ICPD+5

Reviewing progress five years after the International Conference on Population and Development
ENTRE NOUS

The European Magazine for Reproductive and Sexual Health

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The Women’s and Reproductive Health Unit
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark
Tel: (+45) 39 17 1451 or 1426
Fax: (+45) 39 17 1850
E-mail: entre nous@who.dk

Chief Editor
Dr Ascia Brandrup-Lukanow
Editor
Jeffrey V. Lazarus
Administrator & Editorial Assistant
Dominique Le Buf
French translator
Yvon Prigent

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MEMBERS OF THE EDITORIAL BOARD

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PAGE 2 - NO. 40-41 - WINTER 1998
The ICPD Programme of Action stretches into every area of family, community and national life: its full implementation is a key to the realisation of human rights and of the full development of each individual woman and man. It is fitting that the United Nations system should do justice to the importance of the Programme of Action by preparing a process which will spur countries to take decisive and focused action.

Dr Nafs Sadik, executive director of the UNFPA. (Speech to the IIN Commission on Population and Development, 24 February 1998)

Five years ago reproductive health was emphasised as one of the four main priority areas at the International Conference on Population and Development (ICPD), held in Cairo. For many of Entre Nous’ readers a major event is at the doorstep: the five-year progress review of ICPD will be held from 8-12 February, 1999, in The Hague, the Netherlands. The preparations are well under way, roundtable conferences, seminars and high-level meetings have been held across the globe to discuss the successes and failures in implementing the Cairo Programme.

Many of our readers will certainly be involved in the discussions about the future direction of the work to achieve Reproductive Health For All by the year 2015. Therefore, this issue of Entre Nous is fully dedicated to ICPD+5.

The issue highlights some successes and challenges that are worthwhile considering in the Hague.

As a part of the preparations a recent conference in Rennes, France, focused attention on sexual violence against refugee women, an issue of ever growing concern worldwide. A summary of the conference background document as well as the functions of the UNFPA Emergency Relief Operations (ERO) unit on pages 16-17 makes it clear that these women’s reproductive health needs have not been adequately met, and renewed efforts including financial and technical resources should be allocated to meet them.

The cultural context has always been considered important when implementing the Cairo Programme. Among many other activities in the preparation of ICPD+5, the UNFPA Division for Arab States and Europe and the Regional Office for Europe of WHO, called an expert meeting on the lessons learnt “post-Cairo” in countries with economies in transition in Central and Eastern Europe and the former Soviet Union.

Dr Mikko Vienonen, Regional Adviser for Health Care Reforms of WHO, shared his experience of Reproductive Health services within health-care reform processes with the participants. The main lesson is that Reproductive Health must be considered a part of the basic package of primary health care services to which all women have free access. Both ICPD+5 and the United Nations General Assembly meeting in June 1999 will provide excellent fora to exchange experience in this area.

Despite significant progress made since 1994, abortion rates in countries of Central and Eastern Europe are still amongst the highest in the world. Wanda Nowicka summarises the situation in these countries on pages 12-13. What are the main barriers in implementing the Cairo programme in these countries?

Non-governmental organisations play a major role in the implementation of the Cairo Programme of Action. The International Planned Parenthood Federation (IPPF), the world’s largest voluntary organisation in the field of sexual and reproductive health, and its Family Planning Association members have been active in 180 countries. Their statement on ICPD+5 can be found on page 8.

Intensive work has also been carried out to elaborate a new health policy framework for the European Region of WHO. The renewed Health For All policy, Health21, calls for fundamental changes in health care and social and economic activity in order to foster real health development. This includes policies to eliminate discrimination against women, ensuring quality care for victims of sexual abuse and a rethinking of health-care systems. We have asked Rüdiger Krech, of the former co-ordination team of the renewal of Health For All, to introduce the Health21 policy to Entre Nous readers.

The last issue of Entre Nous featured emergency contraception, a topic which has been increasingly on the forefront of the RH debate. As this topic has provoked many comments we have asked Dr André Ullmann to briefly recap the main issues including World Health Organization studies and the importance of over-the-counter availability of emergency contraception.

Following the concept of comprehensive Reproductive Health, we are increasing research efforts focused on the reproductive health of older women. Keneva Kunz highlights the importance of osteoporosis research and prevention on page 21.

Entre Nous has also decided to bring back the “From our Readers” section. We encourage readers to contact us with questions, some of which will be printed here with the corresponding answers. In this issue the need to maintain abortion statistics is discussed.

Readers can also use the new question/answer feature added to the UNFPA web site. There, readers can anonymously pose questions about RH. It is hoped that adolescents who might be reluctant to discuss methods of contraception, sexually transmitted diseases, etc. with their parents or family doctor will make use of the web site.

In addition to coverage of the ICPD+5 preparations, adolescent health and HIV/STIs issues, recent events in the news as well as country reports round out this issue of Entre Nous. We invite readers to continue sending in information about new studies, developments in their community, country or region and other issues relevant to reproductive and sexual health in Europe. This exchange of information as well as a successful meeting in The Hague are essential for a renewed emphasis on achieving progress in reproductive health.

Dr Assia Brandrup-Lukanow
Regional Adviser, Women’s and Reproductive Health Chief Editor, Entre Nous

Jeffrey V. Lazarus
Editor, Entre Nous
International Conference on Population and Development

ICPD '94

Summary of the ICPD Programme of Action

The International Conference on Population and Development (ICPD) was held in Cairo, Egypt, from 5 to 13 September 1994. Delegations from 179 States took part in negotiations to finalise a Programme of Action on population and development for the next 20 years. The 115-page document, adopted by acclamation on 13 September, endorses a new strategy which emphasizes the numerous linkages between population and development and focuses on meeting the needs of individual women and men rather than on achieving demographic targets. Key to this new approach is empowering women and providing them with more choices through expanded access to education and health services and promoting skill development and employment.

The Programme advocates making family planning universally available by 2015, or sooner, as part of a broadened approach to reproductive health and rights, provides estimates of the levels of national resources and international assistance that will be required, and calls on Governments to make these resources available.

The Programme of Action includes goals in regard to education, especially for girls, and for the further reduction of infant, child and maternal mortality levels. It also addresses issues relating to population, the environment and consumption patterns; the family; internal and international migra-

tion; prevention and control of the HIV/AIDS pandemic; information, education and communication (IEC); and technology, research and development.

After a week of intense negotiations, the Conference reached general agreement on the Programme of Action, with reservations or comments added by thirteen countries. The ICPD was a United Nations conference, organized principally by the United Nations Population Fund (UNFPA) and the Population Division of the UN Department for Economic and Social Information and Policy Analysis.

The UN Economic and Social Council in 1991 explicitly linked population and development when it decided on the name of the ICPD. The same year, as preparations for the 1992 UN Conference on Environment and Development (UNCED) focused attention on how to achieve sustainable development, the first session of the ICPD Preparatory Committee resolved that population, sustained economic growth and sustainable development would be the themes of the Cairo Conference.


It also builds on UNCED's outcomes, Agenda 21 and the Rio Declaration, as well as on the agreement reached at the 1990 World Summit for Children and the 1993 World Conference on Human Rights. In turn, the ICPD's emphasis on meeting people's needs and empowering women influenced preparations for the World Summit for Social Development, the Fourth World Conference on Women and the celebration of the 50th anniversary of the United Nations, all of which took place in 1995.

Of key importance in helping to shape the Programme of Action were the recommendations made at five regional population conferences (for Asia and the Pacific, Africa, Europe and North America, Latin America and the Caribbean, and the Arab States) in 1992 and 1993, and a number of subregional preparatory meetings; expert group meetings on six issues identified by ECOSOC as requiring the greatest attention; and a series of ad hoc round tables on other important Conference themes. Important input also came from the second meeting of the Preparatory Committee, from discussion in the UN General Assembly in 1993 and from national population reports prepared in more than 140 countries.

At its forty-eighth session in 1993, the General Assembly (in resolution 48/186) strongly endorsed the ICPD by deciding to make the Preparatory Committee a subsidiary body of the Assembly, giving the ICPD a status comparable to that of UNCED. Delegations from 170 States took part in PrepCom II, held at UN Headquarters in New York. Negotiation of the draft Programme of Action to be finalized in Cairo was the central activity.

The Conference itself had 10,757 registered participants — from governments, intergovernmental organizations, UN programmes and specialized agencies, nongovernmental organisations (NGOs) and the news media — and received an unprecedented level of press coverage. Dr. Nafis Sadik, Executive Director of the UNFPA, was Secretary-General of the ICPD.

Egyptian President Mohamed Hosni Mubarak was President of the Conference; Dr. Maher Mahran, Minister of Population and Family Welfare of Egypt, was ex officio Vice-Chairman. Dr. Fred Sai of Ghana was Chairman of the Main Committee, which negotiated the final Programme of Action.

Some 249 speakers addressed the week-long plenary, including: UN Secretary-General Boutros Boutros-Ghali; Prime Minister Benazir Bhutto of Pakistan; then Prime Minister Gro Harlem Brundtland of Norway (now Director-General of WHO); Prime Minister Ivo Sanader of Slovenia; Prime Minister Kenneth Kaunda of Zambia; Prime Minister Cesar Chvez of Mexico; Prime Minister François Mitterrand of France; Prime Minister John Howard of Australia; Prime Minister Margaret Thatcher of the United Kingdom; Prime Minister Helmut Kohl of Germany; Prime Minister Jean Chrétien of Canada; and Prime Minister Ross Perot of the United States.

In addition, more than 4,200 representatives of over 3,500 non-governmental organizations from 133 countries attended the NGO Forum '94, an independent gathering held alongside the Conference.

Other parallel activities were: the International Youth NGO Consultation on Population and Development, held from 31...
August to 4 September and organized by nine youth and youth-related NGOs; the International Conference of Parliamentarians on Population and Development, held on 3 and 4 September and organized by five international organisations of parliamentarians; and the 1994 Parliamentarians' Day assembly organized by the Inter-Parliamentary Union. In addition, the Population Division's Population Information Network provided an electronic communication and reference centre at the Conference site. Four independent daily newspapers on the ICPD were produced in Cairo for distribution at the Conference. In addition, the UN Department of Public Information and the UNFPA co-sponsored a 3-4 September Encounter for Journalists on ICPD issues.

Summarised by Jeffrey V. Lazarus
Editor, Entre Nous

For the full text of the ICPD Programme of Action in English, French or Spanish, please visit the United Nations Population Fund (UNFPA) homepage: www.unfpa.org

INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

Commitments to Reproductive Health & Rights

The Facts

- 500,000 women die every year, one every minute, from pregnancy-related causes – 99% of them in developing countries;
- 120 million women say they do not want to be pregnant but are not using family planning;
- 20 million unsafe abortions occur every year resulting in tens of thousands of deaths and millions of disabilities;
- more than 15 million girls aged 15 to 19 give birth every year;
- over 3000 million new cases of sexually transmitted diseases occur every year, affecting 1 of every 20 adolescents;
- by the year 2000, up to 40 million people could be HIV-infected.

Reproductive Health for All by the Year 2015

Reproductive health, including family planning and sexual health, through the primary health care system, should include:

- quality family planning, including a full range of contraceptives;
- maternal care, including prenatal, delivery and post-partum care, as well as essential obstetric care;
- prevention and treatment of reproductive tract infections, including sexually transmitted diseases, prevention of HIV/AIDS, and availability of affordable condoms;
- access to quality services for the management of complications from unsafe abortion; in circumstances where abortion is not against the law, such abortion should be safe; and post-abortion family planning counselling and services;
- information, education and counselling (IEC) on human sexuality;
- and referral for these and other conditions, such as breast cancer, cancers of the reproductive system, and infertility.

Rights & Principles

Reproductive rights should be a fundamental basis of all programmes and policies. Reproductive rights include:

- the right to freely decide the number and spacing of children, and to have the information and means to do so;
- the right to attain the highest standard of sexual and reproductive health;
- and the right to make decisions concerning reproduction free of coercion, discrimination or violence.

Special Needs

- Eliminate discrimination against girls and women;
- End all harmful practices, including female genital mutilation;
- Ensure quality care for victims of sexual abuse or violence;
- Provide adolescents with appropriate sexual and reproductive health information and services;
- Develop innovative sexual and reproductive health programmes to reach men.

Actions

Promote reproductive health and rights throughout national policies and programmes.

Give reproductive health high priority in national agendas and budgets.

Launch education programmes to increase gender sensitivity eliminate violence against women and children, and raise awareness of sexual and reproductive health, and reproductive rights.

Empower women from a young age to exercise their rights, especially through education. Enable pregnant adolescents to continue their schooling.

Improve the quality of services, including better training and interpersonal skills, availability of reliable supplies and equipment, monitoring and supervision, and expanded reproductive choices.

Stress sensitivity to gender issues and the needs and perspectives of adolescents in the training of health care providers.

Integrate services to maximize use of resources and improve access.

Support research to improve sexual and reproductive health.

Working Together

Involve all levels of society in making reproductive health and rights for all a reality.

Mobilize partnerships between government and civil society, including non-governmental organizations and the private sector.

Implementation

In September of 1994, governments reached consensus and committed themselves to a programme of action which places reproductive health and rights at the center of the population and development agenda. Implementation is the right and responsibility of each country, responsive to its national priorities, needs and cultural context.

UNFPA World Bank WHO
Over the past seven years the Working Group on Population, Sustainable Development and Reproductive Health has served as a forum for ongoing dialogue within the European Parliament and the other European Union (EU) institutions on the related issues of population growth, reproductive health, sustainable development, gender equality and the environment. The Working Group aims to raise awareness within the EU of the need for an integrated approach to these issues.

In accordance with the ICPD Programme of Action, the Working Group, established in 1991, advocates the support of gender equality, reproductive health and reproductive rights as the basis for sustainable development and balanced population growth. To this end, it acts as a strong force in upholding the principles and fostering the implementation of the Programme of Action through awareness raising, resource mobilisation and policy making at the European Union level, in order to ensure that the pledges made at Cairo are fulfilled. As a member of the steering committee organising the International Parliamentarians Forum on ICPD review in February 1999, the Working Group aims to have a significant input into the ICPD+5 Intergovernmental Forum.

Input to EU policy-making
At the EU policy level, the Working Group mainly works to foster discussion on, and mobilise support for, population and reproductive health issues in all relevant fora within the EU institutions. Within the European Parliament it facilitates and encourages debate and initiatives among MEPs concerned with the inter-related issues of sustainable development, health, women’s rights, and environmental concerns. It provides a forum for debate and a platform for support for reproductive health care policies and programmes particularly within the Development, the Women’s Rights and the Environment Committees of the European Parliament and as such has a direct impact on European development cooperation policies.

Over the past year the Working Group has been galvanising inter-institutional support for a forthcoming new Communication by the European Commission to the Council of Ministers and the European Parliament which will lead to a new EU integrated sexual and reproductive health policy. The Communication will bring together the various elements of sexual and reproductive health, as identified by the ICPD, namely population growth, family planning, safe motherhood, sexual health, HIV/AIDS and STI prevention, and sexual coercion, and also looks at the provision of quality care for under-served groups such as adolescents. The new Communication is foreseen to be presented under the German Presidency of the EU in early 1999, possibly coinciding with the ICPD + 5 Forum.

Resource mobilisation
Commitment to resource mobilisation is crucial if the Programme of Action is to be implemented and if the pledge made at Cairo to ensure that reproductive health be universally available by the year 2015 is to become a reality.

Given that the international community committed itself at the ICPD to mobilise $17 billion a year for a package of reproductive health care by the year 2000, and that according to UNFPA current global resources in this sector are under a third of this total, it is imperative that the EU, for its part, honours the commitments it made at Cairo to “substantially increase” its resources for population programmes. I am very pleased that the Commission’s commitment to allocate ECU 300 million for population and reproductive health programmes by the year 2000 was fulfilled by 1996. However, despite this commitment, the EU budget allocations for population and reproductive health policies and programmes in developing countries have been under threat due to the increasing budgetary stringency over the past few years which has resulted in cuts to budget lines across the board. As Working Group members and members of the Development, the Women’s Rights and the Environment Committees, we have endeavoured to maintain the EU’s budgetary allocations for reproductive health and advocated for their increase. This has resulted in a steady increment in EU resources from 2m ECU in 1991 to 8m ECU for 1999.

Raising awareness of the importance of safe motherhood
During the past year, the Working Group has worked to raise awareness within the EU institutions on the scourge of maternal mortality and morbidity in the developing world. It is estimated that over half a million women die every year of pregnancy-related complications, 99% of them in the developing world. For every woman who dies at least 30 develop chronic debilitating problems. Major causes of death are poor health and inadequate care during pregnancy and childbirth.

Ten years ago, the Safe Motherhood Initiative was launched to eliminate this needless waste of women’s lives. It set out its aim to halve the number of maternal deaths by the year 2000, yet maternal mortality and morbidity continues to strike too many young women. To mark the tenth anniversary of the Safe Motherhood Initiative, the Working Group therefore organised a series of activities at the European Parliament aimed at ensuring that safe motherhood be given due attention, especially in view of the ICPD + 5 evaluation process.

I hope that these initiatives will ensure an effective input by the EU to the ICPD+5 process.


For more information about the Working Group please contact:

Costanza de Toma,
Secretariat, Working Group on Population, Sustainable Development and Reproductive Health
rue du Commerçe 72
B-1040 Brussels, Belgium
Tel.: (+32) 2 545 9078
Fax: (+32) 2 545 9077
E-mail: wgp@arcadis.be
http://www.maristoposes.org.uk/european_union_working_group.html


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YUGOSLAVIA
CONTRACEPTIVE USE AMONG YOUNG PEOPLE

The Federal Republic of Yugoslavia (FRY), one of the states formed in the territory of former Yugoslavia, has experienced turbulent socio-political and economic changes. Before its fall, Yugoslavia was known for progressive ideas towards family planning, availability of contraceptives and an adequate level of knowledge by youth about unwanted pregnancy.

Nearly a decade later, only one research project has been carried out in the area of sexuality. One of the points of departure addressed the dynamics of contraceptive use, i.e. the variety of such use among youth. The sample included senior secondary school students from the southern urban areas of the FRY, aged 18-20.

One of the most important problems faced by youth entering into sexual intercourse is clearly protection from unwanted pregnancy, i.e. the use of contraceptives. A question posed in the above research was which contraceptives they are using NOW and what they were using THEN. The latter covers the time period from the first sexual intercourse till the first half of their sexual activities, and NOW covers the time period of the second half of sexual activities of the young persons up to the moment when the research was initiated. So NOW and THEN tend to differ depending on the age when sexual intercourse was initiated. NOW the young individuals are using contraceptives more than THEN. NOW, young people tend to use condoms and the traditional methods more, and less hormonal pills, intrauterine devices, diaphragms and local chemicals. The important differences in the use of contraceptives NOW and THEN are presumably due to growing, personal experiences and the social practice of contraceptive use.

The analysis of our research results regarding the use of the methods and means of contraception per subject showed that 8 out of 10 subjects are using some method of contraception.

Our research has shown that young people tend to use one or several contraceptives during sexual intercourse. The majority of them only use condoms (31.18%). They also tend to resort traditional methods alone, such as coitus interruptus, and Ogino-Knaus or rhythm method. This indicates that one-fifth of them are at high risk of unwanted pregnancy. Due to lack of experience and irregular menstrual cycles, the index of conception when traditional methods are used is high. If one adds to this that almost one-fifth of the young people have claimed not to use any contraceptives at all, then the number of young persons who are at risk of unwanted pregnancy is nearly twice as large. The combination of two agents or methods of contraception is used when the contraceptive methods are less efficient, accompanied with the use of condoms which protect them not only from unwanted pregnancy but also from sexually transmitted diseases and AIDS.

In the study group, the males tend to use condoms more than females, which indicates that the former are more motivated to take care of self-protection, i.e. to protect themselves from sexually transmitted diseases, and less to prevent unwanted pregnancy. In the structure of contraceptive use NOW and THEN the young persons most commonly use condoms and the majority of them considers condoms as the most acceptable contraceptive device for them.

The most common reasons for lack of use of modern contraceptives were: a lack of modern knowledge about contraception, misconceptions that modern contraceptive are harmful, unsafe and unavailable and that there is no proper choice of modern contraceptive for young people. Research on sexual behaviour and contraception use in some countries has indicated that similar statements for lack of use of contraceptives have been given by young people.

Regarding responsibility for contraceptive use the majority of them (86.51%) responded that there is a shared responsibility between a boy and a girl while only 1.54% revoke any responsibility of either party. However, there is a statistically significant difference (p<0.01) by sex in the opinions about responsible use of contraception. While more than two-thirds of boys expressed the opinion that there is a shared responsibility for contraceptive use, the figures for girls are relatively higher. This indicates that the girls are more aware of the shared responsibility in birth control.

Birth control and family planning are not solely the problems of a female, although she ultimately gives birth, uses contraceptives or deliberately seeks abortion. One can hardly imagine that this responsibility should be left to a girl alone; rather, it must be shared.

Our research has shown that the opinions regarding the most acceptable contraceptive devices for young people are likely to differ between those who have sexual experience and those who do not, both in terms of the percentage and order of the most acceptable contraceptive. Young people who have had previous sexual experiences tend to resort to their own practice and consider coitus interruptus as a more acceptable method than the rhythm method, for example.

From the aforementioned, one can conclude that young people fail to sufficiently use reliable contraceptive devices. One-fifth of them do not use any contraceptive devices, although almost 90% of them are fully aware of the responsibility for contraceptive use. Therefore, it is necessary to introduce an intensive and continued education for the young people. In this connection, the Yugoslav Family Planning Association has organised training of the teaching staff, and there is an ongoing pilot project titled "Training of Youth for Youth" aimed at humanisation of sexual relationships and family planning.

Dr Andjelka Dzelatovic, Institute of Public Health of Serbia, vladadz@eunet.yu Fax: 311-11-685-735

Dr Milan Jovanovic Batut, a member of the Presidency of the Yugoslav Family Planning Association

Prof. Nila Kapor-Stanulovic, The Faculty of Philosophy, Novi Sad, a member of the Presidency of the Yugoslav Family Planning Association
INTERNATIONAL PLANNED PARENTHOOD FEDERATION
IPPF AND CAIRO + 5

The International Conference on Population and Development (ICPD), held in Cairo in September 1994, marked a shift away from demographic targets and embraced the human development approach to population issues. The ICPD adopted a 20 year Programme of Action which reflects the goals of IPPF's 1992 Vision 2000 Strategic Plan. Five years on, the United Nations is reviewing the implementation of the Programme of Action. The review will culminate in a special session of the General Assembly in June 1999.

Reducing abortion rates through family planning and eliminating unsafe abortion

In Chapter 8 on Health, Morbidity and Mortality, the Programme of Action urges a reduction in the recourse to abortion by improving family planning services. Goal 1: Objective 4 of Vision 2000 calls for the elimination of unsafe abortion. In Russia, the FPA has helped reduce an over-reliance on abortion by providing access to modern and reliable contraception. In South Africa, with the direct involvement of the FPA, black women, once denied access to safe abortion can now legally and safely terminate a pregnancy.

Informing young people on sexual and reproductive health. Chapter 7 of the Programme of Action and Goal 1: Objective 6 of Vision 2000 call for increased access to information, education and services for young people to meet their reproductive and sexual health needs. In Denmark the FPA provides Sexline, a telephone service for young people and a website page for sexual health problems. Algeria’s Kamikaze youth project, designed by the FPA and young volunteers, provides information about sexually transmitted diseases, unsafe abortions and unwanted pregnancies.

Promoting sexual and reproductive rights by providing legal advice and assistance

Chapter 7 of the Programme of Action, focusing on Reproductive Rights and Reproductive Health, and Goal 1: Objective 1 of Vision 2000 recognize the right of couples and individuals to make free and informed choices about their reproductive and sexual health. The FPA in Columbia provides legal advice to women and helps them seek redress for rights violations. The Palestinian FPA provides legal counselling and education for women.

Encouraging the empowerment of women and girls through education

Chapter 4 on Gender Equality, Equity and Empowerment of Women identifies education as a key to women’s participation in the development process. Goal 3: Objective 3 of Vision 2000 notes the links between women’s equality and decision-making power. FPAs in China, Malaysia and Thailand are helping to empower women by involving them in income generation activities and training. In Pakistan, the FPA’s Girl Child Project provides information and training to young women aged 13-18.

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IPPF, Regent’s College, Inner Circle, Regent’s Park, London NW1 4NS, UK.
Tel: +44 171 487 7900.
Fax: +44 171 487 7995.
E-mail: info@ippf.org
IPPF web site: www.ippf.org

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The integration of HIV/STD and MCH/ Family Planning (FP) into a comprehensive re-productive health programme has been considered essential since the ICPD conference in Cairo in 1994. So far, most countries which have developed their own reproductive health strategies have accepted integration as an important means to development:

- more client-orientation e.g. one-stop services;
- increased service-utilisation and efficiency;
- behavioural changes towards responsible sexuality, etc.

At present, however, only very sporadic experiences of successful integration and cost analyses are available. Did we only dream of utopia in Cairo?

There are numerous reports on existing obstacles and the underlying causes for integration – partly assumed, partly based on facts and research findings. Should we therefore conclude that the call for integration is idealistic and utopian?

Without again presenting a detailed analysis of hindrances, this article suggests a practical approach for selective integration of RH at different levels.

However, reproductive health is much more than an agenda for services: reproductive health of individuals and groups is a result of at least five causal areas:

- the local “geographic” conditions such as socio-economics, housing and workplace;
- external influences like religion, politics, distribution, migration, international co-operation, etc.;
- influences within the society like values, peers, relations, positions, power, rights, etc.;
- personal decisions based on individual experiences, responsibility, participation, etc.;
- influences from programmes both direct (like health education, preventive and curative services) and indirect (e.g. education, employment, income generation, etc.).

Therefore, any attempt to improve reproductive health needs to consider these conditioning factors in the local context. In order to develop a systematic and realistic approach for integration it is necessary to consider the following four levels:

1. Politics and legislation;
2. Health strategies and planning;
3. Health services; and
4. Community and individuals.

1. Integration of reproductive health in politics and laws

The obvious social factors and effects of reproductive health demand a strong political response, often beyond the reach of ministries of health. Their influence is too limited to deal effectively with issues such as empowerment of women and sexual rights. They could and should, however, be effective advocates for these issues.

Nevertheless, the development aspects of RH have to be integrated in national politics and translated into laws and strategies as a priority. To do this, the most suitable actors in the government, among NGOs and in the private sector should be identified and supported. Such a catalyst function at the highest possible level has been proven to be very effective in some Asian countries: e.g. Thailand in the crisis situation of the HIV epidemic, all national HIV-control measures were co-ordinated under the Prime Minister’s Office. Operational research findings were used to design effective strategies. Sexual health, for example, became a part of the school health education programme for ten-year-old children.

2. Health strategies and planning

In most ministries of health RH has been added as an additional task to departments dealing with MCH/FP. However, control of STD/HIV, due to separate external funding, is mostly situated in different organisational sections, and quite often different components of reproductive health are part of different departments. Such organisational structures do not promote an effective translation of RH strategies into practice.

Ministries of health need to develop a capacity for co-ordination of RH planning. Ideally, such a planning team would involve other colleagues from related disciplines, including from the non-governmental and university sectors. In order to design a need based and realistic plan the following issues need to be integrated:

- clear analysis of the local RH situation, people’s perception and needs including the development context;
- analysis of existing related services (preventive, curative care, IEC), their potential shortcomings and needed support included the comparative cost;
- identification of partners in the NGO and private sector and their possible role, e.g. for reaching marginalised groups or to cope with “sensitive issues”;
- identification of feasible avenues to induce behavioural change, particularly among adolescents and men;
- suggestions and advocacy for legislation and inter-sectoral activities.

This list is certainly not complete, but it is obvious that such planning can only succeed with strong political support and the participation of those affected.

3. Health services

Realistic reproductive health plans will define the level and services which might best be integrated or separated. The arguments for integration are based on the perception that one-stop services are:

- more convenient for the clients;
- more efficient;
- ethically needed.

Integration of RH care is therefore seen as a means to improve quality of care. This would certainly apply in the case of natal care which includes diagnosis and treatment for reproductive tract infections. Only a few success stories on integration of FP and STD/HIV promotion have been reported so far (e.g. from Jamaica, India, Vietnam).

However, the client’s perspective and the traditional role of most basic health services serving (pregnant) mothers and their babies set a limitation to integration: men, adolescents and commercial sex workers, for example, can hardly be convinced to be best served at a MCH clinic – even if the scope of services were to be expanded. At the same time, one has to maintain a realistic view about the real potentials and needed financial and training inputs of largely deficient MCH-services. An added message about STD prevention will hardly change sexual behaviour. The full set of clinical RH services will only be feasible in well-equipped district or provincial hospitals.

Integration of information, education and communication (IEC) should be based on an analysis of the best possible form of interaction with different types of clients.

To increase utilisation of RH services we need – now more than ever – to involve the private and the NGO sector to the greatest extent possible.

The guiding principle for better quality must be to offer services based on client needs.

4. Community and Individuals

The social and behavioural dimensions in reproductive health clearly suggest giving higher priority to community based approaches in IEC and in services.

Individual counselling by service-providers will produce very limited results. On the other hand, there are quite a number of reports on successful peer-group approaches among students and military recruits. In addition, knowledge, attitudes, practices and beliefs (KAPB) surveys have to indicate the most effective means of communicating different messages to a variety of clients.

Community based services (CBS) for family planning have been successful in several countries. To what extent their services can be expanded towards reproductive health is
still being studied and should be developed around the expressed need of the clients. Some new CBC programmes have been started in Asia for industrial workers of both genders and their particular needs. Such tailor-made programmes might show a great degree of variability: some have integrated health insurance aspects (e.g. the Philippines), the local drug supply, preferential referral systems, etc. Integration in this context would refer to their perceived social and health needs.

First experiences show that such innovative schemes are highly accepted but also very vulnerable to adverse external factors or interrupted supply. It should not be forgotten that individual behaviour is strongly influenced by the immediate social environment. Therefore, safe and convenient RH services are needed.

Ultimately, we have to integrate the conditioning factors for RH in our operational research (Epidemiology, social and behavioural sciences and service-analysis have to join in a team approach); only then can we expect a better, well-rounded understanding, the design of more need-oriented programmes and increased participation.

Arthur Erken
This is a short report on UNFPA's activities in the area of HIV/AIDS since 1994 in the countries of Central and Eastern Europe (CCEE), the CIS and the Baltic States.

Given the limited resources available for this region (in 1997, only US$ 4.5 million), UNFPA's overall policy is to assist the CEE and NIS in facilitating the transition from a reliance on abortion to regulate fertility to an approach based on the comprehensive concept of reproductive health, which includes the prevention of HIV/AIDS. Therefore, most of the projects funded by UNFPA do not have an exclusive focus on HIV/AIDS, but do, however, indirectly contribute to the prevention of HIV/AIDS.

Over the years, UNFPA has supported a number of activities in the CEE/NIS that were directly or indirectly related to the prevention of HIV infection and AIDS. These activities fall into five categories: (1) provision of contraceptives, including condoms; (2) reproductive health projects with HIV/AIDS components (training of service providers/contraceptive supplies); (3) sex education programmes; (4) umbrella projects; and (5) regional projects.

(1) Provision of contraceptives, including condoms

UNFPA has approved several projects for the procurement of contraceptives, including condoms, since the early 1990s. In 1993 an emergency contraceptive supplies project was approved for Georgia, worth US$ 311,000. Since 1994, under a World Bank Health Rehabilitation Project Loan, UNFPA procures the contraceptives, including condoms, for the Government of Romania, worth almost US$ 990,000. In 1995 an emergency contraceptive supplies project was approved for Moldova, worth US$ 422,000. This project covered the contraceptive needs of one third of Moldovan women of reproductive age for one year. Also in 1995, UNFPA approved a project for the social marketing of condoms in Sverdlovsk, Russia, executed by Population Services International (PSI), worth US$ 174,000. Through the project, almost 3 million condoms were sold in one year (December 1995-December 1996). In 1996 UNFPA approved a project for the procurement of 360,000 condoms for Poland, worth US$ 200,000. And in 1997 the Fund approved an emergency contraceptive supplies project for Bulgaria, worth US$ 335,000.

(2) Reproductive health/family planning programmes

In recent years UNFPA has approved a number of comprehensive, nation-wide, reproductive health/family planning programmes. Most of these programmes have components for the procurement of contraceptive supplies, as well as training and information components in which the prevention of HIV infection and AIDS are integral parts. It is, however, impossible to single out those parts and their related budgets that are exclusively devoted to HIV prevention. UNFPA funded these programmes in the following countries: Albania (since 1991-1996), worth US$ 1.5 million; Romania (since 1993-1996), worth US$ 620,000; Bosnia-Herzegovina (1995-1997), worth US$ 509,000; Armenia (1995-1998), worth US$ 873,000; and Georgia (1996-1998), worth US$ 916,000.

(3) Sex education programmes

In 1994, UNFPA approved a sex education project for Poland (November 1994-November 1997), entitled "Promotion of responsible family planning and healthy family lifestyles for adolescents and their parents," worth US$ 422,000. Information on HIV/AIDS is an integral part of the sex education curriculum that is being developed through this project. In Russia, UNFPA approved two sex education projects in 1995, i.e., one for out-of-school youth through a project entitled "Sex education and reproductive health care of teenagers" (August 1995-August 1997), worth US$ 224,000, implemented by the Russian Family Planning Association, and a project for in-school youth, entitled "In-school sex education for Russian teenagers" (November 1995-November 1998), worth US$ 741,000, implemented by the Ministry of Education. In both projects attention to HIV/AIDS is an integral part of the sex education curriculum that are being developed. And in Romania the Fund approved a project entitled "Reproductive health and sexuality education for adolescents" (May 1997-May 1999), worth US$ 265,000, aimed at reducing the number of abortions as a result of unwanted pregnancies, and reducing the number of STIs (especially HIV/AIDS) among adolescents.

(4) Umbrella projects:

In nearly all CEE/NIS, UNFPA Representatives have approved so-called umbrella projects. Umbrella projects can be approved up to a maximum of US$ 100,000 a year in countries with a UNFPA Representative in residence Albania (since 1988) and Romania (since 1996), US$ 50,000 in countries with a non-resident UNFPA Country Director: Armenia (since 1995), Belarus (since 1994), Bulgaria (no umbrella project approved yet), Georgia (since 1994), Moldova (since 1994), Russia (no umbrella project approved yet), Ukraine (since 1997), and US$ 25,000 a year in countries without a designated UNFPA Country Director: Estonia (since 1994), Latvia (since 1995), Lithuania (since 1995) and Poland (since 1992). These projects are mostly used to fund small-scale activities that are not covered by regular projects. In many instances umbrella funds are being used by UNFPA Representatives/Country Directors to finance activities related to World Aids Day or other information activities related to AIDS awareness creation.

Because of the multifaceted nature of these projects, it is impossible to give an indication on how much is spent on AIDS-related activities in the different countries.

(5) Regional projects

The Division for Arab States and Europe has financed two regional training projects: one in the Netherlands ("Family planning, sexual and reproductive health course"); 1996-1997, by the Netherlands School of Public Health) and one in Hungary ("Post-graduate training in reproductive health/family planning for service providers from countries with economies in transition", 1995-1998, by the University Medical School of Debrecen, Hungary), for service providers from CEE/NIS. Both courses pay extensive attention to HIV/AIDS prevention strategies.

Mr. Arthur Erken
Former Programme Officer, Division for Arab States and Europe
United Nations Population Fund (UNFPA)
220 East 42nd Street
New York NY 10017
USA
Now Deputy Resident Representative
UNFPA Dar-es-Salaam, Tanzania

References and tables are available from the author.

Dr Alfred Merkle
(Dr. med., Msc.)
Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH
Postfach 5180, D-65726 Eschborn
Germany
Tel: (+49) 6196 79-1215
Fax: (+49) 6196 79-7104
EMERGENCY CONTRACEPTION: A EUROPEAN PERSPECTIVE

Dr André Ullmann

Despite a massive use of cheap and efficient contraceptive methods in Western Europe (approximately 80% of the couples use a form of contraception), there are still a significant number of abortions: in France it is estimated that 36 per cent of all pregnancies are undesired. Currently, 22 per cent of pregnancies end by a pregnancy termination. As expected, pregnancy terminations occur most often (more than 80 per cent of the cases) in the women who use less efficient contraceptive methods (e.g. barrier, or “natural” methods), or no method at all. In France efforts to prevent AIDS have led to an increased emphasis on male condoms, especially in teenagers, but the contraceptive aspects have been somehow neglected, hence a rise in the number of pregnancy terminations in adolescents. As in every other part of the world, there is therefore a need for dedicated emergency contraceptives. Indeed, emergency contraception has been prescribed by gynaecologists for years with regular high-dose oral contraceptives, but except in a few places (Scotland, the Netherlands), it has never been actively promoted until recently, although in some countries a dedicated product (PC4 or Tetragynon) had been available by prescription for a long time.

During recent years awareness has started to grow about emergency contraception: in Finland 4 per cent of all women have used emergency contraception at least once. A British study indicates that 93 per cent of school boys and girls have heard about emergency contraception, although they had imprecise ideas about what it is exactly. Large-scale trials in Edinburgh have shown that making emergency contraception easily available does not lead to less use of regular contraception and may actually decrease the rate of abortions.

In addition, the studies undertaken by the World Health Organization have demonstrated that the use of progestin (levonorgestrel) alone, without an estrogen component, is at least as efficient as, and significantly better tolerated than, the classical estrogen-progestin combination used in this indication. This has opened the way to safer products, without any medical contraindication, thus being usable without medical prescription. This is a very important aspect since the WHO trials have shown that the earlier emergency contraception is taken after unprotected intercourse, the more efficient it is in preventing an unwanted pregnancy.

In France, HRA Pharma, a start-up company focused on Women’s Health has just obtained market approval for a levonorgestrel-only emergency contraceptive (Levo-Nor®) which will be launched at the beginning of 1999. The product will then be made available in the rest of the European Union and in other countries later in 1999.

Because of the safety of the product, and of the lack of contraindication due to the absence of estrogen, the product is suitable for over-the-counter (OTC) use, which is the most efficient way to benefit most from emergency contraception. The French regulatory authorities envisage making Levo-Nor an OTC drug and it is likely that they will be followed by other countries.

YUZPE REGIMEN VS LEVONORGESTREL
IN EMERGENCY CONTRACEPTION

Countries participating in the Multicentre trial

More information about emergency contraception can be found in the last issue of Entre Nous.

André Ullmann.
M.D., Ph.D.
CEO, HRA Pharma
19, rue Frédéric Lemaître
F-75020 Paris, France

EMERGENCY CONTRACEPTION
MAINSTREAMING THE GENDER PERSPECTIVE INTO THE HEALTH SECTOR

Factors Affecting Women's Health in Eastern and Central Europe with particular emphasis on Reproductive Health
by Wanda Nowicka

Introduction
1999 will mark the 10th anniversary of dramatic political changes in Eastern and Central Europe, which began with democratic changes in Poland, followed by the fall of the Berlin Wall and the final collapse of the Soviet Union. The entire process of political and economic transformation in this region has resulted in the establishment of many new independent countries.

Countries in Central and Eastern Europe and Asia, most of them newly established, have been named and officially recognised by the international community as countries in transition or countries with economies in transition due to the common post-Communist and totalitarian heritage and, therefore, shared problems resulting from political and economic transformation. These countries do not fit easily into the categories of developed or developing countries and break the so far well-grounded North-South duality of this world.

This region embraces the countries of Central and Eastern Europe and Asia, including those established after the fall of the Soviet Union. These countries could be subdivided into:

- Countries of Central and Eastern Europe (CCEE) (Albania, Bulgaria, Czech Republic, Hungary, Poland, Romania, Slovakia);
- Republics of former Yugoslavia (Bosnia and Herzegovina, Croatia, Macedonia, Slovenia, Serbia);
- Commonwealth of Independent States (CIS) (Armenia, Azerbaijan, Belarus, Georgia, Republic of Moldova, Russian Federation, Ukraine);
- Central Asian Republics (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan);
- Baltic States (Estonia, Latvia, Lithuania).

In spite of many commonalities between the countries, there have been significant differences within the region due to the level of development, conditions, resources and cultural backgrounds. These differences tend to become even greater over time as political independence enables individual countries to choose different developmental patterns and solutions to common problems. Nevertheless, comparison of this region with the countries of the North or the South still justifies the differentiation and recognition of the particular specificity of the region.

Women's reproductive health
The problems of women's reproductive health include high levels of maternal mortality, a large number of abortions per woman in her life time and per live birth, poor availability of information and services for family planning and the growing incidence of STDs. Teenage pregnancy, which has a serious impact on young women's education, has also increased.

Maternal mortality is still very high. The highest maternal mortality rates are found in the Central Asian Republics and in Romania. Maternal mortality in Romania and Albania fell dramatically after the legalisation of abortion in 1969.

Nevertheless, abortion remains a major cause of maternal mortality in both countries. As a result of the absence of or limited access to affordable contraceptives, abortion is still a main method of family planning and one of the leading causes of maternal mortality. Abortion rates are among the highest in the world. Social phenomena such as violence against women, increased trafficking in women and prostitution contribute to the worsening of reproductive health.

Abortion
In most countries of the region abortion was legalised much earlier than in the developed countries. In most countries it has been performed broadly, because family planning was not sufficiently popularised.

In Russia and other countries of the former Soviet Union, abortion remains the most common and effective means of family planning. As a result of pro-natalistic tendencies in some countries, there were attempts in the early '90s to restrict liberal abortion laws or at least to limit access to abortion services. The most extreme example of such policies is the case of Poland where abortion was finally restricted after almost forty years of being legal and widely available. Under Communist policies promoting motherhood, some countries in CEE attempted to increase birth rates by making contraception and abortion illegal (Romania, Albania). Naturally, these policies failed. Instead of achieving their purpose, these policies led to extremely high maternal mortality in some countries. After having abolished such policies, the situation began to improve. For example, the very high abortion-related mortality for Romania in 1990 actually represents a fall from earlier figures and the improvement appears to be continuing. Nevertheless, abortion is still a major cause of maternal death.

Decreasing maternal mortality rates have also been observed in Albania after legalising abortion in 1991. In Russia, abortion has been legal since 1956 and is widely available and performed. Abortion rates per 1,000 births have reversed their steady decline, from 253 in 1970 to 170 in 1987, they rose to 216 by 1992. The number of induced hospital abortions is unknown. Considerable regional differences in abortion rates are believed to exist, with rates twice the national rate reported in some areas, including the far eastern areas of Russia.

Family planning
A fundamental prerequisite for women to have control over their lives is to be able to maintain control over their reproduction. Family planning, however, continues to be considered from a demographic perspective in the region. As a consequence, the low population growth experienced in the region often makes it difficult to promote family planning. Many national programmes do not recognise family planning as a priority. As a result, women's reproductive choices remain limited. The most outstanding example is the widespread availability of abortion free of charge while contraceptives, when they are available at all, are usually not reimbursed. In general, family planning services are not sufficiently integrated into primary health care programmes; rather they are provided by non-governmental organisations whose capacity to meet needs of women is relatively limited.

Moreover, lack or inadequate access to sex education at schools or other forms of family planning counselling contributes to insufficient contraceptive use. In Romania, according to the Romanian Reproductive Health Survey, only 34 per cent of women stated that their most recent pregnancy had been planned, whereas 12 per cent said that the pregnancy was ill-timed and 51 per cent said it was unwanted. The proportion of women with unwanted pregnancies rose with greater number of living children. Women with a low level of education were more likely to say that their last pregnancy was unwanted.

In Russia, tremendous unmet needs for family planning exist as testified by Andrei Papow in his 1994 paper Family and Induced Abortion in the Post Soviet Russia of the Early 1990's: the Unmet Needs in Information Supply. The options available to Russian women were increased by the legalisation of female sterilisation in 1990 and male and female sterilisation on social grounds in 1993. Nevertheless, abortion still remains the main method of birth control.

AIDS and other sexually transmitted diseases
Although the numbers of people with AIDS in the in the CCEE and CIS are small, they are rapidly increasing. For example, in the Ukraine AIDS has increased almost 50 times during the last five years. There is little knowledge about the prevalence of HIV infection. Fear, denial and lack of information are barriers to knowing the extent of the HIV and AIDS problem in the CCEE and CIS. Lack of sex education increases the risks of HIV transmission. Although the
THE RENEWED HEALTH FOR ALL - GOOD NEWS FOR PUBLIC HEALTH PRACTITIONERS

In September, 1998, the Regional Committee for Europe of the World Health Organization approved the renewed European Health Policy Framework “Health21”. During the past three years, extensive consultation has been carried out with Member States, other International Organisations, NGOs, WHO Collaborating Centres, and selected technical experts, to agree on a forward-looking and challenging policy which will enable to guide the public health development in this Region.

There is a lot at stake. Health development is ever more dependent on macro trends such as changes in technology, globalisation, decentralisation or pluralism. Health is intrinsically linked to social and economic development. However, the inverse is also true: Investments for health can trigger social and economic pay-off.

This, in turn, means that public health professionals will be at the centre of development if public health succeeds in finding appropriate answers to the following questions:

- Where is health created and sustained?
- Which investments result in best health gains?
- Which investments are compatible with human rights?

The renewed European Health Policy framework gives direction on how best to promote the public health agenda. It applies a gender perspective. How could transport systems, for example, be oriented if they are to promote the health of women? How would community services be oriented? What would it mean in practice if businesses oriented their strategies towards the health of the employees, and would thus take account of the multiple roles of many women as mothers or carers? What would it mean to orient health services on primary health care, with special focus on marginalised groups?

General agreement on the direction has now been reached. Member States have committed themselves to re-orienting national health policies within the framework of HFA. They agreed to ensure structures and processes at different policy levels to facilitate harmonised collaboration of all sectors and actors in health development. The good news is that it will highly depend on the practitioners to make it a success. Practitioners are asked to bridge clinical and public health practice and their training should be based on HFA principles. Therefore, Health21 provides nothing but a useful tool for creating the structural and political environments to improve health in societies. Sometimes, which seems to be a quite natural thing in policy making, one has to remind decision makers to implement the agreements they have accepted. Information on the Health 21 documents can be found on the WHO/EURO web site on the Internet: http://www.who.dk.

Ridiger Krech, MPH, Technical Adviser, Adolescent Health and Social Change, was a Member of the former Co-ordination team of the Health For All Renewal.

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numbers of HIV-positive women are not high, the lack of services and programmes for women and for particularly vulnerable young girls may soon result in increased numbers of HIV/AIDS infected women.

The incidence of other sexually transmitted diseases has dramatically increased in recent years in most countries of the former Soviet Union, particularly in Russia, Belarus and the Baltic Republics. In Russia the rate for syphilis grew from 4.9 per 100,000 male inhabitants in 1989 to 92.0 in 1994 with a similar increase for the female population. In 1996 syphilis prevalence increased from 10 to 30 per cent in comparison with 1995 data. The same trends have been noted with relation to chlamydia and gonorrhoea.

In the Ukraine, syphilis has increased 16-fold in the last five years among women. Among 16-18 year old girls, syphilis increased from 5.2 per 100,000 inhabitants in 1990 to 63.3 per 100,000 in 1996.

The full 12-page report with references is available from:

Dr Wanda Nowicka
The Federation for Women and Family Planning
Ul. Robatynska 8
01-140 Warsaw, Poland
Tel./fax: (+48) 22-632 0882/
(+48) 22-631 1817
E-mail: polfedwo@iaw.pdi.net

What is the importance of maintaining abortion statistics?

An initial issue concerns the definition of abortion itself. The intention to preserve women’s confidentiality in abortion recourse to a sensitive procedure is very appropriate. However, the implication is that “abortion” means induced abortion rather than spontaneous abortion. It also supposes that a procedure ending pregnancy is an abortion, whereas recommended forms of contraception is a life-saving surgical intervention that is not classified as abortion, and is therefore undertaken in Roman Catholic institutions. Accordingly, it is necessary to separate induced from spontaneous abortions, and to separate abortion procedures from non-abortion procedures that result in termination of pregnancy.

Recent United Nations conferences, for example, in Cairo in 1994 and Beijing in 1995, have characterised unsafe induced abortion as a public health concern as well as a concern in clinical medicine. Accordingly, management of a competent public health service requires collection of data on the number of abortions performed in hospitals and clinics (both public and private where they co-exist) and of abortions occurring in such facilities following induction of abortion by women themselves and unqualified practitioners. Data on maternal mortality and morbidity have to be maintained as part of public health care, and the proportion of these associated with induced abortion is significant.

The rate of abortion indicates whether abortion is being used as a form of contraception, and whether the country’s duty to protect reproductive health by provision of sex education and particularly by provision of alternative means of contraception is being properly observed. Suspicion may be raised that failure to gather abortion statistics is explained not by a concern for women’s confidentiality but by a concern to conceal the extent of governmental failure to provide access to contraceptive means.

Abortion statistics should be maintained, in addition to identifying the incidence of lack of access to contraception and of contraceptive failure (reflecting perhaps poor product quality control), to identify the incidence of rape, incest and intercourse with young girls. For instance, it is important to know how many girls aged 13 or younger are ending pregnancies by abortion, as a measure of abuse and lack of parental protection. In addition, statistics on abortion of fetus with congenital deformity should be kept. These may show, for instance, the incidence and location of environmental and industrial pollution that damages fetuses in utero or that predisposes women to terminate congenital defects.

While a woman’s abortion choice raises sensitive and conscientious concerns that require preservation of her confidentiality, a country must be able to give an adequate account of its abortion experience within a framework of its duty to maintain public health interests and due observance of its human rights undertakings.

The aggregate abortion picture has negative but also positive implications for a state. International human rights monitoring committees, for instance, the Committee on the Elimination of all Forms of Discrimination Against Women and the Human Rights Committee, monitoring state compliance with UN human rights conventions, have criticised countries for human rights failures indicated by high rates of abortion, both medically undertaken and undertaken by unqualified practitioners. They have also commented favourably on state performance showing a decline in recourse to abortion through promotion of women’s reproductive health and choice. Absence of data would expose a country to criticism for disregard of unduly high abortion rates, and deny a country credit for effective measures to reduce the public health concern represented by such rates. Accordingly, a decision to discontinue collection of abortion statistics seems seriously flawed.

Dr Rebecca J. Cook, J.D., J.S.D.
Associate Dean, Graduate Studies
Faculty of Law
University of Toronto
78 Queen’s Park, Toronto Canada M5S 2C5
TAJIKISTAN

SOCIAL FACTORS DETERMINING THE
DEVELOPMENT OF REPRODUCTIVE
BEHAVIOUR IN ADOLESCENTS

S. Muhammadova

In accordance with the World Health Organization (WHO) classification, the term “adolescents” includes people aged from 10 to 19 years, “youth” those between 15-19 years and “young people” those aged between 10-24 years. Adolescents do not constitute a homogeneous group: they may be male or female; they may or may not be married; some may work, others may not; some live in rural areas, others live in cities; they may be in the early or late period of adolescence; they may be sexually active.

The issues of safeguarding the health of adolescents will be one of the most serious problems that the world will encounter in the next decade. Young people continue to be sexually active regardless of all the resulting problems, including unwanted pregnancies and sexually transmitted diseases (STDs).

For girls, early pregnancy is a serious problem for their further education and employment, not to mention the fact that it poses a serious threat to their health. In Russia the fertility of young women has increased over the past few years from 28.4% to 47%. In Moscow up to 32% of women aged 15-19 require protection against unwanted pregnancy, while only 8% are married. The main causes of death among adolescents are complications of pregnancy and childbirth and unsafe abortions.

A number of experts have noted that the high maternal mortality rate of 25-30 per 100,000 live birth is linked to cases of terminating pregnancies of young primigravidae at different periods and also to complications arising during or after this procedure.

According to WHO figures, the highest incidence of AIDS is recorded in the age group 20-24 years, followed by the age group 15-19 years. The highest incidence of STDs is also recorded in the age group 20-24, followed by the age group 15-19.

The health of adolescents is a serious problem for Tajikistan. Adolescent girls make up 49% of the female population (according to national statistics, 1995): 24% of them suffer from menstrual disorders; 13% to 19.6% suffer from genital inflammation and 34% have extragenital diseases (6, 7, 8). Toxaemia of pregnancy among pregnant girls up to 18 years of age is seen in 4.5% of cases. Abortions among adolescents represent a great danger at present, 0.03% of all abortions are in girls under 15 years of age and 9.97% are in those aged 15-19 (according to national statistics, 1995), and this trend shows no sign of decreasing.

Sex education for adolescents. Hygiene and planning family life are new issues both for our adolescents and for the experts. To date, no targeted sociological research has been carried out among adolescents in Tajikistan to study the social factors of their reproductive behaviour. The purpose of this survey was to study social factors which could affect: the reproductive behaviour of adolescents.

The purpose of this survey was to study social factors which could affect the reproductive behaviour of adolescents.

To achieve this aim, a 35-question sociological survey was. The questionnaire made it possible to analyse the sexual behaviour of adolescents, their awareness of and attitudes towards modern methods of contraception, and their knowledge of STDs and ways of preventing them. In view of the fact that the questionnaire contained embarrassing questions, the survey was completed anonymously.

The survey was conducted in the cities of Dushanbe and Kurgan-Tyube among young people studying at secondary schools and vocational colleges (in classes, in the street or at home). The method of selection in the street (with interviews held at a predetermined place) created a greater atmosphere of confidence between the respondent and the interviewer.

Statistical analysis of the results of the study was carried out through computerised processing of the data obtained. 696 adolescents aged 15-17 were questioned, 304 (43.68%) boys and 392 (56.32%) girls. 40.52% of those who participated in the survey were aged 15, 33.52% were 16 years old and 25.86% were 17 years old. The ethnic make-up of the group studied was mainly Tajiks (47.70%) and Uzbeks (29.61%); Russians accounted for 11.84%.

The majority of the adolescents (85.06%) had been living in the city for more than 5-7 years, the rest (14.94%) had moved to Dushanbe over the past three years from other regions and provinces in the Republic.

The results of the study showed that 16.04% of the young people lived in unsatisfactory material conditions. Around half of those questioned (47.70%) lived in families where there were more than six people living in one house.

11.49% of the adolescents indicated in the questionairre that they were ill in some way; a greater number of girls (12.25%) than boys (10.53%) did so. 29% of the girls were, however, unable to assess the state of their own health.

Questioning showed that the majority of young people led a healthy lifestyle. Nevertheless, 22.9% of those questioned smoked, and among the girls the figure was 11.71% (Tajiks accounted for 4%). 26.15% consumed alcoholic drinks, with girls unfortunately accounting for 20.92%.

A predominant majority of the respondents were in favour of sex before marriage and were of the opinion that they were mature enough to be sexually active and were capable of making decisions about this themselves.

Only 24.43% of those questioned did not allow sex before marriage; boys accounted for 17.76% of these and girls 29.5%.

39.4% of the boys and 15% of the girls allowed premarital sexual relationships.

41.95% of respondents answered negatively to the question whether an early start of sexual activity had a negative effect on health, and 5.46% did not know.

The majority of girls questioned (49.4%) believed the right age to marry was 18-20, while one third of boys (33.5%) preferred to marry at 21-24. As the survey showed, however, 21.55% of the adolescents were sexually experienced: 12.24% of the girls and more than a third of the boys (33.5%).

The reasons for becoming sexually active were worrying in that only 12.36% of adolescents named the main reason as love, 10.34% said sexual attraction, 4.89% said curiosity, 2.06% said pressure from the partner, and the rest did not give an answer.

These results determined the main direction of further study: to study adolescents’ awareness of methods of contraception.

Questioning showed that 31.56% of the boys and 8.69% of the girls did not know what menstruation was. The source of information among boys was mainly friends (32.24%) and literature (25.65%), while for girls it was parents (49%) and friends (23.47%). For young people, medical personnel (7.47%) and teachers (8.05%) were a very insignificant source of information about the menstrual cycle. The sources of information were diverse. Nevertheless, the majority of adolescents were well informed.
Table 1. Adolescents awareness of methods of contraception

<table>
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<tr>
<th>Method of contraception</th>
<th>All %</th>
<th>Boys %</th>
<th>Girls %</th>
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<tbody>
<tr>
<td>Intra-uterine device</td>
<td>45.69</td>
<td>37.50</td>
<td>52.04</td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>52.59</td>
<td>49.34</td>
<td>55.10</td>
</tr>
<tr>
<td>Condoms</td>
<td>74.14</td>
<td>84.21</td>
<td>66.33</td>
</tr>
<tr>
<td>Injection</td>
<td>9.77</td>
<td>3.95</td>
<td>1.53</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>29.60</td>
<td>40.13</td>
<td>21.43</td>
</tr>
<tr>
<td>Rhythm method</td>
<td>20.40</td>
<td>17.76</td>
<td>22.45</td>
</tr>
<tr>
<td>Abortion</td>
<td>40.80</td>
<td>39.47</td>
<td>41.87</td>
</tr>
<tr>
<td>Do not know of any</td>
<td>8.33</td>
<td>9.21</td>
<td>7.65</td>
</tr>
</tbody>
</table>

Note: several answers were permitted.

about various methods of contraception (Table 1).

The above data indicate that of the more modern methods, young people were most informed about the use of condoms and oral contraceptives. More than half of the girls (52.04%) and 37.50% of the boys knew about the intra-uterine device (IUD). Of no small importance is the fact that 39.47% of the boys and 41.87% of the girls knew of and possibly preferred abortion as a method of contraception.

Questioning showed that adolescents not only knew about condoms but also used them. Among the boys, 26.97% used condoms and 15.7% preferred the withdrawal method. As the questionnaires of girls showed, 3.57% of them used an IUD, 6.12% were on the pill, 9.18% used condoms and 8.16% relied on the withdrawal method. The number of abortions among the adolescents questioned is alarming: 14 girls (4.15%) had resorted to this method. Six of them (1.33%) indicated the abortion themselves in the questionnaire, and the boys mentioned eight of the cases (2.63%).

A fact that deserves attention is that, while there was adequate knowledge about condoms as a method of contraception, the respondents were poorly informed about STIs. It was found that 57.4% of the adolescents knew absolutely nothing about AIDS, 35.34% had heard of the disease, and the rest did not answer. 39.08% of those questioned did not believe that AIDS was a dangerous disease, and 68.1% pointed to the high probability of being infected with AIDS. According to WHO figures, one in twenty adolescents/young people contracts an STD each year. In the age of AIDS, however, the percentage of people using condoms (at some 10% to 30%) is not high enough, according to WHO figures.

In answer to the question “From whom did the adolescent receive information on contraception”, it was found that the majority of respondents obtained information from friends and acquaintances (56.60%) and various literature (40.52%). Unfortunately, medical staff (6.98%) and teachers (8.05%) played a minimal role in educational work with adolescents.

The knowledge obtained by adolescents from hygiene and sex education at school was inadequate—the answers of 85.62% of participants attested to this. Adolescents were more inclined to discuss sexual and reproductive health among themselves than with parents and teachers. The survey’s findings showed that a third of the young respondents felt too shy to talk about sex with adults, and this was more the case among the girls (36.70%).

16.09% of the adolescents did not trust adults, with boys predominating (51%). 8.05% of those questioned were certain they would not receive the necessary information, and 9% felt there was no mutual understanding between them and adults.

Questioning the adolescents showed that more than a third of respondents (37.64%) wanted to receive information about methods of contraception in the form of individual consultations, a quarter of those questioned preferred special lessons at school (25.29%) and special literature (25%), and only 15% preferred the form of lectures.

This study therefore shows that adolescents play a decisive role in shaping the reproductive health of a population. They are sexually active, some of them begin sexual life early, and they require help regarding contraception.

The study also shows that a number of social factors affect the development of sexual behaviour of adolescents: the socioeconomic level of the population, the degree of awareness, attitudes towards pre-marital sexual relations and sexual activity and so on.

Adolescents in Tajikistan clearly require help as regards contraception.

Dr. S. Muhamadieva
Tajik Research Institute for Obstetrics and Gynaecology, Dushanbe

Addressing the needs of adolescents has become a priority also for many other countries. These photos show WHO workshop on Adolescent Reproductive Health held in Kazakhstan and Kyrgyzstan in October 1998
UNFPA EMERGENCY RELIEF OPERATIONS

The UNFPA decision to become involved in the area of humanitarian action is a recent one. This activity first commenced in May, 1994, when our policy in regard to reproductive health was modified in response to crisis situations.

Recognition of three principles have underscored the UNFPA’s position in this initiative:

- First, that every person confronted with a crisis situation, whatever its cause, has the fundamental right to benefit from basic reproductive health services like anybody else.

- Secondly, that the vulnerability and fragility of populations during crises places them ipso facto at the forefront of our concerns. In the midst of conflict, violence, particularly of a sexual nature, is ubiquitous and women and young girls are its primary victims. This necessitates appropriate responses, adapted to the circumstances.

- Finally, reproductive health in general is rarely included on the agenda of the agencies and NGOs which are specialised primarily in the initial phases of crises.

Therefore, the role of the UNFPA occupies a natural place in concerted humanitarian initiatives, with the unique objective of ensuring the availability of adequate reproductive health services.

Of course, reproductive health is only one health issue, but the conditions for its provision appear quite different and above all more difficult in a crisis environment. This new sphere of engagement has necessitated the implementation of training programmes at all levels within the UNFPA. In this context, an emergency operations unit was created in Geneva in October, 1994.

The primary purpose of this unit is to facilitate the development of UNFPA activities in the area of reproductive health during crises and to ensure their co-ordination. This intentionally general objective is realised through a plethora of varied activities. It was necessary at the outset to become familiar with the milieu, to integrate it, to circulate this newly acquired experience within the UNFPA, to identify new partners and to create privileged formal ties with the principal agencies (IFRC, UNHCR). It was also necessary to gain recognition from the established humanitarian action bodies and to forge the way for acceptance of the concept of reproductive health.

New tools have been created: a reproductive health guide adapted to crisis situations, a Reproductive Health Kit for Emergency Situations, technical notes for internal use, technical aids such as videos, CD-ROMs and other pamphlets. At the UNFPA it was necessary to define the role of each of the actors: representatives, technical support teams, Emergency Relief Operations and so on. Another equally important problem was to identify means of financing which would be both adequate and immediately available when required.

Gradually, staff have been mobilised and now they initiate activities in the field themselves; our partners appeal to us for our involvement; and 52 projects have already been undertaken. It is now time for this unit to redefine its functions and to concentrate on three types of main activities:

- Sensitisation of decision-makers and training of health personnel in the process of being dispatched;
- Co-ordination of all the UNFPA activities in periods of crisis so that the tools created can be shared and all specific and innovative internal information can be circulated amongst our external colleagues;
- Immediate technical support on the country level to those units of the UNFPA facing emergency situations by affording them the personnel and material resources necessary for the provision of minimal reproductive health services.

Dr Daniel Pierotti
UNFPA Senior Advisor for Relief Emergency Operations
Bureau du FNUAP
9 Chemin des Anémones
CH-1219 Genève Chatelaine
Switzerland

Direct Dial (+41) 22 979 9313
Office (+41) 22 979 9314/15
Fax (+41) 22 979 9049
E-mail: unfpao@undp.org

The Reproductive Health Kit for Emergency Situations (UNFPA 1998, 44 pp) provides a detailed description of how to obtain the kit, its contents and cost. The manual is a first version prepared for field testing and will be updated within the next two years based on user input. The manual includes an order form for the kit which can be submitted by:

- UNFPA/Emergency Relief Operations (ERO) Geneva;
- UNFPA Country Representatives;
- UNFPA/HQ Geographic Divisions: Africa, Asia and Pacific, Europe and Arab States, Latin America;
- Financing Agencies such as EVHO, World Bank, DFID, CIDA, etc;
- UN Agencies such as UNHCR, WHO, UNICEF, UNDP, etc.;
- International Agencies such as IFRC, NGOs and Organizations having entered into a Memorandum of Understanding with UNFPA such as IDM, IPPF, etc.;
- Host governments.

Available from UNFPA, 9 chemin des Anémones - CH-1219 Chatelain, Geneva, Switzerland
Fax: +41 22 979 90 49
E-mail: unfpaero@undp.org

The draft background paper for the ICPC+5 Technical Meeting on “Reproductive Health Services in Crisis Situations” held in Rennes, France, from 3 November 1998 to 5 November 1998 is available from

United Nations Population Fund
Emergency Relief Operations
Operations d’Urgence
Palais des Nations
CH-1211 Geneva 10
Tel.: (+41-22) 979 9314
Fax: (+41-22) 979 9049
SEXUAL VIOLENCE AGAINST REFUGEE WOMEN

A summary from the background report for the ICPD+5 Technical Meeting on "Reproductive Health Services in Crisis Situations" held in Rennes (France), from 3 November 1998 to 5 November 1998.

Sexual violence is inherent in any conflict. It has become a weapon of war too often used to undermine the national and cultural identity of civil populations. Women and girls are the first victims. They suffer from sexual abuse, exploitation and subjugation committed at all stages from flight to repatriation. In times of conflict, women may

"despite the systematisation of rape during war time, it is almost impossible to assess the magnitude of the problem."

Despite the systematisation of rape during war time, it is almost impossible to assess the magnitude of the problem, not be sexually abused, but they may be obliged to offer sexual favours to gain access to basic needs such as food and shelter, safe conduct or refugee status for themselves and their children. The rapist may be a soldier, member of the community, family member or even someone in charge of their protection.

Systematic rape has a disastrous effect on women’s mental and physical health. It may comprise STDS (HIV/AIDS), complications of unsafe abortions resulting from the deliberate policy to rape women to force them to bear the enemy’s child, and damage to their future reproductive capacity. However, despite the systematisation of
rape during war time, it is almost impossible to assess the magnitude of the problem. Indeed, rape is shrouded in shame. Fear prevents victims from seeking help or treatment.

Immediate and adapted responses must be provided to these women through their physical protection including treatment of STDS, emergency contraception, management of unsafe abortions and adequate and individualised psycho-social counselling. Legal advice should also be granted to women. Indeed, sexual violence is a violation of fundamental human rights and, when committed in the context of armed conflict, a grave breach to humanitarian law. Moreover, rape is now considered as a crime against humanity. It is essential that women be aware of the diversity of resorts offered to them even if international law is not always applied at the national level. United Nations organisations, NGOs, humanitarian agencies and the refugee community provide financial and technical support to female victims of sexual abuses. Sexual violence is a very sensitive issue which must be treated carefully and conflict and emergency situations do not facilitate interventions of specialised organisations. But the global community can no longer ignore the Reproductive Health needs of these women and has to work very hard to ensure that refugee women have access to Reproductive Health services when they have been raped.

Candice Moral
UNFPA
Emergency Relief Operations

The full background report, which reviews what steps have been taken since the Cairo Conference to combat sexual violence and what is still to be done to physically protect women and guarantee their rights is available from: UNFPA Emergency Relief Operations Operations d’Urgence Palais des Nations CH-1211 Geneva 10 Telephone: (+41) 22 979 9314 Fax: (+41) 22 979 9049


"Countries should take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women. This implies both preventive actions and rehabilitation of victims. Countries are urged to identify and condemn the systematic practice of rape and other forms of inhuman and degrading treatment of women as a deliberate instrument of war and ethnic cleansing and take steps to assure that full assistance is provided to the victims of such abuse for their physical and mental rehabilitation."
ACTION-ORIENTED HEALTH PROMOTION AND EDUCATION

Marilyn Rice

Since the International Conference on Population and Development, held in Cairo, Egypt, in September 1994, Marilyn Rice of the World Health Organisation’s Reproductive Health Division has been working with countries from each continent of the world to apply a conceptual framework and action-oriented process for designing and carrying out reproductive health-related promotion and education initiatives. This Framework for Action-Planning was first introduced to the International Union for Health Promotion and Education (IUHPE) during its XVth World Conference in Japan, after which a special issue of Promotion & Education featured a description of the most salient portions of the Framework.

The Framework is based on the premise that advocates for reproductive health initiatives can use an action-planning process to induce collaboration among policymakers and programme managers; health and education services personnel; and consumers and their families, peers, and related community organisations. All these players must become involved and committed in order to have an impact on the reproductive health situation of the population. Jointly, these groups can create priorities and action plans that will move forward a reproductive health agenda on national, regional and local levels.

In 1997 the IUHPE formed a partnership with the World Health Organisation’s Reproductive Health Division and the United States Department of Health and Human Services, Health Resources and Services Administration to support the use of the Framework in various countries around the world.

The first activity of the partnership was a meeting held on 19-22 October 1997 which included a large and diverse group of reproductive health professionals from different parts of the world. The purpose of the meeting was to introduce the participants to the concepts of the Framework, to discuss its components and usefulness in planning, and to orient the participants in devising a plan for applying the Framework to conduct ongoing reproductive health activities in their countries. Participants came from ten different countries and have since been working to integrate the concepts of the Framework into their existing RH initiatives. The unique, collaborative relationships that were initiated laid the foundation for a larger international partnership that has been maintained through an electronic discussion list, originating in Argentina. The discussion list has enabled these countries to share with one another their experiences in applying the Framework within their national settings, and to create a knowledge base which helped in the development of training sessions on the Framework for the XVI World Conference of the IUHPE. The hope is that use of the list as a network will expand, as more people are introduced to the Framework.

Pre-Conference Workshop
On 18-20 June 1998 just before the start of the IUHPE’s XVth World Conference, the original three project partners sponsored a workshop on the use of the Framework. During the workshop several of the participants from the October orientation meeting served as facilitators to incorporate their lessons learned from applying the Framework and building and maintaining partnerships at the local level, as well as to help further develop training materials for introducing the Framework internationally.

Special Session
In addition to the pre-Conference workshop, a special Conference session on the Framework was held on 22 June 1998. The purpose of the session was to briefly introduce the Framework, to give those with experience in using it a chance to present their experiences, and to provide a forum for discussing participatory planning, partnership building and collaboration in general. Emphasis was placed on the uniqueness of the Framework’s planning process, which includes identifying behavioural objectives, and then developing educational objectives and activities to meet the desired behaviour changes. Also addressed was the importance of international learning and the extent to which resources had been mobilised and maximised since the beginning of the partnership, as well as the importance of nationally mobilising people at all levels and sectors and the necessity for creating partnerships.

Over time, the Framework has also been refined, expanded and revised, taking into consideration lessons learned from its application. It has also been translated into Spanish. The recent pre-Conference workshop has led to the formation of new partnerships, as well as to furthering the development of a trainer’s guide for teaching the Framework.

For more information or for a copy of the Framework for Action-Planning, please contact:

Marilyn Rice
Reproductive Health Department, WHO
Avenue Appia - 1211, Geneva, Switzerland
Tel: (+41) 22 791 3397;
Fax: (+41) 22 791 4189
E-mail: ricem@who.ch

The brochure “Prevention of Sexually Transmitted Diseases” including HIV/AIDS prevention was developed by the Youth for Youth Foundation Romania under UNFPA supported Project on Reproductive Health and Sexuality Education for Adolescents. This brochure compliments the video series on the same subject which will be used in Youth for Youth Foundation peer education programme.

For further information on the project, please contact:
Dr Katy J. Shroff
UNFPA/WHO Chief Technical Adviser
Family Planning and Reproductive Health
United Nations Population Fund
P.O. Box 1-701
70188 Bucuresti 1,
Romania
HEALTH CARE REFORMS IN EUROPE:
What about reproductive health?

Dr Mikko Viinonen

Introduction

The widespread nature of health care reforms suggests that they are being generated by broad secular trends crossing national boundaries. In many cases, health care reforms are not an isolated phenomenon but are instead part of wider structural efforts to reform various state-supported welfare and other social sectors. Health policy in Europe over the last two decades has been increasingly bedevilled by the growing cost of care. The aging of the population associated with higher levels of chronic diseases and disability, the increased availability of new treatments and technologies, and rising public expectations have exerted an upward pressure on overall health-related expenditure.

After the collapse of communism in 1990, the central and eastern European (CEE) countries have joined the club of health care reformers, but with clearly different motives: they wanted to have more funding for their run-down health care facilities and better standard of living for their pauperised health professionals first and foremost for doctors. What went unnoticed in the euphoria of freedom was that countries can only spend on health as much as their economy will allow, and no system of collecting the funds could create more money by itself.

The third mainstream of reform is not only linked with money, and it connects both east and west, north and south in more equal terms: this is the quest for better quality, for more citizens' choice and voice, and for better functioning health care services.

Health Care Reforms and Reproductive Health

When it comes to reproductive health, health care reforms usually have made it more difficult for the citizens. Preventive services such as maternal health care, school health and student health have been cut because of economic constraints, as reproductive health has not been considered a priority. In the same way, in many countries where abortions are legal, it was considered that those who need them should pay full price for them. Even in several western European countries, services related to artificial insemination and other types of infertility services have been considered a luxury and often not part of the basic package of services.

Health care reforms have been focusing on the financing side of the services, cost containment and rationing being the most prominent features of this process. WHO analysis has concluded that countries would do much better in focusing on the delivery of services and less on the financing side. By this we mean that focusing on quality, effectiveness, efficiency and evidence-based medicine would provide much better results than trying to either raise more money through health insurance or to cut costs through rationing and shifting expenses to the patients through over-the-counter drugs or co-payments.

In our work with the countries, WHO Health Care Systems unit has been a strong advocate for emphasizing reproductive health as a positive and useful area in health care reform. The reason is that countries need positive results from what they are doing and this is what reproductive health can provide. Doing the proper things when it comes to family planning, abortion services (reducing the number of abortions), treatment of sexually transmitted diseases (STDs), etc., can provide quick results in comparison to, for instance, prevention of cardiovascular disease or cancer. The positive effects and statistics that would show
the impact on health care reform could then help governments and ministries of health to carry on necessary but sometimes unpopular reforms elsewhere.

Most European countries have decided to base their health care systems on a primary health care/ general practice fundamet. In principle this is a good and useful model provided that general practitioners are really sufficiently trained in providing family planning services and other reproductive services to their clients. Unfortunately, in many central European countries primary health care is understood as general practice and the strong impact that well trained, health nurses and midwives could have is forgotten and even neglected. The remuneration of GPs should definitely be based on capitation and not on fee-for-ser-

vice. As well, many other types of incentives in the field of reproductive health should be used. For instance, doctors should not be paid by the number of abortions they have provided but in fact by the number of abortions they have avoided through family planning. Repeated abortion can be seen as a failure and neglect of the health care services much more than ignorance or indolence on the part of the woman or her family. Health care services have all the possibilities to provide the woman with information and means where-by she can avoid a second unwanted pregnancy. Unfortunately, as contraceptives are expensive and as many health care providers benefit financially from abortions performed, women are not provided with adequate family planning services.

STDs in many central and eastern European countries are rising to unbelievable proportions. And yet, we have, with the exception of HIV/AIDS, very effective drugs to cure STDs and also methods of preventing them through the rigorous use of condoms. Health care reforms which cannot stop the epidemic of STDs, are not reforms at all, and are burdening in a dangerous way our future generations. We who work in the administrative and financial areas of health care reforms should collaborate much more with those who are developing the content of reproductive health and find synergies which are there just waiting to be used.

This article and the illustrations were a part of a presentation at the Regional Experts Meeting on follow-up to ICPD, 5 years later, held at the WHO Regional Office for Europe from 28 September 1998 to 1 October 1998.
NORDIC RESEARCH INVESTIGATES OSTEOPOROSIS PREVALENCE AND EPIDEMIOLOGY

Kenova Kunz

"Fractures are common, unusually common, among older women in Nordic countries as compared with other European countries. This research is part of an attempt to discover why and what can be done about it." Dr. Gunnar Sigurdsson, professor at the University of Iceland and chief physician at the Department of Medicine of the Reykjavik City Hospital directs a research programme which involves all 70-year-old women residents of the city of Reykjavik. The programme began in September 1997 and concluded during the summer of 1998. All the women who come to the research centre provide information on their medical history especially concerning fractures; when they have occurred and how, and their bone density is measured through x-ray absorptiometry in several locations. Parallel research is being conducted in Oslo and Gætaborg.

Bones in the body are continually being replaced through a complex interaction of minerals such as calcium and phosphorous in the blood, certain hormones, the specialised bone cells called osteoclasts and osteoblasts - and the stesses and strains of body activity. In older persons the rate of bone resorption exceeds that of bone formation, resulting in a decrease in bone mass, the condition known as osteoporosis. This programme and other researches is aimed at trying to explain the interplay of the various factors in causing the condition in order to develop effective treatment.

Osteoporosis is a serious problem in elderly women. After age 50 the fragility of the radius and ulna increase markedly and after age 60 the spinal column/vertebral body begin to contract. By age 70 the pelvic bones are often very fragile, fracture easily and take a long time to heal, limiting the patients' movements and often causing other complications as well. Fractures of the wrist, spine, and hip are most common; however, all bones can be affected. Dr. Sigurdsson reports that "according to the women interviewed, fractures occur all year round, many of them indoors - they're not just the result of winter ice and snow, although there is some seasonal variation." The disease affects men as well. But usually does not appear to the same extent until almost 10 years later than it does in women.

As the Nordic countries tend to get very lit-

descent in North America the same osteoporosis patterns occur, even though the environmental and lifestyle factors may have changed considerably."

1999 is the UN-declared International Year of Older Persons

Kenova Kunz,
PhD, Senior Editor
NORDREGIO
Nordic Centre for Spatial Development
Box 1658
SE-111 86 Stockholm
Sweden

2. Bone porosity at outer end of upper arm in Icelandic women

3. Fractures of spinal column

1. Fractures of upper arm
**Articles**

"Preventing Cervical Cancer in Low - Resource Settings" Outlook, Volume 16, Number 1, May 1998 published by PATH (Program for Appropriate Technology in Health) in English and French is also available in Portuguese, Spanish and Russian.

Contact:
PATH
4 Nickerson Street
Seattle, Washington 98109-1699 USA
Fax: +1 206 285-6519
E-mail: outlook@path.org
www.path.org

**Documents**

**Action for Adolescent Health - Towards a Common Agenda** (WHO, UNFPA, UNICEF 1997) is a booklet which provides a framework for Country Programming for Adolescent Health. It discusses country, regional and global level actions to extend quality and reach of programming.

Available from: Adolescent Health and Development Programme, Family and Reproductive Health, WHO, CH-1211 Geneva 27, Switzerland

**Advances and Challenges in Postabortion Care Operations Research** (Population Council 1998, 40 pp) summarises the principal themes and key points from the meeting "A Global Meeting on Postabortion Care: Advances and Challenges in Operation Research".

Available from: Population Council
One Dag Hammarskjöld plaza
New York, NY 10017 USA
E-mail: pubinfo@ppacouncil.org
www.popcouncil.org

**CARAK: Central Asian Republics, Azerbaijan, Kazakhstan** World Health Organization 1998, 24pp) The goal of the CARAK project is to promote maternal and child health in Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan, which suffer from the highest maternal and child mortality rate in the European Region. The CARAK project covers a total of 404,200 women of reproductive age and 227,500 children under five years of age.

This leaflet is available free of charge from WHO Regional Office for Europe or the Internet: www.who.dk

**Care in Normal Birth: a practical guide (WHO 1996)** is the final report of a technical working group on pregnancy and childbirth complications. Over 4 million newborn babies die each year, most of them as a result of poorly managed pregnancies and deliveries. WHO seeks to reduce levels of maternal and neonatal mortality and ill-health significantly by the year 2000.

Available from: Maternal and Newborn Health/Safe Motherhood Unit, Family and Reproductive Health, WHO, CH-1211 Geneva 27, Switzerland

**Injectable Contraceptives: What Health Workers need to know (WHO 1997)** addresses background issue, client concerns, appropriate use and provision of services. The 40-page booklet is set up in a Q&A format. Available free of charge from WHO.

**Population Issues Briefing Kit 1998** (UNFPA 1998, 24pp) is a ten-chapter document highlighting key population issues including, reproductive rights, reproductive health and family planning.

Available from JNFP
2220 East 42nd Street, New York, NY 10017 USA
www.unfpa.org

**Hopes and Realities** Closing the Gap between Women’s Aspirations and their Reproductive Experiences

Available from UNFPA
2220 East 42nd Street
New York, NY 10017 USA
www.unfpa.org

**Injectable Contraceptives: What Health Workers need to know**


Reproductive health research: the new directions (WHO 1998, 164 pp). The Special Programme of Research, Development and Research Training in Human Reproduction was established by WHO in 1972 to co-ordinate, promote, conduct and evaluate international research in human reproduction. As the main instrument within the UN system for research in human reproduction, the Programme brings together a broad group of experts to identify and address priorities for research aimed at improving reproductive health. This report also takes a look at RH in the post-ICPD era.

Available from Distribution & Sales, World health Organization, CH-1211 Geneva 27, Switzerland ISBN 92 4 156 192 0, Price: Sw.fr. 35,-
Price in developing countries: Sw.fr. 17.50

The Road to Safe Motherhood in Europe
(WHO 1998, 12 pp) calls for an intensification of collaboration between organisations interested in Safe Motherhood and Reproductive Health. The goal is to improve the health of mothers and infants through complementary and cost-effective joint action.

Available from WHO Regional Office for Europe, Family and Reproductive Health

Sexual and reproductive health for young men: some clinical experience from Sweden (RFSU, 1997, 84 pp.) is the fifth RFSU report on sexuality and reproduction. This report responds to the RFSU vision that one new way to improve sexuality education is to provide boys and men with information, and to meet their demands for services and support.

Rape and sexual abuse: a guide to victim care is the sixth RFSU report on sexuality and reproduction (RFSU 1998, 64 pp). It highlights lessons learned since the mid-1970s when RFSU set up Sweden’s first rape-crisis centre.

Both reports are available from:
RFSU (Swedish Association for Sex Education), PO Box 12128, S-102 24 Stockholm, Sweden Fax: (+46) 8 653 0823 E-mail: info@rfsu.se www.rfsu.se

TRAINING OPPORTUNITIES IN EUROPE

Liverpool School of Tropical Medicine
Diploma in Reproductive Health in Developing Countries 19 April - 9 July 1999

The Diploma in Reproductive Health course has been run jointly by the Royal college of Obstetricians and Gynaecologists and the Liverpool School of Tropical Medicine for the past four years. Forty-six health professionals from throughout the world have successfully completed the training programme, their capacity to deliver Safe Motherhood and Reproductive Health Services in developing countries substantially increased. Applications for the 1999 course are now invited.

For more information and application forms contact:
Education and Training Office
Liverpool School of Tropical Medicine
Pembroke Place, Liverpool L3 5QA, UK
Tel: (+44) 151 708 9393
Fax: (+44) 151 708 8733
E-mail: robbinsv@liverpool.ac.uk

There are four new WHO documents on selecting reproductive health indicators and on estimating maternal mortality. The first three are jointly produced by WHO’s Division on Reproductive Health (Technical Support) (RHT) and the UNDP/UNFPA/WHO/World Bank Special Programme of Research Development and Research Training in Human Reproduction (HRP). The fourth document is jointly produced by RHT and UNICEF’s Division of Evaluation, Policy and Planning (EPP).

Selecting Reproductive Health Indicators: A guide for district managers
This field-testing version analyses the need for reproductive health indicators and their selection process.

Monitoring Reproductive Health: Selecting a short list of national and global indicators describes the process and outcome of selecting a short list of reproductive health indicators for use at national and global levels. Fifteen indicators have been identified, through the application of objective selection criteria and an expert review process, to offer a general overview of the reproductive health situation in a country. These indicators represent a minimum set and are intended to facilitate inter-country comparisons.

Reproductive Health Indicators for Global Monitoring: Report of an Interagency Technical Meeting summarises the key lessons to be learned from country case studies and describes the essential criteria that should guide indicator selection.

The Sisterhood Method for Estimating Maternal Mortality: Guidance notes for potential users is intended for health policy-makers and planners who wish to use the method to estimate levels of maternal mortality but who may not be familiar with the different variants and the strengths and weaknesses of each. They are not intended to provide detailed technical guidance on how to carry out sisterhood studies.

Available from WHO, Division of Reproductive Health, CH-1211 Geneva 27, Switzerland. E-mail: abouzahrcc@who.ch
 NEWS

UNFPA and the United Nations Regional Commissions are organising and conducting five-year regional reviews on population and development. The meeting for the European region will be: 7-19 December 1998 Budapest, Economic Commission for Europe (ECE)

Pre-Hague Forum Events

- 4-6 February 1999 Global parliametary meeting
- 6-7 February 1999 NGO Forum (Contact The World Population Fund (WPF) for more information: Tel.: (+31) 35-6422304 or office@wfp.org, www.wpg.org

Both meetings will be held at the same site as The Hague Forum: Netherlands Congress Centre, Churchhillplein 10, PO Boks 82000, NL-2508 EA, The Hague, The Netherlands

8-12 February 1999 The Hague Forum

30 June-2 July 1999 United Nations General Assembly Special Session on the review and appraisal of the implementation of the ICPD Programme of Action

For the latest information on ICPD+5 contact dayal@unfpa.org or www.unfpa.org or Fax (+1) 212 557-6416 for the ICPD+5 News Bulletin

20 YEAR ANNIVERSARY OF ALMATY CONFERENCE REMEMBERED

Almaty, Kazakhstan
(27-28 November 1998)

The joint WHO/UNICEF conference on Primary Health Care (PHC) in 1978 in Almaty was a historic event and a milestone in international health development. At the conference PHC was declared the most effective and surest way to achieve Health for All (HFA). The 1948 WHO definition of health as being "not merely the absence of disease or infirmity but complete physical, mental and social well being" was revised. At Almaty the limits of health were defined as "a level of health that will permit [people] to lead a socially and economically productive life. The conference also created the first checklists and directions to achieve HFA. The 20-year anniversary conference focused on PHC experiences to date and key issues for the next twenty years. It was emphasised that health is intrinsically related to social, economic and environmental factors.

THE UNITED NATIONS DECLARED 1999 THE INTERNATIONAL YEAR OF OLDER PERSONS.

Ageing is also one of the main themes of the UNFPA's flagship publication, The State of World Population 1998 entitled "The New Generations".

The Technical Meeting on Population Ageing, organised as part of the ICPD+5 review process, proposed that governments and international organisations should establish gender-sensitive population policies were fertility is below replacement level and ageing is advancing. These should aim to provide wider access to education, reproductive health services, job creation and adequate housing, and to remove barriers that prevent older persons from continuing to work.

More information on the technical meeting on ageing can be found at: www.unfpa.org/ICPD/aging/age-agenda.htm

UNFPA's web site also includes The State of World Population 1998 report.

IF YOU'VE BEEN SWEPT OFF YOUR FEET

YOU'VE GOT 3 DAYS TO GET THEM BACK ON THE GROUND

Emergency contraception isn't just for the morning after - it can be started up to 3 days (72 hours) after unprotected sex. Emergency contraception is free and confidential - ask your doctor or family planning advisor for further information.

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