

**REPRODUCTION
HEALTH
2007**

What to do
so that you have children
when you want to
have them

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Word of introduction

Dear colleagues,

it is great honour for me to write the introduction for a publication that has such a great social importance.

I am originally neonatologist and I remember that formerly, women after abortion were hospitalized on one floor of the gynaecological department and those who wished to have a child on another.

That time is already history. Abortions have stepped back thanks to modern means and women wishing to have a child have the possibility to get pregnant thanks to medical progress. And you are representatives of the group of experts who help those women to solve their problem.

The number of successful IVF's grows. But thanks to those methods, the number of "risks" for obstetricians and neonatologists grows simultaneously as well. The "risk" follows particularly from the origin of multiple pregnancies.

In spite of that, it must be stated that all of you cope well with such risks. Small children are born, but the development of most of them is on a good level.

You deserve acknowledgement for it.

Dean of Faculty of Health and Social Care
Prof. MUDr. Miloš Velemínský, CSc.

Several remarks on new legal regulation in the sphere of assisted reproduction

Ondřej Dostál, lawyer

The development of assisted reproduction has brought a number of new legal problems. They include the question whether the gametes and embryos kept outside human body should be classified as persons or things in legal sense of the word, and if the latter applies, to whom they belong. It must be defined what are the rights of gamete donors, particularly the degree of their anonymity towards the recipients and the biological offspring, and the related question of the possibility of choice of the offspring's qualities by the recipients of the gametes donated. It is necessary to anticipate legally such situations when the partners or the husband and wife who have made use of the possibility of kryopreservation of the embryos split, one of them dies, or they stop agreeing with each other in the matter of further use of such embryos. Last but not least, the question of legal responsibility of the service provider in the sphere of assisted reproduction originates with regard to situation that embryos or gametes are confused, lost, damaged or implanted to incorrect patient, or that a seriously handicapped children is born in connection with incorrect procedure in prenatal testing. Legal regulation of communication with the future or existing patient and the protection of his or her privacy cannot be ignored either, particularly with regard to sensitive facts concerning his or her reproduction health, even in relation to the closest family members including husband or wife.

The legislation in democratic society should recognize as principle and protect liberty and decision-making autonomy of each person. One of the important displays of that liberty is the possibility to decide whether, when, with whom and under what conditions the person will start a family and have offsprings. A part of protection of that liberty is also provision of help to such persons who cannot implement that liberty without medical help because of a disease. The restriction of that "procreation liberty" should be only exception determined always by law, the legislator bearing the responsibility to prove that such restriction is indispensable for protection of important social interest.

On June 1, 2006 the long-discussed Act No. 227/2006 Coll. of research made on human embryonal stem cells and related activities and of change of some related acts entered into force. The Act includes also an addition to Act No. 20/1966 Coll. of care for people's health in form of new provisions § 27d through § 27h, regulating the sphere of assisted reproduction. This new legal regulation substituted the former regulation performed insufficiently by subordinate legislation and methodical instruction of the Ministry of Health.

According to that Act, assisted reproduction is understood as procedures and methods in which gametes and embryos are manipulated, including their preservation, for the purpose of therapy of woman's or man's infertility. Such procedures and methods include gamete taking on one hand and the woman's artificial fertilization on the other hand, i.e. fertilization of the ovum with a sperm outside the woman's body, transfer of embryo into the woman's sexual organs or introduction of gametes into the woman's sexual organs. Such artificial fertilization of the woman can be performed on the base of written application of the woman and the man who wish to undergo such therapy together, if it is little probable or completely excluded, for health reasons, that the woman gets pregnant naturally or if there is demonstrable risk of transfer or genetically conditioned diseases or defects. The application includes the man's consent to execution of the woman's artificial fertilization; the consent must be expressed repeatedly before each execution of artificial fertilization. The application must not be older than 24 months and it is a part of the woman's health documentation. So the Act restricts the

possibility of artificial fertilization only on heterosexual couples; e.g. lesbian couples or women not living in a couple (e.g. widows) are excluded.

The donor donating gametes for the purposes of assisted reproduction is understood as a person not constituting infertile couple. A woman from 18 to 35 years old can donate ovula for the purposes of assisted reproduction. A man from 18 to 40 years old can donate sperms. The ovum must not be fertilized by sperms of which it is known that they come from a man who is related in direct line or sibling, uncle, cousin or child of cousin of the women whose ovum will be used for the method of assisted reproduction or of the recipient. No person deprived of legal capacity or person with restricted legal capacity can be donor or recipient.

The health care institution in which assisted reproduction is performed must provide for secrecy with regard to anonymity of the donor and the infertile couple and anonymity of the donor and the child born from assisted reproduction. Each health care worker who has learned of such fact must keep secrecy with regard to anonymity of the donor and the infertile couple and the anonymity of the donor and the child as well. The physician of the health care institution in which the health capability of the donor was judged, gives information, at request of the woman or the man from the infertile couple, before starting artificial fertilization, or of the legal representative of the child born from assisted reproduction, or of a major person born from assisted reproduction, of findings having direct impact on the development of health condition of the child or the person born from assisted reproduction, particularly of ascertained genetic talents or dispositions. The question is how broadly the concept of such "findings" of the donor, which the physician can communicate to the recipients before starting the procedures, can be interpreted; the legal text speaks for example of genetic talents or dispositions. So it will be probably only information of health character; information concerning e.g. incomings, education or other social characteristics of the donor will probably fall already under the duty of secrecy of anonymity.

It is true that enactment of new legislation was desirable, but several objections can be raised against the current wording. On one hand, the law is considerably restrictive to some categories of infertile persons requiring health care; on the other hand, it does not solve all topical legal problems related with assisted reproduction with complete unambiguousness.

The methods of assisted reproduction can be considered medical interventions serving to overcome health problem of the woman or the couple. Regulations of institutional force generally forbid discrimination, i.e. unequal treatment of persons in consequence of their age, sex, health condition, religion or sexual orientation. It is essentially possible to impose such restrictions that are not applied against others only to some groups of persons only exceptionally, if unambiguous social interest for such procedure exists. The Czech legislation does not essentially define conditions or restrictions of "natural", "non-assisted" reproduction. Leaving aside the prohibition of incest according to § 245 of Criminal Law, the state does not intervene anyhow into procreation liberty of healthy persons. If natural conception takes place, the state does not investigate anyhow the family background, legal capability, qualities or way of selection of the "natural gamete donor"; so any single woman or one of both women in a lesbian couple can become mother if they are capable of non-assisted conception. But that is not possible in a person requiring medical help for conception. It is possible to argument with the child's right to an identifiable father, but if the relevant restrictions have factual impact only on ill persons, while not on reproduction-healthy persons, it is probably a form of discrimination.

On the contrary, the new legislation did not bring consequent solution of legal character of gametes or embryos outside human body. In consequence of that, the question of allocation of property benefit from research performed on embryos (if the couple gives consent to such use

of the redundant embryo) is uncertain; with regard to ban of property benefit for the donor or the originator, all benefit from research results, e.g. patents, will probably fall to those who perform the research, although such research would not be practicable without the research material provided. The question of responsibility for damage or loss of gametes or embryos kept outside human body, including degree and method of compensation, is not consistently solved either.

A special question is communication of therapeutic information to the patient and the members of his family, particularly sensitive facts concerning infertility. According to § 23 par. 1) of Act No. 20/1966 Coll., the physician must instruct the patient, or possibly the members of his family, in suitable way about the character of the disease and of the necessary interventions so that they can become active co-operators at providing curative-preventive care. According to § 6 par. 1) of Act No. 94/1963 Coll. of family, the betrothed must declare, among other things, that they are not aware of any circumstances excluding the marriage and that they know the health condition of each other. But that regulation that would indicate that it is possible under certain circumstances to communicate the information of reproduction health also to the husband or the wife must be interpreted, since 2001, in accordance with art. 10 of the Convention 96/2001 Coll. on human rights and biomedicine, which determines each patient's right to privacy, with superlegal force. So now it is possible to communicate such sensitive information even to the closest relatives only and exclusively with previous consent of the person concerned; any other procedure could probably lead to successful lawsuit on protection of personality. But the law should define more unambiguously the competences in communication between the physicians and the patient's family.

In the end, it must be mentioned that any restrictions of access to methods of assisted reproduction, which are defined only for one country or group of countries, have impact only on a part of patients in their consequence. With regard to easy accessibility of information and the possibility to travel abroad, even the strictest national regulations will not prevent sufficiently wealthy patients from getting care, which can be planned, in more liberal countries allowing e.g. surrogate motherhood or similar selection of the donor's qualities. The restrictions will be applied only against patients who cannot afford such travel. Only worldwide harmonization of such regulations would constitute solution.

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Somatic, neurological and psychological development and health condition of Czech children born after intracytoplasmic sperm injection (ICSI)

Marta Šnajderová, paediatrician

Introduction: Fertility disorders occur in 10-20% of couples in developed countries. So far more than 3 millions children have been born in the world after in vitro fertilization. In our country about 3,1% of children are born after in vitro fertilization (IVF) each year; about 50-60% of them after intracytoplasmic sperm injection (ICSI). So each year there about 1800 children conceived after ICSI in the Czech Republic. The embryologist selects one sperm and injects it into the oocyte at ICSI. So natural selection, occurring in spontaneous conception and in procedures within conventional IVF, is bypassed. ICSI is more invasive method as against the conventional IVF. Potential risks for children related with ICSI are connected both with the primary cause of fertility disorder of the parent couple (it is usually father factor) and with the risk of use of defective or immature sperm and transfer of genetic abnormalities. Other risk of the ICSI method as such is possible chemical or mechanical damage to the oocyte and spread of foreign material into the oocyte. The development and health condition of children conceived after conventional IVF and after ICSI is focus of natural interest of professional and lay public. The studies carried out so far have dealt predominantly with incidence of inborn development defects, some of them also with health condition and psychical development of children. There is more knowledge about younger children, particularly in age under 2 years. Children born after IVF and after ICSI often have low birth weight, particularly in multiple pregnancies, which are more frequent after IVF than in common population. They have also higher incidence of chromosomal abnormalities and development defects as against common population. Less is known about neurological, somatic, psychical development and sickness rate of children over 5 years born after ICSI. So far only one foreign study about children over 8 years conceived after ICSI has been published. At present, the so far first complex study dealing with development and sickness rate of Czech children in ages from 0,3-9,3 years conceived after ICSI is in course at present, which is to be finished this year in the Paediatric Clinics in Prague-Motol. Some results of the respective study are subject of this article.

Characteristics of our set and monitoring methods: In the cross-section open clinical study supported by the IGA MZČR project 8118-4, we gradually incorporated and examined 135 children, conceived after ICSI (60 children and 75 boys; age 0,3 years – 9,3 years; median 5,9) from single and multiple ICSI gravidities (gametes of own parents), in the period from 9/2004 – 12/2006. There were 93 children from single gravidities, 21 couples (42 children) were from twins. All children were from one assisted reproduction centre; the families were selected randomly and invited by a letter to participate in the study. We performed analysis of infertility factors and of the methods used in ICSI and of the perinatal period in the incorporated families; we followed incidence of development defects, as well as sickness rate, somatic, psychical and neurological development. We also ascertained the parents' attitudes towards the children and educational problems and evaluated socio-economic factors. A team of professionals was engaged in the study; the examinations of all children were performed during the whole period of study by one paediatrician, one clinical anthropologist, one children neurologist and two geneticists. Psychological examinations were performed by two psychologists with focus on the age of the children (under 3 years and above 3 years of age). An expert on assisted reproduction was member of the team as well. We compared some results with our own control group of common population; we compared all results with population standards.

Results and conclusions: The data are statistically processed at present; therefore the results presented here are predominantly descriptive. Our study allowed extending the knowledge of children born after ICSI. It is the first study understood in such a complex way in Czech children. The analysis of development of children over 5 years of age born after ICSI can undoubtedly contribute to the so far sporadic studies even at international level.

57% of the families invited expressed interest to participate in the study; 1% of the families excused themselves because of illness; 1% of the families did not appear for examination after initial interest; 1% of the families refused to participate in the study. The letter was not delivered to 12% of families because of change of address and 28% of families did not react to the letter. Therefore it is not possible to assess the health condition and development of children from families that did not participate in the study for different reasons. The families consider their housing conditions good in 83% and their financial situation satisfactory in 88%. High-school education is predominant in the parents. The period of treatment of infertility was 5,5 years in average in the parent couples. It was the second and further gravidity in more than a half of the mothers but in 60% of the cases of such gravidities, the child was the first in sequence and often the only one. The age of the mothers at childbirth was 31,5 years in average, the age of the fathers was 34,3 years. In most cases, the reason for performance of ICSI was the father factor of fertility disorder; less frequently it was combination of father and mother factor; exceptionally, the infertility reason was unclear. The parents were wife and husband in 91%; in 9%, the parents were divorced or lived in free partner relation in the time of the study. Children born from double gravidity had significantly shorter gestation age as against single ICSI gravidities; they were smaller at birth and had lower birth weight. Children born from single ICSI gravidities did not differ significantly from common population in those indicators. The incidence of structural development defects in 19 out of 135 (14%) children is higher in our ICSI-conceived children than in our common population (4%) and in some foreign studies. They were inborn heart defects, marked asymmetry of lower jawbone, redundant external ear, skin and subcutis defect behind the external ear, pes equinovarus, inborn hip joint luxation, hypospadias, radioulnar synostosis, iris cleft and heterochromia, hemangiomas of different extent. Several children had combination of two and more development defects. But our group is relatively small. The sickness rate of the children (monitored in the following periods: from birth to 1 year, between 1st and 3rd year, between 3rd and 5th year and in later age) did not significantly differ in ICSI-conceived children from comparably old children of common population (ÚZIS data). We also monitored "specific sickness rate", the number of hospitalizations, operations. Those data will be subject to statistical analysis later. 70% of children have visited professional consulting rooms so far; the high monitoring rate in consulting rooms can be explained by higher attention towards such children paid by paediatricians and parents. The somatic, motor and cognitive development of most children conceived after ICSI is comparable to common population of children of the same age. The parents evaluated the behaviour of their children predominantly as trouble-free. But they stated higher need to intervene into the child's behaviour in "emotional" and "shame" sphere than in the remaining spheres. The parent's attitudes to ICSI children are more hearty; no difference as against common population has been found in other spheres of evaluation. Children from single and double gravidities do not significantly differ in the monitored parameters of somatic development mutually or in comparison with common population. Certain changes in maturing of muscle tonus on upper girdle have been found in absolute majority of children over 5 years of age.

The development and health condition of Czech children conceived after ICSI does not significantly differ in most monitored indicators from common population. At present, all data

obtained are analyzed in detail. Long-term monitoring of a larger group of "ICSI children" and complex analysis are indispensable for further conclusions.

The study is supported by IGA MZ ČR NR/8118-4.

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Children and adoption and foster care

Anna Stará, psychologist

Last statistical data show that 902 children in total were consigned into adoption or foster care (AFC) in the Czech Republic in 2005. 537 of them were consigned into care of future adoptive parents and 365 children into care of future foster parents. In the same time, 1366 new AFC applications were submitted, 871 of them adoption applications and 495 foster care applications. But in total, 2500 adoption applicants and 703 foster care applicants waited for satisfaction of their application in that year.

Looking at those numbers, high “excess” of applicants can be seen at first sight, which could lead to assumption that it need not be any problem to place children into new families. But the reality is completely different.

If we look at the situation from the child's side, what is needed for him to be placed into adoption:

- the legal representatives (parents) have signed consent to adoption,
- the court proved 2-month lack of the parents’ interest for a newborn child,
- the court proved 6-month lack of the parents’ interest for the child,
- the parents were deprived from parent rights by the court in case of a child with ordered institutional upbringing.

Those conditions need not be satisfied in case of a child suitable for foster care, where:

- institutional upbringing must have been ordinarily ordered,
- the legal representative has signed consent to foster care.

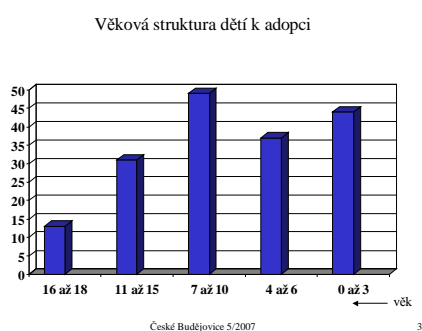
With regard to constantly dropping ability of married couples to conceive a child in natural way, particularly the interest for mediation of adoption increases. So if the child is born healthy, is not ethnically different, his social situation has been solved in early age or it has no marked upbringing problems, it can be quickly placed into a family. If such transfer is implemented really in his early age, he has great hope for “normal” development (development acceleration, minimization of consequences of psychical deprivation). With regard to preservation of anonymity of adoption, we do not have any data of their further development, or only partial ones in case of the parents’ cooperation with the institution from where they received the child. It is mostly institution where there is possibility of cooperation with a psychologist. Their number is influenced by the fact that parents who want to solve a problem are interested in cooperation (upbringing problem, start of school attendance, but also health problems). Such cooperation often ends after the child enters school as well.

In cases of foster care, the children’s situation is monitored by a body of social-legal protection of children, but there are also only very few data of their further development. Contribution in this sphere consists particularly in investigations performed by doc. Koluchová who engaged in long-term monitoring of children in foster care (up to 30 years). Her works show that psychical deprivation of the children is rectifiable at higher level than it was stated at the beginning of the investigation in the Seventies. Further, investigations performed by doc. Sobotková are very contributive, dealing also with function and resistance of foster families from long-term point of view.

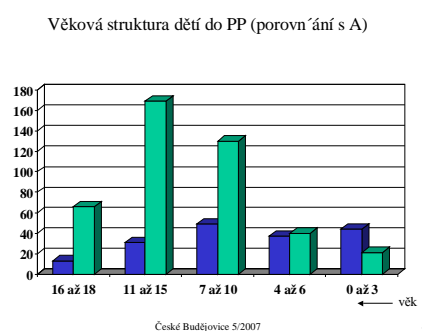
I would like to focus now on children for whom it is difficult to find substitutive family in spite of the above stated high number of applicants at present. They are children who could not be placed within one region and for whom the Ministry of Work and Social Affairs tries to seek substitutive family now.

By 31.12.2006, our records included in total 600 children for whom substitutive family was sought. In cases when the child can be consigned into substitutive family care both in form of adoption and in form of foster care there were 174 children. Most children, i.e. 426, can be consigned into foster care. In dealing with the 174 children suitable for both forms of SFC in more detail, 51 children are members of our population and 123 children members of minority population, particularly Romany, which complicates their situation in seeking substitutive family.

In cases of children suitable for adoption, there are very often delays in court proceedings and their so called legal release is question of a number of months. For this reason, rather children of toddler and older age come into the system of mediation of adoption, the applicants' interest for them decreasing. The biggest age group of children in our records is a group of children in ages of 7 – 10 years.



(Translation
Age structure of children for adoption
age



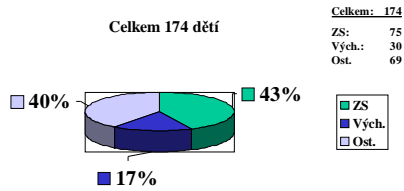
Age structure of children for foster care
(comparison with A))
age)

The highest representation of children for foster care is in ages of 11 to 15 years, which is caused not only by delays in court proceedings, but also by the fact that they are children who grew for a certain time in their biological family, from which they were withdrawn, or their parents asked for their placement into children's home.

Another factor making difficult the possibility of quick placement of the child into substitutive family is health handicap or upbringing demandingness of the child. In cases of children for whom we are seeking suitable families we can find children with mental retardation, DMO, Down syndrome, inborn development defects, psychiatrically treated children, but also children who were confronted with maltreatment or returned from substitutive family care.

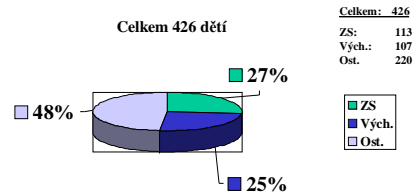
It is very difficult to separate health and upbringing problem, because they are often related. But I tried to do it in my survey in effort to map the prevailing problem. In the group of children suitable for adoption, the highest number of them confronts a health handicap. In the group of children suitable for foster care, the representation of children with health and upbringing problem is almost even. The most numerous group consists of children of older age coming from big sibling groups (three, four, but also five member groups).

Zdravotní a výchovná rizika dětí do A



4

Zdravotní a výchovná rizika dětí do PP



5

(Translation:

Health and upbringing risks of children for A
174 children in total

In total: 174
Health handicap: 75
Upbringing: 30
Other: 69

Health and upbringing risks of children for FC
426 children in total

In total: 426
Health handicap: 113
Upbringing: 107
Other: 220

The Ministry of Work and Social Affairs tries to find substitutive families for all those children together with Regional Authorities, but also with non-governmental organizations. It is very difficult to find such applicants. Foster care is often understood in our country as substitution of adoption, the above stated interest for children in lower age increases. In spite of those problems, the Ministry tries to improve the current situation. I will state at least several examples:

- the amendment to Act No. 359/1999 Coll., valid since 1.6.2006, puts stress not only on examination of applicants, but also on their preparation to become adoptive or foster parents,
- duty of Regional Authorities to provide foster and adoptive parents with professional consulting assistance,
- institute of foster care for temporary period added
- since 2005, the range of benefits of foster care has been extended by the foster parent reward in special cases (at least 3 children or 1 child with long-term handicap), further the basic reward of foster parent has been increased
- last but not least, increase of level of information of substitutive family care.

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Care for girl reproduction health from birth to adolescence

Ondřej Míka, gynaecologist

Child age can be divided into 3 stages from gynaecological point of view. This division is based on hormonal situation of child organism and the displays of hormone effects on estrogen-dependent tissues. Not only their anatomy and functions, but also the displays of their diseases are dependent on estrogens. **1. newborn period:** The girl organism is under influence of mother estrogens. But this period is not finished by ligation of umbilical cord, but it takes about 6-8 weeks more. The effect of estrogens on the reproduction system organs can persist differently long and sometimes physiological bleeding from genital tract can occur as a consequence as drop of estrogen level. **2. inactivity period:** is characterized by almost zero levels of estrogens, therefore the reproduction organs are in a condition of minimum anatomic development and complete function inactivity. **3. period of sexual maturing** is started by gonadarche (start of estrogen production by the ovary), the consequence of which is a whole set and sequence of changes well-known as puberty.

Newborn period.

From the point of view of care for reproduction health, the diagnostics of inborn development defects (IDD) of reproduction organs is in focus here. In this period, it is particularly IDD of external sexual organs, which can but need not be a part of more serious malformations. They are either intersexual malformations, i.e. defects questioning the individual's sexual identification, when it is necessary to decide of determination of the sex of the child affected in such way, or abnormal urethra outfall, or possibly intestine outfall.

Inactivity period.

The reason for the visit of a gynaecologist in this period is usually bleeding, discharge from the genitals, abdominal pains, genital injuries.

Vulva synechia is a disease when the opposite mucous membranes grow together at insufficient or bad hygiene. It does not cause problems to girls in most cases. It can appear because they urinate outside the chamber pot or it is usually detected at preventive examination at the paediatrician's. The solution is usually their blunt breakage in total anaesthesia.

Vulva inflammations are usually signaled by discharge from the genitals, which is always pathological in this period. It is most frequently *vulvovaginitis* (inflammation of vagina and vulva). It is caused most frequently by intestine flora, but sometimes by gonococci in this period. In this period, the patients are much more susceptible to it, so even non-sexual infection is admitted. It can be caused by insufficient hygiene of genitals and perianal region. The sometimes neglected cause can be also spreading of infection by pinworms. Vulvovaginitis is not serious disease, but its risk consists in the possibility of ascension of the infection into urinary tract or into higher floors of the genitals. The therapy consists in elimination of causes (improve hygiene of genitals and clothes, eliminate pinworms and cure urinary tract) and in local treatment with lavages and inserts. *Adnexitis* (inflammation of uterine appendices) is most frequently caused by transfer of infection from the appendix; other possibility is spread of infection through blood in case of inflammation of upper respiratory tract.

Bleeding from genitals. Bleeding in this age is always pathological with regard to zero estrogen levels. Causes: *1. Inflammation of vagina or cervix* - can appear in form of discharge with blood admixture. *2. Genital injuries*, caused mostly by fall with legs apart on a hard

object; other possible cause is introducing of objects or fingers into the vagina with injury of rear wall of the hymen and rear wall of the vagina; sexual abuse must be always considered in case of such injuries. 3. *Foreign body in the vagina* is usually accompanied by massive smelling discharge with blood admixture. 4. *Genital tumours* constitute 2 to 5% of tumours in child age. They are mostly tumours of vagina or ovaries; other reproduction organs are rarely affected.

Period of sexual maturing.

Most frequent causes of visit to the gynaecologist are: bleeding, discharge from genitals, abdominal pains caused by inflammations and tumours, but the girl adolescence disorders and disorders of menstruation cycle add to them. Further reason is the wish to get contraception prescribed.

The girl sexual maturing is started by estrogen production by the ovaries; the estrogen-dependent tissues begin reacting to the increasing levels of sexual hormones. This development is called puberty and it can be observed on secondary sexual signs (breasts, pubic and axillar hairs) and on the development of outside and inside genitals. Manifest puberty changes culminate with the first menstruation that arrives physiologically from 10-15 years of age.

Disorders of menstruation cycle: If menstruation does not arrive until 15 years of age, we speak of *primary amenorrhea* caused by inborn development defects – either by disorders of patency of gynaecological paths, e.g. because of underdeveloped vagina or uterus. Other times, the problems can be caused by genital doubling or by combination of such IDD. The situation is usually solved by operation. *Juvenile metrorrhagia* is a disease when the girl bleeds strongly and long because of hormonal imbalance. It emerges most frequently within six months from menarche and after several months of amenorrhea. The therapy consists particularly in hormone administration. The adolescent girl has claim to irregularities of the cycle, but she should not bleed strongly often and long.

Disorders of sexual maturing. *Isosexual premature puberty (p.p.)*, complete or incomplete. In incomplete form, mainly only one characteristic is prematurely developed. Pure p.p. has similar course as normal puberty, starting with development of breasts and pubic hair and culminating with menstruation, only that everything is accelerated. The cause is not known, but its consequence is small height, because the growth is prematurely accelerated and the patient stops growing several years earlier than normal. The therapy consists in stopping the secretion of sexual hormones with the help of analogues of gonadoliberines. *Ovariogenous p.p.* has hormonally active ovary tumour as cause. This form has quick progress and the sequence of individual signs of sexual maturing is disturbed. The therapy is primarily operational, with subsequent oncological therapy. *Premature heterosexual puberty* can occur as well, when the tumour of ovaries or adrenal glands produces androgens, or it is an adrenogenital syndrome. *Retardations of sexual maturing* can be divided into temporary or permanent, complete or incomplete, with or without disorder of somatic development. The complete permanent retardations include different genetic disorders (e.g. Turner's syndrome); the temporary ones include most frequently the *puberta tarda*, when the retardation is given in the family and the girl will catch everything up without therapy.

Tumours, both benign and malignant, are mostly localized in ovaries in this age. As against the preceding period, they are only other histological types, but with regard to hormonal imbalance, they are mostly benign ovary cysts.

Vulva and vagina inflammations have the same etiology as in adults, with regard to start of estrogen influence on genitals and beginning sexual life - candida albicans, Gardnerella

vaginalis, STD (sexually transmissible diseases), and there is risk of rise of infection into internal genitals leading to cervicitis, metritis and PID (pelvic inflammatory disease). *Cervicitis* – inflammation of cervix is most frequently caused by chlamydiae, mycoplasmas, gonococci. The risk consists in rise of infection into higher floors of reproduction organs or transition to chronic form. It can then cause dysmenorrhea, dyspareunia or sterility, because of scar processes and started immunity response that can damage the sperms directly or indirectly. *Metritis* – inflammation of uterus has the same causes as the previous disease, the clinical picture is similar as well, there is risk of damage to endometrium, its reduced ability to accept the embryo and partial closure of cavity through uterine adhesions. *Adnexitis* – inflammation of uterine appendices – originates in this age mainly because of STD; its risk consists in the tendency to chronic course with frequent outbreak. The most serious consequence is the possibility of damage to Fallopian tubes, or possibly their full closure or adhesions. That can lead to infertility or ectopic pregnancy. Prevention of all such diseases is timely therapy of discharges, correct hygienic habits particularly during menstruation, prevention to chill, monogamy, knowledge of principles of hygiene of sexual intercourse and knowledge of STD risks and means of protection against them. In case of acute or chronic appendicitis, their timely operational solution is more appropriate, and each appendectomy should be followed by gynaecologic examination. The therapy consists in antibiotics in acute stage; enzymotherapy and immunizing and desensitizing therapy are added in chronic stage. Another part of this complex therapy is spa therapy.

Contraception for minors

The aim of contraception is avoid unwanted pregnancy. Natural methods (use of so called infertile days, coitus interruptus) are not much reliable. Barrier and chemical methods (condom, diaphragm, spermicidal have the advantage to protect against sexually transmissible diseases; their reliability is higher than in natural methods, but it is still not good. Intrauterine contraception is usually not good in healthy girls who have not given birth yet, because of higher risk of inflammation of Fallopian tubes and ovaries and because of unsuitable anatomic conditions. Sterilization is recommended in case of impossibility of other contraception for patients deprived of capability of managing their own affairs. Gestagen hormonal contraception has three types. 1. *Postcoital* when 2 pills containing levonogestrel are administered within 72 hours from sexual intercourse, its effect gradually dropping with the time passed from intercourse, so that it is advisable to take it in as soon as possible. It should be used twice a month as a maximum. It leads to irregular bleeding and its effect is lower than that of classical HAK and it should serve as emergency contraception. It is bound on prescription from district gynaecologist or from physician working in gynaecological ward. 2. *Continuous gestagen contraception* – suitable only for risk patients, e.g. for diabetics. 3. *Injection depot contraception or implants*. This type of contraception is not suitable for young patients with regard to lengthy return of regular menstruation cycles; it reduces growth of bone density and there is higher risk of ovarian cysts. Therefore it is suitable only for some internal diseases and mental retardation. Combined hormonal contraception is cyclical administration of preparations containing estrogen and gestagens in form of pills or plasters. They can be simply divided into estrogen or gestagen dominant. Contraindications are identical as in other patients. There are light differences in the decision-making algorithm about what preparation should be selected. Preparations with extremely low contents of estrogens (15 ug EE) are not suitable because woman organism creates whole-life supply of bone mass until 22 years of age. Three-stage contraception is better tolerated in them. The physician can prescribe contraception after parents' consent even to a girl under 15 years of age, but it should be, from medical point of view, at least 2 years from menarche. All types of hormonal contraception are paid by the patient.

HPV vaccine

Cervix cancer (CC) is detected in about half a million women worldwide each year. In the Czech Republic they are about 1000 woman a year; 400 of them die each year and 10000 cases of cervix plasty are performed yearly because of cervix precancerosis. It is a disease caused by Human papilloma virus (HPV) and it is the most frequent sexually transmissible infection. The infections can be divided into low-risk ones, e.g. HPV 6 and 11, and high-risk ones, e.g. 16, 18, 31, 35. Out of all CC, 70% fall on HPV types 16 and 18. Besides cervix, the high-risk HPV's are causes of malign tumours of vagina, penis, outer genitals, anal region and larynx. Low-risk HPV's are causes of genital warts and recurrent respiration papillomatosis.

Pathogenesis of precanceroses of cervix and CC. Origin of precanceroses and subsequently CC's is fully dependent on infection by high-risk HPV's. Several factors are needed for CC origin, because it is multi-factorial cascade. The infection may not appear at all or it may appear in form of small cytological changes that disappear after elimination of infection. If the infection persists, medium precanceroses originate and can become CC in the course of 10 years. The persisting infection is conditioned, besides HPV types, also by immunity disorders and co-carcinogens (smoking, chlamydias). Contact with the virus during life is stated in about 80% of population. HPV infection can be proved mostly in young women, early after start of sexual life. Gradually, with increasing age, the infection disappears spontaneously. If the infection does not disappear before 35 years of age, there is high risk of CC.

HPV vaccination. Until now, only secondary prevention of precanceroses of cervix and CC based on oncological cytology has been available. Now primary prevention in form of prophylactic vaccine is available. Sufficient levels of antibodies and therefore also proved protection is about 5 years, but protection up to 30 years is supposed. Now tetravalent vaccine oriented against HPV type 16, 18, 6, 11 is available. In short, bivalent vaccine against types 16, 18 will be launched. The advantage of tetravalent vaccine consists, besides prevention against CC and precanceroses, also in prevention against genital warts. The advantage of bivalent vaccine is crossed protectivity against other high-risk HPV types 45 and 31, ability of better immunogenicity and achieving of higher levels of antibodies. Recommended application for tetravalent vaccine is 11-26 years, for bivalent vaccine 10-55 years. Both vaccines are applied in three doses, the price oscillates about 10000 CZK. With regard to the fact that the vaccine is prophylactic, the vaccination should take place before starting sexual life; in the U.S.A., it is recommended at 11-12 years of age. Although the vaccine is primarily intended for administration before start of sexual life, it is not contraindicated to administrate the vaccine to women who are already sexually active, because it can avoid re-infection by the same HPV type or contagion by a HPV type the women has not been confronted with yet.

You can find other information:

Gynekologie – Karel Citterbart et al.

Moderní gynekologie a porodnictví (supplementum HPV a karcinom děložního hrdla, Dětská gynekologie, supplementum LNG-IUS, Hormonální antikoncepce a HRT)

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Paediatric andrology

Libor Zámečník, andrologist

Paediagric andrology develops as multi-discipline branch summarizing the most modern pieces of knowledge from paediatrics, urology, andrology and endocrinology in last decades. Specialists from those branches deal with diseases and defects of boy genital, which can have impact on his reproduction abilities in adulthood.

Parents are most frequently confronted with foreskin problems: difficult or completely impossible pulling over (but in newborns, the “adhesions” of foreskin with the glans are physiological), inflammations in foreskin sac and the resulting inflammations of urinary tract. The completely narrowed foreskin can sometimes lead even to damage of urinary bladder and kidneys.

The principle is: let time for the possibility of spontaneous release of the foreskin, not try to release it violently in domestic conditions, consult the physician - paediatrician and visit infant urologist in time. The therapy is either conservative (i.e. training of foreskin) or surgical (partial or complete circumcision).

The most serious diseases of child age related with further fertility include:

1. cryptorchism
2. acute scrotum disease
3. variokéla
4. inborn genital abnormalities
5. disorders of sexual differentiation

Kryptorchism is a condition when the testicle is not or does not stay in scrotum after manipulation even in case of abdominal wall relaxation. We distinguish: retained testicle (it stays anywhere in the path of its embryonal descent into the scrotum), ectopic testicle (out of natural path of descent), the so called anorchia (completely missing testicle). This disease affects up to 1,8% of boys at one year of age. If the testicle does not descend before that time, it is only very improbable after the age of one year. Most frequently (up to 75%), the testicle finds itself in the groin channel (inguinal retention), less frequently in the area of transmission to the scrotum (20%); in 8%, the testicle stays in the abdominal cavity. We can see fully missing testicle in about 2,5%. The condition when no one testicle is palpable can occur in up to 30%. We increase the stress on check of descent of the testicles, or possibly the endocrinological or operational solution particularly because it is known that pathology and changes start occurring at cell level (Leydig's cells) from one year of cryptorchism duration already. **So the testicles should be in the scrotum before 2 years of age, but better before 1 year of age of the boy.** It is because fertility (measured e.g. by fertility index) is reduced in case of a maldescended testicle after the 1st year of age. Full loss of germ cells occurs in 38% of boys at the age of 2 years and in 100% before puberty.

Solution: hormonal therapy (efficiency under 20%, preparations: HCG, analogues of releasing hormone), surgical therapy (orchiopexis = pull the testicle into the scrotum and fix it). Open surgical intervention is sometimes preceded by diagnostic laparoscopy (endoscopic method in which operation is performed in abdominal cavity with the help of tools operated from outside).

Acute scrotum disease endangering future fertility:

- § torsion of semen strand
- § inflammation of testicle and epididymis (orchitis, epididymitis)
- § incarcerated inguinal hernia

§ testicle tumour

The **torsion of semen strand** (in 1/4000 men under 25 years of age) originates at rapid contraction of cremasteric muscle (in the semen strand) and rotation of the strand by 360-720 degrees. The blood flow is reduced, poor perfusion (ischemia) and atrophy (extinction) of germinal tissue of the testicles emerge. **After 1-2 hours, irreversible changes on seminiferous channels emerge, which are completely destructed after 6 hours of duration of the torsion.** The disease appears in form of sudden pain in groin, scrotum, vomiting, sometimes scrotum swelling, strong testicle pain. The abdomen pains provoke the suspicion of abdomen emergency. Most torsions emerge before morning and wake the boy affected.

Solution: Immediate visit to physician, operation solution – removal of non-vital (not showing possibility of return to normal function) testicle is important for fertility prevention (the testicle on the other side is endangered by autoimmune reaction of the organism).

The **inflammations of testicle and epididymis** have, unlike torsion of testicle, slower development of difficulties. Anamnestic data are important; usually, infection finding in the urine, discharge from urethra or other inflammation displays precede. Intumescent and painful epididymis stands at the beginning. Most epididymis inflammations in small boys are reactive in torsion of epididymis or testicle appendix (small formations – “tags” from those organs, remaining after embryonal development).

Solution: It is necessary to differ torsion (immediate operational revision preferred), influence the basic cause, antibacterial and local therapy.

The **variokéla (venous varices of scrotum)** can lead to worse development of the testicle (smaller size, pathologic unspecific testicle changes, pathologic spermiogram and therefore infertility. It is known that up to 20% of children and adolescents with venous varices of scrotum will have problems with fertility (and vice versa: invertile men have venous varices of scrotum in 30-40%). It emerges usually at the beginning of puberty and affects 10-15% of boys. Clinically, we can see enlarged veins filled with blood (mostly on the left). The diagnostics is not demanding (ultrasound). Indication for operation is reduced volume of the testicle, bilateral venous varices, symptomatic venous varices (pains), pathologic spermiogram (worsened values).

Solution: The principle of operation consists in interlacing (occlusion) of dysfunctional veins – the operations are performed in open or laparoscopic way, a variant is sclerotizing operation.

Inborn genital abnormalities and infertility:

- § **exstrophy of urinary bladder - cleft of urinary bladder and abdominal wall** (obstruction of deferent duct after operation, inflammations)
- § **hypospadias, epispadias – unusual outfall of urethra** (curved penis, outfall situated elsewhere, psychological restraints)
- § **abnormality of penis, deferent duct and epididymis**
- § **testicle hypoplasia = reduced volume and bad function of germinal tissue of the testicle**

Disorders of sexual differentiation (it is visually not quite clear of what sex the individual is):

- Diagnostics of intersexes should be determined just in newborn age
- Timely medicamentous and surgical therapy
- Indispensable cooperation of neonatologists, child endocrinologists and child urologists

Conclusion:

- § pediatric andrology = preventive andrology
- § it can influence the child's psychosexual development
- § it can avoid infertility

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Parenthood after treatment of fertility disorders

Hana Konečná

There are not few people whose wish to have a child is fulfilled only after a long time, and their number will keep growing with most probability. It need not be only because of the growing number of fertility disorders proclaimed by physicians; the cause will consist also in the physiologically descending fertility, i.e. the fact that people have children in higher and higher age. According to statistics, 7-10% of all children are born thanks to medical assistance in the Czech Republic at present. The article is called "Parenthood after treatment of fertility disorders" and the name does not state whether after successful or unsuccessful treatment. Perhaps I have puzzled the readers now, but it is necessary to be aware that a person can be parent even after unsuccessful treatment. He or she can do it by adopting an abandoned child. About 500 children are adopted in the Czech Republic each year.

Not only the decision making whether and when to become parent changes. The actual parenthood lives big changes in last decades as well: The number of children descends and the woman and man roles change their contents and it is more and more difficult to hold one's own against oneself with regard to the knowledge from psychology, neurology, embryology or pedagogy and the increasing demands of the society on individual's performance. Unfulfilled wish of parenthood, treatment of fertility disorders and the process leading to adoption are psychically very demanding life situations. Besides, fertility disorder is traditionally considered a special disease; it is looked at rather as inability, non-wanting or punishment for some misdeed than as disease. Such stigmatization is accompanied by doubts of oneself as of full and competent person.

Parenthood after successful treatment

When the treatment is successful and the woman gets pregnant, it often happens that the partners do not live it in joyful anticipation but it is a difficult period for them, full of fears and anxiety from the future. It is not exceptional that they do not have the courage to admit the pregnancy, to look forward to the child and to establish a relation with him or her in fantasy. Particularly couples having suffered miscarriage defend themselves against the trauma from the loss they have lived once or several times already. The milestones include the end of the first trimester, which is most risky from the point of view of miscarriages, then the emergence of the child's first movements as a perceptible proof that the child lives and than achievement of the 25th week of pregnancy, because after that week there are significant chances for the child to survive if prematurely born.

The transition into the parent state is mostly pleasant to the partners. They often say that their chart of values has changed thanks to the suffering lived, and so they are able to enjoy better their parenthood than if becoming parents without problems. The arrival of the child into the family imposes demanding tasks, which can nevertheless be managed. In the moments when the tasks seem unmanageable, the parent can think of why he does not manage them. They are usually high demands on himself as parent or doubts of himself as parent. In parents for whom the parenthood was not a self-evident thing, such doubts are even escalated by perceiving the failures related with the effort to get pregnant and carry the baby to term as incapacibilities. So such parent can put the problems related with managing new tasks, which the person ascribes to a new and unknown situation under normal circumstances, in connection with the causes of fertility disorders (the nature knew why it denied me the parenthood) or with the consequences of the treatment, e.g. with psychical fatigue.

Today people are not ashamed of having got pregnant after assisted reproduction so much any more; some of them do not conceal such fact against the environment. But a great number of them consider it their purely private thing and they do not communicate such facts to anybody also in order to protect the child against inconvenient comments. An urgent question is whether to communicate the circumstances of the conception to the respective child born in such way. Particularly the entry of a third person, i.e. gamete donor, into the therapy is ethically, psycho-socially and legally a complicated and lately very intensely discussed issue. Some states introduce the so called “open identity”, i.e. the practice when the child is informed that he or she originated from donor gametes and he or she is given the possibility even to meet the donor. It is said that the child has the right to know his or her biological parents according to the Convention on the Rights of the Child. Experts state another reason for “open identity”: the non-communicated important information can provoke the parents to feel guilty against the child and the “family secret” can seriously disturb the child-parent relation. There are not sufficient studies available yet, from which it could be deduced whether anonymous or non-anonymous donation is better. The fact is that it is not easy to deal with the topic of perception of parenthood after use of donated sperms, ovula or both of them. The parents have suffered more than enough institutions and interventions from outside on their way to the child, and they want to live normal family life without interventions of anybody including researchers now. It is methodologically impossible to deal with advantages and disadvantages from the child’s point of view.

In my personal opinion, the main variables in this issue are the parents’ personalities and attitudes. Therefore I consider it necessary that the partners to whom the donation helps to become parents consider such questions in advance very carefully, seek answers in literature or possibly consult their opinions with experts and only then decide which strategy to choose. It is definitely not wise to share the fact of having used donated gametes with the environment, and not to tell the child anything. It is easier to pass from the strategy of “not telling” to the strategy of “telling” than vice versa. The donation is anonymous by law in the Czech Republic.

Parenthood after unsuccessful treatment

The only difference in the biological relationship towards the child as against the previous part can consist in the fact that there, the child was born to the parents. But it need not have genes of any of the parents, if donated gametes were used. Our country has two methods of taking an abandoned child into the family: adoption and foster care. Little is known of living and managing adoptive motherhood and fatherhood. Doubts of one’s parent abilities can emerge even before the child is taken into the family. The pre-adoption examination is a very demanding process, the partners undergo psychological examinations and consultations where they are forced to consider themselves as parents in advance. But frankly – who can say about himself with a clear conscience that he will be good parent?

The three-month pre-adoption care means temporary partial loss of privacy and constant fear that somebody could suddenly say that I am not good parent and take the child away from me. Relief comes only after the court proceedings have been concluded. Most parents perceive the arrival of the adopted child as pleasant. But for some, the situation is burdening and difficultly manageable. The new situations bring demanding tasks both to the biological and to the adoptive family. The adoptive parent can think perhaps even more easily than the biological one that the difficulties related with managing the tasks can follow from the causes or consequences of fertility disorders. The consequences include, besides possible psychical consequences of long-term unsuccessful treatment, also the biological consequence, i.e. lack

of kinship with the child. Special problems with which the adoptive parents must cope are the non-fulfilment of biological parenthood, acceptance of the adoptive parents and particularly special upbringing tasks, mainly the communication of the fact of adoption to the child.

External influences

A person who wishes a child in vain is understandably not isolated, he lives in a social group (original family, friends, colleagues, neighbours, ...). How does the environment react to the parenthood of originally childless parents? This fact is stressed when people speak about children or parenthood of a person whose way to the child has not been easy. The child is sometimes considered somehow different and the errors in the parents' upbringing efforts are not justified e.g. with their lack of experience but with the fact that the child did not arrive by himself and the parents were branded by it. A stand-alone and extensive topic is the sight of the environment on adoption or foster care; I refer those interested in information to the relevant professional literature. Here I would only like to add that thanks to the activity of the media, the picture of adoptive parents has become markedly better and their decision to care for an abandoned child is valued. Adoptive or foster children are sometimes urged by the environment not to be naughty and to be grateful to the parents who have actually saved their lives. If such pressure is exerted on the adoptive or foster child, the adoptive parents should not hesitate and tell the child as seriously as possible that he or she is the one who has saved their life. Or is it not true?

Parenthood after successful treatment is perhaps more demanding than parenthood without obstacles. Adoptive parenthood is certainly more demanding than biological. I think personally that it is of big or even decisive influence that the parent after treatment must seek answers to questions that would not have occurred to them under normal circumstances... Expert studies prove that such parents are well equipped to fulfil more demanding tasks, because the way to the child has deepened their partner relations and gave them the possibility to mature internally. These are certainly very important preconditions for good parenthood and reasons for believing in oneself.

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Harmonization of family and professional life

Michaela Marksová-Tominová, former manager of family policy at Ministry of work and Social Affairs, now in parenthood leave

Although last year more children were born than people died for the first time from the crisis of the Nineties, the danger of demographic fall persists. The thing is that at present, the population-strong age-groups, the so called “Husák’s children” started giving birth – and when they stop, the problem will emerge again. But the whole Europe is confronting it. A number of scientists and demographers try to find a recipe allowing people to have so many children as they wish according to the public opinion polls. It is not easy; the situation and the culture are different in each European country, and the pro-family measures differ as well. But we can find at least one common denominator: more children are born in countries where the parents – particularly the mothers - have the possibility to harmonize professional and family life and need not select strictly between the career and the child.

The fact that our politicians finally started getting aware of the serious situation could be seen before last parliament elections – there was no big political party not promising to do something for families with children or not stressing what it had done in the past period. Let us recapitulate the essential changes from the period of 2002-2006:

- The parent allowance was first increased from 2.500,- to 3.635,-; close before the elections, the proposal of the deputy Severa (KDU-ČSL) for rise of the parent allowance was passed, so that its amount corresponded to 40% of average wages; so it has been 7.582,- CZK a month since January 1, 2007.
- Since January 1, 2004 the restricted amount of additional earnings for persons at parenthood leave was cancelled, so that the mother or the father can earn so much extra money they want, drawing the parenthood benefit at the same time (provided that they comply with the condition of due whole-day care for the child, i.e. the child stays in an institution 5 times a month as a maximum).
- Since October 1, 2005 it was made possible to draw the parenthood benefit even in case of simultaneous drawing of the benefit for care for a close person, which improved markedly the conditions for care for handicapped children in family environment.
- A child over 3 years of age can visit the kindergarten or a similar institution up to 4 hours a day under preservation of the claim to parenthood benefit since February 1, 2006.
- The birth grant has been increased to 17 500 CZK since 1/4/2006.
- For children entering 1st class of elementary school coming from families that draw the child benefit, a new benefit, the “benefit for school aids” (the so called “crayon benefit”) amounting to 1000,- CZK has been introduced. The claim to such one-off benefit originates by June 1 to any child entering the first class, if it has been enrolled to compulsory school attendance and has claim to child benefit for the month of May.
- Marked new tax relieves have been introduced as well, consisting particularly in introduction of common taxation of married couples with children, in change of deduction for the dependant child and in introduction of tax bonus improving substantially the income situation particularly in families having lower incomes.

An amendment of the Act of health insurance was elaborated, introducing three important changes from the point of view of parents with children (*that amendment should come into force from 1/7/2007, but as the political parties have not agreed on it, the force is in distance beyond sight for now*):

- a) the possibility of parents – insured persons to take a turn once in caring for an ill child during 9 days, each of them having claim to health insurance benefit - the so called nursing benefit - during the care;
- b) the claim of the child's father (regardless of whether he is husband of the child's mother) to draw the motherhood benefit (i.e. the benefit corresponding to the current motherhood financial assistance) in a period from the 7th week after the childbirth at the earliest (the possibility of drawing the motherhood benefit has still been restricted only to situations when he is a single father, widower or a father whose partner cannot care for the child because of her health condition);
- c) claim to nursing benefit for an employee who cannot perform work because of care for a household membership who has just given birth, if her condition immediately after the childbirth requires it.

As for the current government, it mentions problems concerning families with children at several places:

Taxes: "The government will introduce united income tax for natural and juristic persons amounting to 17 to 19%, it will give preferential treatment to families with children and to low-income inhabitant groups."

Parenthood and maternity leave: "The government will propose a multi-speed flexible parenthood and maternity leaves with degressive payments in the course of the years and with restriction until three years of age of the child, including support to development of services for families and care for children under three years of age."

Pensions: "The changes in the pension system will be based on preservation of inter-generation solidarity, rise of individual responsibility and support to families with children."

We will still have to wait for particular form of what is written in the government declaration. Nevertheless, it is obvious now already that this government wants to change something from what the previous government did: to reduce the birth grant again (but probably down to a higher amount than the original was), to cancel completely the "crayon benefit", and as for the amount of the parenthood benefit - it can be expected here that the parent who spends shorter time on parenthood leave will obtain higher benefit.

The question remains which of the above stated measures are really efficient for improving the harmonization of family and professional life. I believe that e.g. the reduction of parenthood leave is such measure - but it must be followed by the possibility to work in part-time job, and last but not least by strengthening of services for families - particularly existence of available institutions of care for children including for those under three years of age. But such institutions are established mainly by the municipalities, not by the state, so the question remains whether the municipalities will be able to react flexibly to the reduced parenthood leave. I personally maintain optimistic position: The things start moving and I

believe that the conditions for parents of small children so that they can lead both professional and family life will be better and better. If not, we will soon die out.

You can find other information: www.rovneprilezitosti.cz, www.mpsv.cz

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Reactions of visitors of the www.neplodnost.cz portal

Tomáš Mařík, sponsor representative

The visit rate of the www.neplodnost.cz internet portal has become steady over the average of 2000 visits/day, sometimes even exceeding 2500 visits/day. The columns “Discussion forum” and “Advisory centre” contribute significantly to it. While the former is open to all users and the only restriction for active contribution consists of the need of registration, the latter is restricted only to the inquirer (which is almost always a woman) and to the expert on infertility treatment. The restrictions were called for the completely endless discussion exceeding (fortunately only very rarely) the boards of general decency and correctness. In the “Advisory centre”, the expert on reproduction medicine answers only to the inquirer who can refer to him with her specific problem and he answers her question pointedly. His answers, advice and recommendations help undoubtedly a number of inquirers at infertility treatment. The proof is not only the increasing interest in this service but numerous words of thanks from the inquirers both to the expert for the patience in formulating the answers and to the site operator for its administration and updating. Several year long operation of the internet sites and particularly of the two above stated columns allow us giving our opinion to the question which problems trouble the infertile couples the most, which circles of questions they give to the experts and to the other discussants on the internet sites, how they live their fight for having their own child, what troubles them and what satisfaction the possible success brings them. The discussion forum has evidently made friends of a number of patients participating in the treatment process; they arrange meetings, advise each other and above all give each other incredible psychological support. It is typical that only a limited number of first contributions is immediately related to the topic given, and later the discussion passes to quite general things, frequently strongly deviating from the original topic – i.e. from the troubles related with the incapacity of getting pregnant. Women solve very frequently problems of man’s infertility and it is obvious that they are ready to do a lot in order to improve the “home” spermogram. They consult it also with the expert and their suggestions evidence a generally high level of faith in different alternative ways of infertility treatment. Chatting on the topic of the way to the child brings a special vocabulary reflecting their emotional relationship to the gametes, the health and vitality of which is decisive for the success of their effort, and to the resulting embryo as germ of a new life. On the contrary, they do not scant critics and disappointment if the arrival of menstruation bleeding indicates failure. Judging from the discussion and the questions, waiting for the result from embryo transfer to the first gravidity test must be real purgatory and a lot of woman cannot concentrate on anything else in that period, blaming subsequently small things (e.g. light physical effort in chores or in the job, longer car journey, family differences etc.) for the failure subsequently.

The state of mind of the discussants is already reflected in the names of the discussion topics (“in the children rooms” in the vocabulary of some women):

Swots from Moravia

Candidates for IVF, unify

They have it easy saying “DO NOT PANIC”...

Pregnant women and mothers

Effort – disaster for intimate life

Tenderness and emotionality is reflected particularly in the names of gametes and embryos, in the quality of which the women rightly suppose the base of future success of their effort:

Folicles, ovula

- ... My **ovula** are probably in shell or what... like actual hen, isn't it?
- Important is that my 7 brave **follies** are OK...
- ... there were 22 **ovies** so that the harvest is too big...
- The **ovulina** were kind of sleepy, so that we had to wake them up with bigger dosage...
- ... all of the **ovies** were fertilized, but one embryo stopped developing and 2 spermies entered into another one...
- ... I wish you that the **folliclino** grows well and that you manage it...
- I have stimulated only one **ovulino** to burst...

Sperms

- ... he has insufficient quantity of the **small blasties** and some of them miss tails, so that they have difficult life...
- ... slow **spermies** are today no problem any more...
- ... my husband has 300 millions mobile **sperminos**...
- ... we have max. 8 millions **spermitinos**, movement 30%-50%, a part of them shows degenerative signs...

Embryos

- I hope the **embryoni** are already well teethed into!!!!!!!
- ... the **embryitos** started to hatch themselves...
- ... they introduced the **embryinos** too far in the transfer, so perhaps they put them somewhere in the corner to you...
- ... I wish it comes out as well as possible and the **dear embryos** develop successfully!!!
- ... I cross my fingers for you that the **babies** screw themselves well...
- ... I wish your **chuckies** like being with you...

The above stated high visit rate of the infertility internet sites called us to use it for finding out the anonymous opinions of the visitors on a number of aspects of infertility treatment in our country. We were pleased by survey questions and answers showing high level of knowledge of this problem in our lay public, stress on quality and efficiency of the selected therapy procedure, tolerant approach to such a sensitive and intimate issue like gamete manipulations or e.g. donation in assisted reproduction and last but not least the wish to come to the longed-for target – birth of one's own child. Nowadays it is no exception in infertility treatment: according to qualified estimate from the end of last year, about 23 IVF children have been born in the Czech Republic already, and at present, the percentage of IVF children in population of all individuals born in our country exceeds 3%. For illustration of the above stated facts, I further present some interesting survey questions and answers:

For me, it is most important in infertility treatment, besides the final success:

| | | |
|--|------------|-------|
| decent and amiable behaviour and environment of IVF centre and its staff | 106 | 56,7% |
| maximum level of information | 38 | 20,3% |
| financial matters | 30 | 16,0% |
| understanding of the closest circle of family and friends | 13 | 7,0% |
| Total votes | 187 | |

In case of my husband's/partner's infertility:

| | | |
|---|------------|-------|
| I can rely on his understanding for using donor sperms at IVF | 91 | 59,5% |
| I myself would not like sperm donation | 45 | 29,4% |
| sperm donation is out of the question because of my husband/partner | 11 | 7,2% |
| I would solve the situation with another partner even at the price of divorce/separation because of my wish to have a child | 6 | 3,9% |
| Total votes | 153 | |

As for my partner's understanding for infertility treatment:

| | | |
|--|------------|-------|
| I have his understanding, support and cooperation from the beginning | 176 | 85,9% |
| I had to fight for his cooperation | 23 | 11,2% |
| I am confronted with misunderstanding for now | 6 | 2,9% |
| I cannot even think of my partner's cooperation and support | 0 | 0,0% |
| Total votes | 205 | |

| | | |
|--|------------|-------|
| The main reason to terminate the infertility treatment was for us: | | |
| birth of our own child | 90 | 46,2% |
| financial reasons | 42 | 21,5% |
| coping with childlessness | 20 | 10,3% |
| our age | 14 | 7,2% |
| a child's adoption | 12 | 6,2% |
| medical reasons on the woman's side | 8 | 4,1% |
| other family reasons | 8 | 4,1% |
| medical reasons on the man's side | 1 | 0,5% |
| Total votes | 195 | |

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