

SEXUAL AND
REPRODUCTIVE HEALTH
IN A MULTICULTURAL
EUROPE



Entre Nous

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Sexual and reproductive health and rights in a multi-cultural Europe

We would like to start this editorial with thanks to Dr. Assia Brandrup-Lukanow, who was the Chief Editor of *Entre Nous* for many years and who has made the magazine interesting for a broad range of readers not only in Europe, but throughout the world. We wish her the best of luck with her new position at the German Agency for Technical Co-operation (GTZ) and are pleased to welcome her as a member of the editorial board.

The acting chief editor, Dr Gunta Lazdane, comes from a different social and cultural back-

ground than Assia. Born in Latvia, one of the fifteen republics of the former Soviet Union, she lived there at a time when the Beatles were forbidden, when family planning was not available and sexual health was taboo, be it at school or with service providers. This past, which affected so many people in the European

Region, is one of the reasons why multiculturalism is so important a topic for *Entre Nous*.

Culture, traditions and individual perceptions are among the prime factors shaping individuals' reproductive and contraceptive decisions. But what makes sexual and reproductive health (SRH) such a contentious issue? Against the background of rapid population decline in many European countries, advocacy for fertility regulation is often criticised. Yet proponents of SRH programmes and legislation like the United Nations Population Fund (UNFPA) and the World Health Organization are not "working for having fewer children". Our programmes work to reduce maternal

mortality and to move from abortion to contraception, and supporting safe and legal abortion is a natural part of these activities, as is eloquently described in an interview with Thoraya Obaid, the Executive Director of UNFPA, on pages 4 to 5.

This is not always easy in a region with vastly differing cultures, traditions and economic backgrounds. And this is compounded by the US government's attack on a woman's right to choose an abortion. As Vicky Claeys, the new regional director of the International Planned Parenthood Federation (IPPF), describes on pages 16-17, a whole new mindset is needed in Europe because of President Bush. More European funding has been needed to protect sexual and reproductive rights in the light of US cuts to IPPF and the UNFPA. And it was found. Almost half the EU Member States as well as the European Commission immediately increased their contributions to both organizations in response.

Culture and religion are often closely linked and all religions have an opinion on sexuality and human reproduction. There is an emphasis on the role of religion in the current debate because of the increasing difficulties being faced by proponents of sexual and reproductive health as a result of the influence of the Church. It is interesting in Europe with one part (western) where Church influence is diminishing (particularly Ireland) and others, like Poland, Slovakia and the Russian Federation, where it is on the increase. As Dr Nafis Sadik discusses on pages 6-8, the Cairo and Beijing consensus "present every culture with a challenge; but the mark of a lively culture lies in its ability to cope with, adapt to and draw strength from change". In it she laments the Catholic Church's turning a blind eye to preventable maternal deaths, unwanted fertility and the enhanced risk of HIV infection due to their unswerving opposition to abortion and all forms of birth control. However, it should not be forgotten that in a programmatic context any religion has many voices.

Martine de Schutter and Lucie van Mens, on the other hand, present a European initiative targeting the women of the general population of western Europe (pp.12-13). Their network for the prevention of HIV/AIDS and sexually transmitted infections (STIs) in Europe,

called PHASE, draws attention to the increasing incidence of STIs in Europe and the lack of a gender approach. Best practices are not just about availability of condoms, but empowering women to take action in relation to their sexuality and negotiate their sexual relationships. Their newly published volume on best practices is particularly relevant for migrant women.

Social aspects influencing sexual and reproductive health often centre on stigma, isolation and discrimination. Dr Peter Weis writes on pages 18-19 about an Argentine-German initiative which turns target groups into advisers and counsellors. Persons living with HIV/AIDS, often part of vulnerable groups like commercial sex workers and men who have sex with men, are now being helped to develop, implement and evaluate projects for people with HIV. This initiative is similar to that of the political and social participation of young women and men as agents of change in the promotion of health, a subject that will be addressed in more detail in the next issue of *Entre Nous*, which reports on peer training and youth education.

The contributions in this issue of *Entre Nous* overwhelmingly reflect a need for policy to reflect the realities of the current day by revisiting the ICPD Programme of Action, which calls for the elimination of discrimination against girls and women and for the right to freely decide the number and spacing of children. To varying degrees, all 52 countries of the European Region still face this challenge. The Cairo and Beijing meetings laid the groundwork for the progress that has been made to date but maintaining and building on these successes in a multicultural society is the challenge.

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LET WOMEN MAKE CHOICES

An interview with Thoraya Obaid, Executive Director of UNFPA

By Marcia Gillespie

The United Nation's Population Fund (UNFPA) supports family planning and maternal health programs in more than 140 countries that have helped women make reproductive choices and reduce infant and maternal mortality rates. Yet, despite its impressive track record, it has long been a target of anti-choice members of Congress in the United States who have used the "Global Gag Rule," the statute that prohibits any US support of overseas family planning programs that include abortion, as a cudgel. From 1986 until 1992 these zealots succeeded in blocking US support for the fund. This stranglehold was broken when Bill Clinton stepped into the Oval Office, and surprisingly continued during the first year of the George W. Bush administration. That ended in 2002 when the Bush administration froze an appropriation of \$34 million for UNFPA, after anti-choice politicians in Congress charged that UNFPA was supporting China's coercive abortion policy. In July 2002, after months of stalling, the administration officially announced that it was withholding the money. A letter announcing the decision, signed by Colin Powell stated, "regardless of the modest size of UNFPA's budget in China, or any benefits its programs provide, UNFPA's support of and involvement in China's population planning program activities allows the Chinese government to implement more effectively its program of coercive abortion." This despite the fact that a review of the Fund's program in China by the US State Department had found "no evidence that UNFPA has knowingly supported or participated in the management of a program of coercive abortion," and recommended that the money be released. The Bush action also cynically ignored that US funding has always required that UNFPA maintain a separate account for US funds and prohibited their use for abortion-related programs and for any of its work in China.

This mean-spirited decision not only distorts the facts in regard to UNFPA's work in China, it places the health and lives of millions of the world's poorest women and children at risk. According to UNFPA, the loss of the US contribution—12% of its \$270 million budget—will translate to two million more

unwanted pregnancies, 800,000 more abortions, 4,700 more dead mothers and 77,000 more deaths among children under five. Although the US funds will be directed to international health programs run by the United States Agency for International Development (USAID), that organization's reach is only slightly more than half of the countries UNFPA serves. Commenting on this action in the Washington Post, David S. Broder aptly stated, "when our government allows special-interest pleading to cost lives, it shames us all."

Late in 2002, I met with Thoraya Ahmed Obaid, the Executive Director of UNFPA, to discuss the organization's work, and the impact of the withdrawal of US funds. The third person to hold this position, she was appointed in October 2000 by Kofi Annan, the UN secretary general, and took over the post in January 2001. Helping governments establish programs to empower women has long been a central focus of her work. The former director of UNFPA's Division for Arab States and Europe, Obaid also served as the Deputy Executive Secretary of the Economic and Social Commission for Western Asia, where she provided technical assistance to counter gender inequality, as an integral part of social development programs. In 1975, she set up the first women's development program in Western Asia helping governments establish national organizational units for women. Obaid is the first Saudi Arabian woman to receive a government scholarship to study at a university in the United States. Of her work Obaid—who divorced and remarried and is the mother of two daughters—says, "I've had a good life. I got an education, I have good health and healthcare, I have healthy children and a happy family—I've been able to make choices. And that's what I want for all the women of the world."

On the work of UNFPA

Seventy percent of our resources go to the area of reproductive health in terms of decreasing maternal mortality, increasing the number of trained birth attendants, decreasing teenage pregnancy, prevention of HIV and other sexually transmitted diseases, preventing violence against women, and promoting girls edu-

cation. Those are the basics. Our main focus is to create an environment and provide tools so that women and men can determine the number and spacing of their children. Our focus is not on control, it's on planning. For example, in Afghanistan we are assisting the government with censuses, building statistical services, training personnel and monitoring information systems in the area of demographics and health.

I believe that creating a better dialogue that includes and addresses religious and cultural beliefs and practices is extremely important. Last year we began to become more active in this area with the help of the Swiss government's funding of a post for gender and culture. And we have also created an organizational unit focused on culture, gender, and human rights in the technical area. The idea is that no issue is one-sided and each issue must be explored from every side. Gender crosses everything. Human rights is the framework for all of our work and includes much more than civil rights, it encompasses social, economic and cultural rights as well. And there is so much in religion and culture that resonates with human rights.

At the country level, when we are developing a program or project, we first have to assure that the community is on board with us. This will not happen unless you speak their language, understand and work to incorporate their values, and cultural and religious beliefs. And there is so much in religion that is compassionate. So the question becomes, how do you use this compassion to stop violence against women, or promote women's rights, or prevent maternal mortality for example? The idea is to build on those positive beliefs within the society so that communities can help themselves within their own context.

How do you address or circumvent patriarchal belief and practices within cultures and religions?

I believe that essentially all religions are pro-people. It's a matter of interpretation. I was brought up in an Islamic context. My parents saw Islam as a force for good, a force for change, rather than as a restrictive belief system. So I know that it is how you interpret religion and the spirit of the religion that is important. We should be able to select the

Funding UNFPA

In response to the Bush administration's decision not to fund UNFPA in 2002, Lois Abraham of New Mexico and Jane Roberts of California initiated a campaign to encourage 34 million

people to donate a dollar or more to the UNFPA. Donations are accepted by check made payable to "The UN Population Fund," to The UN Population Fund, Attn: Chief, Resource Mobilization Branch,

220 East 42nd Street, 23rd floor, New York, NY 10017, USA. Alternatively, you may make a tax-deductible donation at www.uscommittee.org.

interpretation of the religion that is closest to its essential spirit which I believe is the happiness of human beings. And I believe that we can do a great deal if we can establish a dialogue based on the principle that women should not die giving birth, that women should be able to plan their lives, and that women should not be beaten and suffer violence.

The financial impact

Although several governments have stepped in to help, nobody can fill a gap this huge. For example, the European Union, in a vote of confidence in UNFPA, pledged 32 million euros, an equivalent amount of US dollars. But that money is not for one year—20 million was designated over several years for use in 13 countries. Although we are trying to minimize the impact on the countries by making significant cuts here at headquarters—in administration, travel, and staff training—we are a small organization and our administrative costs are not very high. The overwhelming majority of the money in our budget goes to

our programs, so we will have to make cuts there. Programs that were slated to start this year have been cancelled. There will be no expansion of many existing programs and no major purchases of equipment and other related tools and supplies. As a result, we will be serving fewer people, and the quality of our services will be impaired, and at the end women will suffer from it. For example, a program in Kenya focused on safe delivery and maternal and infant survival in eight rural districts will have to be cut. In India, in the state of Maharashtra, a safe delivery program in remote villages may not be initiated and other pre- and post-natal programs will be cut; several projects to treat and reduce the spread of sexually transmitted infections will be discontinued; and plans to open a counseling and legal aid center for women who are victims of violence will be put on hold. In Burkino Faso our work rehabilitating safe health care facilities will be curtailed, as will a program in Vietnam to train 4,000 health-care workers and supply 500 clinics in remote mountain-

ous provinces with essential medical equipment and drugs. And in Bangladesh, where one woman dies every hour from complications during pregnancy and childbirth, a program that trains doctors in emergency obstetric procedures is now in jeopardy.

Would you leave China?

I was asked if I would be willing to withdraw from China to secure the US funding, and I said "No." With the board's authority I will remain there. The UN is a universal organization, a multilateral organization. It works with every country as long as they abide by the principles of human rights and the Cairo Agreements.

by Marcia Ann Gillespie, former editor in chief of Ms. magazine. Currently a writer and consultant based in New York City.

Excerpts reprinted with the kind permission of Marcia Gillespie and Conscience, a newsjournal of Catholic opinion. The full text article first appeared in Conscience, Winter 2002-3.

In Her Own Words: Thoraya Obaid on religion

Religion Counts

Religion is a powerful motivating force. I can name five main reasons why religion counts when addressing such a sensitive agenda as the Programme of Action for Population and Development [agreed at the 1994 International Conference on Population and Development (ICPD) in Cairo] that guides our efforts.

First, religions share a common moral position with regard to the vulnerable in societies and this moral concern meets the concerns of the United Nations for justice, compassion, solidarity, equality and respect. Furthermore, most people worldwide derive their values from religious beliefs.

Secondly, religion counts because it is a safe haven for people. It is a way of trying to bring order and meaning to the chaos of the rapid changes that are taking place—chaos that is often perceived in the South to be a result of globalization, growing inequality, poverty, and military conflict—in other words, a result of an unjust global system.

Over the years, the United Nations Population Fund has partnered with reli-

gious institutions and faith-based organizations to fashion groundbreaking initiatives to advance common goals and to save lives. Many religious leaders have been supportive of efforts to prevent the spread of HIV/AIDS, to encourage safe motherhood and to uphold the dignity of women and men by affirming their moral capacity to make personal decisions concerning their own reproduction. In our work around the world, we have found that building alliances with and involving members of religious traditions are factors that can actually determine a program's success or failure. This is especially critical in traditional societies where women's actions to regulate fertility may disturb a social contract and where control over women is strong.

Thirdly, religions have constituencies who serve in public and political spheres who decide on major issues, such as policies, resources and programs. Religions have constituencies who are beneficiaries of such programs, and who are capable of mobilizing communities that are empowered to articulate their demands.

Fourthly, religions have institutions that are well-established in communities and provide much-needed services to the

poor, the disadvantaged and the excluded. Constituencies respect their clergy and see them as both spiritual and societal leaders. Consequently, religious leaders exert an influence on how people think and behave.

And finally, religion counts because the dialogue within the United Nations between North and South, and East and West has been about culture and religion, as well as about the politics of power. Thus, the tension ends up being a political confrontation over religious beliefs and cultural values; conflict between the belief and value systems of the various societies.

["Building Bridges for Human Development: The Role of Culture and Religion in Promoting Universal Principles of The Programme of Action on Population and Development," Statement by Thoraya Ahmed Obaid, Executive Director, United Nations Population Fund, at the Center for Contemporary Arab Studies, Georgetown University, Washington, DC on April 25, 2002.]

RELIGION AND PUBLIC POLICY

Correcting the Balance: Excerpts from a paper presented in Stockholm and Madrid, October 2002

By Nafis Sadik



We are considering the role that religion and culture have played in relation to what countries and the international community need to do to meet the Millennium Development Goal of halving the number of people living in extreme poverty, within the next 15 years.

This discussion is very important because it offers an opportunity to consider the progress we have made towards improving reproductive health and rights and moving towards gender equality

Defeating HIV/AIDS, preventing maternal mortality and ensuring good reproductive health all contribute to the ultimate aim of defeating poverty. These goals require a common effort involving not only governments but also civil society—organisations representing people of good will, including faith-based institutions.

The United Nations process aims to generate this common effort by building consensus among its members. The process is cumbersome and inevitably slow. It is delicate, because it includes such a wide spectrum of opinions and approaches. But if all concerned participate in good faith, the results can be impressive.

The Cairo consensus

These were the goals we aimed for in the area of family planning and reproductive rights, and although it took some time, I think that together with governments, civil society and individuals, we have achieved impressive results. When I joined the United Nations in 1970, population was the single most divisive social issue on the international agenda. It was so sensitive that there was barely agreement on how to discuss it, let alone take practical action. Today we have not only agreement, but also action in countries throughout the world, based on the consensus reached in Cairo at the International Conference on Population and Development (ICPD) in 1994.

One of the cornerstones of the consensus is empowering women and improving their reproductive health, as a matter of human rights and as a contribution to development. The other is that—within the framework of universal human rights—each nation is sovereign to make and carry out its own policies. These two principles are buttressed by a third, the requirement for international action.

We have come a long way, but we are not there yet. We also have new challenges, notably HIV/AIDS prevention. The pandemic is already decimating the populations of the worst-affected countries in Africa. In Asian countries, HIV/AIDS is poised to sweep through the population. Yet in the Philippines, for example, the government has ruled out the use of government funds to pay for contraceptives, and has strongly opposed the promotion of condoms. The government justified this policy on the basis that efforts must be made to preserve “the religious and cultural values” of the Philippines.

I am certainly not opposed to preserving religious and cultural values, but I find it hard to understand how exposing people to infection and death preserves anything I would recognise as a cultural

value. This kind of cultural conservatism is one of the major obstacles to progress in the battle against HIV/AIDS and to improving reproductive health and empowering women.

The international consensus

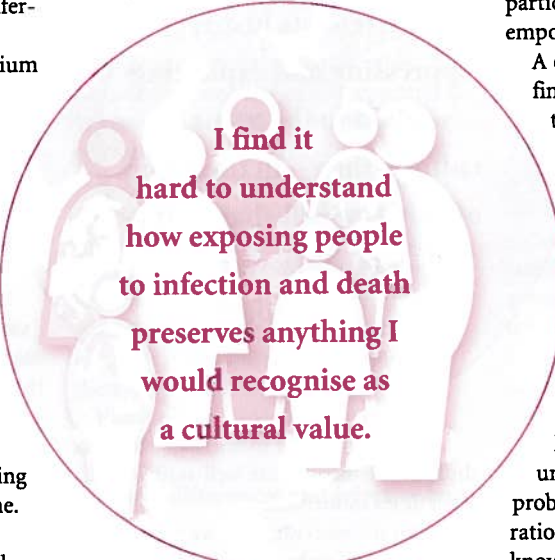
At the international level there has been a consensus on population since 1974, and it has grown stronger and deeper over the years. The great breakthrough at the ICPD was confirmed by the Fourth World Conference on Women in Beijing in 1995. Countries have been pushing ahead on the basis of these understandings. I think it is important to remember this, because the controversy that has been raised at every international conference since Cairo, and the absence of reproductive health from the Millennium Development Goals, might give the opposite impression.

The United Nations consensus-building process is complicated and delicate. A few dedicated opponents can hold it up and sometimes derail it. It is important to note that the opponents to the consensus on population have grown fewer and fewer over the years. In 1974, almost all the countries of Latin America were initially opposed to international action. In most African countries, family planning could not even be mentioned by name. Today, we can count the numbers of opponents on the fingers of one hand.

So, despite determined efforts since Cairo, the consensus on population and development remains in place. Although some national delegations have initially taken a conservative position at international conferences, the eventual outcome has been to protect the consensus language. Sometimes, as at the Earth Summit at Johannesburg, we have had to scramble to alert delegations to attempts to leave out or water down agreed language, but these attempts have always failed. The consensus on reproductive health and women's empowerment grows stronger rather than weaker through these attacks, because delegations are able to see through the tactics of the opposition, and reject them.

I believe that the noise made by the opposition at the international level is in inverse relationship to their real influ-

ence. The great strength of the Cairo and Beijing consensus is that it comes from countries themselves, from governments and from the growing power and influence of civil society, especially the women's movement. Civil society is a term that has come into common use only since the end of the Cold War, but it describes a phenomenon with deep roots in developing countries. The International Planned Parenthood Association celebrated its 50th anniversary in 2002. Back in 1952 it brought together family planning associations in India, Sri Lanka and several other developing countries. Many countries have long-established



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lished professional women's groups and women's associations, including rural women's societies. They are the organizations that made the international consensus possible. In turn, the international discussion of gender issues has empowered these groups and given them a stronger voice.

The Cairo and Beijing consensus is far more than words on paper. It is the distillation of contributions from all of the thousands of participants in the process. Because it is drawn from all societies, the consensus expresses principles common to all societies. This inclusive and universal nature gives the consensus an irresistible moral force.

Attacking the consensus

The Cairo and Beijing consensus is both a measured response to change, and an

attempt to guide it in a positive direction. It presents every culture with a challenge; but the mark of a lively culture lies in its ability to cope with, adapt to, and draw strength from change. Changes of many different kinds are buffeting developing countries today. Navigating them calls for leadership and guidance, but unconditional resistance is the worst of all responses.

The consensus has made it possible for countries to think about population as an essential part of the development process, not a cultural threat or a colonialist diversion. On an individual level, the consensus has opened a lot of minds to the potential for positive change. In particular, it offers women a path to empowerment and equality.

A certain kind of cultural conservative finds this very threatening. I think their reaction reflects a deep-seated fear of women, and in particular of women's fertility. Men in a number of different societies have sought to control fertility and even take it over. Couvade Syndrome, in which a man mimics his wife's birth pangs and takes the credit for producing the child, precisely describes the process, and the reason for it. Many societies continue to ignore unsafe abortion as a major health problem. This is hard to explain in a rational way, because the causes are well known and easily avoidable. However, if we factor in the irrational fear of a healthy woman in charge of her own fertility, the whole thing becomes easier to understand.

The Cairo/Beijing consensus not only offers a way for women to reach equality, but mandates it, starting with universal access to the means of voluntary fertility control. During the Cairo process and ever since then, extreme conservatives—fundamentalists really—have insisted that the real agenda was the promotion of abortion. This is a travesty—it implies for instance that UNFPA advocates family planning information and services in order to encourage promiscuity that results in unwanted pregnancy. UNFPA can then fund abortion programmes, which use coercion to achieve their aims. This is so absurd that it is hardly worth discussing—but we have to take it seri-

ously. The people who make this argument succeeded in denying United States funding to UNFPA in 2002.

According to the ultra-conservatives, the term “reproductive health” actually means “abortion.” At Cairo, they used this wilful interpretation to distort the whole discussion of reproductive health and rights. They pretended, for example, that the proposed language would mean that children as young as 10 would have the right to abortion without parental consent. This is ludicrous, but it shows the devious nature of the opposition. By the World Health Organization definition, adolescence starts at 10, for very good medical reasons: children as young as 10 do get pregnant. This is unfortunate, but it is a fact. Ultra-conservatives at Cairo and since took the position that unpleasant facts like this should be ignored, in the name of what they called “culture.” [...]


This line of argument ignores the whole 20-year process leading up to Cairo, and the language of all consensus documents during that time, which explicitly protects both the sovereignty of states and the right of the individual to free choice. In fact, the language adopted by the UN at Bucharest in 1974 refers to “individuals and couples,” the reference to couples being added specifically to meet the concerns of the Holy See. The process has approached delicate issues—like the rights of parents versus the rights of adolescents—by agreeing on a framework in which countries can debate and decide the issue on their own terms.

[...] Certainly, no cultural value worth the name requires that women be exposed to infection, injury and death as part of their daily lives. If some extremists justify oppressing and exploiting women in the name of culture, then—in the name of values we all share—it is time they were stopped.

The role of the church

Among religious and cultural institutions, the Catholic Church has a unique position at the United Nations. The League of Nations admitted the Holy See to observer status, together with nations such as Switzerland, because it had some of the distinguishing marks of a sover-

eign state, notably that it issued stamps and was a member of the Universal Postal Union. The Holy See has a similar status at the United Nations. In that capacity, the Holy See attends international meetings, and, because of the slow and inclusive process of consensus-building, wields an influence out of proportion to the size of its population. Unlike most small states however, the Holy See has representatives in all capitals of United Nations mem-



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ber states. Its diplomatic missions are well-staffed and sometimes influential.

Cultural conservatives have found a rallying point in the Holy See’s position on reproductive health and rights and gender issues. They have not succeeded in overturning the consensus of Cairo and Beijing, or even denting it. But they have succeeded in creating the impression of an opposition, which has been enough to slow progress towards further integrating population, reproductive health and rights and services and gender equality into international development policy.

This is a tragedy. It is a tragedy because the church has much to contribute. The church has much to say about poverty, its causes and how to end it. The church

could help the poorest countries in the world; it could help the world’s poorest people to escape their poverty.

It is a tragedy because women are suffering and dying, women whose lives and health could be saved. The church could help end the scandal of half a million maternal deaths each year, including 70,000 from unsafe abortion. The church could help to put an end to all the different forms of violence against women: coerced marriage; unwanted fertility; enhanced risk of HIV/AIDS infection; violence in the home; and systematic rape in time of war.

These are the aims of the Cairo and Beijing consensus. Our goals are clear, practical and affordable. More than that, they are necessary. Most of the poorest people in the world are women. The consensus we have built over the last three decades is helping both them and their countries. When we started work, only 10-15% of women had access to family planning. Today, the figure is over 60%. That alone is a real contribution to humanity and to human values shared by all. I hope the conservatives of the world will soon realise that they have real enemies in poverty, oppression and injustice; and that they have nothing at all to fear from women.

Excerpts reprinted with the kind permission of Dr Nafis Sadik. The full text article first appeared in Conscience, a newsjournal of Catholic opinion, Winter 2002-3.

HEALTH ISSUES OF ETHNIC MINORITY AND MIGRANT WOMEN

Coping with cultural barriers

By Margareta Ackerhans

In September 2000, the WHO Regional Office for Europe arranged a meeting focusing on the recommendations from the conference "Health issues of ethnic minority women living in Europe", held in Gothenburg, Sweden, in November 1999.

This article is based on the results of a literature review focusing on health issues of immigrant women living in Scandinavia and includes reproductive health, domestic violence and HIV/AIDS. As there is no universally accepted terminology to describe migrants and non-native ethnic groups, the article uses the terms migrants and ethnic minorities interchangeably to indicate non-native ethnic groups. It is also important to note that not all members of ethnic minority groups share the same level of conditions and it would be misleading to present them as one disadvantaged category.

Health and social exclusion

The rapid increase in migration, war and unrest during recent decades have put ethnic minority and migrant women and their families at higher health risks all over the world. This applies particularly to more than four million women living in the European Region, requiring a response from the public health sector if the goals for equity and health are to be fulfilled (1). Equity in services requires equal access to some minimum standard for everyone. To meet such a standard at least three elements are essential:

- a. entitlement for all without financial or other impediments;
- b. comprehensive services including prevention and public health as well as medical care; and
- c. a society-wide scope (2).

The relationship between migration and health is a complex one, including socio-economic factors such as unemployment, structural and cultural elements, and a low level of education.

Other sources of inequality are gender and ethnicity. The health of migrant women is reported to be worse than men's already upon arrival to receiver countries and continues to deteriorate whilst they are living there (3). However, when discussing health issues of migrant and ethnic minority women, it is important to emphasise that the health care system is only one of the factors influencing people's health.

The Scandinavian countries offer equal service to all citizens and permanent residents regardless of socio-cultural background in order to minimise stigmatisation and exclusion. However, it is still argued that "equal services and policies that are colour blind, not taking specific linguistic and socio-cultural differences into account, might serve to further exclude migrants and others who tend to be rendered invisible in the provision of services to the mainstream population" (4). With some variations, migrant women are the most marginalised groups in the new society. Few international and national guidelines exist in the planning, implementation and monitoring of programmes dealing with this vulnerable group. It is also important to note that there is a reluctance of most national authorities to include ethnicity in the routine collection of health indicators.

Cultural differences and selective barriers

Barriers exist between patients and health professionals. Some of these barriers are easy to recognize while others are more sophisticated like the presence of structural barriers and hidden racism. Some identified factors, like sex roles, language and religion, seem to be of essential importance when it comes to understanding the health and reactions of migrant women. According to sex roles in general, it can be said that the status of women is often closely tied to childbearing age and the husband's position. The degree of oppression (when existing) is related to both social factors and to the competence of the individual women in her different roles defined in the traditional society. It is also argued that restriction in the vocabulary of emotion in different languages might lead to somatisation of the emotional experiences. Furthermore, religion plays a cen-

tral role in many migrant groups.

According to Islamic interpretation, for example, illness and suffering can be considered either as punishment for sin or trial.

This is compounded by a situation in which migrant women of non-European origin are introduced to a new health concept which might be culturally quite different to their traditional one. This means that migrants are exposed to new meaning of words, treatments and familiar concepts, which requires new tools when it comes to describing and coping with illness and distress in the new country. Furthermore, the pluralistic view on health care and treatment combined with differing opinions about ill-health and disease often create unrealistic expectations about what can be achieved by health professionals within the health care service in the new country. Taken together, a weak grasp of the language, a low-level of education and different cultural, religious and social backgrounds, including the women's position in the family and in the society of origin, are present and create communication problems. Moreover, when discussing the health status of migrant women, the degree of acculturation has been shown to be a strong determinant.

Areas of interest

A number of studies have highlighted specific health areas where some certain groups of migrant women are significantly affected. These areas include reproductive health, HIV/AIDS and domestic violence.

Reproductive health

The unsatisfying interaction between migrant women and health care professional has often had unfortunate consequences, particularly during pregnancy. Good pregnancy outcome has a combination of biological, social and cultural origins. Improving obstetric care is more than simply offering good medical services. One also has to take into account the social and cultural background of the women concerned in order to achieve a successful perinatal outcome.

A Swedish study has shown increased perinatal morbidity among immigrants from Ethiopia and Somalia. Potentially avoidable deaths and intrapartum and neonatal deaths are probably related to

pregnancy strategies, such as refusal to participate in antenatal care programmes, avoiding caesarean section or not seeking perinatal care when needed. In Denmark, it has been shown that ethnic minority and migrant women use reproductive check-ups to a limited extent. Furthermore, it has been found that migrant women are less likely to participate in courses arranged before and after delivery, or in other mothers groups. The traditional pregnancy procedures of, for example, Somali women are sometimes not understood by health professionals. Lack of communication between the two sides due to language difficulties and misconceptions might result in a higher incidence of perinatal mortality (5). Also, Turkish women have been shown to be more vulnerable than e.g. Danish women and it is argued that the main problem is related to language (6). It is emphasised that culturally specific prophylactic education should be given. An interpreter could help make the value of birth control and other important issues connected to pregnancy and birth more understandable (7).

A Norwegian study revealed that in all age groups of women living in Oslo, non-western women were over-represented when it came to both birth and abortion rates. The interpretation of this finding is that contraception might be used to a limited extent, which in turn might be related to ethnic or religious affiliation. Moreover, it is argued that the great number of abortions among foreign-born women in Oslo leads to linguistic and cultural challenges for health professionals within the preventive and curative health service (8).

HIV/AIDS

Medical expertise alone is insufficient to tackle the variety of multifaceted problems involved in the spread of HIV/AIDS. Cultural differences seem to be one of the greatest obstacles when it comes to ensuring that information on HIV/AIDS reaches migrant groups. Many developments including a decline in new cases of infection in some groups, and proved medical therapy has significantly extended life expectancy for persons living with HIV. However, all groups have not shared equally in the progress. The number of women infected by heterosex-

ual contact is still increasing. The reason is that women, particularly married women or those in committed relationships, and recent immigrants are not aware of the risks (9).

To date, all attempts to do something positive for these women have been dominated by conventional thinking as seen from a male perspective. The important issues for ethnic minority women are related to their sex, their cultural habits and their economic and social disparities as well as to their traditions concerning pregnancy and procreation.

Domestic violence

Until recently, domestic violence among ethnic minority and migrant women was a hidden problem (10). Women who have immigrated to

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problem

Scandinavian countries with their husbands or have arrived later by help of relatives are at risk for experiencing domestic violence. In some cultures the woman is traditionally expected to be responsible for the happiness, health and honour of the family and therefore she is blamed if family life in the new country does not meet expectations. The woman feels alienated, isolated, far away from family, relatives, friends; she cannot understand the new language and knows nothing about her rights.

There is apparently resistance on the part of health professionals to asking injured women about maltreatment or other conditions, which might be connected to violence, or they are interpreting signals incorrectly. Health professionals often do not have enough time, feel helpless and are afraid of insulting the

woman and her integrity by asking if her partner has physically abused her. It is important, however "to dare to see, to dare to ask and to dare to talk about the forbidden topic" (10) which means to talk about relationships and sexual patterns which regularly cause conflicts. If health professionals keep silent, women themselves are left to face the problem. It is therefore important to inform health professionals about this problem as part of their training and to provide guidelines about how the situation should be handled. Domestic violence within a culture is not just a matter of cultural pattern, it depends on the willingness of men to accept the women as equals. We cannot ignore the fact that patriarchal values exist even in the equality minded Scandinavian countries.

Culturally sensitive strategies

In order to provide better health, equity and the wellbeing of migrant women, specific strategies are required.

However, these strategies are not always possible to implement when targeting migrant women. Health and social care has to meet the demands of the non-Scandinavian born with sensitive approaches, and the foreign born patient must try to understand and get a sense of coherence around what happens to him or her in the new country. There is a need for migrants to learn the national language, which in turn will increase the degree of acculturation, or, in other words, enlighten the process of incorporating characteristic ways of living from the new and differing culture. Aaron Antonovsky describes that health is a feeling that one belongs in certain context, i.e. the development of a sense of coherence, and that general resources are of great importance for maintaining good health under severe stress.

Conclusions

Equity in health for migrant groups has to be improved. Cultural differences are found to influence the health of migrant and ethnic minority women. Culturally sensitive and specific programmes require the involvement of relevant migrant groups when it comes to formulating strategies in order to achieve a balance between a general and a culturally specific strategy. In addition, the integra-

tion of multi-ethnic health professional staff is needed.

Recommendations

In order to reduce health gaps, the following improvements are suggested:

Overall improvements

- national migrants health guidelines and monitoring programmes - well-known throughout the health care system - including guidelines for utilizing interpreters;
- public health interventions targeted at ethnic minorities;
- active participation by ethnic minority women in planning and implementation processes;
- integration of multi-ethnic health professional staff;
- the mutual exploration of meaning between patient and clinician, in which the doctor tries to understand what is beyond the words and expressions;
- education in cultural differences;
- make key persons understand the significance and importance of cultural competence;
- make key persons understand the role of religion as a framework in the meaning making system;
- target ethnic minority groups in order to facilitate mutual exploration between patient and clinician.

Improvements within areas of interest

Reproductive health

- discuss with the patients the delivery concept and the routines required in order to achieve safe motherhood, compared with the methods in the country of origin. It should be explained that it is essential to have antenatal care check-ups, to participate in mothers groups and to seek help as soon as symptoms appear.

HIV/AIDS

- culturally sensitive HIV/AIDS programmes must explain clearly the danger of infection and how to prevent it.

Domestic violence

- health professionals should have good knowledge about domestic violence, legislation and policies;
- battered migrant women should be given help and information, in their own language about social and legal services available to them;
- health and social services must be trained in recognizing situations where

women have been to subject to domestic violence;

- all new immigrants should receive information and education about their obligations and their rights – if possible in their own language by a teacher of their own nationality;
- police, prosecutors and lawyers must be informed about violence against migrant women and the public in general must be informed about how to act and where to seek help.

Improvement within postgraduate education and research

- post-graduate education in the integration of gender and equality in all health programmes is needed;
- more information is needed on the rate of acculturation;
- additional knowledge is required about the health and social situation of migrants;
- more research should be carried out on the health of specific ethnic groups, taking into account geographical origin, religious affiliation and cultural habits;
- new methodologies and health indicators should be developed to measure the health status of migrants;
- interdisciplinary collaboration should be strengthened.

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BEST PRACTICES IN HIV/STI PREVENTION AMONG WOMEN IN WESTERN EUROPE

By Martine de Schutter and Lucie van Meus

The women's network PHASE (Prevention of HIV/AIDS and STIs in Europe) is a project targeting women of the general population in Europe and includes the participation of Austria, Germany, Greece, Ireland, Italy, the Netherlands, Portugal, Spain, Sweden and the United Kingdom. Most of these countries lack a gender approach in their sexually transmitted infection (STI) policies and do not consider women of the general population a priority group for prevention efforts. However, in the European Region, a rising number of STIs are being reported, particularly Chlamydia, gonorrhoea, genital warts and syphilis, as discussed in our publication presented on page 13. Although there is a general pattern of higher STI incidence among men, significant increases in STI diagnoses have been observed among adolescents and women in most of these countries. The observed trends of increased heterosexual transmission of HIV and other STIs and their increased incidence in women urgently demand more attention for women-specific prevention policies.

Best practices

More than 40 STI prevention projects targeting women were systematised and analysed by the 10 organizations involved in PHASE. Lessons learned from this analysis are disseminated and applied by these organizations and their networks. UNAIDS uses the term "best practice" to cover anything that works, whether fully or in part, and from which useful lessons can be learned. In spite of the different aims and methods used in the projects to target a variety of women, several common approaches were considered fundamental for effective STI prevention for women. These approaches can be summarised as best practices:

A gender-specific approach

In order for STI prevention to be effective for women, it should take the gender position and roles of women into consideration. Since gender inequities affect women's risk of infection, the health sector must work towards realizing gender equity through an empowerment process. A gender-based approach to the prevention of HIV/AIDS and other STIs demands male involvement as well. Effective STI prevention strategies take

into account diverse needs and develop activities that respond to the needs of both men and women.

A positive perception of female sexuality

Female sexuality has historically been restricted by double standards and influenced by gender inequities. As a result, women's perception of their own sexuality and sexuality in general may be negative. STI prevention programmes may even magnify women's negative perception of sexuality through fear-inducing approaches. For this reason, prevention of STIs must be embedded in a positive approach to female sexuality. This approach should enable women to make their own informed choices about their sexual lives. The message about female sexuality should furthermore be based on positive aspects of sex, such as physical and emotional pleasure, satisfaction and mutuality. Making informed choices also implies that one can reduce the risks of negative consequences and aspects of sex, not only of STIs but also of unwanted pregnancy or sexual violence.

Tailoring education and services to the needs of women

Women's diverse realities and gender roles should be taken as a starting point for tailoring education and services to their particular needs. The increasing cultural diversity (see box) in European countries must also be taken into account. Sexual norms, male and female gender identities and behaviours, as well as the power to make decisions about health and sexuality are influenced by the cultural group setting to which the individual belongs.

From information to skills and behaviour

Knowledge about sexuality in general and STI prevention in particular is a necessary condition for making healthy choices, but not adequate in isolation. Gender equity remains theoretical as long as women are not skilled in applying their rights in practice and integrating these rights in their day-to-day lives and (sexual) relationships. Skill-building in women is a necessary basis for the effective prevention of HIV/AIDS and other STIs.

Peer education and self-support groups

Peer education has been shown to challenge gender-related normative beliefs and behaviour through dialogue and personal interactions. Peer education can actively support the strengthening of an individual's skills for improved partner communication and negotiation about safer sex. Peer support groups can also play an important role in breaking through the isolation of girls and women, such as HIV positive or disabled women. Furthermore, self-help groups for girls and women living with HIV/AIDS and other chronic STIs should be encouraged and supported.

Integrating the prevention of HIV/AIDS and other STIs

Most STI prevention efforts to date have focused on the prevention of HIV/AIDS, while other STIs have been virtually neglected. Many women do not associate themselves with the "traditional" target groups of HIV prevention. As a result, they may not regard prevention messages as being relevant to them. The attention being paid to HIV/AIDS must be more equally balanced with attention to other STIs, as they can affect women's physical and mental health and cause irreversible damage. Incorporation of STI prevention in HIV/AIDS prevention programmes will also benefit the effectiveness of HIV prevention itself since STIs are a co-factor in the spread of HIV. Our experience shows that women seem to be more receptive to a comprehensive approach to the prevention of STIs in general.

From disease prevention to health promotion

Effective prevention strategies for women reach beyond mere disease prevention. Promoting the sexual health of women of the general population through skill building, empowerment and the promotion of gender equity will positively impact more aspects of women lives, their health and their relations than only aspects related to their sexual lives. A sexual health promotion strategy reinforces women's skills and abilities to exert control over the determinants of health, and challenges existing gender inequities that put women at risk for STIs.

Conclusion

An important lesson learned from the analysis of best practices is that effective prevention of HIV/AIDS and other STIs among women of the general population is a process towards enabling women to make choices and to take action in relation to their sexuality and their sexual relationships in order to improve their sexual and reproductive health. This process demands that activities in relation to STI prevention target and involve women both as individuals and groups. In addition, women's sexual and reproductive health is intricately linked to men's and targeting both boys and men as partners and husbands must be an integral part of STI prevention. Striving for gender equity is at the core of STI prevention among women and as long as women are subordinated sexually, they will lack the power to make healthy choices and to take action to improve their health.

Based on the analysis of best practices and of the epidemiological situation in the countries involved, the Women's Network PHASE recommends the following general actions for more effective prevention strategies of STIs including HIV/AIDS among women:

- target women of the general population in information and education campaigns, since they tend not to consider themselves at risk for HIV or other STIs;
- embed prevention methodologies within a broader comprehensive gender-based approach towards improving women's health, rights and well-being;
- promote further research into women's sexuality and their experiences with safer sex negotiation and with living with HIV/AIDS and other STIs;
- develop reliable data records on the sexual health of women, including STIs and related topics, and make them easily accessible;
- learn from and disseminate lessons learned from holistic approaches in women's health services/clinics and apply these lessons to general health services;
- increase the dissemination and interchange of information about innovative approaches in women's health and sexuality;
- inform policy-makers and governmental services about best practices and methodologies for the prevention of HIV/AIDS and other STIs in women and lobby to put or keep the topic of women and STIs on the public health agendas;
- promote networking, the interchange of information and joint actions

between women's groups and STI-prevention organizations, both governmental and non-governmental;

- reach out particularly to young women, migrant women, pregnant women and women living with HIV.

The organizations participating in PHASE have recently finalized pilot projects that aimed to further develop gendered approaches to HIV/AIDS and STI prevention. The results from these pilots will be published in June 2003 and presented in issue 56 of *Entre Nous*.

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Prevention of HIV and STIs among women in Europe



Prevention of HIV and STIs among women in Europe is the first major achievement of Women's Network PHASE, a project for the prevention of HIV/AIDS and other sexually transmitted infections (STIs) for women of the general population in ten countries of the European Union. The publication gives an overview of the data available on the incidence of HIV/AIDS and other STIs among women in the participating countries. It also provides insight into existing legislation and policy on gender-related issues in these countries and STI prevention activities that have been car-

ried out to reach women of the general population. Based on an analysis of these data, the publication highlights lessons learned from best practices in STI prevention for women.

Examples of unique initiatives highlighted in the book

Austria

In Austria, the "park project" organized specific health promotion activities to reach Turkish and Serbian migrant women via interpreters in parks in Vienna. Language barriers hamper migrant women's access to common media like radio and television. The project sought to involve women directly in improving the health status through personal conversations in which they were able to become better informed about sexuality and STIs. One thousand, two hundred and ten women were reached at

54 different parks in 2000. The activity was repeated in 2001.

Greece

In Greece, the AFRODITE project aimed to promote health and prevent the spread of HIV and other STIs among migrant sex workers in regions bordering Albania and Bulgaria. Migrant sex workers lack access to general STI prevention and control programmes due to language barriers and their illegal residence in Greece. Educational materials in different languages were developed and disseminated, and free medical tests and health services were provided, along with condoms and lubricants.

Prevention of HIV and STIs among women in Europe
 pp 140, ISBN 90-5182-030-5
 Available online at www.phase-network.org

SOCIO-CULTURAL ASPECTS OF SEXUAL AND REPRODUCTIVE HEALTH IN KOSOVO

by Jim Goodson

Kosovo is languishing in post-conflict recovery and suffering from a protracted identity crisis, a weak economy, persistent ethnic tensions and fragmented communities. The fledgling governmental structures formed there in 2002 offer a very weak social safety net and fall well short of providing adequate health care for all. Humanitarian aid organizations continue to fill the void through their integrated programmes, which meet the needs of individuals and strengthen the existing fabric of communities.

The health of women and children continues to suffer. Single mothers and children less than five years of age are particularly vulnerable. The estimated

than 20% of women of childbearing age reporting using any form of contraception, including modern medical or traditional methods (UNFPA, IOM, 2001). Only 59% of women believe that condoms are effective for preventing pregnancy (PSI, 2001).

Lack of knowledge regarding modern family planning methods among women and a parental preference for the sex of children may be due to some socio-cultural aspects of communities in Kosovo. The value and role of women in Kosovo is changing, along with many other changes occurring in the society of Kosovo. As women begin to take more responsibility and gain some independence, it is important to understand historical influences that may have shaped attitudes towards women in Kosovo.

The Turks of the Ottoman Empire dominated the region from the fifteenth century until 1912 and instituted a patriarchal structure of Shariat law. Today, most Kosovar Albanians still follow Islam, although adherence to customary Shariat law is not common. Kosovar Albanians, which make up about 90% of the people in Kosovo, also have traditional roots in a centuries-old book of laws, called the Code of Leke Dukagjini, or simply the "Kanun". Although most Albanians no longer follow this code of laws, the Kanun has significantly shaped the customary rules of modern Kosovar Albanian society (Kanuni I Leke Dukagjinit, translation 1989).

The laws of the Kanun outline the traditional Albanian clan system, and offer an understanding of the role and value of women within the clan structure viable in Kosovo today. With regards to inheritance rights, the Kanun recognized a son as the legal heir, but not a daughter. It states that "if the male line of a house dies out, even though there may be a hundred daughters, none of them have the right to any share in the inheritance of their parents, nor do any of their sons or daughters". The Kanun also states that "a mother does not have power over her children" and gives "the father the right to beat, bind, imprison or even kill his son or daughter without being liable before the law". Also, "a husband may beat and bind his wife when she scorns his words and orders". The Kanun "considers a woman as a superfluity in the household" and states that "her parents

are not concerned about their daughter's trousseau or about anything else; the man who has become engaged to her must take care of such matters" (Kanuni I Leke Dukagjinit, translation 1989). Although, Kosovars do not adhere to these laws today, remnants of these beliefs exist and the tradition of the clan system remains quite strong.

Kosovo has always been a largely agrarian society and labour-intensive farming may have further contributed to a parental preference for male children and little emphasis on family planning. An ethnographic survey of programme beneficiaries by the International Federation of Red Cross and Red Crescent Societies found clear delineations of gender appropriate daily living activities in Kosovar society. For example, tasks such as manual labour, caring for animals and advising the family were reported as clearly part of a man's role. While cleaning house, washing clothes and caring for children belonged exclusively to a woman's role. This survey also found a gap in the level of education between men and women surveyed. A greater percentage of all men surveyed, 67%, continued their education after primary school compared with 23% of all women surveyed (IFRC, 2002). Only 2% of women surveyed attended university compared with 10% of men; and 16% of women reported receiving no education at all compared to 7% of men (IFRC, 2002). Female education indicators, such as female literacy, can often serve as proxy indicators for the overall public health status of a community.

Poor access to health care is another factor conspiring to create a dire health situation for women and children in Kosovo. Barriers to access are the result, in part, of the systematic discrimination of the Albanian minority in the former Yugoslavia throughout the 1990s. Albanians were virtually banned from utilizing any public services or health institutions. Many alternative underground networks were established and served the oppressed communities. While these organizations helped fill the void of much-needed human services for these marginalized communities, it also strengthened the practice of individuals avoiding official health care institutions. This behaviour of avoidance continues to linger today and inhibits individuals



infant mortality rate in Kosovo is 35 per 1000, which is two to three times higher than the rate in other European countries and one of the highest in southeast Europe (UNFPA, IOM, 2000). The perinatal mortality rate is also quite high at 33 per 1000 infants born (UNFPA, IOM, 2000). Many women receive inadequate or no antenatal care at all as low levels of health education and promotion persist.

Also relevant is the fact that the population of Kosovo is remarkably young. Sixty percent are under the age of twenty-five, and a fourth of the population is between 15 and 25 years of age. Women of childbearing age make up 26% of the entire population of Kosovo (UNDP, 2002).

Furthermore, a parental preference for the sex of children has been detected. For example, in families with only one child, male children outnumber female children by three to one. This preference is also seen, albeit to a lesser degree, in families with more than one child (UNFPA, IOM, 2001). The knowledge and practice of contraception is quite low, with fewer

from seeking health care in Kosovo.

In theory, everyone living in Kosovo is entitled to free access to basic health care services. Unfortunately, the reality is a bit different. A survey conducted by the World Bank found that around 28% of those surveyed reported having had a medical problem at some point for which they did not seek treatment because they could not afford the health care. The high incidence of spurious "fee-for-service" treatment is partly due to low salaries received by doctors who work in the health care institutions (UNDP, 2002). Currently, doctors in Kosovo receive 200 per month as a salary. A significant shortage of doctors increases their demand and further encourages these prohibitive payment practices. In Kosovo, there are an average of 13 doctors per 10 000 inhabitants, a statistic that falls well below the European average of 35 doctors per 10 000 inhabitants (UNDP, 2002).

With overall unemployment estimated to be around 55%, any undue payment demands are an additional burden on limited households. This burden may prove to be prohibitive particularly to women seeking health care. Women still do not achieve the same level of development in education, literacy and employment as their male counterparts. Female enrolment rates for primary, secondary and higher education are all lower than for males. This lower level of education also affects women's ability to secure employment. Only 9.9% of total able-bodied females in Kosovo were employed in 1999 (UNFPA, IOM, 2000).

With significant funding from the American Red Cross, the International Federation of Red Cross and Red Crescent Societies has partnered with the local Red Cross in Kosovo to establish the Community Resource Center Initiative. The Community Resource Centers provide various services, including counselling, support groups for women, children and families of the missing, health education, community building activities, relief distributions and referral services for psychological support and legal assistance. Through a community mapping process, these centers have established networks for linking beneficiaries and various service providers. Through a formalized referral system, the centers provide follow-up to ensure that individual

beneficiary needs are met. These community resource centers have proved to be an ideal vehicle for implementing various community-based strategies.

One such Community Resource Center initiative has worked toward improving women's health by improving access to reproductive health care and family planning methods. This project is implemented in cooperation with the UNFPA and local gynaecologists from the various targeted communities. A baseline survey found that sixty-three percent of all programme beneficiaries were women, with twenty three percent being not married, and twenty-six percent being widowed. Furthermore, seventy eight percent of all widowed females were women of child-bearing age (IFRC, 2002).

The programme design includes a three-day training session that covers reproductive health, pre-conception, antenatal care, family planning methods, human rights, women's rights, domestic violence and sexually transmitted infections. The training sessions are co-facilitated by a UNFPA gynaecologist and selected local gynaecologists from various community health care facilities.

This community-based approach provides reproductive health information and family planning methods to vulnerable women in the community and also improves their access to free health care by establishing links to participating local practitioners. Access to modern family planning methods is further strengthened by the distribution of free supplies, such as condoms, spirals, and oral contraceptives to the participants and local gynaecologists with support from the Pharmaceutical Corporation of Kosova.

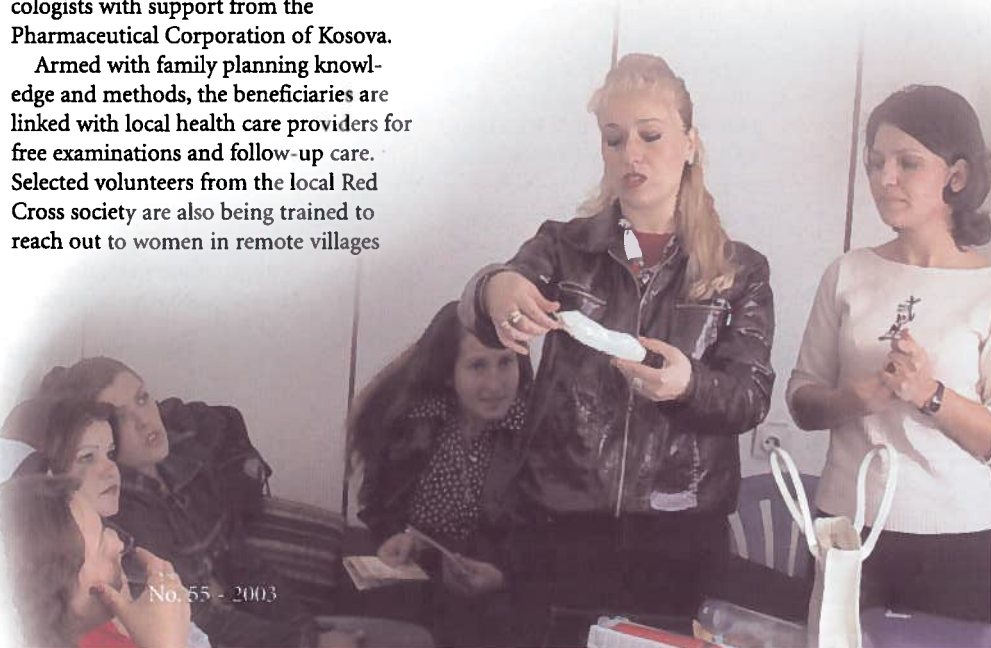
Armed with family planning knowledge and methods, the beneficiaries are linked with local health care providers for free examinations and follow-up care. Selected volunteers from the local Red Cross society are also being trained to reach out to women in remote villages

and provide them with the basics of reproductive health, family planning and information regarding available community resources. The training sessions are currently being implemented by the Red Cross and have been greatly successful to date. There has been an increasing demand from other women in the target communities for additional training sessions. With additional funding, this community-based project may be scaled up to improve the reproductive health, family planning methods and access to care for vulnerable women throughout Kosovo.

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IPPF EUROPEAN NETWORK: BUSH IS LEADING A SECRET WAR ON WOMEN

By Nina Pedersen

President Bush and his allies in Europe put sexual and reproductive health and rights of women at risk. "The Bush administration will do everything they can to undermine women's health and rights. It's a very long, drawn-out process," says Vicky Claeys, the new Regional Director of the International Planned Parenthood Federation European Network



Photo: Jeffrey Lazarus

Vicky Claeys

On the second day of his presidency, the 22nd of January 2001, President Bush reinstated the Mexico City Policy, also known as the Global Gag Rule. This policy cuts off US international aid from any family planning organization that is engaged, directly or indirectly, in abortion-related activities.

With no funds, clinics are closed, and men and women are denied counselling and contraceptive services. An increase in unwanted pregnancies and unsafe abortions will be the probable result. AIDS prevention activities are also likely to suffer worldwide, making the Global Gag Rule even more frightening.

And Bush's forces are operating at both community and political levels in Europe as well. Vicky Claeys, the Regional Director of the International Planned Parenthood Federation (IPPF) European Network, sees the Global Gag Rule as also having repercussions on this side of the Atlantic. "We can see immediate effects in eastern Europe, but further down the road it gets much more difficult to get a clear picture. We can only assume and anticipate," says Claeys.

Loss of funding

The world's two largest organizations in this field have been hit hard. The International Planned Parenthood Federation (IPPF) has lost US \$18 million in funding. The next blow fell upon the United Nations Population Fund (UNFPA), which operates worldwide to improve reproductive health. In the summer of 2002 President Bush stopped a transfer of US \$34 million to the Fund, defying congressional approval of the contribution.

Before the Global Gag Rule was reinstated, the United States was active in supporting reproductive health in eastern Europe. Member organizations of the IPPF European Network, family planning associations in Albania, Armenia, Moldova and the Russian Federation all received US aid in 2000 and 2001. But not anymore. Today, family planning associations in the eastern countries refuse to sign contracts which stipulate Global Gag Rule conditions, and associations avoid negotiating aid with the United States because they are aware of the rule. According to Claeys, these are lost opportunities that are difficult to measure the effect of as the IPPF European Network does not know what their success rate would have been.

She is afraid that the Bush administration's next step will be to put pressure on the governments of the eastern European countries. The situation in eastern Europe will come to a head if the United States introduces restrictive clauses on its bilateral government funding as well.

"The overall effects could be very damaging", says Claeys. She advocates the need for more research and co-operation between NGOs and governments in order to monitor the effects closely.

Need to be on alert

With the inequalities in wealth between west and east, women in central and eastern Europe are an easy target in Bush's campaign. In central and eastern Europe, abortion still remains the principal means of fertility regulation, whereas in western

Europe, contraception is more widespread. The average contraceptive use in the European Union (EU) is around 65%, but in the candidate for accession to the EU countries it is only around 35%, according to Claeys.

Both the EU and the candidate countries need to be alert. The Bush administration is using political weapons to influence the health policies of the EU. "We know that the Bush administration will do everything they can to undermine women's health and rights. And it's a very long, drawn-out process", she says.

European Commission shocked by attack

As the former advocacy manager at the IPPF European Network, based in Brussels, Vicky Claeys has been close to what goes on in the European Commission for years. When US contributions were cut off from the UNFPA and the IPPF, the European Commission and some European governments were shocked by these attacks. Almost half the EU Member States immediately increased their contributions to both organizations in response, and the European Commission took the lead to fill in what the European Commissioner for Development Aid, Poul Nielson, called a "decency gap".

"The Bush administration deliberately undermines IPPF and UNFPA by spreading propaganda in an attempt to weaken the two leading champions of sexual and reproductive health and rights", she says, referring to US Senator Chris Smith, who, among others, attempted to stop the European Commission from funding the UNFPA and IPPF.

Unfortunately, this example of the Bush administration's attempted political influence in Europe does not stand alone, says Claeys. She believes the future structure of the EU is endangered by the Catholic Church, which Bush supports morally. On 16 January 2002, the Catholic Church published a Doctrinal Note that makes clear the Vatican's attempt to undermine laws which are not in line with Catholic teaching.

"An increasing number of European governments are already in the hands of right-wing parties and most of the candidate countries are influenced strongly by the Catholic Church. Poland and Malta

for instance. Since they are soon to join the European Union, all EU decision-making on health and ethical issues may be threatened in the near future", she says.

"The unholy alliance between Bush and the Pope puts Europe's principles of democracy and human rights at risk, particularly the sexual and reproductive rights of women and young people".

In Poland, only some 12% of women use modern methods of contraception compared to the European Union average of 65%, according to an IPPF press release from 21 February 2003. Abortion in Poland is permitted only under very restrictive conditions. However, there are an estimated 80 000 to 200 000 illegal abortions per year. In comparison, in 2001, 124 abortions were performed legally in Poland.

According to IPPF, recent statements indicate that the Polish president is unlikely to consider reform of the country's current ban on most abortions, even though, the President earlier in his presidency voiced his commitment to reform

the law. Despite the fact that 90% of the Poles consider themselves Catholic, 49% of the population want the abortion law relaxed according to recent polls.

Temporary versus fundamental rights President Bush was on everyone's mind when the IPPF celebrated 50 years of advancing sexual health and rights last November. The future has never been this challenging, and the need to reclaim the old spirit of the brave and angry organization is profound.

"In western Europe young women of today were born with the rights their mothers fought for. But now a whole new mindset is needed because of Bush. You can always lose your rights again. Bush has made it clear that rights can be temporary", concludes Claeys.

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Bush Administration Proposes to Extend Global Gag Rule to HIV/AIDS and other programs

www.planetwire.org/details/3836

26 February 2003-Bush Administration officials recently indicated they intended to expand the Global Gag Rule also known as the "Mexico City Policy," to cover HIV/AIDS funding and other program areas that save women's lives. The Global Gag Rule prohibits organizations overseas from receiving U.S. international family planning assistance if they engage in abortion services, counseling or lobbying, even if they support such work with separate money of their own. A recent State Department memo on the subject indicates there would be two excep-

tions in the case of HIV/AIDS funding: "Foreign NGOs that either perform or counsel abortions that also implement discrete HIV/AIDS projects would be eligible for funding these projects; Foreign NGOs not otherwise compliant that merely serve as a pass-through to a subcontractor that is compliant with the Mexico City Policy would be eligible." Expect considerable debate among moderate, liberal and conservative members of the U.S. Congress on this controversial subject.

INTEGRATING VULNERABLE GROUPS: PERSONS LIVING WITH HIV/AIDS AS PEER COUNSELLORS IN ARGENTINA

By Peter Weis

An Argentinean-German sexual health project in Buenos Aires focuses on persons living with HIV/AIDS and other vulnerable groups: not primarily as target groups, but as local and national advisors and peer counsellors.

As in many other countries with concentrated HIV epidemics, many if not most persons currently living with HIV/AIDS in Argentina still belong to so-called vulnerable groups: men who have sex with men (MSM), drug users and commercial sex workers. An Argentinean-German public health project supported by the German Agency for Technical Co-operation (GTZ) since 1999 promotes, in close collaboration with the civil society and government institutions at the Federal Capital and the Province of Buenos Aires, alternative ways of HIV work: all project interventions promoting safer sex, harm reduction, gender and human rights issues are developed, reviewed, implemented and evaluated by persons living with HIV, other vulnerable groups and young people. In addition, they have also assumed the central task of street work and peer counselling, especially pre- and post-test counselling of young people by young people, of commercial sex workers by commercial sex workers, of MSM by MSM, and of persons living with HIV by persons living with HIV.

Helping stigmatised vulnerable groups to stand up and to be in the limelight is not always without problems in a society whose middle and upper class has a predominantly conservative mentality, where machismo is widely accepted and gender perspectives are still a rare exception. And where talking openly about sexuality and rights of sexual minorities is largely taboo: *De eso no se habla*.

Two examples of the collaboration of people living with HIV:

Alejandro Freyre, gay, has lived with HIV since 1989. He is a founding member of the NGO *Fundación Buenos Aires Sida*, which is managed by committed young people, focuses on promoting safer sex and stands up for the rights of sexual minorities. He has been a GTZ counsellor since 2000.

Maria Eugenia Gilligan has lived with AIDS since 1996. She helps NGOs to network and build up an expanded multi-sectorial response to the epidemic in various communities in the outskirts of Buenos Aires. As a former cocaine addict, she knows from personal experience the risks for her adolescent target groups stemming from the project's three core subjects: sex, violence and drugs.

The direct participation of persons living with HIV in the planning and steering of the project has a considerable impact. Whereas from the classic public health and technical co-operation viewpoint HIV prevention work gets the highest priority (if due only to cost-benefit arguments based on scarce resources), other subjects often are more important

for the people directly affected by HIV. These include the defence of their human rights and dignity, access to antiretroviral treatment and the networking of self-help groups. Rightly, people living with HIV/AIDS want first and foremost to stay alive - and live a life in dignity. This has been a learning process for our entire project, including our government partners. They sometimes still find it difficult to get along with activist Alex Freyre, who comes across well in the media, or with vocal demonstrations in the streets outside the Health Ministry calling for a better treatment policy or for better availability of lab services (such as viral load and CD4 count). The project also occasionally runs up against the borderline of conflicts of loyalty between civil society and target group orientation on the one hand, and co-operation with government partners in the ministerial bureaucracy on the other.

The collaboration of people living with HIV in advisory functions enabled in particular the following lines of work to be developed or deepened more easily:

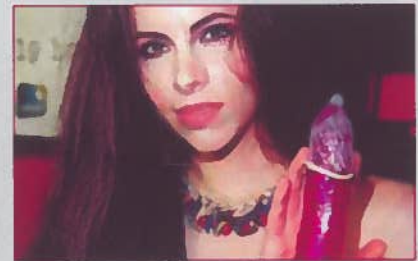
- human rights work, such as professional secrecy, the confidentiality of laboratory results, and media relations;
- voluntary counselling and testing (VCT) of vulnerable groups by their peers, for example on coping strategies or on antiretroviral treatments and individual risk and harm reduction (covering sexual practices, condom use, needle exchange);
- the expanded multisectorial response



The project offers individual peer counselling on safer sex and harm reduction in discos of Buenos Aires, predominantly in poor neighbourhoods. Those who know to answer some easy questions on proper condom use at the end of the counselling are given right away - thanks to our Polaroid camera - a Safer Sex Diploma: "This person knows how to use condoms properly!"



The issue of safer sex is complex, gender sensitive and different in different socio-economic and cultural environments. But access of young people to high quality condoms is of foremost importance for all sexual health projects, if HIV prevention and avoidance of teenage pregnancy are to work: Condoms must not only be cheap and of good quality, they must be part of the youth culture.



Many, if not most, men in Argentina know Barbara. She used to be moderator of the Pay-TV Erotic Channel Venus. Barbara closely collaborated as a volunteer with the project. Her central message: Attractive women don't do it without a condom!

to AIDS and the demedicalising of HIV programmes;

- street work with young people (for example in outdoor activities, in discos, sports clubs, leisure pursuits);
- sex education in schools, using peer group approaches and combining the HIV issue with prevention of teenage pregnancies;
- participatory models of co-operation between the government and civil society and capacity building within the civil society;
- access to work with vulnerable groups, in sub-cultures and 'scene' cultures (gays, transvestites, male and female sex workers, among others).

The teamwork with people who are living with HIV led to new challenges: young people who live with HIV have a different attitude towards their life and work than older people do. This must be tolerated and accepted. Despite the progress of HIV therapies (in Argentina, all patients have free access to them by law) the disease often progresses. True, the fear of early death is not omnipresent, but it also cannot always be suppressed. The daily life of the project must also allow for that. Sick leave, hospital stays and the death of friends and loved ones are an inseparable part of project experiences, which need time, understanding and compassion in the routine running of a project.

During the last two years, Alex, our 33 year-old colleague, was hospitalised twice with immunodeficiency problems, each time in a critical condition. To work daily in a team with persons who are living

with HIV at first-hand enhances a realistic approach to the epidemic. It gives AIDS a very meaningful human dimension, in addition to the epidemiological and social sciences one. If only for that reason, the experience has been important for us. It enriched not only the project work, but also our entire professional and private lives.

Project advisers are chosen from among the target groups

Alejandro Freyre*

Aged 33. Learned by chance in 1989 that he was suffering from a HIV infection. Since then he has worked in self-help groups and increasingly carried out peer counselling. Since 1994 he has also been active in media work, especially in the TV and newspaper sector. Well-known as a gay activist. Founded in 1996 the NGO Fundación Buenos Aires Sida. Work focal points: empowerment and building networks of vulnerable groups, youth work, safer sex. Has worked as an advisor to GTZ since 2000, responsible for NGO support and monitoring of project implementation in the Federal Capital of Buenos Aires. Personal creed: Do not work for young people, but with young people!

*NB: Both colleagues ask that their names not be altered.

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Maria Eugenia Gilligan*

Aged 40, gave birth to her daughter, her only child, at 19. Increasing consumption of alcohol from the age of 22, originally because of her shyness in discos. Three years later she was addicted to cocaine and lost contact with much of her social network. She dropped out of studying, was unemployed, broke with her family, suffered growing emotional isolation. In 1996 she was diagnosed as having AIDS and told she probably had a short life expectancy. After overcoming her existential crisis she was reconciled with her family and since then has worked in various self-help groups, including Alcoholics Anonymous, and social care for drug addicts. Leading member of the Argentinian Network of Women Who Live With HIV (Red Argentina de Mujeres Viviendo con VIH), and collaborates with the Argentinian-German HIV project in several communities on the outskirts of Buenos Aires, mainly in harm reduction, safer sex and VCT activities.



Gaston Pauls, one of the stars of the New Argentinian Movie and Show Biz, promotes condom use in collaboration with the well-known NGO Fundación Buenos Aires Sida.



Information, education and communication materials, developed and periodically reviewed by male and female peer groups, are the prerequisite that the right messages come to the right people: a weekend workshop in Buenos Aires.



Close collaboration with civil society organizations such as the Fundación Buenos Aires Sida improved street work with different vulnerable groups: poor adolescents and children sleeping rough, drug users and young male and female sex workers.

ROMA WOMEN AND PUBLIC HEALTH CARE

By Corinne Packer

Roma communities and those who work closely with them are well aware of two pressing health concerns for Roma. The first is the generally poor health status of Roma across the European Region. Inextricably linked to this is their inadequate access to health care (1). These issues are particularly pressing in post-communist societies which have shifted towards privatization of public services and the promotion of a free market economy.

Pomykala and Holt note that “several countries are in the process of reforming their healthcare systems. In this climate, care is required to ensure that the most disadvantaged and vulnerable in society are given the same opportunities in these developments as other members of the population (2).” They are quick to add that Roma in western Europe equally face significant barriers to adequate health care.

Who are the Roma?

Roma is the common name given to what is in fact a variety of ethnic groups located mainly in central and eastern Europe, and who identify themselves as Romani. They are also found in smaller numbers across western Europe, where they are referred to by various names including Roma, Sinti, Gypsies and Travellers. All share similar aspects of culture and history.

They also share similar experiences of systematic and systemic prejudice, discrimination, economic hardship and social exclusion.

The general health status of Roma

Although there is relatively little information on the specific health status of Roma, existing studies on Roma in both eastern and western Europe create a broad picture of higher rates of illness, lower life expectancy (3) and higher infant mortality (4) than the population at large. Low rates of vaccination among Roma are evident across Europe. Tuberculosis breeds in overcrowded houses that have no heat in the winter-

time (5) and Roma children are disproportionately affected by polio, diphtheria and meningitis (6). High rates of smoking among teens and adults, stress or mental ill-health, and chronic diseases like heart and asthmatic ailments are common problems for which they do not easily find help. There is generally little knowledge about proper nutrition and a lack of means to secure it. Many Roma women are not aware of the need to modify their lifestyle and diet during pregnancy: meat, milk, fruits and vegetables are insufficiently consumed. Roma children suffer from vitamin deficiencies, malnutrition and anaemia to a greater degree than non-Roma (7).

Sexual and reproductive health concerns

Roma women generally exhibit high fertility rates and begin childbearing at a young age. In line with their general situation, studies paint a broader picture of a scenario wherein Roma women are less likely to have access to preventive sexual and reproductive health information and care. For example, studies of rural Roma communities in Romania reveal that many Roma women have not been able to access gynaecological care and family planning due to a lack of doctors and nurses; women generally cannot afford transportation to seek these services even in nearby towns (8). Another study conducted by Medecins du Monde found 65% of migrant Roma living in irregular circumstances have never had recourse to contraception (9).

High rates of infant mortality, birth and abortion among Roma women have been attributed in large part to a lack of access to family planning and natal care. According to one study, of 272 women ages 16-50 in settlements in Belgrade, nearly 28% had 6 to 10 children and 6.7% over 10 children; almost half of these had had induced abortions, with 83.5% of them having had up to 5 abortions and over 9% having had 6 to 10 abortions (10).

Such problems exist in western Europe as well. For example, Traveller women in some parts of England tend to have a higher number of pregnancies than the wider population, averaging 6.5 per woman (11).

Few studies exist concerning sexually



transmitted diseases, including HIV/AIDS. The finding of one study of a Roma settlement in Romania that nearly one in three Roma are HIV positive (12) suggests at the very least the need for more research and action.

Problems specifically related to sexual and reproductive health

A number of attitudes and practices among the Roma are specifically detrimental to women's sexual and reproductive health. First among them is their apparently poor understanding of the value of preventive screenings or what constitutes a serious health risk or problem. Women also tend to postpone attention to personal well-being in the interest of attending to family care and the home. Since they most commonly take responsibility for family planning, this means that obtaining contraception for themselves is among the last on their list of medical priorities. This, in addition to a possible feeling of shame when seeking help (especially if this requires a break in social codes of modesty), prevent women from doing it. Other customs may deter women from asking questions about reproductive health matters or from seeking any care during or after pregnancy. Unequal gender relations may also impede women's access to sexual and reproductive health care. Rigidly defined gender roles, including the subordination of women to men in many aspects of daily life, appear characteristic in many Roma communities. In this context, Roma women feel little power to choose when, with whom and with what form of protection, if any, to have sex. Suggesting that partners use condoms risks being understood as encouraging infidelity. Some do not seek medical attention because they fear violence, abandonment or ostracism from their partner, family and community.

On the other hand, some Roma

women claim that doctors do not provide this information, suggesting an element of gender (and/or ethnic) discrimination. The stereotypical view that Roma women do not think of the future might cause health care workers not to offer family planning information and services. Some might provide information only on certain kinds of contraception on the stereotypical assumption that Roma women are unable to follow directions or need to



use contraception in a clandestine fashion. In so doing, health care providers are complicit in reinforcing ethnic stereotypes and gender inequality (13). Another concern arises in the context of fears of sterilisation – a sensitive topic with a documented history in a number of countries and there are still reports of this from Slovakia.

Roma girls, in both rural and urban settings, traditionally marry early, between 14 and 16 years of age. Early marriage is typically quickly followed by early pregnancy. The age at marriage and childbearing appears to be increasing in some communities, but much has yet to be done to achieve widespread and sys-

tematic change. Traditional beliefs and practices, coupled with isolationism, within these communities still reinforce the suppression of information on reproduction and family planning.

Discrimination in accessing health care

Roma populations in Europe generally have lower access to care than the population at large (14). The physical, economic and information-based barriers to health care that many Roma confront result from the complex and inter-related effects of poverty, discrimination and unfamiliarity with government institutions generally, and health services in particular. They experience discrimination in accessing health care in different ways depending on a variety of factors, including whether a community is urban or geographically isolated, or whether the Roma population is sedentary or nomadic (15). They may experience direct discrimination in, for example, the refusal of physicians or health care institutions to treat them. At a recent non-governmental organization meeting on Roma women and access to health care, women gave testimony of being denied basic health services on the basis of their ethnicity (16). For example, authorities were said to have refused to send ambulances to

persons calling under a Roma name or under an address in a Roma settlement. Roma are reportedly often the last in line to receive medical aid and devices, even if disabled. Cases were also reported of Roma women suffering abuse by local authorities and being unable to receive help and redress. For example, women who suffered sexual or physical abuse by police were refused medical certificates of injuries suffered.

Living conditions contributing to poor health

To varying degrees, the Roma across Europe are amongst the poorest and most marginalized of populations.

Housing and living conditions in Roma settlements leave much to be desired. Practical problems, such as a lack of infrastructure within the settlements, prevent Roma from accessing both health care and health education and further contribute to their poor health. Most sites lack proper sanitation, garbage collection, running water and electricity. This is not limited to eastern Europe. A survey of Travellers living on Council sites or roadsides in the Bristol area of England found that 39% had no access to fresh water on their site, 41.5% did not have access to a toilet, and 43.9% lacked refuse collection (17). Travellers in authorised camps in Italy fare much the same (18). All of these factors encourage the breeding of bacteria and infection while reducing opportunities to access and maintain adequate hygiene and curative conditions. It is no surprise that there also exist higher rates of contagious diseases such as hepatitis, scabies, pediculosis and other skin problems in Roma settlements.

Initiatives to include women in family and community health planning

The effects of inadequate and discriminatory access to health care are felt disproportionately by women. It is women who typically bear principal responsibility for family health care and form the contact between Romani communities and public health services. And yet it is they who are often overlooked in policies devised on behalf of Roma (19).

In order to achieve substantial and widespread improvement in their situations, it is important that States with a Roma population involve Roma women in developing policies and programmes specifically for them. With this understanding in mind, there has been a recent inter-governmental initiative to encourage the formation and functioning of a broad-based Roma women's network with the aim of addressing health care reform. This is part of a tripartite project undertaken by the Organization for Security and Co-operation in Europe, the European Monitoring Centre on Racism and Xenophobia, and the Council of Europe (20). The two-year project will soon culminate in an inter-governmental conference at which a substantial report will be discussed. It is especially hoped

that the presentation of good practices will provide a basis for governments and civil society to build better access to health care for Roma women and their communities along the principles of equality, non-discrimination and participation. These are likely to include strategies for public awareness campaigns, the coordination and supervision of measures to ensure the consideration of a broad range of Roma health issues, including sexual and reproductive health issues, adequate anti-discrimination laws enforced by specialized bodies and measures to improve the Roma's access to health care information and services. The underlying values of public interest, social inclusion and responsibility form the basis for concrete steps which should be taken to improve the health of Roma women and their families, including their sexual and reproductive health. Any success in this direction can only be welcome.

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The Advocacy Project

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Lund University, in Sweden, in collaboration with The Blekinge Institute of Technology offers a selection of courses in Public Health

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Training in sexual and reproductive health in Europe

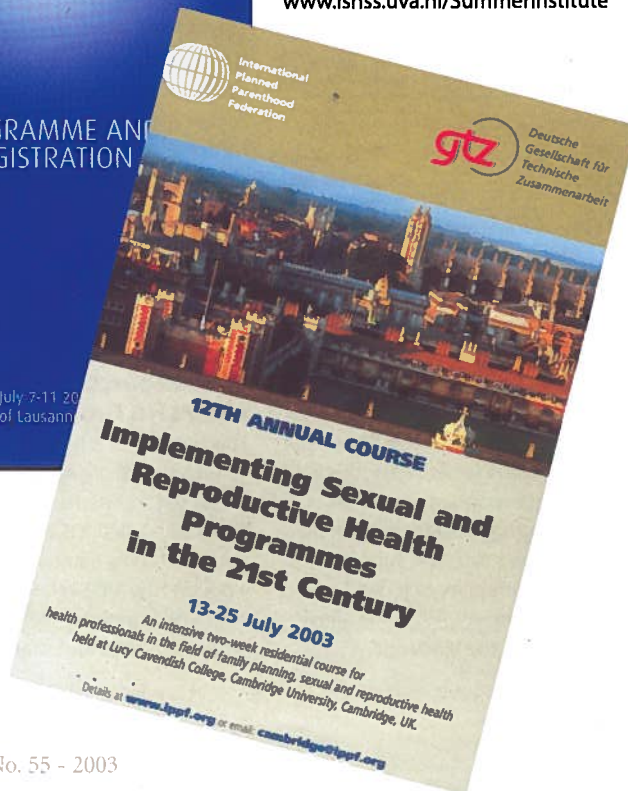
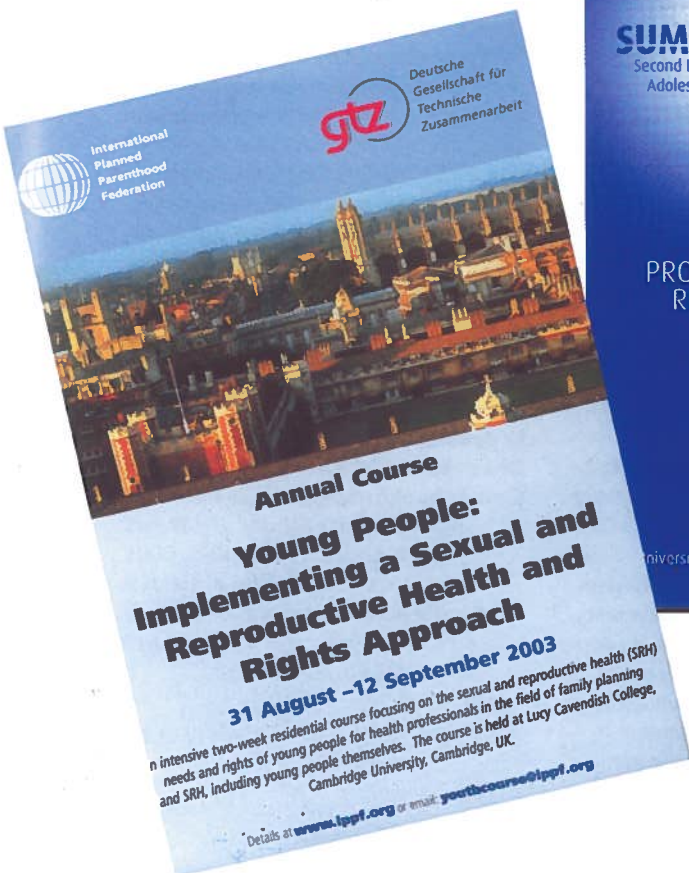
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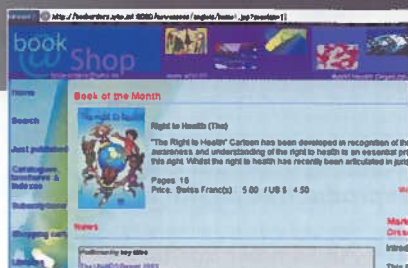
The scientific directors are: Carole Vance and Han ten Brummelhuis and the faculty is Mike Tan, Stefan Dudink, Saskia Wieringa, Radhika Chandiramani, Oliver Phillips, Geetanjali Misra, Theo van der Meer and Mirjam Schieveld.

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Guidelines for the Management of STIs in Female Sex Workers

These guidelines for public health specialists and health professionals are on how to develop or improve STI (sexually transmitted infections) services for female sex workers. One of the objectives is to support the expansion of the 100% condom use programme (CUP) strategy, which has been shown to contribute to a reduction in STI transmission. Included are guidelines on clinical care, HIV counselling and testing, education for behaviour change and promoting the use of condoms and social services.

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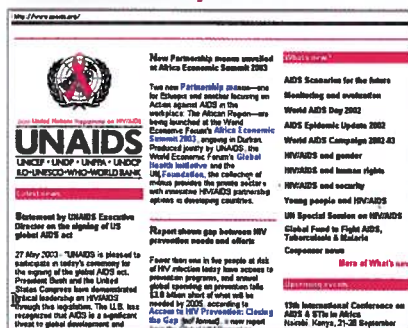
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This report describes the structure, role and scope of the Joint United Nations Programme on HIV/AIDS (UNAIDS) as the main advocate for global action in the context of HIV/AIDS. With the support of its eight co-sponsors (UNICEF, UNDP, UNFPA, UNDCP, ILO, UNESCO, WHO and the World Bank), UNAIDS leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV/AIDS, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic.

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Employers' Handbook on HIV/AIDS: A Guide for Action

Inevitably, HIV/AIDS has taken its toll on workforces, production systems, markets and local communities. As a result, companies of all types face higher costs in terms of training, insurance, benefits, absenteeism and illness.

Based on feedback from members of the International Organisation of Employers (IOE), and through IOE's extensive business networks, this handbook documents selected initiatives in the workplace designed to minimize the impact of HIV/AIDS and to maximize prevention efforts. These include educating employees about HIV/AIDS, promoting changes in attitudes and behaviour towards sex, and, in some cases, establishing care and treatment programmes to treat workers and families. The handbook also provides details of results obtained and lessons learned by employers worldwide.

Joint United Nations Programme on HIV/AIDS

2002, 39 pages [E, F, S]

ISBN 92 9173 173 0

Swiss francs 15.-/US \$13.50

In developing countries: Sw.fr. 7.50

Order no. 1880012

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Handbook on Access to HIV/AIDS-Related Treatment: A Collection of Information, Tools and Resources for NGOs, CBOs and PLHA Groups

This handbook is intended to assist non-governmental organizations, community-based organizations and groups of people living with HIV/AIDS in finding ways of understanding, planning and undertaking work on HIV/AIDS-related treatment. It builds on practical skills by using participatory activities and sharing experiences;

provides a training resource for NGO support programmes, training organizations and individuals; and facilitates ongoing learning about the treatment work being carried out by the various groups involved.

Applicable at all levels of experience, the handbook offers flexibility to facilitators who need to gear their work towards specific schedules or situations.

Joint United Nations Programme on HIV/AIDS

2003 [E]

ISBN 92 9173 161 7

Swiss francs 15.-/US \$13.50

In developing countries: Sw.fr. 7.50

Order no. 1880013

E-mail: bookorders@who.int

Selected Practice Recommendations for Contraceptive Use

Selected Practice Recommendations for Contraceptive focuses on how contraceptive methods can be used safely and effectively once they have been deemed medically appropriate. Also aimed at policy-makers, programme managers and scientists, this book answers 23 specific questions related to the use of contraceptives - for example: What can a woman do if she misses taking a combined oral contraceptive pill? When can a woman start using an implant? When can a copper-bearing IUD be inserted? The answers to these questions are detailed, presented in simple terms and based on the best available evidence. The overall objective of the two guidelines is to improve the quality of family planning care.

2002, 112 pages [E]

ISBN 92 4 154566 6

Swiss francs 20.-/US \$18.00

In developing countries: Sw.fr. 14-

Order no.1930200

E-mail: bookorders@who.int



Summary Measures of Population Health: Concepts, Ethics, Measurement and Applications

This book addresses a wide array of critical issues regarding the measurement of population health using comprehensive indices combining information on mortality and ill-health. The various uses of such summary measures of population health are described, and the appropriate measurement framework and specific ethical and social value choices are discussed and debated. The contributors include leading experts in epidemiological methods, ethics, health economics, health status measurement and the valuation of health states.

Summary measures of population health are used by WHO to report on levels of health and inequalities in health for its Member States, to report on the causes of loss of health in terms of diseases, injuries and risk factors, to advise on potential gains in health through cost-effective interventions, and in the analysis of the efficiency of health systems around the globe.

Summary measures of population health are likely to become increasingly topical and debated as the international community invests large amounts of money in tackling global problems such as HIV/AIDS, malaria, tuberculosis and poverty. How effective are these efforts? What is the appropriate metric for quantifying levels of health at population level, or for identifying those diseases, injuries and risk factors contributing most to loss of health? This volume will serve as the fundamental reference for the construction and use of summary measures of population health for scholars across all public health disciplines.

Edited by Christopher J.L. Murray, Joshua A. Salomon, Colin D. Mathers and Alan D. Lopez

**The World Health Organization
2002, ISBN 9-24-154551-8**

**Available online at:
www.who.int/pub/smph/en/index.html**

Monitoring the Declaration of Commitment on HIV/AIDS Guidelines on Construction of Core Indicators. Geneva: UNAIDS.

http://www.unaids.org/UNGASS/docs/JC718-CoreIndic_en.pdf

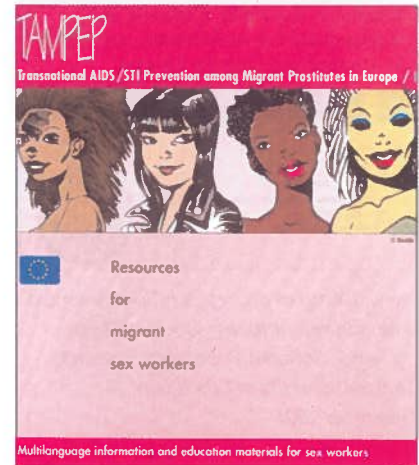
The purpose of the guidelines is to provide countries with technical guidance on the detailed specification of the core indicators, on the information required and basis of their construction, and on their interpretation. These guidelines aim to maximize the validity, internal consistency and uniformity across countries and over time of the indicator estimates obtained, and to ensure consistency in the types of data employed and in the methods of calculation employed. The guidelines also provide detailed specification of global indicators, the information required to measure them and their interpretation for easy reference.

Turning the Tide: CEDAW and the Gender Dimensions of the HIV/AIDS pandemic

<http://www.unifem.org/resources/turningtide/>

"Turning the Tide: CEDAW and the Gender Dimensions of the HIV/AIDS Pandemic," contributes to understanding how the world's foremost blueprint for women's human rights can be put to work to address the HIV/AIDS epidemic from a gender perspective. The publication discusses different aspects of the pandemic for which the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) has special relevance, such as gender-based violence and sexual exploitation, access to health services, gender inequality and safer sex, and issues of care and care-giving. The book also contains some of the key government responses that are required under CEDAW, guiding articles of the Convention, and statements of the CEDAW Committee that relate to HIV/AIDS.

Transnational AIDS/STI Prevention among Migrant Prostitutes in Europe



Project (TAMPEP)

Since 1993, TAMPEP has worked to develop and implement effective HIV/STI programmes for sex workers by:

- outreach and street work with migrant sex workers;
- the involvement of cultural mediators and peer educators within services for migrant sex workers;
- the development of multilingual information and education material for sex workers.

TAMPEP has now released a CD featuring a number of guidelines, general leaflets, documents, training manuals and reports to help promote effective interventions with migrant sex workers.

INTERNET RESOURCES

Sites dealing with religious and cultural aspects of reproductive health in eastern Europe

Prepared by Josh Gross and Jeffrey V. Lazarus

Lowest in the World: Evidence and interpretation of rapid fertility decline in central and eastern Europe



www.frw.rug.nl/prc/reseach/Publications/download/presentations_sobotka/P2.ppt
By Tomá Sobotka, Population Research Centre, University of Groningen, 19 December 2001

A direct link to a very informative and well-designed presentation examining decline of fertility in eastern Europe. Type the below link in the URL window and it will open the presentation in PowerPoint.

Demographic Crisis in Post-Communist States: The Next Stumbling Block



www.worldmarketsanalysis.com/InFocus2002/articles/health_Balkans.html
Source: World Markets Research Centre: www.wmrc.com

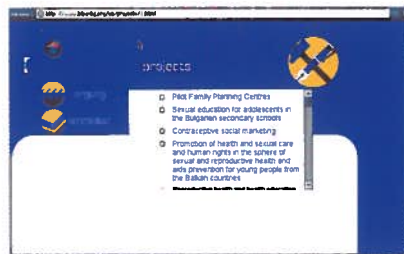
Just as the countries of central and eastern Europe are developing into relatively stable economies; a new problem is looming large: shrinking populations. At 1.3 children per woman, post-Communist states have the lowest fertility levels in the world - even lower than the 1.6 average of eastern Europe. United Nations research predicts that the population in the region will decrease by one-third in the first half of this century due to a mixture of economic hardship, poverty and migration.

The Internet and reproductive health in eastern Europe

<http://www.ippf.org/regions/europe/choices/v27n1/internet.htm>

This article examines the internet as a technological information tool and makes a pitch for its use as an instrument for an expanded reproductive health information exchange in eastern Europe.

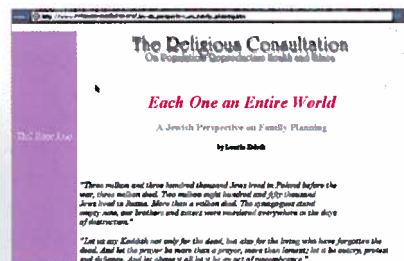
Reproductive health and health education for the Roma minority in central and eastern Europe.



www.bfpa-bg.org/en/projects/1.html
In the beginning of April 2002 the Bulgarian Family Planning and Sexual Health Association started working on a project named "Reproductive health and health education for the Roma minority in central and eastern Europe". This initiative covers regions with compact Roma population in Moldova, Slovakia and Hungary - three of the countries with a relatively high percentage of Roma people in the population (7%-11%).

Source: Bulgarian Family Planning and Sexual Health Association: www.bfpa-bg.org

The Religious Consultation on Population, Reproductive Health & Ethics



www.religiousconsultation.org
The site is a huge resource of theological analysis on reproductive health and ethics related issues. Half of the site is used to

promote the book Sacred Choices, by Daniel C. Maguire, the organization's founder and president. Excerpts from the book are available at the site. There is even a Sacred Choices study guide authored by Planned Parenthood International. Some of the articles at the site are: **Contraception and abortion in Islam** Excerpt from the book Sacred Choices, by Daniel C. Maguire http://www.religiousconsultation.org/islam_contraception_abortion_in_SacredChoices.htm Islam's views on family planning are important for our planet since one out of every six people on this earth is a Muslim. What can be said from the outset is that there is pluralism in the Muslim world as there is everywhere.

Each One an Entire World A Jewish Perspective on Family Planning, by Laurie Zoloth

http://www.religiousconsultation.org/Jewish_perspective_on_family_planning.htm
In a world clearly facing significant, vexing issues with justice, with environmental challenges, with a steady increase in human population and consumption, and significant shifts in world wide fertility, why not begin the discussion of Jewish ethical and religious perspectives on family planning with a far more general description of Jewish perspectives on reproduction, contraception, abortion, families, and health?

Islam, Women and Family Planning: A Primer, by Heather Boonstra

www.gutmacher.org/pubs/journals/gr040604.html

The events of September 11 have focused attention on just how bad things can be for women living under the rule of Islamic extremists...In reality, however, Islamic thought is flexible on reproductive matters, and political interpretations of Muslim law are as varied as the countries that make up the Muslim world. By and large, however, Islam is permissive of family planning, and many Muslim countries have active population and family planning programs.

Source: The Alan Guttmacher Institute: www.gutmacher.org



Ecumenical Women 2000+

www.ew2000plus.org

Ecumenical Women 2000+ (EW) is a coalition of denominations and ecumenical organizations at the United Nations (UN) who focus on the global intersection of religion and human rights with a gender perspective.

This is certainly one of the most vital religious oriented NGOs operating in the UN sphere.

As a coalition, they participate each year in the UN meetings most visibly at the UN Commission on the Status of Women. EW unites women of faith from around the world to lobby government delegates in order to hold their countries accountable to the Platform for Action from the 1995 Fourth World Conference on Women, in Beijing, China.

Controversy continues over sexual health report, by Nicola Smith

<http://www.euobserver.com/index.php?id=9386>

A fierce battle between pro-life and pro-choice members of the European Parliament reached its conclusion on Thursday when the European Parliament voted to increase funding for reproductive health programmes in the developing world to 74 million.

Source: *EU Observer*

www.euobserver.com

EUobserver.com is an independent website published by EUobserver.com ASBL in cooperation with the Group for a Europe of Democracies and Diversities in the European Parliament.

Q Web - A Women's Empowerment Base

www.qweb.kvinnoforum.se

Q Web is a global network for the exchange of knowledge, experience and ideas on women's health and gender issues. On its website, the members have a page of their own where they can introduce themselves and their activities.

Members are updated on seminars, conferences, literature and interesting links in addition to various other related materials concerning women's issues. Members receive e-mails with information on one of the 30 specific areas of interest they chose while joining the network. Q Web also

responds to requests for information from researchers, NGOs, students and others.

The main areas of interest are:

1. Empowerment of Women: equal rights and opportunities for women in society and family;
2. Society and Women's Health: women's health in a cultural and social context;
3. Sexuality and Reproduction: sexual and reproductive health and rights;
4. Violence and Abuse: actions against domestic violence and sexual exploitation and abuse of girls and women;
5. Adolescents: teenage pregnancies, access to education and services on sexuality, fertility and gender issues,
6. Trafficking of women, girls and boys.

To become a member you simply go to the web-site www.qweb.kvinnoforum.se, click on "Join the network" and fill out the registration form.

New Online CIRE System Offers Latest Findings Related to Family Planning Guidance

A new online service offers access to new research findings potentially relevant to WHO international family planning guidance. Family planning professionals and consumers will be able to learn of findings as they are collected from the world's scientific literature as part of a continuous effort to assure that WHO guidance stays up-to-date and remains based on good scientific evidence.

The service (known as CIRE, for Continuous Identification of Research Evidence) notifies professionals and the public about new findings in three ways:

- at the new CIRE website (www.infoforhealth.org/cire),
- through an e-mail listserv (sign up for the listserv at the CIRE website),
- in the weekly e-zine "The Pop Reporter" (sign up at www.jhuccp.org/popreporter) (Current subscribers to "The Pop Reporter" will receive CIRE announcements as part of their subscription.).

CIRE is a collaborative effort of WHO's Department of Reproductive Health and Research, the Centers for Disease Control and Prevention, and the Johns Hopkins Bloomberg School of Public Health's Center for Communication Programs (CCP). CCP culls reports

selected for CIRE from POPLINE (<http://db.jhuccp.org/popinform>), the comprehensive bibliographic database on reproductive health and related topics managed by CCP's INFO Project.

CIRE collects and reports on new research findings potentially relevant to WHO's Medical Eligibility Criteria for Contraceptive Use (MEC) and Selected Practice Recommendations for Contraceptive Use (SPR). The MEC provide family planning providers worldwide with guidance on the appropriateness of the various contraceptive methods for women and men with certain health conditions; for example, should women with high blood pressure use the Pill? The SPR answer major questions about providing contraceptives; for example, when can an IUD be inserted? (The MEC and SPR are available at http://www.who.int/reproductive-health/family_planning.)

To update its guidance and address new issues regularly, WHO will consider the findings that CIRE collects, evaluate them, and present the analysis to consensus-development meetings of family planning experts from around the world. WHO plans to update both the MEC and SPR within the next 18 months.

Entre Nous

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WHO Regional Office for Europe
Reproductive Health and Research Programme

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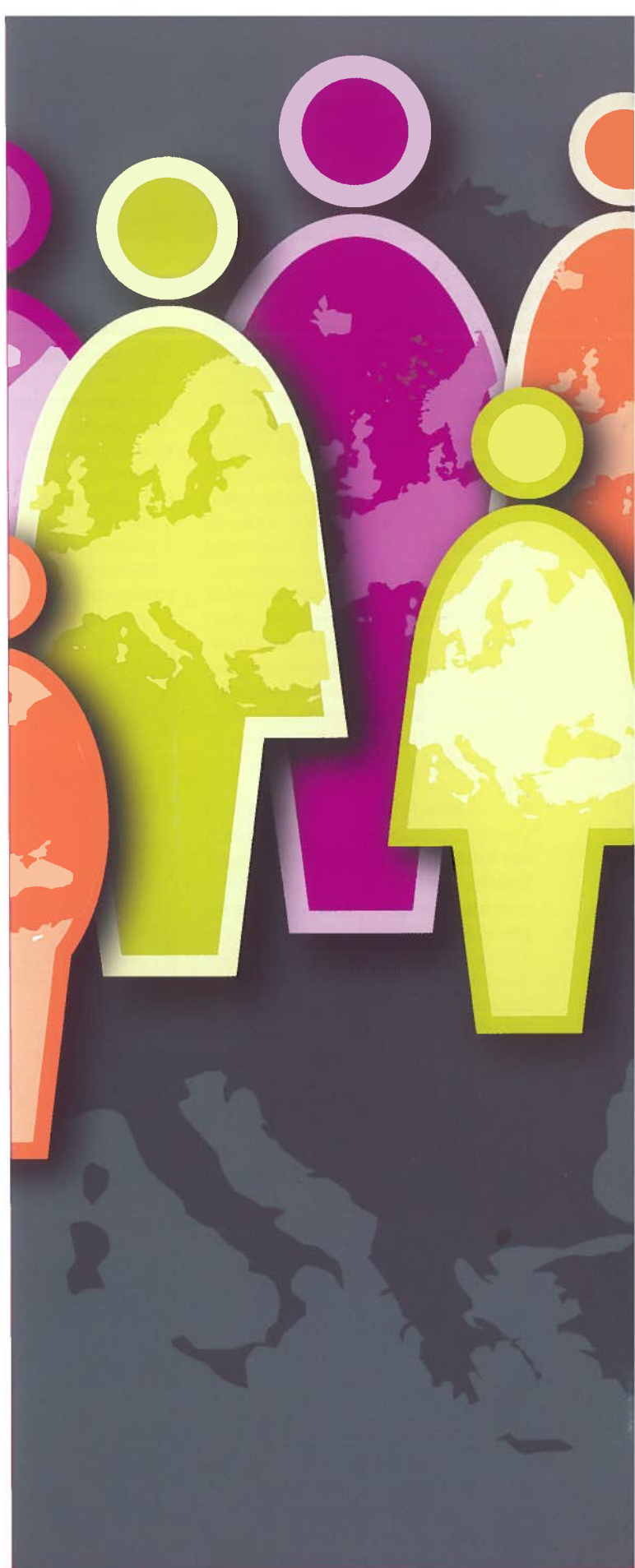
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