus have to take the route of increasing women’s control over their situations, especially in improving their possibilities to take decisions about their own reproductive and sexual health. It means increasing the knowledge and sense of responsibility of both women and men about HIV prevention. It also means increasing women’s access to antiviral drug regimens which can cut the risk of mother-to-child transmission.

For infected children the report reveals a very grave situation, particularly in many poorer countries, which have been unable to benefit from the recent advances made in antiviral therapy and where even expensive medicines to treat HIV-related illnesses and reduce suffering are often unavailable.

In Europe, more than 20% of HIV-positive children are still alive at the age of 10 years. In Zambia, by contrast, a recent study showed that nearly 50% of HIV-positive children had died by the age of two.

Children orphaned by AIDS: an exploding problem

“Children do not have to contract HIV to be profoundly harmed by it,” stressed Carol Bellamy, Executive Director of UNICEF. Over 9 million children are estimated to have lost their mothers to AIDS. “The number of orphans is growing dramatically, children are traumatised by watching parents die, forced out of school, and their entire future jeopardised,” Bellamy continued. In Uganda, for instance, some 1000 children lose one of their parents to AIDS every week.

In some of the worst-hit African communities, the report shows, there are literally only children and old people left - the age groups in between have been practically wiped out. And in all countries families and the traditional safety net of the extended family are coming under increasing pressure: a recent survey of social care in seven countries participating in the European Collaborative Study showed that almost two of every three children born to HIV-positive mothers were living in alternative care by age 8.

Opening a window of hope

If children are an increasing part of the AIDS problem, they are also a critical part of the solution. Information and the promotion of children’s rights are important keys to reducing risk behaviour.

The UNAIDS report recommends a number of areas in which sustained efforts can improve the situation for children, including providing sexual health education, expanding both educational and employment opportunities and strengthening health and social services to families and communities.

“AIDS has changed the world for children,” said Dr. Piot, “and everyone - governments, communities and individuals - has to help to support children facing the uniquely painful realities of life in a world with AIDS.”

MAKE A CONNECTION!
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Fax.+32 2 736 3216).
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Lisa Jacobs, Ogilvy, Adams
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(Tel.+1 212 880 5325).

WEBSITE! UNAIDS home page has
more information about their
programme: http://www.unaids.org
PROGRESS IN REPRODUCTIVE HEALTH PRACTICE

Community-based distribution projects in Turkey

by Dr Didem Gürses

Community-based Distribution (CBD) is an approach to reproductive health education being implemented by the Family Planning Association of Turkey (FPAT) with success in several provinces of the country. The CBD projects are designed to meet the health needs of a given community and, in particular, to interest and involve the community actively in the delivery system.

Family planning is one of several primary health measures that can be delivered safely, effectively and cheaply through community-based services. FPAT is the first organization in Turkey to introduce this model and continues to implement this approach with several Safe Motherhood/Woman-to-Woman Projects.

FPAT: Historical perspective

FPAT is a non-governmental organization founded in 1963 and has been an affiliate member of International Planned Parenthood Federation (IPPF) since 1964. The Association played a significant role in having the Turkish Grand National Assembly pass the 1965 Population Policy Act introducing an anti-natalist policy, legalizing the sale and distribution of contraceptives.

As a leading, innovative, voluntary organization working in the fields of reproductive and sexual health, FPAT advocates the reproductive and sexual rights of all individuals, carries out work for marginalized and unserviced groups and strives for the improvement of service quality. FPAT has planned and carried out actions in the fields of mother-child health, sexual health, reproductive health and equality for women.

In addition to the central office in Ankara, FPAT has three regional offices in Istanbul, Mersin and Diyarbakir and 25 branch offices in various provinces of Turkey.

Turkey: Demographic and health indicators

Turkey is a large country with a young population. The population is 63 million and 39% of the population is under the age of twenty-one. The population growth rate per year was 1.8% in 1990-1995 period. Children under the age of 16 and women of reproductive age constitute 62% of the population.

In 1983 this law was revised and made more comprehensive, legalizing the termination of pregnancies before 10 weeks by induced abortion. Voluntary surgical sterilization methods (tubal ligation and vasectomy) are legal and paramedical personnel can insert IUDs after being trained. By 1993 the total fertility rate had fallen from 39 children per woman in 1978 to 2.7, which is still among the highest in Europe.

The infant mortality is 53 per 1000 live births, under-five mortality is 61 per 1000 live births and the maternal mortality rate is estimated to be 132 deaths per 100,000 live births. Almost every woman is aware of at least one contraceptive method and 35% of married women use an effective method. Linkages among family planning, antenatal and postpartum services could be improved. There is one induced abortion for every four live births.

Urbanisation bringing social upheaval

Increasing urbanization in Turkey, especially from the 1950s onward, has resulted from a lack of employment opportunities and material comforts in underdeveloped rural areas. This process has caused problems in the provision of urban services such as health and education and led to the emergence of squatter housing in unplanned cities.

The squatter settlements on the outskirts of big cities have a highly heterogeneous social and cultural structure. People who have migrated from the rural parts of the country try to adapt themselves to new conditions of city life while also trying to keep their conservative, traditional values. They are in a transition period.

Although they have migrated to seek better living conditions, they quite often fail to find them, at least not at once. They live under poor socio-economic conditions, benefiting only to a very limited extent from services provided by the Ministry of Health. The fertility rate is high and modern contraceptive prevalence rate is low.

These underserved groups, living in the semi-urban parts of the cities, are one of our target groups and CBD projects have proved to be an appropriate approach to solving their problems related to maternal health and family planning.

CBD: Programmes to mobilize the community and its resources

Using this approach, leader women selected from among the people living on the project site are trained in maternal and child health, FP methods, STDs and communication skills. During the field work, these local leaders make daily house visits and motivate couples to practice family planning, update their information on contraceptive use, distribute contraceptives and refer people to health clinics.

The objective of CBD programmes is to enhance the level of mother-child health and to improve access to FP services by removing some of geographic, financial, bureaucratic, cultural and communication barriers that limit the use of these health services. Greater availability is an important goal of all CBD services.

In order to be effective, CBD programmes should focus on:
- common and important health problems in the community;
- health problems for which there are effective remedies;
- services and supplies that are relatively safe and easy to deliver.

CBD programmes have two essential features:
- community residents who are not health professionals deliver the supplies and services;
- the programmes reach each household.

Clinics and medically trained personnel provide necessary backup and referral, but they are not the main source of services and supplies. In the case of FP, for example, the CBD workers usually distribute pills and condoms and refer people to backup services for IUDs and voluntary sterilization procedures.

CBD increases access to services and supplies in four ways:
- by overcoming geographical barriers - people are often unwilling or unable to go more than a few kilometres for contraceptives;
- by overcoming cost barriers - services are provided free or for a minimal charge so no one is excluded because of lack of money;
- by eliminating bureaucratic barriers - CBD avoids the long waiting lines, lengthy forms and limited hours of operation typical of clinics that discourage many people;
- by overcoming cultural and communication barriers - CBD makes households aware that the services are available and provides them in ways that are acceptable in the community.

**Implementation of CBD programmes**

After the project site is selected, a baseline survey is conducted to learn about the characteristics of the population. The follow-up and referral system, together with educational materials for leader women are developed. A project office with the necessary equipment is established.

Announcement about the project is made by means of primary schools, and candidates fill in a questionnaire form.

**Selection Criteria for Leader Women:**
- must be at least a primary school graduate;
- must be married;
- must have a positive attitude to FP.

Selected women receive two weeks of training in maternal and child health, FP methods, STDs and communication skills. The most dynamic, enthusiastic and respectful woman from each area is selected as supervisor/team leader. Each supervisor is responsible for 5-6 leader women, each of whom makes at least 8 house visits every day.

The personal information and reproductive history of the client visited is recorded on the follow-up cards by the leader woman. These follow-up cards are collected by supervisors in the weekly meetings, reviewed and delivered to the operators to be recorded in the computers. At weekly meetings, the activities of the last week, failures and progress are discussed, follow-up cards are delivered and cards of the clients to be visited next week are selected. The Project co-ordinator her/his assistant attends these meetings.

The Project Co-ordinator also makes periodical visits to project sites in order to obtain first-hand information about the activities.

**FPAT's experience with CBD projects**

The CBD model was implemented by FPAT for the first time in Turkey between the years 1985 and 1989 in a squatter settlement of Ankara with a population of 110,000. As this approach resulted in a large increase in modern contraceptive prevalence rates and enhanced continued use, the Association expanded the model to a number of other provinces of the country.

The results of these projects show us that CBD continues to be an effective tool to change attitudes towards FP and to improving the level of maternal health.

As the Table shows, the projects have caused remarkable increase in modern contraceptive prevalence rates. Our experience of the CBD approach has shown us that leader women still continue to be the sources of information and referral for services after the project ends, which adds a lot to the sustainability of the program.

Local women, serving as the agents of change in their communities, gain a higher social status in their families and in their surroundings. Once informed about maternal and child health the people in the project site learn to use these services by themselves and to seek higher service quality after the project ends.

**Problems faced during implementation**

In spite of the remarkable success of the model, it does have some problems which can have negative impacts on the project activities. Among the special challenges are:
- recruiting eligible leader women who can promote and provide health measures effectively;
- training local women in the variety of skills needed (such as communication skills, proper recording of follow-up cards);
- co-ordinating the back-up with the existing medical system.

CBD programme managers should take into account these aspects in the implementation process and must be ready to make changes in order to deal with problems as they arise.

**Conclusion**

The CBD programme of FPAT has proved to be a major and successful outreach mechanism for improving the level of maternal-child health. Within the last 10 years the Programme has been able to take FP to underserved and disadvantaged populations. Following the remarkable performance of CBD other NGOs and the municipal authorities have adopted the model and started implementing it in various parts of the country. Much more still needs to be done, however, especially to expand the programme to cover adequately those parts of the country that are still underserved.

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**Table 1 - Percentage of women using modern contraceptives before and after CBD projects**

<table>
<thead>
<tr>
<th>Women using modern contraceptives before CBD projects (%)</th>
<th>Adult</th>
<th>Mexico</th>
<th>Ankara</th>
<th>Istanbul</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women using modern contraceptives after CBD projects (%)</td>
<td>21</td>
<td>36</td>
<td>42</td>
<td></td>
</tr>
<tr>
<td>Women who begin to use modern methods in CBD projects (%)</td>
<td>41</td>
<td>38</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Total proportion of contraceptives before methods (%)</td>
<td>62</td>
<td>74</td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

**CONTACT: Dr Didem Gürses, Region Coordinator, The Family Planning Association of Turkey (FPAT), Atatürk Mah. Alemdag Cad. 124/4, 81240 Umraniye Istanbul, Turkey. Tel. +90 216 443 4247, Fax +90 216 443 42 48**

ENTRE NOUS 36-37, December 1997
REGIONAL HEALTH STATISTICS

HUMAN DEVELOPMENT INDEX (HDI) AND TOTAL FERTILITY RATE (1993-95)

HUMAN DEVELOPMENT INDEX (HDI) AND MATERNAL MORTALITY RATE (1993-95)

MATERNAL MORTALITY AND ABORTION IN ROMANIA

This study has been undertaken at the request of the United Nations Population Fund by Prof. Vasile Ghetau, University of Bucharest

Maternal deaths and abortions, 1989-1996

Live births and abortions, 1989-1996

Maternal mortality has dropped significantly in Romania over the past 6 years.

ENTE NOUS 36-37, December 1997
The access scores for each contraceptive method are estimated of the extent to which couples in a given country have access to that method. The scores fall within a range of 0 to 20. *Data Source: Population Action International 1997*
Cervical cancer screening - For and against

Reader's letter:
Dr Anne Webb, Consultant in Family Planning and Reproductive Health Care at the Women's Health Directorate in Liverpool, wrote Entre Nous concerning the value of screening.

"...I am certain that the overwhelming majority of doctors with their screening to reduce the incidence of serious disease and that which ever programme they institute they believe it is in the best interest of their population. However, there is a negative side to screening and it is very important that the process does not convert a healthy woman into a worried patient."

Referring to studies on the benefits of screening vs. cost, Dr Webb continues: "Even the evidence for the benefit of cytological screening can be argued against, ... despite the advice from many gynaecologists there is very little evidence that routine pelvic examination is of any health benefit whatsoever."

"Like most clinicians, I wish to do the best for my clients, but I have yet to meet a woman who looks forward to having any of these screening processes, although the majority will put up with them because they have been told this will somehow benefit their health. It is therefore behonon on us to be sure that we are not wasting money, time and effort as well as causing some discomfort and unnecessary anxiety to women who are not going to be any healthier for these procedures. This is especially important in countries where there is a limited amount of money to be spent on health services. One particular comment that worries me is that in certain countries people wish to carry our regular colposcopies as a screening procedure. Knowing the price of a colposcope surely there is a better use for the money."

CONTACT: Dr Anne Webb at the Women's Health Directorate, 16 Lord Street, Liverpool, tel. +44 151 708 9473, fax +44 151 708 9476.

On the other hand ...

In March of this year, WHO and the European Organisation on Genital Infection and Neoplasia (EUROGIN) released a joint report on Cervical Cancer Control, reviewing past efforts and discussing the present and future of screening for cervical cancer. It contains recommendations in such areas as epidemiology, management of cervical neoplasia, development of vaccines against human papilloma virus (HPV), screening programmes and strategies, as well as pap smears and new technologies in cervical screening.

Cancer of the cervix is a global health problem, known to be strongly linked with an early onset of sexual activity and multiple sexual partners. More than 90% of new cases are due to sexually transmitted HPV infection of the cervix and, if detect ed in an initial asymptomatic stage it is nearly always curable by surgery or radiotherapy.

Mass screening programmes, in which women have cervical smear tests at least once every three to five years, have proven effective in reducing cervical cancer mortality and morbidity rates. Yet close to half a million women worldwide develop cervical cancer annually - more than half of them will die from it. 75% of all these women will be in the developing world, where, because of financial constraints, mass screening programmes are still wishful thinking.

The factors determining the success of cervical cancer screening are 1) coverage of the population at risk through organised "voluntary" screening, and 2) quality assurance in the collection and interpretation of cervical smears. The major reasons why cervical cancer sometimes cannot be detected through cytological screening, the report suggests, are large intervals (more than 5 years) between tests and a high number of false negative results (10-30%).

The principal causes of failures are the poor quality of samples and inappropriate interpretation of results, both of which can be overcome through improved sampling and the introduction of automated devices which can detect 30-50% more false negatives than humans. Colposcopy is yet another technique widely used for cervical precancer diagnosis in women with abnormal smears. By taking biopsies, the nature and extent of cervical lesions in these women can be determined.

Dr Mark Tsecklovski, Director of Non-communicable Diseases at WHO Geneva, says "The time has come to improve strategies for cervical cancer screening. In order for cytological screening programmes to be cost-effective, they should cover most of the female population at risk, and be initiated only when their quality at all levels, including sampling and interpretation of results, has been ensured."

Readers can find a more extensive discussion on cervical screening techniques and strategies, as well as research on cancer in Entre Nous, No. 34-35 of December 1996.

CONTACT: Igor Rozov, Health Communications and Public Relations, WHO, Geneva Tel.+41 22 791 2532, fax +41 22 791 4858, e-mail rozovi@who.ch; Dr Annie Sasco, WHO Programme on Cance: Control, IARC Lyon, tel.+33 4 7273 8412, fax +33 4 7273 8342, e-mail sasco@iarc.fr. Info on WHO publications can also be obtained from the home page http://www.who.ch.
In October, the Safe Motherhood Initiative marked its 10th anniversary with a meeting of experts in Sri Lanka, to review the experience and research of the past decade and map out effective strategies for reducing maternal mortality and disability worldwide. Their conclusion: that every year over half a million women still die unnecessarily due to pregnancy complications because of lack of political will and refusal to take action in these areas.

The coming year, 1998, has been declared Safe Motherhood Year by WHO. The move is intended to raise the awareness and increase the commitment of all professionals involved, from the medical, social, political, psychological and statistical sectors to preventing deaths and illnesses caused by pregnancies and promoting safe motherhood issues.

Regular news and information on motherhood issues are available in the Safe Motherhood newsletter, published three times each year (in English, Arabic and French) by the Maternal and Newborn Health/Safe Motherhood Unit, Family and Reproductive Health, WHO, 1211 Geneva 27, Switzerland.

Resources

**Books**


This technical report, prepared by the Reproductive Health Branch of the Technical and Evaluation Division of UNFPA, analyses community participation strategies in reproductive health programmes and UNFPA support for involving the community, particularly women, in the design, implementation and evaluation of projects. This document intends to circulate information on the Rapid Assessment Procedures (RAP) methodologies both within and outside UNFPA; to identify successful innovative participatory approaches in UNFPA-supported projects, and to disseminate this information among programme officials and United Nations staff.


Price: US$5.00

Available from: United Nations Population Fund, 220 East 42nd Street, New York, NY 10017, USA.

Sexual and Reproductive Health and Rights for Youth - The Danish Experience, by Nell Rasmussen, Director, The Danish Family Planning Association (1997).

Denmark is in many respects a pioneer country in providing youth with rights, information, education, communication (IEC) and services in sexual and reproductive health. It has integrated services into the primary health care system and sex education into the public school system in order to meet young people's basic needs, building also on cooperation with NGOs in reaching young people outside school.

The aim of this booklet is to describe the Danish sexual and reproductive health services and IEC for youth and to demonstrate some effects - since the Danish approach seems to reflect some of the intentions of the ICPD Plan of Action and represents almost 30 years of experience. Thus, it may be inspiring to others who are in the initial phase of meeting young people's needs within sexual and reproductive health and rights.

ISBN: 87-89943-82-1

The United Nations Population Fund (UNFPA) supported the publication of this booklet.

Available from: The Danish Family Planning Association, Skindergade 28, 1 & 2 sal, DK-1159 Copenhagen K, Denmark.

**Documents**

Generation 97 - what young people SAY about sexual and reproductive health.


This publication is a snapshot of the views expressed by young people in 1997 on issues relating to their sexual and reproductive health.

Copies available from: International Planned Parenthood Federation, Regent's College, Inner Circle, Regent's Park, London NW1 4NS, United Kingdom.

Tel: +44(0)171-4877990 or from: United Nations Population Fund, 220 East 42nd Street, New York, NY 10017, USA.

Tel: +1-212-2975020.

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RESOURCES

Informationen zur Sexual aufklärung (Information on Sex Education). Bundeszentrale für gesundheitliche Aufklärung (BZgA)(Federal Center for Health Education -FCHF).
Packet contents:
- General Concept for Sex Education of the Federal Centre for Health Education in cooperation with the Federal States.
- Sexuality and contraception from the point of view of young people and their parents
- Sex Education and Family Planning - Research and Model Projects
- Boys will be men - Proceedings of the 1st Specialist Conference on Sex-Education Work with Boys.
- Learn to love - Proceeding of the FCHE's 1st European Conference "Sex Education for Adolescents". Federal Centre for Health Education, Cologne

For further information on the various items (in German or English), please write to: Bundeszentrale für gesundheitliche Aufklärung, Ref. Sexualaufklärung, Ostheimerstrasse 220, D-51109 Köln, Germany.


The Consortium for Emergency contraception is an international collaboration among seven organizations involved in family planning and women's health initiatives in over 100 countries.
For further information, please write to Sharon L. Camp, Ph.D. Consortium Coordinator, 8930 Camp Road, Wecome, MD 20693 USA. Tel: +1-301-753-1926.

Working with young people on sexual health and HIV/AIDS. Appropriate Health Resources and Technologies Action Group (AHRTAG), 1996.
This pack contains a list of materials and games, activities and ideas on sexual health, including the human immunodeficiency virus (HIV). It lists resources and contacts that can help youth workers and educators network with each other and discuss sexual health and HIV with young people, as well as share experience with others working in the same areas.
Price: £5.00/US$ 10 - Free to developing countries. Available from: AHRTAG, Farringdon Point, 29-35 Farringdon Road, London EC1M 3JB, United Kingdom. Tel: +44 171 242 0666.

Chapter 1: introduction to the steps needed to conduct research on unsafe abortion.
Chapter 2: information about data collection, management, and analysis, including a description of the basic research tools necessary to conduct the research.
Chapter 3 and 4: literature sources, examples, and various suggestions for conducting local-level, hospital and community studies on the problem of unsafe abortion.
Available from: Maternal and Newborn Health/Safe Motherhood Unit, Division of Reproductive Health (Technical Support), WHO, 20 av. Appia, CH-1211 Geneva 27, Switzerland.

Violence Against Women
The package presents a global overview of violence against women, particularly as it pertains to the health of women and girls. It focuses on violence in families, rape and sexual assault, violence against women in situations of conflict and displacement, as well as violence against the girl child. The consequences of violence on women's health and the role that public health workers can play in multi-sectoral efforts to end the violence are explored. A sample of governmental and non-governmental activities taking place worldwide to end violence against women and alleviate its consequences are also highlighted.

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The Vatican and Politics of Reproductive Health, by Frances Kissling, Catholics for a Free Choice (CCFF), 1996. One of the most complex and controversial questions facing many societies today is the role of religious institutions in the formulation of public policy. Allowing religious doctrine to be institutionalized into public policy without a critical analysis and debate can lead to unacceptable consequences and policies. This was the topic of a speech given by Frances Kissling, president of CCFF to parliamentarians in the House of Lords in London in 1996.

Available from: CCFF, 1436 U Street, NW, Suite 301, Washington, DC 20009-3997.

Wall charts

"Sexual and Reproductive Rights" derived from the IPPF Charter on Sexual and Reproductive Rights, published in 1996 in English, French, Spanish and Arabic by IPPF, Regent's College, Inner Circle, Regent's Park, London NW1 4NS, UK. Tel. +44 171 486 0741, fax +44 171 487 7823, e-mail: ifppinfo@ippf.atmmail.com

"Contraceptive choice: Worldwide access to family planning" presents a colourful comparative picture of the choices - or lack of choices - available to people in different countries of the world. The reverse side explores family planning needs and progress (in English and French). Another black-and-white chart gives detailed information on "Choosing a Contraceptive: Considerations for Youth". All are available from Population Action International, 1120 19th Street NW, Washington DC, 20036 USA.

Videos

The Game: Alcohol Sex and Vulnerability and Winning Moves: Defensive Strategies that Work. Two videos, to be shown consecutively, from Aids Impact Inc. of Seattle. Specially designed for adolescents, the videos are part of the program "Talking to Teens about Alcohol, Drugs and Sex." Each video is accompanied by a facilitator guide designed to help the presenter lead an engaging discussion based on the trigger points embedded in the videos. Aids Impact also provides other educational materials and holds a Workshop Series for professionals and parents focusing on teaching them how to help adolescents reduce risk and become part of the solution. PO Box 9443, Seattle, WA 98109, tel. +1 206 284 3865, fax +1 206 284 3879.


TRAINING IN EUROPE

5th Family Planning/Sexual and Reproductive Health (FP/SRH) Course, 5 February - 1 March 1998, Netherlands. This 3-week training programme is organized by the Netherlands School of Public Health, the Rutgers Foundation and the World Population Foundation to familiarize health professionals and policy makers with strategies and approaches currently used in Western countries in the areas of FP/SRH, and to explore possibilities of applying or adapting them to their local, or national situation. For additional information please contact: Henk Roling, World Population Foundation, Amperestreet 10, 1221 GJ Hilversum. The Netherlands. Phone: +31-35-6422304, Fax: +31-35-6421462.

Evaluation Economique des Programmes de Santé. How can we make sure, in a world of soaring health costs, that we get value for money - a course offered in French on evaluating the economic efficacy of health care. Held at the International Centre for Childhood and the Famili

ly from 2 to 26 June 1998. Contact: Miloud Kaddar, Département formation, Centre International de l'Enfance et de la Famille, Carrefour de Longchamp, Bois de Boulogne, 75016 Paris, France. Phone: +33-1-44-302000, Fax: +33-1-45-257367, E-mail: cidef@compuserve.com.

UNFPA Training Courses in Reproductive Health/Family Planning for Service Providers from Countries with Economies in Transition. Between February and May 1998, one Basic Training with 20 participants and two Advanced Courses (each with two participants) will be held. Contact: István Batár, MD, PhD, Associate Professor, Director of Training, Department of Obstetrics and Gynaecology, University Medical School of Debrecen, P.O. Box 37, 4012 Hungary. Tel.: +36-52-411-600 Ext. 5447 or +36-52-417-144 Ext. 4058, Fax: +36-52-414-577, E-mail: ibatar@cgbym.dote.hu.

WEB SITES TO EXPLORE

http://www.b3eeu.jussieu.fr/ceses/ Data on HIV/AIDS in Europe, including maps and graphs, is available on the Internet at the homepage of the European Centre for the Epidemiological Monitoring of AIDS (CESES).

http://www.populationaction.org Information on access to contraceptives by country and region, strategies for expanding contraceptive choices, educational materials.

http://www.oneworld.org/ippf/ Website of the International Planned Parenthood Federation includes information on instructional materials, contacts and activities.

http://www.columbia.net/vb/index Like to make a journey of exploration - through your heart? Visitors to this website of Columbia/HCA Healthcare Corporation can look around the inner reaches of the heart while listening to information or the organ. The site received top marks for accessible health information and other organs are on the way.

http://www.menshealth.com Articles and information from the periodical Men's Health - everything from advice on STDs to physical fitness.

http://www.HELIIX.com Website with medical and pharmaceutical news, research reports and other information. May be charges for some services.

http://www.reuters.com Medical and pharmaceutical news, research reports and other information. May be charges for some services.

http://www.itz.se/tobak/ Interesting material on tobacco use prevention from Sweden.

http://www.cancernet.nci.nih.gov/ Cancer information, including information for patients and their families.

http://www.breastcancer.net Research results and other information on breast cancer.