



# ENTRENOUS

The European Family Planning Magazine



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**A child - at any price?**

## ENTRE NOUS

Sexuality and Family Planning Unit  
WHO Regional Office for Europe  
Scherfigsvej 8  
DK-2100 Copenhagen Ø  
Denmark  
Tel.: 39 17 14 51 or 39 17 14 26  
Fax : 39 17 18 50

### Coordinator

Dr Assia Brandrup-Lukanow

### Editor

Dr France Donnay

### Administrator

Dominique Dalsgaard

### Translators

Keneva Kunz

Yvon Prigent

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Cover photo: Logo of HEDEC - the Development Unit for Foreign Assistance, which is an independent unit in the National Research and Development Centre for Welfare and Health (STAKES - a national expert agency subordinate to the Finnish Ministry of Social Affairs and Health).

# IN THIS ISSUE

## Infertility

This issue focuses on infertility, that fluctuating pathological, emotional and existential sphere. We have attempted to approach the subject from diverse points of view, ranging from epidemiology to the economics of health, from ethical questions to the psychological implications for the individual and the couple.

For all European countries, in both the west and the east, it is more and more difficult to meet rising health expenses. How then can we discuss these techniques, which are among the most costly?

The problem is even more serious in the developing countries, where the prevalence of infertility of infectious origin is much higher and the medical solutions practically unavailable for the vast majority. But even with the development of innovative and much less expensive techniques, referred to in one article, of "natural incubation", how will it be possible to avoid the commercialisation of these silent children of the future, who will be reserved only for the privileged?

The non-medical solutions: adoption, acceptance of infertility, voluntary sterility, are even more difficult to obtain or to make acceptable in our societies. Another article reports how other nations have long since found the answers to these problems to lie in separating biological parenthood from social responsibility towards the children.

Finally, as always in questions of public health, prevention is the best solution: safe abortion, availability of modern and effective methods of contraception, prevention and early treatment of sexually transmitted diseases.

For each individual, and for all of us, this is what the realisation of the desire to have a child costs.

Dr France Donnay and  
Dr Assia Brandrup-Lukanow

## How should fertility be expressed in figures?

In any single population sterility affects 3 to 5% of couples.

But, on the average, in different countries, 15 to 20% of the population will be confronted with difficulties in not being able to have a child at the moment they desire. Finally, at 45 years of age, only 3 to 5% of the women do not have children.

These figures are much higher in countries where the prevalence of sexually transmitted diseases is very high.

The results of assisted conception are now approaching natural fertility. For example, in 750 centres, located in 31 countries, the following figures were obtained (Cohen, 1991): for every 100 treatment cycles there were 18 clinical pregnancies, 13 deliveries (and a higher number of births, due to multiple pregnancies).

WHO intends to express the results in standardised manner, as the number of live births per 100 treatment cycles.

Dr France Donnay



Logo: José Jacinto da Silva Matias

## The male factor

In most countries, men are reluctant to be involved in the investigations while the male factor seems to be more and more important.

In a WHO study entitled the standardized investigation of the infertile couple in more than 1000 couples a possible cause in the male partner was found in 33% of cases. A possible cause in the female partner was found only in 25% of cases. In about 20% of couples both members were involved, in the remaining 22% no cause could be found in either partner ("idiopathic infertility"). (*Progress*, No 15, 1990).

A Danish study examined 61 semen quality studies published between 1938 and 1990 that involved nearly 15.000 men. Seminal volume declined by about one-fourth, a change that was just statistically significant. The average sperm concentration fell by almost 50%, from 113 millions per ml in 1940 to 66 millions per ml in 1990. The trend remained the same when the analysis was limited to men of proven fertility. (Carlson, cited in *FP Perspectives*, 25, 1, 1993).

A Belgian team recently succeeded in obtaining pregnancies by intracytoplasmic microinjection, one single sperm being injected directly into the cytoplasm of the ovum. This treatment could be applied to men whose sperm alterations are so serious that no hope was left until this technique was completed in 1993. (*Panorama du Médecin*, No 3829, 1993).

As Ann Lalos says, "historical studies of different cultures and civilizations reveal that infertility has been regarded as the woman's problem and she was subjected to numerous humiliations. Only in the last 30 years has the male partner in an infertile couple been included in the fertility investigation. Still knowledge of male factors lags far behind knowledge of female factors in this disorder and there is insufficient information about the impact of childlessness on the male." (See also Ann Lalos article on p. 6)

## Glossary

The following operational definitions, as they relate to couples, have been proposed by a WHO Scientific Group and were detailed in a recent FIGO Manual of Human Reproduction (ref: Rosenfield, A. and Fathalla, M.F., The Figo Manual of Human Reproduction, 1990, vol.3, p. 66).

**Primary infertility** means that the couple has never conceived, despite

cohabitation and exposure to pregnancy for a period of two years.

**Secondary infertility** means that the couple has previously conceived, but is subsequently unable to conceive despite cohabitation and exposure to pregnancy for a period of two years.

**Pregnancy wastage** is the term used when a couple is able to conceive, but unable to produce a live birth.

**Family planning** permits the regulation of the fertility of individuals and therefore of a designated population. It includes the prevention and the treatment of infertility, which is basically involuntary, and, naturally, contraception and the interruption of pregnancy, practiced under proper medical and psychological conditions.

**Fecundability** is the probability of a couple conceiving per menstrual cycle (25% at 25 years of age, almost 0 after 45 years of age).

# Prevention of infertility



The various facets of family planning work together: "safe abortion" and contraception, to an even greater degree, have a protective effect on

fertility and thus reduce the incidence of infertility, and the percentage of sterile couples remains stable.

Safe abortion, carried out under proper technical conditions (asepsis, vacuum aspiration), reduces the frequency of pelvic inflammatory disease (PID), cervical lesions, uterine perforations, and synechia (intrauterine scars or adhesions which impede nidation (the reception of the fertilized ovum) resulting from repeated curettages.

In fact, a study by WHO involving 10,000 couples in 25 different countries has shown that for women undergoing an abortion under these conditions the risk of tubal occlusion is increased fourfold.

**Oral contraceptives** reduce the incidence of ovarian cysts and make the cervical mucous more resistant to bacteria (although not to viruses), as they are to spermatozooids. It reduces by one-half the risk of increasing bacterial infections. There is disagreement,

however, about its effect on endometriosis and the development of fibromas, another cause of infertility. The reversibility of the treatment is total, contrary to what many women, even today, still believe. Return to fertility is rapid and does not depend upon the length of use.

The other hormonal contraceptives, **injections or implants**, have the same anti-bacterial effect and also reduce the risk of PID.

The **barrier methods (condoms, diaphragms and cervical caps)**, and to a lesser degree spermicides, significantly reduce the incidence of sexually transmitted disease (STD) and thus provide the best protection against infertility.

The **rhythm method**, in preventing unwanted pregnancies, also has a protective effect and contributes to a better understanding of the individual fertility of each of the partners.

**Intrauterine devices (IUDs)**, on the other hand, increase the risk of PID, but the most recent figures calculate that the incidence of infections to be from 1-5% per woman/year. The risk is very low in women who are not at risk of STD. It decreases with time during the months following the insertion, the reversability is good if attention is paid to contraindications. Women who have numerous

sexual partners or commercial sex workers are not desirable candidates.

Both **male and female sterilizations** must be preceded by an interview which is sufficiently thorough to establish clearly the reasons of the patients and to limit to the utmost requests to reconnect the fallopian tubes or deferent ducts, operations which are very expensive.

All the contraceptive methods, in reducing the incidence of unwanted pregnancies and thus of abortions, have a protective effect which is proportionally more significant the more effective they are.

About one-third of all cases of infertility is caused by infections which could have been avoided. The prevention of STD is thus a priority and would lead to a reduction of the incidence of cervical cancer, as it is now known that this is a result of the combined action of a virus and of other oncogenic factors. The screening of asymptomatic infections of chlamydia trachomatis, which is the principal cause of infertility of infectious origin, costs much less and is much more effective than is treatment for infertility.

Dr France Donnay

## From ethics to rights



The new French law adopted in January 1994 is based on the inviolability of the human body and its genetic patrimony. It forbids,

for example, screening prior to implantation. Is it necessary to go this far in regulating scientific research?

In the final analysis the only really new legislative problems concern the fate of the embryos or pre-embryos (groups of 4-8 cells which are placed in a favourable environment and form an embryo). The question of the legal and moral existence of this "phantom population" (Cardinal Lustiger) could well start the debate on abortion all over again.

According to German law an ovum or embryo may not be taken from a woman and transferred to another, infertile woman. Like the majority of other European countries, Germany does not authorize in any case recourse to a bearer mother.

**"The industrialised societies, exalted by technology, are in fact rediscovering archaic solutions to the problems of infertility."**

It is doubtless useful for us to recall that the industrialised societies, exalted by technology, are in fact rediscovering archaic solutions to the problems of infertility. These solutions have always been practiced by pre-industrial societies (insemination by, for example, the brother of an infertile husband). In certain African populations the biological parents are less important than in European societies, and sterile individuals maintain their place within the group (M. Vekemans, *Introduction à la Reproduction humaine*, 1992).

In the developed countries, the "social" solutions to infertility, such as adoption,

for example, are much more difficult to achieve and much more costly for the couples involved than the medical solutions. These require Health services to provide expensive and sophisticated technology.

**"In the developed countries, the "social" solutions to infertility, such as adoption, for example, are much more difficult to achieve and much more costly for the couples involved than the medical solutions."**

Dr France Donnay

# Is the treatment of infertility a luxury in a world in the middle of a population expansion?

by Marcel Vekemans



Everywhere in the world couples are saddened by not being able to satisfy their desire for a child. Often the social pressures increase their despair,

when their close relatives become involved. The outcome: depression, conflict, divorces, rejections and ostracism. Infertility is feared and reproved.

Modern medicine, however, offers preventive, diagnostic and therapeutic means of treatment, ranging from the very simple to the extremely sophisticated and onerous. They are able to cure almost 50% of cases of sterility. The people affected, the general public, the medical professions, the decision makers will obviously attempt to develop these possibilities within publicly financed health services. But health budgets are already strained. There are a number of arguments which can be advanced against this increased expense.

In the first place, sterility can be combated through behavioural changes and funding should be directed to prevention rather than curing. In the second place, excess population growth is inhibiting development. Perhaps there are more important things to do than to offer treatment for infertility, the more so as only rarely do societies nowadays base their survival on an abundance of progeny. But here we must keep things in perspective: the number of children born as the result of treatment of infertility is marginal in relation to the problem of overpopulation especially in poor countries.

Let us look at the aspect of prevention. In poor countries, the predominant cause of sterility (up to 85% of the cases) is sexually transmitted disease (STD) and pelvic inflammatory disease (PID). Prevention should be the priority of priorities, both to avoid suffering and for economic reasons. The aim should be the alteration of sexual habits (a single partner and/or the usage of condoms), correct antibiotic treatment, and the treatment of contacts. The prevention of postpartum and postabortion infections, the principal causes of pelvic inflammatory disease (PID), and the resulting tubal lesions should be energetically carried out. All countries should develop strategies in this direction and liberalise induced medical abortion.

The attempt could also be made, at least in theory, to work on other social and cultural factors contributing to sterility:

sexual mutilation, prostitution and endogamy (which increases the genetic causes). Sterility is not just an accident! Rural exodus and anarchic urbanisation, internal civil conflicts and war contribute to disrupting the traditions which principally control sexual behaviour. In these "deregulated" societies, in refugee camps, the frequency of STD is constantly increasing.

It is even more basic for societies to cease to consider the sterile individual as a "useless element" of society. This is not a utopian dream. The pleasure of individual life is of value in itself. Some people will remain without children in any case, voluntarily (for reasons of celibacy or religion) or involuntarily. If societies were more positive towards couples and adults without children, humanity would make moral progress. It would result in great psychosocial (and financial) benefits. The sterile individuals could pursue a rich life without restraint, without children or awaiting patiently a possible child, without useless and costly treatment. The social pressures would disappear. But major educational efforts will be needed. I advocate an intense, worldwide, educational campaign: to eradicate the idea of sterility as a disgrace. To make people understand that the transmission of life is not a necessity for everyone. Nothing has yet been done in this area.

**"An attempt should be made to eradicate the idea of infertility as a disgrace."**

Must the therapeutic aspects accordingly be neglected? No, but the extent of the resources available should be taken into account and several limitations should be respected: the number of children which the individuals already have (2 or 3?), the age of the woman (35 years?). Repeated diagnosis of irreversible sterility should be prevented. The investigation should not be undertaken unless both partners are prepared to submit to it (men are often hesitant). Each country should draw up, with regard to its financial position, a list of the examinations and treatments of infertility which public health services can offer to all. Leaving the wealthy, in this world of inequality, free to make recourse to private clinics or to go abroad.

In the favoured countries as well it is becoming necessary to impose limitations. The cost becomes prohibitive: a pregnancy following treatment of infertility costs 4.5 times more than usual. The result of treatment is only 50% overall and much lower for certain sophisticated techniques. Furthermore, they present ethical problems, many of which are discussed in other articles (multiple pregnancies, pregnancies in elderly women, the fate of excess embryos, the possibility of producing identical twins, the rental of a uterus, etc.).

It is evident that poor countries cannot develop assisted conception (sperm banks, in vitro fertilisation), the sophisticated diagnostic methods (laparoscopy, hysteroscopy) and the complex therapy (the technique of induced ovulation, microsurgery). The attempts described elsewhere in this issue of developing less costly techniques testify to the ingenuity of their authors but their effectiveness has not been demonstrated. At the very least, with regard to the present state of budgets and health services, we must resist the temptation to offer these services in a "high-tech hospital", supposedly public, which swallows up resources and is reserved for the favoured, to the detriment of more important activities. We must also prevent the creation of new infrastructures, personnel groups and facilities devoted to infertility. On the contrary, we should integrate simple preventive, diagnostic and treatment activities for infertility and STD into the family planning consultation, in a manner which would increase their prestige. To summarize the priorities: an attempt should be made to eradicate the idea of infertility as a disgrace. Emphasis should be placed on prevention. In each country a list of the services which the public health system can offer should be prepared and in countries with limited resources, services for family planning, STD and infertility should be integrated. Then, and only then, will dealing with sterility become more than a useless luxury.

Dr Marcel Vekemans  
John Snow Inc.  
ONAPO B.P. 914  
Kigali  
Rwanda

# The emotional impact of infertility in couples

by Ann Lalos



The problem of infertility is as old as civilization itself, and the childless marriage has always been considered a great misfortune. Religious,

cultural and social values have all set a premium on fertility. Barrenness has been viewed as a punishment imposed by the gods. Historical studies of different cultures and civilizations reveal that infertility has been regarded as the woman's problem and a barren woman was subjected to numerous humiliations. Only in the last 30 years has the male partner in an infertile couple been included in the infertility investigation. Knowledge of male factors still lags far behind knowledge of female factors involved in this disorder and there is insufficient information about the impact of childlessness on the male.

## Will the couple survive infertility, or its treatment?

Despite changing views on family size and alarming reports about overpopulation, the notion that children are an integral part of marriage is still widely accepted. A large part of human life is centered around reproduction, parenthood and the raising of a family. These attitudes and values still affect - consciously or unconsciously - those who wish to conceive but cannot do so.

Although the childless couple is more socially acceptable in modern society, there is, nevertheless, a distinct group of infertile couples who feel the pressure to bear and raise children.

These pressures, overt or covert, take many forms and most couples will feel their influence through their own family, friends, acquaintances - and even strangers. Thus, involuntary childlessness can be described as an invisible handicap and many couples experience emptiness, a sense of not belonging, a deficiency in their perspective of the future and a lack of purpose in life.

Fertility is an integral part of a person's identity and role and is associated with femininity/masculinity, sexuality, body image and self-esteem. Infertility can, therefore, create feelings of physical inferiority which can overshadow all other personal and social values. The adult who experiences the trauma of infertility has to cope with the lost ideal of him- or herself as a biological parent. For some, this means abandoning all hope of immortality. The social and psychological impact of involuntary childlessness can seriously affect a couple's sex life. Sexual disturbances

and sexual inferiority may be the most complex of many emotional problems with which an infertile couple has to cope.

## **“Most couples assume that they can have children if and when they desire.”**

Today the ability to control fertility is often taken for granted. Most couples are accustomed to thinking in terms of preventing pregnancy, and they usually assume that they can have children if and when they desire. Many couples, therefore, plan their families as meticulously as they do their education, choice of career, residential situation and major financial investments - measuring all factors and waiting until the moment to start a family is exactly right.

When a man and a woman become increasingly aware that reproduction is delayed and perhaps even unattainable, their emotional reactions will follow a pattern similar to that of any general crisis reaction. The emotional crisis is characterized by definite psychological stress and behavioral changes which put the couple at risk of maladaptive intrapsychic and interpersonal consequences. A person in crisis is extremely vulnerable and the couple often face emotional turmoil. Thus, the crisis must be dealt with individually as well as within the marital relationship.

The crisis of infertility evokes many feelings in the couple, and the first reaction seems to be one of shock, surprise, disbelief and denial. Thereafter, feelings of frustration, anger, loss of control and anxiety usually arise. Subsequent reactions often include feelings of guilt, embarrassment, disappointment, isolation, grief, depression and mourning. Nevertheless, the crisis of infertility differs from that of a general traumatic crisis in which the duration of the reactive phase is usually around six weeks. New events, hopes and disappointments prevent the adaptation to and resolution of the previous trauma (e.g. ectopic pregnancy, miscarriage or acute laparotomy). Many individuals therefore remain in a state of prolonged chronic crisis.

The psychological trauma of infertility is usually more apparent in sterile individuals. They may experience both a traumatic crisis, caused for example by the knowledge of defective fallopian tubes or azoospermia, and a developmental crisis, caused by their inability to

have children with their loved one and by being denied one of their main goals in life. If the other partner is fertile, he or she will not experience the same kind of traumatic crisis, but may suffer from a similar existential crisis. Thus, the two partners can have different reactions and exhibit different types of behavior. Furthermore they can have varying attitudes towards childlessness and sometimes conflicting opinions on how infertility influences their relationship and sexual life.

There is a risk that the existential problem of infertility in many cases may be transformed into a mainly medical problem which should be solved by medical intervention, such as tubal plastic surgery, heterologous insemination or in vitro fertilization. A major objective in the treatment of the infertile couple should instead be to facilitate a positive resolution of the crisis of infertility, regardless of whether the couple conceives or not. A couple can, however, face substantial difficulty in finding a solution to the crisis without the assistance of professional psychosocial counselling. Supportive counselling should therefore be offered throughout the investigation and treatment of infertility.

## **“Some couples choose adoption convinced that being a psychological - rather than a biological - parent is the crucial experience in childrearing.”**

Successful resolution of the crisis of infertility may result in a prospect of positive growth and increased insight. Some couples choose a life without children, fulfilling personal needs through marital love, their careers and social participation. Other choose adoption in order to share their love with a child, convinced that being a psychological - rather than a biological - parent is the crucial experience in childrearing.

Dr Ann Lalos  
University of Umeå  
Department of OB/GYN  
University Hospital  
S-901 85 Umeå  
Sweden

# To bear, or not to bear

by Silvia Tubert



In our highly medicalized society it is normal for a woman or a couple who cannot realize the wish to have a child to ask for medical assistance.

However, this signifies that the absence of a child is defined as sterility and that this, in turn, is considered an illness. These concepts do not correspond strictly to the real situation but are the product of a certain ideology.

One cannot always speak of sterility when there is no child. According to epidemiological studies there are cases of men or women who are totally sterile. The majority of these persons who experience problems of conception are however, subfertile. On the other hand it is necessary to abandon the term of "responsibility" for infertility, be it masculine or feminine. If we accept that we are talking of sterility as hypofertility we are localizing the problem in the functioning of the couple and not in the anatomy of one of its members. This is a dynamic notion very different from the static concept of "responsibility for sterility".

A hypofertile couple who consults one or more doctors, after one year or a few trial attempts to conceive, has a possibility of 75% of conceiving in the subsequent months without any type of medical intervention. In this case the real therapeutic agent is the passing of time. The problem is the anguish of the patient and the therapeutic "furor" which is dominant in our medical system both of which prompt us to undertake all types of interventions immediately. If we take into account the importance of the time factor, we could help women to undramatize the situation, thus avoiding an excess of medicalization. It is clear that the exercise of a medicalized sexuality in which the only interest would be in reproduction programmed and controlled by the medical authority is hardly an attractive prospect. If we add to this the psychological effects which repeat themselves each month we can speak of a real pathology of sexual behavior which does not at all favor the possibility of a pregnancy and can develop into a vicious circle.

To speak about sterility as illness means to define it as an anatomical or physiological problem, the solution or the consequences of which are of medical character. However, among human beings reproduction is not a mere physiological process: in the realization of maternity there is the desire of the subject. The difficulty of realizing it has psychological and social implications for which it is necessary to find comprehensive solutions which are not

limited to medical action.

From a psychological point of view, the woman who wants to have a child and cannot have it suffers from a profound narcissistic loss of self-love. This does not extend only to her body, which does not function adequately, but also affects the image that she has of herself as a woman and as a person. The most common effect is that she will feel humiliated and offended, different from other women, inferior and thus culpable, and the absence of children can be experienced as a punishment. She will tend to insist each time more strongly on her desire to have child - not only to have the child she desires but also to re-establish her self-esteem and to counteract her feelings of inferiority and guilt.

The other side of this evaluation of maternity as biological reproduction is experienced by many people as a curse or punishment. This prevents us from understanding the extent of the suffering and anxiety of women who desire to but cannot have a child and the irresistible demand made of the medical system.

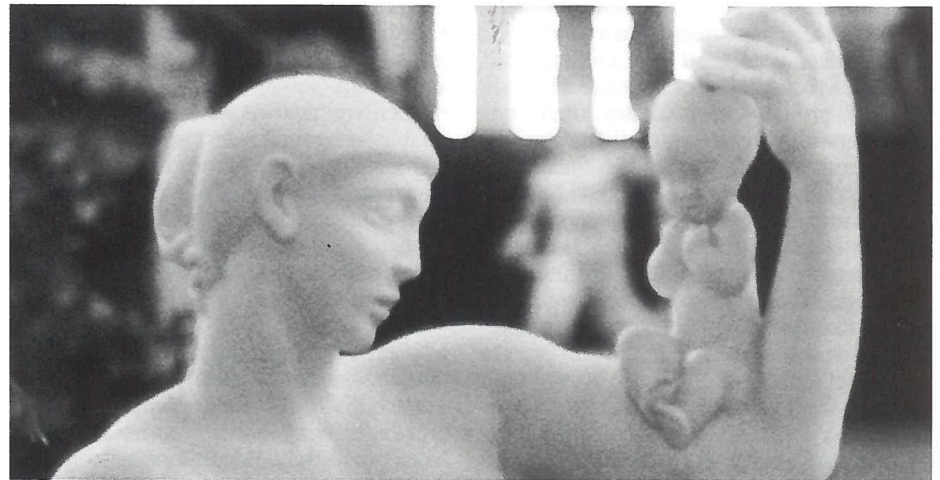


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The pressure of this demand can be very strongly felt by a medical professional who will easily feel himself obliged to respond immediately with some type of intervention.

However the medicalization of the problem of sterility produces in women major anxiety, above all when the analysis shows no results. This begins a vicious circle where doctors keep investigating "deeper and deeper into my body" as one of them said. For doctors it is important that each patient can be given an immediate answer to her question. Psychoanalysis has taught us that these questions should be put in parenthesis - that they should not be immediately answered or satisfied. The patient and the professional should allow for a period of reflection without giving

a significant value to the symptom itself in order that by speaking about it contradictory desires can be expressed.

In this sense idiopathic infertility can be considered as a real symptom. Wherever it is localized in the body, it has the same character as any psychogenic symptom, indicating a conflict which is not evident unless it is specifically investigated. It is a silent symptom which cannot be traced to a particular painful organ: it seems that the only problem is a psychological one. It is not easy to locate the obstacle to conception when the results of examinations are negative. Why then localize the feelings of anxiety and impotence in the reproductive organs?

As I have already said, we are not speaking of an illness, since infertility appears as a symptom only at the moment when the need to conceive a child arises. What we are dealing with is the impossibility of satisfying a desire. The manipulation of organs which are normally invisible and inaccessible because they are the key to the fantasies

and intentions of the individual reduces a woman to confronting her body as an object.

If we accept that infertility is not an indication that something is not functioning in a machine and by pressing a button it can be repaired we could help women by not medicalizing the problem. In this sense, it is important to promote self-help groups who, assisted by the health system when necessary, can promote alternatives such as adoption or forms of lives which are not centered exclusively around biological children.

Dr Silvia Tubert  
c/Silvano No 9  
28043 Madrid  
Spain

# UNFPA FILE

## The role of UNFPA's involvement in the management of infertility: prevention and treatment

by Matanda Sabwa



### Overview

Clinicians, epidemiologists and demographers use different terminology for infertility or subfertility.

WHO has proposed operational definitions which were detailed in recent FIGO's (International Federation of Gynaecology and Obstetrics) manual of reproduction for primary infertility, secondary infertility, pregnancy wastage, "unproven infertility" or "unproven fertility" and childlessness.<sup>1</sup>

Worldwide, some form of infertility may affect 8 to 12% of couples in their reproductive life, i.e. some 50 to 80 million people. In the majority of the cases (55% to 95%)<sup>2</sup>, primary and secondary infertility are the consequences of sexually transmitted diseases (STDs), pelvic inflammatory diseases (PID) or complications of post-abortion or post-partum infections. Patterns of sexual habits (e.g. extramarital relations, prolonged post-natal abstinence, restriction of sexual relations within marriages) can also be associated with levels of sub-fertility. Sterility affects 5.4% of couples in developed countries, its incidence in other parts of the world may be higher, due to socio-economic conditions, general health and to nutritional status.<sup>3</sup>

Although the issue of infertility would seem to be a marginal problem worldwide, in some regions and countries, the proportions of couples affected may be so high that this social and individual disaster constitutes an important public health problem. This is the case for the so-called "sterility belt" countries in sub-Saharan Africa, such as Gabon, Central African Republic and the Northern parts of Congo Republic and Zaire.

A clinical standardized investigation into the aetiology of infertility/sub-infertility through a WHO-sponsored multicentre study conducted between 1979-84 over 5,800 couples from 25 developing countries revealed:

- the majority of African couples had secondary infertility;
- African women had higher rates of STDs and pregnancy wastage than women from other regions;
- 90% of pregnancy complications were

due to infections, and 85% of women had a diagnosis attributed to tubal occlusions, pelvic adhesions and accessory gland infections.<sup>4</sup>

In a similar WHO standardized investigation of infertility on over 10,000 infertile couples in 25 countries, infection accounted for infertility in 36% of the cases in developed countries; 85% in Africa; 39% in Asia; 44% in Latin America, and 42% in the Eastern Mediterranean Region.

The implications of the above review of the problem suggest the following requirements for the management of infertility:

- specialized facilities and sophisticated techniques for the diagnosis of infertility, and
- expensive curative services needed for established infertility.

These complicated procedures not being of any help in most cases, greater efforts should therefore be directed towards preventive measures, including social and behavioral changes, to avoid the spread of infections and improve early treatment.

### UNFPA's involvement in the management of infertility

The UNFPA's mandate encompasses a broad range of population activities. Nearly half of the Fund's assistance is directed to maternal and child health care and family planning programmes. Another 18% is used for population information, education and communication.

UNFPA also helps developing countries collect and analyze population data, organize census, formulate population policies, and undertake research in fertility, mortality and migration, and their relationship to development. The Fund supports special programmes concerning women, youth, the aged, AIDS and population, and the environment.

UNFPA's involvement in management of the infertility is generally related to the extent of the problem, the feasibility of operational programmes and the importance of prevention. For those reasons, UNFPA support for diagnosis and treatment services for infertility and sub-fecundity may be considered, particularly for countries or for regions of a country where the incidence of infertility is high

and related health and social problems are serious.

- Assistance in this area is limited to:
- simple diagnostic screening to identify the cause of infertility;
  - treatment for sexually transmitted diseases (STDs) associated with infertility;
  - education and counselling designed to prevent STDs, and
  - related training activities.

Most FP services are unable to provide the full range of diagnostic and treatment services for STDs. However, support could be provided for improved recognition of the signs and symptoms of STDs, and the referral of such clients to specialized services for more complete evaluation of their conditions.

### Interagency cooperation

Infertility is a very sensitive human problem that affects the reproductive rights of couples and individuals. Its successful management is a complex process that requires a lot of facilities, expertise and financial resources which go beyond the reach of one single organization. There is also an urgent need for an active inter-agency collaboration at community level.

UNFPA promotes a coordinated and integrated approach in all its population programmes, and encourages, in collaboration with other agencies, the development of collaborative planning and coordination mechanisms in order to promote the delivery of integrated sexual and reproductive health services at country level.

Governments, multi-bilateral agencies and NGOs can also play an important advocacy role in reducing the preventable causes of sterility, and thus help to diminish the magnitude of this problem at national level.

Dr Matanda Sabwa  
Senior Technical Officer  
MCH/FP Branch  
Technical and Evaluation Division  
United Nations Population Fund  
220 East, 42nd Street  
New York, N.Y. 10017  
USA

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# WHO FILE

## Reproductive health legislation in Central and Eastern Europe: new developments\*

by S.S. Fluss



**WHO's Health Legislation Unit in Geneva has been carefully monitoring all significant laws, regulations, and other legal instru-**

**ments dealing with reproductive health both in the European Region and in other Regions. While WHO has no mandate to express any views concerning the appropriateness of particular legislative approaches to critical issues in reproductive health, it clearly does have a mandate to report and transmit information (pursuant to Article 63 of the Constitution) to its Member States concerning legislative and other developments in the health and related sectors. We report below on some items of legislation that have been promulgated or issued in various countries in the European Region, all of which have undergone political, economic, social and legal changes over the last few years.**

In the Russian Federation, the years 1992 and 1993 were characterized by a significant amount of legislative activity in the maternal and child health fields. From the institutional standpoint, reference should be made to a Decree issued on 20 January 1992 by the President of the Russian Federation establishing a Coordinating Committee on Family, Maternity and Childhood Problems. This Committee, under the direct jurisdiction of the President, seeks to ensure concertation between State agencies, public and other organizations, and citizens towards the achievement of a unified family policy at the level of the State, as well as a policy for improving the status of women and the protection of maternity and childhood. It also seeks to implement the goals formulated by the United Nations General Assembly for the period 1992-1995 in relation to the family, the status of women, and the rights of the child.

After a substantial process of consultations (including intensive consultations involving WHO), the erstwhile Supreme Soviet adopted the "Principles of the legislation of the Russian Federation on the protection of the health of citizens"

on 22 July 1993. The Preamble to this important text places strong emphasis on the protection of civil and human rights and freedoms in the field of health protection and recognizes the fundamental role of health protection. Part V deals with the rights of certain population groups in the field of health protection; thus, it is laid down that the State is to guarantee pregnant women the right to work under conditions that are appropriate to their physiological circumstances and their state of health. The rights of minors are likewise specified; thus, minors above 15 years of age have the right to give their free and informed consent to medical procedures, or to refuse such procedures. Part VII deals with family planning and the regulation of human reproduction. The Section dealing with artificial insemination and embryo implantation prescribes that every woman who has reached the age of majority and is of child-bearing age is entitled to benefit from these procedures. With regard to voluntary termination of pregnancy, it is laid down that every woman has the right to decide for herself whether she wishes to carry the pregnancy to term. Voluntary termination is carried out at the woman's request, within the first 12 weeks of pregnancy; the period may be extended to 22 weeks in the presence of medical indications, with the woman's consent. As regards sterilization, it is laid down that this may only be performed in response to a written declaration by the person concerned, who must be at least 35 years of age or have at least two children; however, where there are medical indications, and subject to the person's consent, there are no criteria as regards age or number of children.

In the case of Kyrgyzstan, a 1992 Law on the protection of public health proclaims that every woman has the right to take her own decisions as to maternity. For purposes of health protection, a woman may, with her consent, undergo modern methods of prevention of unwanted pregnancy. Sterilization may be performed only with the woman's consent, on medical indications (a list of these indications is to be drawn up by the Ministry of Public Health).

In another of the Newly Independent States, Ukraine, a Long-Term Programme for the Improvement of the Condition of Women and Families, and for Maternal and Child Protection, was adopted by the Cabinet of Ministers on 28 July 1992. It seeks to: improve women's conditions in the production sector; improve the living conditions of women with children; and protect maternal and child health.

Many readers of this magazine will be aware of the Hungarian Law of December 1992 on the protection of the life of the fetus, and the Ordinance for its implementation issued by the Minister of Social Welfare in December 1992. The Preamble to the Law indicates that Parliament of the Hungarian Republic is conscious that: "the life of the fetus must be respected and protected from the time of conception; the protection and the life of the fetus can be assured only by granting increased assistance to pregnant women, the responsibility for assuring conditions enabling the healthy development of the fetus devolving upon the parents in the first instance; pregnancy termination cannot be considered as a means of family planning or birth control; and family planning is both a right and a responsibility on the part of the parents". Within the confines of this article, it is not possible to enter into any detail on the substantive provisions of the Law; it is however noteworthy that emphasis is placed on the transmission of information to schoolchildren, pregnant women, and the public at large. Thus, it is laid down that primary and secondary educational establishments are to provide education concerning the value of human health and life, how to lead a healthy life, the responsibilities entailed by relations between partners, and a family life that is consonant with human dignity, as well as means of contraception that are not harmful to health. Within the framework of prenatal services, pregnant women are to receive information concerning the lifestyle to be followed in order to ensure the healthy development of the fetus, appropriate diet, and the need to avoid factors liable to harm the fetus (including, in particular,

alcohol and tobacco consumption).

An Albanian Decision of May 1992 endorses family planning activities in the country, while in Romania a 1990 Order approved technical standards for hormonal contraceptives and intrauterine devices (in December 1989, a Romanian Decree-Law, enacted by the Council of the National Salvation Front, repealed earlier legislation on abortion).

Finally, reference should be made to the Polish Law of January 1993 on family planning, protection of human fetuses, and the conditions under which pregnancy termination is permissible. Here again, space constraints preclude any detailed discussion of the contents of this statute, although it is noteworthy that, under Section 1, "Every human being shall have a natural right to life as from the time of his conception". The detailed provisions under which an abortion is permissible in a health care

establishment in the public sector are as follows:

1. the pregnancy is endangering the mother's life or seriously jeopardizing her health, according to the diagnosis of two physicians other than the physician carrying out the procedure, - such diagnosis being unnecessary if the threat to the mother's life has to be eliminated immediately;
2. the death of the unborn child is due to measures taken to save the mother's life or prevent serious injury to her health, this risk having been diagnosed by two other physicians;
3. a prenatal diagnosis established by two physicians other than the physician carrying out the procedure ... has demonstrated the presence of a serious and irremediable defect in the fetus; or
4. there are valid reasons, confirmed by an attestation on the part of the Office

of the Public Prosecutor, for suspecting that the pregnancy resulted from an unlawful act.

Mr S. S. Fluss  
Chief, Health Legislation  
World Health Organization  
Geneva  
Switzerland

\* It should be emphasized that this informal article does not purport to present the legislation covered in an official manner; readers are referred to the original texts of the various legal instruments cited in the article. Most have been reported in the WHO quarterly journal, the *International Digest of Health Legislation*, and its French-language counterpart, the *Recueil International de Législation Sanitaire*.

## EUROPEAN NEWS

# SECS - An active organization in Romania



One of the first laws changed in Romania when the former regime fell was the law on abortions. Abortions became legal on request in

December 1989 during the first 12 weeks of pregnancy. But there was still an absence of contraceptives, and of any kind of information regarding family planning and sex education. Therefore a group of 20 volunteers created SECS, the Society for Education in Sexuality and Contraception.

Under the old regime no contraceptives were available and there was a campaign in the media against contraception. IUD insertion and surgical sterilization were illegal under any circumstances. Abortions were only permitted for women older than 45 with more than five children, or for medical reasons. During this period unsafe, illegal abortion was practiced widely, which made maternal mortality rate the highest in Europe. The total maternal death rate was 1.69 deaths per 1000 live-births. Of these, 1.47 deaths were attributed to illegal abortions. After the repeal of the law, the number of abortions has remained high, with a rate of 4 abortions for each birth, but the maternal death rate has fallen sharply.

SECS is a non-profit, non-governmental and non-political association.

It has grown since 1989 and is now actively involved in all aspects of family planning information, education, training and service delivery.

In 1992, the organization became affiliated to IPPF. Initially the role of SECS was to lobby for a national family planning programme, to start training activities for health professionals and to set up model family planning clinics.

At the present time, Romania has a national programme for family planning within which governmental family planning services will be set up all over the country in Mother and Child Health Centres.

SECS will continue to run its six model clinics, but will orientate its activities more towards information and promotion as well as motivation of professionals to provide family planning service to their patients. Activities such as provision of condoms for soldiers and information and consultation on family planning at holiday resorts have started on a pilot basis and will be extended.

### A drop in the ocean

One of the model clinics is placed in Timisoara in North-West Romania. It opened in April 1993. Since that time the clinic has been fully operational, but it is only a drop in the ocean. With the average of 200 clients per month, the clinic might potentially reach 2400 clients per year. This number should be

compared with the 19,200 abortions taking place each year in Timisoara. 50,000 women are in need of contraception. Practically no contraceptives are prescribed through governmental clinics.

In general, family planning has a very low priority at the gynecological departments of the university clinics.

The situation in Timisoara is not unique. It only illustrates the sort of problems SECS are facing.

SECS is financed by two donor organizations, CEDPA and IPPF. All services offered by SECS at present are provided for a minimal fee. Students do not pay for consultations or contraceptives, neither do the unemployed or people with more than three children.

Despite this only 2% of the clinic costs are covered by these contributions. Hopefully, other resources will be found in the future.

Edited by Dr Beth Pedersen, based on:

1. 1992 Annual Report of SECS
2. SECS - Profile
3. IPPF secretariat trip report, June/July 1993 by Dr A. Brandrup- Lukanow

# Raise in the use of family planning for migrant workers

by Muhsin Akbaba

By giving intensive education at suitable off-work hours parallel to primary health care services a 10% family planning method usage rate was raised to almost 50% in a group of migrant workers in Turkey.

These are the results of a programme carried out in Adana, in the Southern part of Turkey. Adana is the fourth largest city of the country and about 100,000 migrant workers arrive every year from spring to fall to work in the cotton fields. About 40,000 of these workers arrive at the territories of Dogankent Health Region of Cukurova University which itself is a region with 50,000 native inhabitants. The migrant workers are young, of fertile age and have many children. The mean number of children alive was 4.3; 40% of women have had a previous abortion and 62% lost one child. 70% of the migrant workers are illiterate. The workers mostly come from the eastern cities where the birth rates are highest compared to the other parts of Turkey.

The programme was carried out by Dr Muhsin Akbaba and Dr Nazan Alparlan

from Cukurova University in cooperation with three health centres of Adana.

Between April and October 1989, a little more than 3000 of the migrant workers were interviewed and given information about contraceptive mix. Their initial attitudes and subsequent changes were registered. This service was given in integration with the primary health care assistance in the form of out-patient care, vaccination, mother-and-child health care, and environmental health services. Six months later a follow-up was carried out.

At each of the three health centres, a team made up of a doctor, one health official, one nurse and a midwife visited the tents of the migrant workers during off-work hours and gave face-to-face education to the workers gathered in groups of 15-20. Every group was visited periodically once a month and contraceptive supplies, needs and claims for method changes were dealt with. When the programme ended, after the return of the migrant workers to their native villages, official letters were written to the doctors of the health

centres in those villages, so that follow up was possible.

Close to 80% of the 3000 workers that initially used some kind of traditional family planning method, switched to effective ones, namely IUDs, pills, condoms, foam tablets and tubal ligation. When the programme ended close to half of the 3000 people were either themselves or their spouse using modern contraceptives. 78% started up using pills or condoms, the remaining ones used foam tablets (18%), and IUD (10%).

Dr Muhsin Akbaba  
Associate Professor  
and  
Dr Nazan Alparlan  
Associate Professor  
Cukurova University  
Medical Faculty  
Public Health Department  
01330 Adana  
Turkey



# EURO works on infertility

The WHO Regional Office for Europe has, on various occasions, organised review sessions regarding the problem of infertility.

In 1985, a seminar on artificial reproduction focused on the ethical, medical and psychosocial aspects of the techniques of assisted conception, including the following topics:

- artificial insemination by donor (AID): the selection, payment and anonymity of the donors, the evolution and legal belonging of children, private sperm banks;
- in vitro fertilisation (IVF): the cost of various techniques, embryo or pre-embryo banks;
- the problems of bearer mothers and donor mothers were discussed, with reference to the fact that in the UK (since 1984) and Denmark (since 1986) these practices have been prohibited (the legal limitations, rights of the child).

(Source: Artificial Reproduction, WHO Regional Office for Europe, 1986)

In 1990, specialists in assisted conception, epidemiologists, sociologists and economists were called together for a consultation in Copenhagen and reached agreement on the following proposals:

- an infertile couple should be given the opportunity of making an informed choice between medical and social solutions;
- adoption is often subject to severe restrictions and is more expensive for the couple, who must undergo a longer waiting period than if they chose assisted conception, which also is partially subsidized by social security;
- assisted conception, and in vitro fertilisation with embryo transfer (IVF/ET), should be subjected to strict assessment:
- as to the results, calculated in terms of live births per 100 treatment cycles;
- as to the estimated costs, with the inclusion of all elements, such as the increased risk of neonatal pathology, due especially to multiple pregnancies, the increased number of Caesarian

- sections performed, etc.;
- as to the approval of the centres in a given country;
- as to indications of who is eligible, with possibility of inclusion of certain fertile couples who are at risk of genetic disorder;
- as to the surveillance of the quality of the services;
- universal access within the prescribed limits, without consideration of race or income;
- as to whether the patients are informed of their rights (especially within the context of medical research, on the preservation of frozen pre-embryos, etc.).

(Source: Consultation on the Place of IVF in Infertility Care, WHO Regional Office for Europe, 1990)

Dr France Donnay

## Note from Estonia: From abortion to contraception

by Daniel Pierotti

Estonia is a newly independent state of the former USSR, located between Latvia, Russia and Finland, with 1.5 million people.

The rate of abortion is extremely high. In 1991, there were 158 abortions per 100 live births.

With the political changes and the aggravation of the economic situation, Estonia has to fight its own way to switch from a centrally planned economy to a market economy. To quote the Minister of Health "Abortion is a social norm in Estonia and the situation has recently worsened as the traditional suppliers of contraceptive products have vanished". Due to conflicting priorities in the Ministry of Health, there are no funds available or earmarked to buy contraceptive supplies.

Abortions are performed in a safe environment, which explains the absence of death from abortion.

Contraceptive prevalence is said to be approaching 23% for IUDs and another 7% for contraceptive pills. Contraceptive supplies are only obtained with difficulty

and at a very high cost. One month's supply of pills costs approximately 8 to 10% of a basic monthly salary.

The Swedish International Development Agency, through the Göteborg University Community Medicine Department, and the World Health Organization, has granted US \$ 135 000 for MCH/FP and an information campaign among women.

The family planning component, planned for a two-year duration on an experimental basis, will consist of reducing the number of women having an abortion from January 1993 to December 1994 in Tallinn.

The project will consist in informing women on contraceptive measures and giving clinical examination and family planning services free of charge, or at extremely low cost, in immediate post-abortion or through subsequent appointments.

To complement this, information material will be devised for women, guidelines printed for gynecologists and an information service organized before

the start of the project for concerned personnel.

Among the objectives: strengthening family planning at national level through the creation of a central administration at the Ministry of Social Affairs; decreasing abortion by 80% in selected areas in Tallinn among 1750 women having an abortion from July 1993 to July 1994; improving family planning services offered to 2000 teenagers; and giving family planning services to women delivering in Tallinn hospital.

This project, which is regarded as an experimental pilot project, will be evaluated after 18 months. Depending upon the results, an extension will be considered.

Dr Tomberg, Dr Karro, Dr Svanberg, Dr Petersson, Dr Pierotti and Dr Brandrup-Lukanow have and will be participating in this project at various stages of development.

# Abortion legislation in Europe, 1991-1993

by Henry P. David

During 1991-1993, Albania, Hungary, and Poland changed abortion legislation. In Germany, the prevailing law was overturned by the Constitutional Court. Henry P. David reports on the current situation.

On 15 June 1991, by a Ministry of Health Directive, Albania revoked its law permitting abortion only on narrowly defined grounds. The new directive makes abortion available on request up to 12 weeks, for social reasons up to 15 weeks, and on medical grounds without time limit. The Council of Ministers approved the Directive by Decision No. 226 of 27 May 1992. Since legalization of abortion in 1991, and the possible greater availability of contraceptives in maternity clinics, women's health centers, and pharmacies, abortion-related maternal mortality decreased from 57% to 32% of all maternal mortality in 1992.

In Hungary, Parliament, on 17 December 1992, approved a new "law on the protection of fetal life." Legal abortion continues to be available in the first twelve weeks of gestation if there is a grave danger to the health of the pregnant woman, if there is a grave danger or a handicap or defect to the fetus, if the woman was raped, or if the pregnancy has caused a "grave crisis situation" for the woman. Counseling on contraceptives and on abortion alternatives with a representative of the Family Protection Office is mandatory. Women must wait three days after counseling but not more than eight days before the procedure can be performed. The "grave crisis situation" is defined by the pregnant women and is considered a private matter that does not have to be discussed during counseling. Minors must have parental consent. In actual practice, abortion continues to be readily available but the reported numbers are decreasing.

In Poland, a strict anti-abortion law became effective on 15 March 1993, following approval by a one vote margin in the Upper House of Parliament. Known as the Law on Family Planning, Human Embryos Protection, and Conditions of Abortion, it overturned the liberal 1956 legislation and permits abortion in public hospitals (never in private clinics) only when there is a demonstrated threat to the life or health of the pregnant women (as certified by three physicians); "serious and irreversible malformation of the fetus (as documented by prenatal tests in cases with a known history of genetic illness), or when a public prosecutor renders a formal finding that the pregnancy

resulted from a criminal act such as rape or incest. Physicians performing clandestine abortions are liable to a penalty of up to two years imprisonment, or ten years if the woman dies from complications. The Polish Bishops Conference expressed regret about any exceptions while public opinion polls showed that most respondents want access to legal abortion. The law also has a clause obligating the government to provide sex education in the schools and to assure ready availability of contraceptives throughout Poland. These provisions have yet to be implemented; contraceptives remain in short supply. A few days after the law's effective date, travel agencies began offering "a full range of gynecological services" across the border in Russia and the Ukraine with costs about equal to one month salary for a nurse. Deaths from self-induced abortions are increasing. Poland joined Andorra, Ireland, and Malta as the only countries in Europe where abortion is strictly prohibited except for narrowly defined medical reasons.

In Germany, on 28 May 1993, the Constitutional Court in a 6:2 decision declared unconstitutional a law designed to strike a compromise between abortion provisions prevailing in East and West Germany before unification. The Court held that Parliament had violated a

constitutional guarantee protecting the life of the fetus. Until Parliament passes new legislation, abortion remains illegal, except for narrowly specified situations involving rape, incest, or fetal malformation. However, no punishment is imposed on the woman or her physician in the first 12 weeks of pregnancy, provided she attends mandatory counseling, which, the justices ruled, "must be oriented to the protection of unborn life." Abortion services could no longer be provided in state facilities and cannot be subsidized by social assistance funds or by statutory or private insurance plans (except for cases permitted under the ruling).

Professor Henry P. David,  
Director,  
Transnational Family  
Research Institute  
8307 Whitman Drive  
Bethesda, Maryland 20817  
USA

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# RESEARCH

## Male fertility regulation: The challenges for the year 2000

**"Male fertility regulation: the challenges for the year 2000" is an article published in the British Medical Journal (1993) Vol 49, No 1, pp 222-236. Entre Nous found it very interesting and in order to present a short review on the search for new, safe effective and reversible contraceptive methods for men, the article was shortened with permission of the author Dr G.M.H. Waites.**

Research to develop safe, effective, reversible and acceptable methods of fertility regulation for men has been supported by several international agencies, many national research councils and some pharmaceutical companies. Recently, through increased public awareness, statements supporting research on male methods and the greater involvement of men in reproductive health have been forthcoming from several quarters, including international women's organizations. Together with strong support from the governments of some developing countries with major population growth, e.g. the People's Republic of China and Indonesia, these trends are encouraging.

This article will attempt to show the global implications and to suggest the likely future developments until the year 2000.

### Vas occlusion

Prevalence of vasectomy can be taken as a measure of male participation in family planning programmes. The rates vary widely, with the developed countries of North America and Europe having higher prevalence rates compared with those of most developing countries.

The safety of surgical vasectomy has been carefully monitored in the interests of the reproductive health of men.

Different studies have shown vasectomy to be associated with cardiovascular ill-health, predisposition to prostate cancer and possibly to pre-existing testicular tumours. A WHO Consultation reviewed the available evidence and reported the following as its main conclusions: . any causal relationship between vasectomy and the risk of cancer of the prostate or testis is unlikely; . no changes in family planning policies are warranted.

While these conclusions are encouraging, it will be important to continue to monitor the safety of vasectomy.

It has been recognized for some time that two main factors limit the acceptability of vas occlusion: one is the necessity for a skin incision, which is unacceptable in some cultures, and the other is the lack of certain reversibility should the circumstances require this. Amongst many attempts to develop simplified methods to overcome these limitations, research in China, which started in 1970, has led to two major technical improvements: the isolation and ligation of the vas through a puncture (non-scalpel) opening in the skin; and the development of a technique for the percutaneous injection into the vas lumen of sclerosing or occluding agents through a hypodermic needle.

### Hormonal methods

The suppression of sperm production by hormonal means has been a general research strategy for all agencies interested in male contraception. There are 3 main aspects to this strategy: the suppression of the secretion of gonadotrophins, either of both LH and FSH or of FSH alone; the recovery of circulating androgen to physiological levels without re-stimulation of spermatogenesis; and the assessment of the functional capacity of residual sperm, should the treatment fail to achieve azoospermia in all cases.

For the World Health Organization, a major consideration is the affordability of the drugs for use in developing countries. To date, suppression of spermatogenesis by hormonal means has been shown to be fully reversible in all clinical and non-human primate studies.

The first ever multicentre contraceptive efficacy study of normal men receiving a prototype hormonal regimen of testosterone, which was conducted during 1986-1990, provided convincing evidence that, once the laboratory diagnosis of azoospermia had been achieved, normal men were rendered infertile and able to sustain safe, effective and reversible contraception for at least 12 months. There were variations in the rate of achievement of azoospermia among men of the same genetic background. Also, men in the Chinese centres achieved azoospermia more frequently than men in the Caucasian centres. The second stage, to find out if hormonally-induced severe oligozoospermia is associated with an acceptable level of contraceptive efficacy, started in 1990. If this study demonstrates that the contraceptive efficacy is high even when spermatogenesis is not fully suppressed,

the goal of developing a male hormonal antifertility agent will be greatly simplified.

The studies on androgen suppression of spermatogenesis to date have been conducted with relatively short-acting preparations. More physiological means of androgen replacement with prolonged duration would be needed, not only for the treatment of male hypogonadism but also in the development of all types of hormonal methods for men. These are now becoming available, for example biodegradable testosterone microcapsules and testosterone pellets.

Studies in the 1970s with progestogen-androgen hormonal regimens established their safety and relative effectiveness in sperm suppression in Caucasian men but rarely achieved more than 50% incidence of azoospermia. Recently, Indonesian studies have shown that the azoospermia rate with different combinations of androgen and progesterone reached more than 97% during 6 months of treatment.

These studies, together with the results of the multicentre contraceptive efficacy studies, have underlined the importance of comparing the pharmacokinetics and pharmacodynamics of contraceptive steroids in men of different ethnic origins. They have also rekindled interest in the potential of a combination contraceptive drug regimen based on long-acting progestogens and androgens. One advantage of such a regimen would be that the dose of exogenous androgen required would be much less than in an androgen-alone approach.

Clinical studies and studies in non-human primates have shown that GnRH antagonists are more potent in the suppression of gonadotrophin secretion and of sperm production than are GnRH agonists. Research on these compounds is well justified for their application for the treatment of cancers but the cost of synthesis of peptide hormones such as the GnRH antagonists is likely to remain too high for contraceptive use in developing countries.

Just as it has been important to monitor the safety of the contraceptive steroids used by women, it is equally important to establish the safety of such methods for men. All assessment protocols routinely include a wide range of conventional clinical chemistry assessments to monitor general health status. Medical discontinuations in the contraceptive efficacy studies were infrequent and mostly due to acne.

Current clinical studies should include more sophisticated monitoring procedures when available, including prostate size by ultrasound or by measurement of prostate-specific antigen.

#### **Other agents acting on spermatogenesis**

A large number of chemical agents have been described but all tend to lead to total spermatogenic arrest and, ultimately, to irreversible sterility. Gossypol was one of the more attractive drugs in this category. It was identified as an antifertility agent by Chinese scientists and clinical studies on more than 8000 men were conducted. Because of the high incidence of irreversibility and potentially serious side effects such as hypokalaemia, gossypol use for contraception has been discontinued.

Physical agents such as irradiation, ultrasound and high temperature also lead to spermatogenic arrest when applied at certain dose levels. Their limitations for contraceptive application lie in the equipment needed and the careful monitoring of the dosage that is required to avoid irreversible damage. One exception is the local application of heat. Recent clinical studies have shown that long-term mild elevation (1-2 degrees C) of temperature by the simple expedient of close apposition of the testes to the abdominal cavity during waking hours can lead to azoospermia or severe oligozoospermia. Evidence is being accumulated on the safe reversibility, contraceptive efficacy and potential acceptability of this simple and inexpensive procedure.

#### **Inhibition of sperm maturation**

A reversible, post-testicular drug action on the normal function of sperm stored in the epididymis would be rapid in onset and, on withdrawal of the drug, normal sperm would return quickly in the ejaculate. Clearly this approach would have some major advantages over hormonal methods. There would be no disruption of normal endocrine function and the long latent period required to suppress spermatogenesis would be avoided. Since sperm spend only a relatively short time in the epididymis (3-10 days in the human), any interference with their competence at this stage would be more likely to involve their motility, capacitation and/or the acrosome reaction-events specific to sperm.

Many chemical compounds with reversible effects on sperm stored in the epididymis have been described but all have been discarded because of their toxicity. Alpha-chlorohydrin and the 6-chloro-6- deoxy sugars were amongst the more interesting and best explored. They at least established that the principle was attainable and, at anti-fertility doses, demonstrated the ideal characteristics of a post-testicular drug. A variety of other compounds and their analogues are currently under invest-

igation by various agencies, e.g. sulphasalazines, imidazoles, pyrimethamine.

A collaborative programme has been established between Chinese, Thai and UK centres to isolate, identify and screen pure compounds extracted from the plant *Tripterygium wilfordii*, long used in Chinese traditional medicine. It is known to reduce sperm motility and concentration.

#### **Contraceptive vaccines**

Passive or active immunization against FSH has resulted in significant decreases in sperm counts in macaque monkeys but inconsistent effects on fertility. The Population Council has developed a vaccine strategy based on GnRH. Several agencies are supporting studies to establish if sperm surface proteins, crucial for sperm-egg interactions, offer hope as immunogens for the development of a vaccine. However, such a vaccine would be more likely to lead to a contraceptive method for the female, given the difficulty of access of antibodies to the male reproductive tract.

#### **Year 2000**

There is reasonable hope that, by the year 2000, there may be methods for men based on infrequent steroid injections, reversible vas occlusive systems and possibly other affordable options. However, unless serendipity turns up a post-testicular drug already in clinical use for another application, it seems unlikely that any newly discovered drug could be developed through the long and expensive route of toxicological and regulatory requirements by the end of the century.

On the other hand, several events could dramatically accelerate the process. Since the major demographic increases are occurring in the developing world, an understanding of the basis of ethnic differences in response to contraceptive steroids, and possibly other methods, could lead to appropriate options not, as in the past, required to be based on the physiology of Caucasian men. A recovery of interest by the pharmaceutical industry would also be a major factor. Several other events could accelerate the quest. For example, the identification of simple biochemical tests of sperm function, together with their transformation into home-use, "dipstick", methods by which a man could check his own fertility status, would be one significant achievement.

Perhaps the most important factor of all is the acknowledgement that men everywhere have the right and obligation to share in family planning options. The ease with which clinical studies attract volunteers suggests that the new generation of men is more ready to respond than has been generally believed.

Dr G.M.H. Waites  
Special Programme of Research,  
Development and Research  
Training in Human Reproduction.  
World Health Organization  
20, avenue Appia  
CH-1211 Geneva 27  
Switzerland

*Photo: WHO / Jørgen Schytte®*



## WORLD NEWS

# Vietnam is overloaded by abortion practice with limited use of contraceptive methods

In February 1993, Dr France Donnay visited Vietnamese family planning centers and major obstetric and gynecological institutions. This is a summary of her trip report.

In the main health institutions a huge number of patients were waiting for abortions, with family planning consultancy rooms almost deserted.

The abortion procedures are done very quickly, lasting no more than two minutes per patient. After an examination by a midwife the procedure is performed by a doctor. Anaesthesia is rarely used. In the North, the D and C technique is still predominant, in the South either a Karman syringe, in the early stage of pregnancies or a vacuum pump are used. For second trimester abortions, D and C or sodium hypertonic solution are the methods offered. After the abortion the woman rests for half an hour before going home, sometimes riding her bicycle or a motorcycle. Vietnam has strict rules on sexuality before marriage, and pregnancies in adolescents are infrequent. At the obstetric/gynecological hospital in Hanoi, 7% of the abortions were requested by adolescents.

Abortion is used as a fertility regulation method in Vietnam. The abortion ratio is from two to four abortions for each birth. The official figures are lower. In 1992, there were 2 million deliveries for 1.3 million abortions. The total population is 68 million. Half of the fertile population do not use any contraceptive method. One third use an IUD, 8% the rhythm method and 7% withdrawal. In 1992, the mean number of children was 3.2.

### Contraceptive advice

The women were supposed to get counselling on contraceptives while waiting in the institutions for the abortion procedure. This did not seem to happen. Thirty to fifty procedures are routinely practiced in 2-hour sessions, including sterilization of all instruments. There is hardly time to have individual or collective counselling for patients.

When a woman requests an abortion, the procedure is performed the same day. She has no opportunity to discuss contraceptive use beforehand with her husband and eventually obtain the agreement of her family.



Photo: Christina Borella®

### Modern methods

There is a high level of knowledge of family planning methods, including abortion. Around 90% of the women know of at least one modern method, and about half of them had at a certain period used a modern method. Few fears or prejudices about modern contraception exist. The providers have strong ideas about possible reactions to modern methods, stating that most women are unable to take pills, IUD is by far the best solution, or sterilization for older women. Female sterilization is more common than male sterilization, 2.5% of women have had tubal ligation and 0.5% of men had a vasectomy. Vasectomy has been promoted through a campaign which included incentives.

### Training

The professionals practicing are predominately women (80% of the doctors and all nurses and midwives). We were impressed by the discrepancy between gentle technical procedures and coolness of relationships.

During their three year training the midwives get a one-week session on family planning techniques. They are allowed to perform MR, IUD insertion and removal. Medical students have to serve in obstetric/gynecological departments for 20 weeks. The general practitioners attend a special training to

perform MR, abortions and IUD insertion. Some have been trained in sterilization with quinacrine.

Equipment and antiseptics are very much needed for the abortions. Educational training material would be of great use, as well as training in pedagogical skills.

Dr France Donnay

## The Infant King

In various developing countries "foetology" has become very popular: the determination of the sex of the infant, caring for high-risk pregnancies, and assisted conception. These techniques are expensive and an Indian team recently proposed replacing the in vitro fertilisation and incubation of the embryos with a natural incubation in the vagina of the future mother. The tube is placed there for a 24-hour period, after which the transfer of the embryo or embryos to the uterus is carried out.

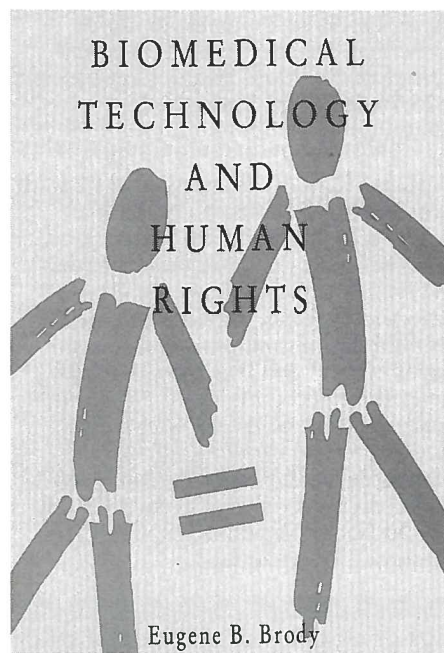
(Malpani, *Human Reproduction*, Vol 7, No. 22, 1992)



# RESOURCES

## Books

**Biomedical Technology and Human Rights**, by Eugene B. Brody (1993) is a timely book which tackles the problem of possible conflict between human rights and new biomedical technology, covering many crucial areas, from reproductive technology to organ transplants, from gene manipulation to the right to die legislation. Along with questions raised, it lists the findings of conferences and commissions on this subject, as well as details of practices and laws all over the world. Available from: UNESCO Publishing, 7, place de Fontenoy, 75352 Paris 07-SP. Co-published with Dartmouth Publishing Co. Ltd, who has exclusive sales rights in the USA and the UK. ISBN 92-3-102806-5. Price: French francs 215.



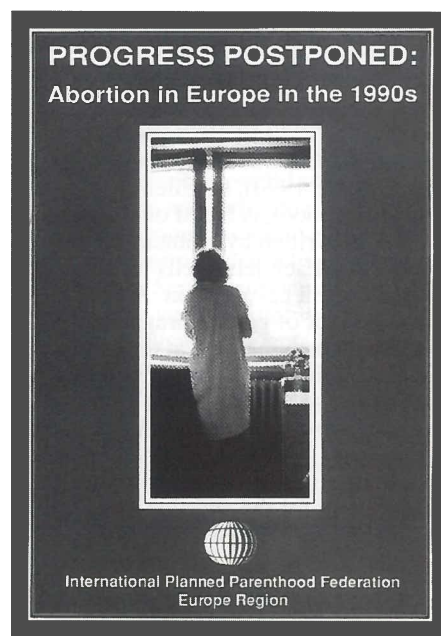
**Tough choices. In Vitro Fertilization and the Reproductive Technologies**, edited by Patricia Stephenson and Mardsen G. Wagner (1993). This timely collection of articles discusses medical and social options for couples facing infertility; the effectiveness, safety, costs, and benefits of the new reproductive technologies; and some of the legal and ethical issues surrounding the use of these services. Bringing together key issues in health policy analysis, this volume argues for a public health approach to infertility, maintaining that far too little attention has been given to the important social, ethical, and legal issues involved. Available from Temple University Press, Philadelphia 19122, USA. ISBN 1-56639-060-5.

**Diagnosis and Treatment of Infertility**, by P.J. Rowe/E.M. Vikhlyeva, Editors (1988). The investigation and management of the infertile couple remains haphazard and lacks standardization in terminology and diagnostic procedures. This has resulted in conflicting claims as to the accuracy of various diagnoses and the appropriateness and efficacy of treatment regimens. In an attempt to rectify this situation, The World Health Organization's Special Programme of Research, Development and Research Training in Human Reproduction has developed and tested, in 8500 couples, a protocol and data collection forms for a standardized investigation of the infertile couple. This approach has proved so successful in the 33 centres in 24 countries worldwide, that a simplified management of the infertile couple has now been adopted. This book is the compilation of the papers presented at a symposium on the diagnosis and treatment of infertility in Yerevan in 1985. Published on behalf of WHO (Special Programme of Research, Development, and Research Training in Human Reproduction) by Hans Huber Publishers. Bern - Stuttgart - Toronto - Lewiston N.Y. ISBN 0-920887-14-7. ISBN 3-456-81537-9.

**Teaching tools for health professionals**, by Luc G. Van Parijs and Betsy Abraham, TALMILEP, (1993). The purpose of this book is to provide health professionals with a guide to the selection and use of seven of the most widely available and effective tools for teaching. It also provides an understanding of the principles of teaching and learning that are relevant for using those tools. Distribution: Teaching and Learning Materials, The Leprosy Mission, 80 Windmill Road, Brentford, Middlesex TW80QH, United Kingdom. Tel: (44) 81 5697292. Fax: (44) 81 5697808. ISBN: 90-9006496-6.

**Adolescent Sexual and Reproductive Health**. (1992). Report of an international workshop presenting a variety of experiences from programmes in the following countries: Brazil, Burkina Faso, Canada, Ethiopia, France, Jamaica, Mexico, Netherlands, Senegal and Switzerland. These proceedings are essential reading for any professional working with young people on issues related to adolescent's health and sexual maturation, whether they be in medical, community based or educational programmes. Editors: Assia Brandrup-Lukanow (GTZ), Sylvie Mansour (CIE), Kirstan Hawkins (IPPF). Price: 10£. ISBN 2 900 498-18-X.

**Progress Postponed: Abortion in Europe in the 1990's** (1993), brings together political, social and technological aspects of the abortion issue as they manifest themselves in Europe today. Twelve chapters cover specific areas, including women's perspectives on abortion, the role of the law, abortion, contraception and ethnic minorities, psychosocial effects of early and late abortion, and services for adolescents, while other chapters outline the situation regarding contraception and abortion throughout Europe, and in the former Soviet Union, and perspectives on RU-486 - the so-called "abortion pill". Available from: Europe Region, IPPF, Regents College, Inner Circle, Regents Park, London NW1 4NS, United Kingdom. ISBN 0 904983 18 8. Price US \$10.00.

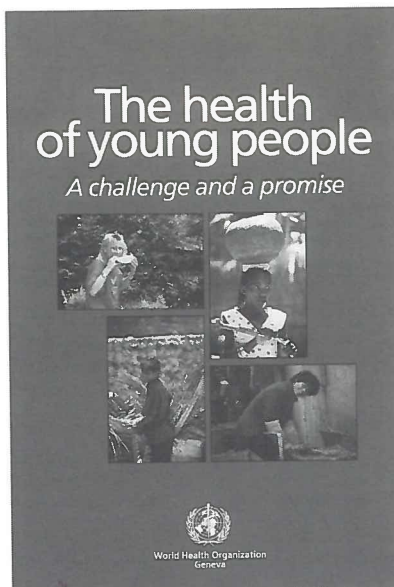


**Recent Advances in Medically assisted conception**. This report of a WHO Scientific Group examines the development of medically assisted conception, including artificial insemination, in vitro fertilization and related techniques, and discusses both medical indications for their use and recent technical advances in methodology. In reviewing the results of these methods of infertility treatment, the report identifies requirements for personnel, equipment, and quality assurance, as well as for future research in such areas as sperm abnormalities, oocyte quality, embryo culture and cryopreservation. Available from: Distribution and Sales, World Health Organization, 1211 Geneva 27, Switzerland. ISBN 92 4 120820 1. Price: Sw.fr. 15,- (Price in developing countries: Sw.fr.10.50.)

**The health of young people:  
A challenge and a promise** (1993).

Young people, even if they are less vulnerable to diseases than children or the very old, do suffer from a range of problems, often associated with particular patterns of behaviours, such as substance abuse, sexual behaviour, and risk-taking. All societies are faced with the challenge to respond to the needs of young people, to help them to make wise choices for the future and to achieve self-esteem through constructive action. This book discussed the strengths and weaknesses of traditional responses to their needs, and suggests ways in which they can be improved.

Available from: Distribution and Sales,  
World Health Organization, CH-1211  
Geneva 27, Switzerland.  
ISBN 92 4 156154 8. Price: Sw.fr. 23,-



## Documents

Report on a **Family Planning Workshop for participants from the Central Asian Republics**, held in London, 7-14 June 1993. Editor: Assia Brandrup-Lukanow, Co-Editor: Sarah Gardiner. The aim of the workshop was to acquaint the national coordinators of family planning from the Central Asian Republic countries with concepts and implementation strategies in other countries of Western and Eastern Europe and the South Asia Region. Available from: IPPF Europe Region, Regent's College, Inner Circle, Regent's Park, London NW1 4NS, United Kingdom.

**The Crisis of Public Health: Reflections for the Debate** aims at stimulating public health professionals to undertake a more thorough analysis, with the hope of effecting a change in what is examined and how it is examined. It is not merely a culmination of current concern over public health but rather a point of departure for further analysis and action. From: Pan American Health Organization/Pan American Sanitary Bureau, Regional Office of the World Health Organization, 525 Twenty-third Street, N.W., Washington, DC 20037, USA

**Natural Family Planning. What health workers need to know** (1993). The purpose of this booklet is to give health workers a clear understanding of what NFP is, how the methods work, how effective they are, the risks and benefits of NFP, the advantages and disadvantages of NFP, and how they, as health workers, can communicate this information to their clients in a way that is acceptable and understandable. Available from: Family Planning and Population, Division of Family Health, World Health Organization, CH-1211 Geneva 27, Switzerland.

## Book review

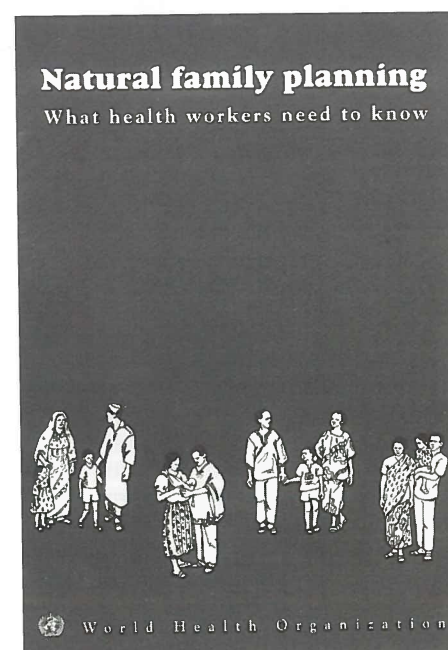
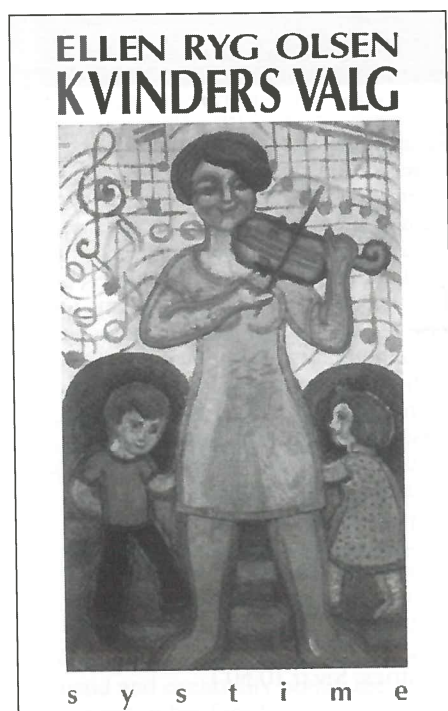
by Hanne Risoer, President, Danish Family Planning Association

**Kvindens Valg. Historier om illegale aborter fra 1930 til 1970** (Women's choice. Stories about illegal abortions from 1930 to 1970), by Ellen Ryg Olsen (1993). The book is based on more than 100 letters written by women and a single man. Each letter tells its own story about illegal abortion. A story about the fear of getting pregnant, about lies to convince the staff at the Mother's Aid Institution of how miserable the woman felt so that she could obtain an abortion on social grounds. About degradation, morals. About obscure backyards and money that had to be found to pay for the abortion. The letters describe in details how the abortions

were performed: with catheters inserted in the womb, with soapy water injections, sometimes administered by the woman herself, or her and her husband together. About women who in a hurry had to be hospitalized due to profuse bleedings. About women who died after the abortion or became sterile. But is also tells the story about a few doctors who tried to help the women in a decent way.



**Women's choice** is in its description a very simple but strong book. An essential document about how the situation was at a time which in fact is not that long ago. At a time when women did not have the right to decide for themselves whether they wanted to carry to term an unwanted pregnancy or not. The abortion opponents often use in their argumentation the term "Respect for human life". In this book Ellen Ryg Olsen writes, "since we have so little respect for life, I think that we should use our respect for human life to work towards making the life of every newborn child as good as possible". We should ensure that "Wished-for" children, also after they are born, grow up surrounded by love and care. We are indebted to Ellen Ryg Olsen for having written this book before it was too late. The book deserves to be read by many people. Available in Danish from: Forlaget Systime a/s, Viborgvej 1, DK7400 Herning, Denmark. ISBN 87-7783-411-9. Price: Danish Crowns 188,-



**Les programmes de planification familiale dans les missions MSF**, by France Donnay (1993), describes various steps for implementing a family planning programme, from training of personnel, to the funding and evaluation of the programme. This draft is published by: Médecins Sans Frontières Belgique, 24 rue Deschampsleer, 1080 Bruxelles, Belgique.

**Erratum:**

Reference is made to the article on Men and family planning in Portugal, published in *Entre Nous* 24, 2nd para.: Use of contraceptive methods. The first sentence should read: Most women use the pill (47,6%) and not (17,6%) as stated. We apologize for this mistake.

## General

**Expanding Access to Safe Abortion: Key Policy Issues**, is the latest in the series of Population Policy Information Kits prepared by Population Action International. The kits are intended to provide overseas colleagues with updated information on controversial issues relating to family planning. The kit addresses important issues related to abortion. It includes: an overview of issues such as the incidence and legal status of abortion worldwide, the impact unsafe abortion, and appropriate strategies for improving abortion care; abstracts of articles from scientific and medical journals; official statements from governments, international conferences, and leading reproductive health organizations on safety and

other issues relating to abortion; several inserts which provide supplemental information on the current status of abortion laws worldwide, the essential elements of good quality abortion care, safe abortion techniques, and issues relating to post-abortion contraceptive use. For further information write to Population Action International, 1120 19th street, N.W., Suite 550. Washington. D.C. 20036, USA. Tel: (202) 659-1833. Fax (202) 293-1795.

**Sexually Transmitted Diseases: Diagnosis, Treatment, and Follow-up**, is a 2-sided wall chart guide to the syndromic approach. It was published as a supplement to Population Reports, Controlling Sexually Transmitted Diseases, Series L, No 9, Vol XXI, No.1. Write to: Population Information Program, The John Hopkins School of Public Health, 527 St Paul Place, Baltimore, Maryland 21202, USA. Fax: (410) 659-6266.

## Magazines/ Newsletters

**ICPD newsletter** is the official newsletter of the 1994 International Conference on Population and Development. Published every two months in English, French and Spanish, it will keep you informed of all new developments regarding the preparations for the decennial conference schedules for September 1994 in Cairo, Egypt. There is no subscription fee. Available from: ICPD Secretariat, 220 East 42nd Street, 22nd floor, New York, NY 10017, USA. Tel: 1(212) 297-5244/5245. Fax: 1 (212)297-5250.

**IPPF Open File** is a monthly newsletter produced by the International Planned Parenthood Federation, covering international, national and IPPF events, with various subheadings: Law and Policy, Medical File, Status of Women as well as a broad section for Resources and Meetings. Write to: IPPF, Regent's College, Inner Circle, Regent's Park, London NW1 4NS, United Kingdom.

**Sexologies**, the European journal of medical sexology, is a quarterly magazine covering issues on urology, sociology, andrology, gynaecology, psychoanalysis, endocrinology, somatotherapy, medical psychology, psychosomatic medicine. Yearly subscription: France 500FF, outside France 600FF. Send your subscription fee to: Editions Sexologies, 21 place Alexandre Labadiç, 13001 Marseille, France. Tel: (33) 91 95 76 76. Fax:(33) 91 50 52 77.

**Passages** is published quarterly by the International Center on Adolescent Fertility (ICAF), a project of the Center for Population Options. CPO works to reduce unintended teenage pregnancy and the spread of HIV/AIDs among adolescents; to promote family planning, and to improve access to health care. Passages is available in French and Spanish editions, as well. Indigenous organizations and individuals in developing countries receive Passages at no charge. Subscribers help support free distribution. Send your subscription fee (\$15 for one year; \$25 for two years) to: CPO Publications Dept; 1025 Vermont Avenue, N.W, Suite 210, Washington D.C. 20005. Tel: (202) 347- 5700.



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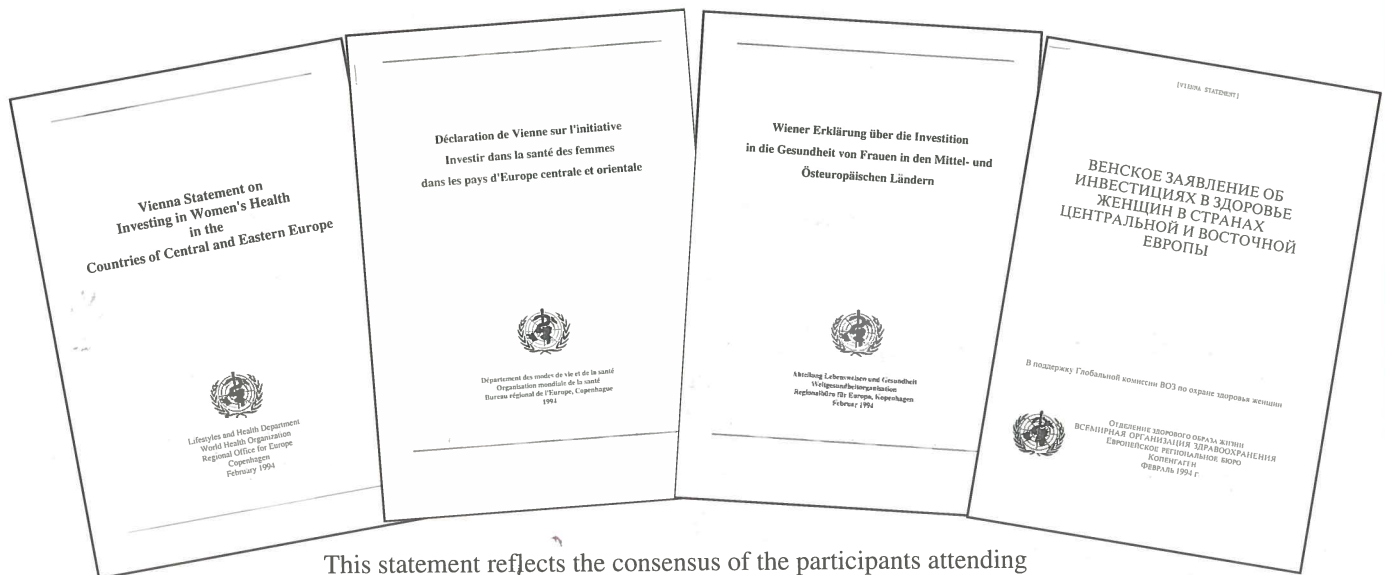
**ICPD '94**

ICPD 94 is the monthly newsletter of the International Conference on Population and Development.

For further information please contact:

ICPD Secretariat  
220 E. 42nd Street, 22nd floor  
New York, N.Y. 10017, USA  
Tel: (212) 297-5244/5245  
Fax: (212) 297-5250  
E-mail: ryan@unfpa.org





This statement reflects the consensus of the participants attending Women's Health Counts: Conference on the Health of Women in Central and Eastern Europe (Vienna, Austria 16-18 February 1994). This document can be ordered from: World Health Organisation, Regional Office for Europe, Scherfigsvej 8, 2100 Copenhagen Ø, Denmark.

## WOMEN'S HEALTH COUNTS

16 - 18 FEBRUARY 1994 UNO-CITY/VIENNA

KONFERENZ ÜBER DIE GESUNDHEIT VON FRAUEN IN MITTEL- UND OSTEUROPA

CONFERENCE ON THE HEALTH OF WOMEN IN CENTRAL AND EASTERN EUROPE

КОНФЕРЕНЦИЯ ПО ЗДОРОВЬЮ ЖЕНЩИН В СРЕДНЕЙ И ВОСТОЧНОЙ ЕВРОПЕ



Vienna Statement on Investing in Women's Health in the Countries of Central and Eastern Europe



# Health promotion research Towards a new social epidemiology

Edited by Bernhard Badura and Ilona Kickbusch

WHO Regional Publications, European Series No. 37

Twenty-one articles describe the state of the art and give examples of interventions (and their results) in five areas of health promotion research. The first part of the book focuses on healthy public policy: expanding health policy from a concern solely with illness and health care to multisectoral policies to create environments that promote health. The other four parts examine important issues in health promotion: social and behavioural factors, appropriate settings, special populations and community intervention. The editors urge a new and fruitful alliance between the social and natural sciences. This book provides valuable reading for people working in health planning and

service delivery, and for those working in health promotion or training others to do so. In helping to bridge the gap between knowledge of and action on social factors and health, this book makes an important contribution to health for all.

ISBN 92 890 1128 9

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