Would it not be possible to maintain supplies of urofollitrophin (Metrodin (Serono)) until further consultation? In addition, Organon has just launched a gonadotrophin preparation with low luteinising hormone concentrations (Normegon). Perhaps, Serono will reflect on the consequences of its unilateral action.

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Manufacturer's response

EDITOR,—The human gonadotrophin preparations that have been used for 30 years are crude urinary extracts: 95-98% of the proteins are derived from serum and urine, and the hormone constitutes only 2-3% of the proteins.

The urine derived proteins in these preparations are uncontrolled and mostly unidentified; some are biologically active (uromodulin, IgG, epidermal growth factor, etc) (unpublished data). In analytical tests this heavy bulk of proteins masks the follicle stimulating hormone, which therefore is not characterised with respect to its isoform composition and profile. The only quality control is an in vivo animal bioassay developed in the 1950s, and this has a large inherent variability.

Recently, state of the art purification methods have been applied to obtain follicle stimulating hormone that is more than 95% pure, the other proteins being reduced to a minimum. To increase purity from 2-3% to over 95% entails severe losses during purification and expensive procedures. Stringent quality control of the highly purified follicle stimulating hormone preparation (Metrodin high purity (Serono)) is of a physico-chemical nature and guarantees batch to batch consistency of the hormone. This may reduce the intercycle variations in patients' responses that were observed with former gonadotrophin preparations.¹

The large amounts of extraneous proteins in gonadotrophin preparations have important clinical disadvantages. A recent report described severe local reactions to crude urinary gonadotrophins that did not reappear when the highly purified follicle stimulating hormone preparation was administered.² Further case reports from other countries confirm this observation.

Metrodin high purity is suitable for subcutaneous self administration, which appreciably reduces the stress and the financial burden of treatment as injections may be given at the patient's convenience without the need for frequent trips to a clinic or general practitioner's surgery. Thus the availability of a highly purified follicle stimulating hormone preparation may reduce the stress of infertility treatment, a factor linked to some cases of failure.³

In summary, Metrodin high purity is a state of the art drug whereas the old gonadotrophin preparations are obsolete crude urinary extracts. When a high purity drug is available the use of crude extracts cannot be justified. Serono has therefore discontinued Metrodin in the United Kingdom. Administration of a human gonadotrophin preparation such as menotrophin

(Pergonal (Serono)) is justified only in a small proportion of patients with hypogonadotrophic hypogonadism. In the near future the recombinant gonadotrophins that we are clinically evaluating should become available and replace all urinary preparations.

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Increasing rate of deliberate self poisoning

EDITOR,—We note with interest the recent figures highlighted by the Samaritans showing that the incidence of suicide in males seems to be increasing. Our experience indicates that this also applies to hospital admission for deliberate self poisoning. Since 1987 the Cardiff Poisons Treatment Unit has received more than 90% of all patients admitted with self poisoning in South Glamorgan (population 403 400). The table shows the data on men and women.

Although violent methods and gassing are the commonest means of committing suicide or

Numbers of men and women admitted with self poisoning in South Glamorgan by year with ratio of men to women

	1987	1988	1989	1990	1991	1992
Women	513	464	537	582	537	629
Men	299	283	357	432	441	557
Total	812	747	894	1014	978	1186
Men: women	0.58	0.61	0.66	0.74	0.82	0.89

inflicting fatal self injury in England and Wales (36.8% and 30.4% of deaths respectively),¹ self poisoning is the cause of death in 22% of cases. Non-fatal incidents of deliberate self poisoning may identify men at risk of subsequent fatal events. A regional poisons unit, as advocated in a report of the Royal College of Psychiatrists in 1983,² enables psychiatric and social support to be coordinated for such patients as soon as they have recovered medically; we commend such an approach in tackling this difficult problem.

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HIV infection in Uganda

EDITOR,—In the Rakai district of Uganda, Maria J Wawer and colleagues have shown that, despite universal knowledge of AIDS, extensive education, and programmes for distributing condoms, the incidence of HIV infection remains high.¹ The failure of such programmes to curb the epidemic

may not be unique to Rakai, given that HIV continues to spread in many parts of Africa where prevention programmes exist.² Rather than intensifying programmes,¹ however, we must ask why the necessary behavioural change has not occurred. We therefore conducted in depth interviews about the context in which people have sex. We drew our sample—17 key informants from three villages in Rakai and 31 female prostitutes and 44 other residents from Kimwanyi, a poor neighbourhood of Kampala—from those used in two unpublished studies that required representativeness of the population.

Preliminary analysis suggests the importance of three themes. Firstly, despite knowledge that a man has died of AIDS the tradition of "widow inheritance" continues; secondly, technical knowledge of use of condoms is poor: 25 of 32 men expressed uncertainty about how to put on a condom; and thirdly, many places where sexual intercourse is practised lack privacy and this thus adds stress to sexual play. In Rakai all respondents were or had been living with their parents until marriage; as love making is prohibited in the parents' house they could have sexual intercourse only in the banana plantation and the bush. In Kimwanyi 31 of the 44 non-prostitutes had frequented public latrines, 19 had used back streets, and 22 had used the bush for sex with premarital or extramarital partners in the past five years. Most of the prostitutes (26 of the 31), however, took their clients to their rooms, regardless of the presence of others.

Several questions emerge from the above. Firstly, why do men sleep with widows of men who have died of AIDS and why do widows have new sex partners? Secondly, how can young people learn to use safer sex? Thirdly, how can people practise safer sex in the bush? There are no straightforward answers, but, clearly, information in itself does not make people change behaviour. Sexuality is deeply rooted in people and cannot be modified in isolation of sociocultural and emotional aspects of life. Sex education will continue to remain difficult, but, unless contextual factors are taken into account, studies like that of Wawer and colleagues are likely to continue to generate concerns about the adequacy of prevention of transmission of HIV in many parts of Africa.

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Women's reproductive health

Women left destitute by AIDS

EDITOR,—Though women's reproductive health in the developing world undeniably depends on a country's "social, economic, and cultural pressures,"¹ the profound additional influence of HIV infection and AIDS should not be forgotten. Uganda seems to be doing its best to wake up the world. With 20 years of unrest and civil war, a ruined economy, minimal healthcare equipment, a dearth of medical professionals, and a 12% prevalence of HIV infection in the adult population, Uganda may seem from the outside to have a problem too bewildering to contemplate. Yet with insight into Ugandan society it is possible to under-