WEALTH THROUGH HEALTH
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Association of Interbalkan Women's
Cooperation Societies (A.I.W.C.S.)
Thessaloniki, Greece
Wealth Through Health

A workshop on legal and ethical challenges in reproductive health at the twelfth World Congress of the World Association of Medical Law, held in Hungary in 1998, reinforced the obvious: economic hardships constrain the options open to many countries and their means to remedy the inadequacy of health services. However, the workshop did not stop here, it was pointed out that the wealthiest nations bear ethical responsibilities as do private and parastatal insurance companies.

In this issue of Entre Nous the links between social deprivation and reproductive health are discussed from a number of perspectives. Elaborating on the "obvious" stated above, a strong case is made for governments to target health as a means to improving economic conditions by among other things reducing costly treatments for preventable infections and ensuring a healthy workforce. Articles in Entre Nous will show how reproductive health is particularly vulnerable and how cost-effective strategies to improve reproductive health, such as reducing vertical transmission of sexually transmitted infections through public information campaigns, can also be implemented in low-income settings.

One important link between poverty and reproductive health is the growing recourse to abortion as a form of contraception. Contraceptives are often too expensive or unavailable and women choose to abort in part due to the expense of raising a child. In Hungary, for example, the abortion rate increased immediately following the removal of state subsidies from contraceptives. This same situation is also found in Romania: as costs to prevent unwanted pregnancy rise, abortion becomes the only economic option since the national health insurance plan covers the majority of the cost. However, even where abortion is supposedly free, women become increasingly impoverished as they are often forced to borrow money to make under-the-table payments demanded by physicians.

Another link between reproductive health and poverty is the increase in incidence of sexually transmitted infections (STIs) as a result of prostitution. As Irina Tulayinova writes in her article on Kyrgyzstan on pages four and five, commercial sex workers "present the highest risk for the spread of STIs due to a lack of knowledge about STI prevention, safe sexual behaviour and hygiene". Similar to the developments in many countries, economic changes in Kyrgyzstan have had a direct impact on the spread of sexually transmitted infections and the increased reliance on prostitution as a form of income.

The rising maternal mortality and abortion rates, an increased incidence of sexually transmitted infections, the spread of prostitution due to poverty, the dearth of contraceptives among the poor and inadequate sex education have provoked a massive response across Europe. National governments assisted by UNFPA, WHO and the World Bank, as well as IPPF and other non-governmental organisations, are increasingly recognising that there is a direct link between poverty and health and that, moreover, health should be directly targeted to alleviate poverty. This is recognised and expressed in a new measurement for social progress, the UNDP Human Development Index. Here it is shown that poverty is not only an issue of money but of access to social services and education.

In spite of the realisation of the direct link between poverty and health, Janet Jackson of the European Network of the International Planned Parenthood Federation (IPPF-EN) points out on page fourteen that "The thrust of investment of the last ten years has been to other sectors, especially those that appear to have a clearer and more direct link to the country's drive for economic development and buoyancy".

Ultimately, intersectoral action for health will need to be increasingly implemented. Poverty is now the single greatest cause of ill-health in the world and action to improve health should be coordinated with initiatives to reduce poverty. Targeting the improvement of economic conditions alone is not a guarantee for improved health. While the enhancement of income-earning potential should not be ignored, accessible, free or low-cost health services as well as public information campaigns are the first steps to improving the situation.

Assia Brandrup-Lukanow
Chief Editor, Entre Nous

Jeffrey V. Lazarus
Editor, Entre Nous

Upcoming issues of Entre Nous include: the role of men, reproductive health in emergency situations and genetic disorders.
TARGETING REPRODUCTIVE HEALTH TO REDUCE POVERTY

"Without intersectoral action that can address the major underlying causes of ill health, the growing burden of disease will compromise efforts to achieve... economic growth"

- Panos Kanavos and Martin McKee, 1998 Critical challenges for Health Care Reform in Europe, Open University Press

Entre Nous interviewed acting Regional Adviser on Women’s and Reproductive Health at the WHO Regional Office for Europe, Dr Joe Kasonde, about social deprivation and health. More specifically, we were interested in hearing Dr Kasonde’s views on why and how targeting reproductive health (RH) can reduce poverty. While the opposite equation is also true, i.e. targeting poverty improves the population’s RH, Dr Kasonde argues forcefully for countries to also adopt the former. Below are Dr Kasonde’s comments on the subject.

Health is an essential target in the effort to increase economic growth and reduce poverty in Central and Eastern Europe. The combination of a decline in the growth of GDP and an increase in health expenditures experienced by several countries (e.g. Albania, Bulgaria, Poland and Romania) has resulted in reduced productivity and increased demand on scarce resources. In this equation the contribution of women’s and reproductive health is particularly important: there has been a decline in nutritional status and an increase in maternal morbidity and the spread of sexually transmitted infections. Therefore, targeting reproductive health is a sure way to achieve socio-economic progress in the subregion as in the long run it will reduce national health costs and ensure a healthier population.

Nutrition
Nutrition is the first victim of economic deprivation. There is a high prevalence of nutritional anaemia, especially in the Central Asian republics. For example, in Uzbekistan there is increasing poverty among the population, affecting particularly women. Food is expensive and in short supply, with pregnant women being particularly at risk. The effect is to make them vulnerable to illness in addition to their decreased capacity to work.

Abortion
Abortion complications are a major cause of maternal mortality. Yet deaths due to unsafe abortion can be reduced or eliminated through appropriate measures. In Romania, a study of maternal mortality between 1989 and 1996 showed a sevenfold decline in maternal mortality, and 95% of the decline was of deaths due to abortion, reflecting the benefit of access to safe abortion. The contrary effect has been observed in Kazakhstan, where deaths due to abortion complications have remained high due to illegal practices to which women are driven by "unofficial" (under the table) fees demanded by doctors. Paradoxically, one of the reasons for relying on abortion is that poor women cannot afford contraceptives.

Infections
The spread of STIs is encouraged by poverty, as has been shown in many Eastern/Central European countries. In some countries of the former USSR the incidence of syphilis increased 15 to 30 times, from 5-15 per 100,000 in 1990 to 120-170 per 100,000 in 1995. The same factors will affect the spread of HIV/AIDS, which will have an even greater impact on economies while demanding more expenditure on health services.

Maternal mortality
Maternal mortality has increased during the period of economic transition. In a reproductive health survey conducted in Armenia in 1997 it was observed that "the high cost makes some women reluctant to use these (delivery) services and about 5% of women prefer to deliver at home the next time". This experience has been found elsewhere. For example, in Nigeria hospital fees introduced as part of a Structural Adjustment Programme deterred women from utilising health services and this led to an increase in maternal mortality.

Concluding remarks
There is evidence that the decline in health services and health status in Central and Eastern Europe in the last decade has contributed to, and been caused by, economic decline. A significant part of this effect is attributable to reproductive ill-health. I propose that one strategy to reverse the economic decline is to invest in improving reproductive health through raising the standards of and increasing accessibility to reproductive health services.
SCOTLAND

Inequalities in Women's Reproductive Health

Scene Setting
Poverty places a considerable burden on all aspects of the health of women, including reproductive health. The article will examine the approach of one city to setting up structures and policies to promote the health of women providing specific examples of activity designed to address the reproductive health needs of women experiencing poverty.

Glasgow, the largest city in Scotland, is a place of notable paradoxes. Its industrial past made it a city of extreme wealth and it was once known as the second city of the British Empire. Despite this wealth, large numbers of the population experienced great poverty and this disparity still exists today; 50% of the poorest areas in Scotland can be found in Glasgow. Alongside this poverty are significant inequalities in health in neighbouring areas sometimes having the worst and the best health in the country.

Although the city is considered to be a cosmopolitan one with a rich scientific and cultural heritage, there is nevertheless only limited acceptance of gender equality, and a male-dominated ethos which shows up in the political, employment and domestic arenas, is often very obvious.

Over the past fifteen years there have been attempts to place women's health at the heart of policy and planning for health with some success. This effort is characterised in three main ways. Firstly, the work is informed by a social model of health in which the determinants of women's poor health are considered as important as the type of health care available for women. Particular attention is paid to preventing and managing the health consequences of gender inequality, whether they be created by the stress of managing work and child care, domestic abuse or sexual assault or the experience of being a lone parent living on a low income.

Such an approach requires a recognition by a range of agencies that they have a responsibility for health and the second characteristic of the work in Glasgow is that it has a multi-agency focus.

Although supported in this approach by the World Health Organization Healthy City Project of which Glasgow is a participating city, those working to promote women's health realised early on that substantial improvements would not be realised without the involvement of the employment, education, housing and welfare sectors in addition to the health care sector. Lastly, women from all sectors of society are involved in helping to determine the types of action that need to take place to promote their health. In 1992 a Women's Health Policy for Glasgow was finally launched.

A number of inter-related coalitions exist to develop, implement and carry out research on Glasgow's way of working on women's health. Recently, a number of agencies have come together to form the Glasgow WHO collaborating centre for women's health. This partnership comprises the public health and health promotion departments of the local health authority, the local council, the Centre for Women's Health (a demonstration project aimed at supporting the implementation of the Women's Health Policy), a local college, two of the Glasgow universities and the providers of family planning, well woman and sexual health services and a reproductive health service for women with social problems. It is supported by the Glasgow Healthy City Partnership Office.

To some, this attention to structures and policy may appear a bureaucratic response to women's health problems. In Glasgow, it is felt that this strategic response has helped the issue to flourish and to create an awareness of the links between social and economic factors and the type of health and social care that is required by women.

In the next section, three of the partners of the collaborating centre write in more detail about the way their work explicitly links women's experience of poverty to the way that health care and information on women's reproductive health is provided.

S. Laughlin, Women's Health Co-ordinator, Dept. of Public Health
E-mail: Suelaughlin@glasgow-hb.scot.nhs.uk

Glasgow New Model Well Woman Clinics

Introduction
In Glasgow the Family Planning and Sex-ual Health Directorate has gradually adapted its services since the mid 1990s to incorporate the health needs of the city's female population. Rather than solely focus on medical solutions to medical problems as was previously undertaken, clinic services have embraced a broader concept of health. Particular emphasis is placed on three main aspects of care: improved access, preventive health and the promotion of women's emotional well-being.

Improved Access
Improved access is available in seventeen well-women clinics located in areas of social and economic deprivation across the city. Clinics are accessed through a drop-in facility; an appointment is also available if required. A welcoming, friendly atmosphere is important. Seating is informally arranged in the waiting area and health information readily available in a variety of media formats and in different languages where local need determines. Child care, tea and coffee are available.

While in the clinic, women attending hold and read their own case records. They are encouraged to question any issue during their private consultation. Condoms are free and dispensed discretely as a self-help activity. All staff are female. Indeed at consumer feedback women gave this as a main reason for attending. New improved access for disabled people has recently been established as a result of a collaborative initiative.

Preventive Health
A corporate health education programme which offers different monthly topics runs in each clinic. The schedule incorporates national priorities for health promotion as well as women's expressed need for information. Each month experts from other agencies play an active part in the delivery of each specific topic.

Women's Emotional Well-being
Access to a social model of health is consistent during the consultation process. The provision of information, advice and counselling is facilitated by an open-ended consultation period. Referral for more discrete care is made through an information database of local organisations and specialist clinics.

Support for the Model
Pivotal to the operationalisation of the whole concept is the role of the "Health
Examples of this include:

<table>
<thead>
<tr>
<th>Monthly Topic</th>
<th>Specialist Topic Expert Input</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex, sun and sexually transmitted infections</td>
<td>Greater Glasgow Health Authority HIV &amp; AIDS Directorate provided quiz games and prizes</td>
</tr>
<tr>
<td>Women’s safety</td>
<td>The Scottish Office and Glasgow Police provided videos and information leaflets</td>
</tr>
<tr>
<td>Education for women</td>
<td>Glasgow Universities and Colleges provided education prospectuses</td>
</tr>
</tbody>
</table>

Care Worker. Employed from the local community the Health Care Worker is a lay member of staff. She ensures the welcoming atmosphere, runs the health education programme and maintains the information directory in addition to other organisational tasks. Training and support for the role is essential.

Summary
The introduction of a social model of health into a traditionally medical setting has not been secured without some degree of difficulty. However, many of the interim objectives towards the broad concept of women’s health in the face of poverty have been met and the quality of the family planning services has demonstrably improved as a result.

N. Graham, Well Women Co-ordinator, Family Planning & Sexual Health Centre
Fax: (+44) 141 211 8139

Glasgow "Women Talking" Magazines
Glasgow "Women Talking" mini-mags were first produced by Greater Glasgow Health Board’s Health Promotion Department in 1993 as a group resource for use in a number of settings to generate discussion on topics relevant to women’s health. There have been fourteen issues of the magazine over the years on topics ranging from exercise and mental health to the menopause. The most recent publication looked at surviving domestic violence.

Issues 9 and 11 focused on Becoming a Mother and Sexuality.

Women talking about sexuality
(Issue No. 11):
Anna Mae (29)
"Everyone assumes that because you use a wheelchair you have no sexual feelings or needs. As a teenager no one bothered to tell me about any aspect of sex, presumably because they thought I would never need to know."

Jeanne (38)
"Sexuality is a confusing word. It means different things to different people. For me now it touches on most areas of my life. It is not just who you have sex with, it’s an important part of who you are."

The mini-mag format is kept consistent so they become easily recognised to women across the city. The editorial teams identify a topic of interest to women and invite women from the field in question to join the group to research and advise on material. It is this process of actively involving women in the development of a health resource which allows for looking at the wider determinants of women’s health that makes the mini-mags different from other health education material.

The lay-out of the mini-mag has a front page that sets the scene for the topic, the middle pages are composite stories of women’s real experiences. The back page covers women’s views, useful tips and contact addresses and telephone numbers for follow-up information. The magazine are upbeat, easy to read and include original art work from the designers who have worked on all the issues of the mini-mags. They are currently published in three languages: Urdu, English and Chinese.

Evaluation of the mini-mags confirm that Glasgow women identify with the resource. They find the stories enjoyable, thought-provoking and convincing. There was general enthusiasm at introducing other languages in recent issues and women said they enjoyed sharing experiences across cultures.

N. Greenwood, Programmes Manager
Greater Glasgow Health Board
Fax: (+44) 141 201 4901

The Glasgow Women’s Reproductive Health Service
Background
The adverse effects of poverty on both health and service use are evident in all areas of women’s reproductive health. In addition, women from deprived backgrounds often have a range of other problems, both medical and non medical which exacerbate these effects.

Service Response
Based in Glasgow Royal Maternity Hospital, the Women’s Reproductive Health Services (WRHS) was established in 1986 to provide appropriate, accessible care for women with social problems. Its development was informed by the views of the target women. The service adopts a multidisciplinary approach with a city-wide network of community and hospital clinics each offering all types of reproductive health care as well as help with non-medical problems. The service is accessible by any route including self referral.

Reasons for attendance
Women attend for many reasons but more than half have drug or alcohol problems. Many women have mental health problems or learning difficulties. A history of violence or abuse is common as is a history of statutory care for either the women or their children. Drug using women frequently finance their habit by shoplifting or prostitution and many women have been in prison. Homelessness and extreme poverty are often encountered and there is frequently a history of non-attendance for reproductive health care. The service also has a specific remit to provide reproductive health care for women infected with or affected by HIV and other blood borne viruses.

Results
Numbers attending have steadily increased to a current level of around 250 pregnant women and a similar number of non pregnant women each year. The continuity afforded by provision of all types of reproductive health care has encouraged earlier attendance in pregnancy and the average booking gestation in the WRHS is now the same as that in the rest of the hospital.

Summary
Experience in the WRHS has confirmed that women with severe social problems will attend for care if provided with appropriate services. Academic activities include study of service design and delivery for women with special needs as well as research into effects of deprivation and associated problems on all aspects of reproductive health. The service provides undergraduate and postgraduate education and training to a wide range of professional groups.

Dr Mary Hepburn, Senior Lecturer in Women’s Reproductive Health/Consultant Obstetrician and Gynaecologist
University of Glasgow
Fax: (+44) 141 211 5269
ENDOMETRIOSIS
its implications on quality of life and financial stability

An estimated 2-4% of all women and girls suffer from endometriosis, which may prevent them from reaching their full potential due to the often debilitating effects of the disease on their lives. They may not be able to finish their education, maintain a successful career or even hold down a job.

Apart from being a leading cause of infertility in women, the most common symptom of endometriosis is pain. For some women this can escalate into a month-long nightmare, which in turn affects their normal daily activities. A North American study from 1998 showed that as many as 79% of women with endometriosis indicated that at times they were unable to carry out day-to-day activities. A quarter were incapacitated between two and six days every month.

Despite the disease’s ramifications, including obvious financial implications for both society and those affected, endometriosis is still not well understood, often misdiagnosed and there is no cure.

Whilst endometriosis affects women equally, regardless of social status or ethnic origin, opportunities for treatment are not quite as equal, often depending on the country of residence, or even the woman’s ability to afford to be treated by a specialist. The North American patient study, conducted by the Endometriosis Association, showed an average diagnostic delay of 9.3 years. What is more, 47% of the women had to see five doctors or more before they were either referred or diagnosed. 61% were told that there was nothing wrong when they first presented with symptoms. Many physicians are not familiar with all the symptoms and manifestations of endometriosis, and others are not up to date with or have access to the latest surgical techniques or medical treatments. This is particularly worrying when we compare last year’s study to data from the mid-80s, which shows that endometriosis appears to be starting at a younger and younger age, and that the symptoms are increasing in severity. 66% of the Association’s members had symptoms before the age of 20, and 38% before the age of 15.

Neither surgical nor medical treatments for endometriosis come cheap. As a result, an even greater divide is occurring between those who can afford to see private practitioners and those who cannot. The former have access to specialists who can treat disease which is diagnosed early, and in some cases may prevent recurrence of a severe nature. The latter may have to fight for years within a rigid public health system which does not recognise endometriosis, has no specialised surgeons and which may decide that medical treatment is too expensive to provide. In many countries, the latest medical treatments are no longer provided through the national health care system due to their costs. Women then have to suffice with outdated hormonal treatments and to endure insufferable side effects, some of which are irreversible.

Too many women and girls subsequently have to undergo a hysterectomy, even if they have not yet had children, despite the fact that there appears to be a success rate of less than 50%.

Can it really be right that millions of women and girls worldwide still have to fight for endometriosis to be recognised so that they can receive equal and efficient treatment?

Endometriosis is a serious disease, and should be treated as such. Recent studies suggest that what we see now may just be the tip of the iceberg of a whole series of other health related problems, such as allergies, chronic fatigue syndrome and a link to certain cancers in the families of those with endometriosis. The next generation should not have to have their lives impaired, their education and careers jeopardised nor to struggle to get diagnosed or not have access to adequate treatment, simply because they do not live in a country where qualified care is available or affordable.

References are available from the author.

Lone Hummelshøj, European Representative, Endometriosis Association

What is endometriosis?
Endometriosis is a disease in which tissue similar to the endometrium (the inside lining of the uterus) is found outside the uterus, typically in the pelvis. The tissue responds to hormones, so it swells and bleeds each menstrual period. Because the bleeding occurs in an abnormal location, with no outlet, it can cause inflammation, formation of scar tissue, and develop into cysts, implants or growths. There are many theories as to the cause of endometriosis, including recent work linking dioxin and environmental pollutants to the disease in animals. Endometriosis is treated either surgically, with hormones, or with painkillers, with varying degrees of success.

4,000 case studies indicated the most common symptoms to be:

- Pain: 95%
- Fatigue, exhaustion, low energy: 87%
- Diarrhoea, painful bowel movements: 83%
- Abdominal bloating: 84%
- Heavy or irregular bleeding: 65%
- Pain during or after sex: 64%
- Nausea, stomach upset at time of period: 64%
- Dizziness, headaches at time of period or when having pain: 63%
- Low resistance to infection: 43%
- Infertility: 41%

Source: Endometriosis Association Data Registry

The Endometriosis Association
The Endometriosis Association was the first self-help organisation in the world devoted to endometriosis, and now supports women in 66 countries. As an independent, non-profit organisation of women with endometriosis, doctors, researchers and others interested in the disease, it is a recognised authority in its field. It offers mutual support and assistance to those affected by endometriosis, educates the public and medical community about the disease, and promotes and conducts research. The Association recently teamed up with the prestigious Vanderbilt University School of Medicine to create a dedicated, multi-disciplinary research facility to address the mechanisms responsible for causing endometriosis.

It has published 2 books: Overcoming Endometriosis and The Endometriosis Sourcebook, and information is available in: Arabic, Chinese, Croatian, Danish, Dutch, English, French, German, Greek, Hebrew, Hindi, Hungarian, Italian, Japanese, Korean, Lithuanian, Malay.

For additional information please contact:
Lone Hummelshøj, European Representative
Tel/fax: (+44) (0)171 354 4708
E-mail: info@endo.dk
www.endometriosisasassn.org
KYRGYZSTAN

Experience of the Bishkek Centre on treatment of commercial sex-workers

How economic change directly affects sexually transmitted infections and in turn reproductive health as a whole. Due to the dramatic increase in incidence of sexually transmitted infections (STIs) during the last years, in 1997 the Ministry of Health in

The most vulnerable groups of prostitutes are "street" commercial sex workers, who go to the central motorways at night. Most of them came to Bishkek from rural area and have no steady residence nor possibility to find work. They are commonly teenage girls from families marked by alcoholism and drug-abuse. This group presents the highest risk for the spread of STIs due to a lack of knowledge about STI prevention, safe sexual behaviour and hygiene.

Taking into consideration the aforementioned arguments, the WHO Regional Office for Europe came forward with an initiative to establish a Centre for the treatment of commercial sex workers in order to reduce the incidence of STIs in Bishkek. The Centre was established at the Kyrgyz State Medical Academy.

Kyrgyzstan declared the situation to be an "emergency" (Fig. 1). However, due to financial difficulties the Government was not then ready to organise the appropriate preventive measures and activities aimed to treat and examine patients with STIs.

Among the generally known risk groups vulnerable to STI and HIV, the following groups were determined as especially vulnerable to STI in Kyrgyzstan:

- drug addicts;
- commercial sex workers and their clients;
- men and women whose jobs related with the long time trip;
- women who have had several partners (as a source of income);
- the unemployed.

Bishkek is the capital of Kyrgyzstan and has a population of 800,000 inhabitants (1999), in part due to significant internal migration from rural regions.

According to a survey conducted by the non-governmental organisation (NGO) "Socium", it is estimated that more than 2,000 women are involved in commercial sex activity in Bishkek. Most of them work in independent groups of 5-8 persons, with one woman functioning as a leader, performing the role of the chief-manager (souteneur).

In order to provide anonymity and facilitate the work with commercial sex workers, the Centre established a separate entrance and special rooms with educational materials on STIs and for consultation with physicians and medical procedures.

The main purpose of the Centre is to provide laboratory analysis, anonymous treatment and consultations on safe sexual behaviour for commercial sex workers with STIs, on a free-of-charge basis.

The Centre's main tasks are:
- diagnosing STIs;
- treatment and prevention of STIs;
- to attract and treat the STI infected;
- consultation on safe sexual behaviour;
- condom distribution to commercial sex workers.

Unfortunately, the mass media does not always encourage commercial sex workers to be examined and treated; in some cases they do the opposite. Therefore, the medical centre on STI prevention and treatment co-operates with the national association "AIDS" of the Ministry of Health and the NGO "Socium", which disseminates information about the necessity for commercial sex workers to be examined and treated for STIs. WHO Regional Office for Europe has provided equipment, drugs for treatment, condoms, disposable syringes and gloves.

During February and March of 1999, one hundred and sixteen women visited the Centre and one hundred and six were examined by the staff of the Centre. Eighty-seven of the women were "street" commercial sex workers and sixteen of them were members of illegal "call girl" sex firms. 76% of them were aged 15 to 25 (Fig. 2).

The results of the examinations showed the seriousness of illness among commercial sex workers, especially among "street" prostitutes. In 93.1% of the cases at least one STI was diagnosed among those who visited the Centre for the first time. In 31.2% of the cases an STI was diagnosed among those patients who repeatedly visited the Centre. 23.3% of the patients had never made use of health-care facilities before; 31% of the patients had not had a medical examination during the last year; and 30.2% of patients were examined only immediately prior to a medical abortion. Only 15.5% of the patients who work in the call-girl firms were periodically examined by obstetric and STI specialists.

The following STIs were diagnosed among the patients (Fig. 3.):
- bacterial vaginosis;
- chlamydia;
- gonorrhoea;
- syphilis;
- candidiasis;

Forty-eight patients had one disease; twenty-three patients had two; twelve patients had three diseases; and three patients had four or more STIs. Almost all vaginal smear indicated an increased rate of leukocytosis. The case histories revealed that sixty-four patients had had one or more pregnancies, 39.2% had given birth, 50.6% had had multiple abortions and 18.6% had had miscarriages. All patients were treated according to WHO recommendations (World Health Organization. STD Case Management. Geneva, 1995).

It should be noted that from the Centre's first days of operation, it was the souteneur that insisted that the commercial sex workers be examined. Return visits were of their own initiative.

The main factors attracting commercial
During the mid-1990s the Bulgarian Council of Ministers requested technical assistance from international agencies in order to improve reproductive health in Bulgaria. As a result, the European Union-PHARE Programme’s Family Planning Project was approved as part of health service restructuring aid in 1994. Project implementation began in 1995.

The project goal was to lay down the basis of a national policy for reproductive and sexual health, and prevention of unwanted pregnancy and sexually transmitted infections. The project was implemented by the Ministry of Health, the Bulgarian Family Planning Association, Women’s organisations, WHO Regional Office for Europe, and the International Planned Parenthood Federation. The project continued until January 1998.

In order to achieve their goals, a large-scale training programme for health professionals was started, a mass media campaign initiated and a clinical management information system developed. This booklet highlights what has been achieved to date.

ACHIEVEMENTS
The project catalysed excellent collaboration between governmental and non-governmental institutions of all levels, as well as between health promotion activities and curative care. The media were widely involved from the beginning of the project.

National Standards were designed for education and training of health professionals. These were implemented in all five medical universities and within medical colleges.

Five hundred health and other professionals were trained in reproductive health and information, education and communication through short training courses.

Medical students in all universities and colleges received new postgraduate training of at least 60 hours in reproductive health.

Thirty family planning information centres were established throughout the country within the clinics of the Bulgarian Family Planning Association and in Women’s NGO clubs. These were provided with materials and audio-visual equipment.

Through the network of Hygiene Inspectors, health promotion work among adolescents was reinforced.

Through training of health service providers and provision of client information materials, the quality of care in family planning services was improved and the increasing demand shows the growing awareness of the population on reproductive health issues.

This was also reflected in the Knowledge, Attitude and Practice Survey conducted once at the beginning and again two years later towards the end of the project.

In order to be able to have a better understanding of the population’s reproductive health needs in the future and to provide a base for policy making and future planning, a national management information system for reproductive health/family planning used in clinics was included within the national health information system.

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**Fig.2. Commercial sex workers by age**

- 34.60% in 15-20
- 42% in 20-25
- 13.60% in 25-30
- 9.80% in 30-35

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**Fig.3. STIs among commercial sex workers**

- Syphilis: 15%
- Candidiasis: 13%
- Gonorrhoea: 17%
- Other: 6%
- Clamydiosis: 19%
- Bacterial vaginose: 30%

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Sex workers to the Centre are:
- a confidential and attentive staff;
- anonymous examination for STIs;
- free-of-charge ambulatory and confidential treatment of the patients;
- no compulsory treatment in a specialised hospital;
- the opportunity to receive medical consultations on various aspects of health.

The positive response to the Centre includes:
- it will allow staff to acquire skills in the new approaches in diagnosis and treating STIs;
- it will offer the opportunity to receive medical consultations on various aspects of health.

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Irina Tulayinova
Chief-physician of the Centre on treatment of commercial sex-workers
Tel: (+998) 312 34 5800
Bulgaria is located in Eastern Europe and is on the crossroads between Western Europe and the Near East. There are 8.34 million inhabitants. The capital, Sofia, has a population of 1.2 million. The country is divided into twenty-eight regional administrative districts. Bulgaria is still a country with a low incidence of HIV/AIDS. As of the end of 1998 the number of officially registered HIV positive persons was 243, fifty-six of them have AIDS and sixty have already deceased.

The main means of infection continue to be sexual: 82-84%, of which 68-70% is by heterosexual relations and 12-14% by homosexual or bisexual relations. 3% of the cases are a result of intravenous drug use and 1% from vertical transmission (mother to child). The ratio of infected men to women is 2:1. 72% of the HIV positive are between the ages of 20-29, which is relatively young. According to current legislation, all citizens have the right to take a confidential AIDS test at their own request. AIDS tests are free of charge and all patients are offered pre- and post-test consultations. The funds necessary for the purchase of diagnostic equipment and the treatment of people living with HIV/AIDS with specific anti-retrovirus medicines is provided from the budget of the Ministry of Health. AIDS is not only a medical but an even greater social, demographic and ethical-moral problem and is, ultimately, a problem of the entire society.

Taking into account the fact that AIDS is being spread at this stage predominantly through sexual relation, and over 70% of the infections are within the 20-29 age group, the guiding principle to combat AIDS has to be contraception and public information campaigns. A number of projects for sex education at schools have been developed including the project "Health Promoting Schools". In addition to HIV/AIDS, there has been an overall increase in incidence of sexually transmitted infections (STIs) in general, especially syphilis. Over the past eight years the number of people infected with syphilis has steadily increased. In 1990 only 378 persons were registered as infected with syphilis; in 1998, according to preliminary data, the number was 2,520, i.e. over the past eight years the number of persons with syphilis has increased 6.6 times. In 1999 the new Ordinance on Syphilis, developed in accordance with WHO guidelines, was passed. Moreover, there are a number of bilateral projects between Bulgarian NGOs and NGOs from other countries such as Spain and Greece.

Prevention and control of AIDS
In 1998 the "Working Plan for the Prevention of HIV/AIDS" was initiated in a number of areas. The main principle is prevention and there has been a growing trend towards transparency and information amongst medical specialists and society in relation to HIV/AIDS which have been lacking in recent times. The plan is being assisted financially by UNAIDS.

In 1998 the second phase of the "AIDS on Wheels" projects was implemented. This is a joint effort by the Bulgarian foundation "Health and the Social Environment" and the Spanish NGO "A.B.S.". There are also plans for the implementation of a joint project between the Min-

"Cool" ostriches handing out Cool condoms and informational leaflets in Sofia's Central Park

"Connecting People" is a five-year Contraceptive Social Marketing (CSM) project, designed to address current obstacles to reproductive health and safer sex in Bulgaria.

Journalists at the "Connecting People" launch press conference
BULGARIA, THE CHALLENGE:
New Approach for Minority Issues

The Project "Contraceptive and health choices for the marginalised Roma people of Bulgaria", financed by the EU, is the first community-based, Roma-targeted and reproductive-health-oriented macro-project in Central and Eastern Europe.

The project will be implemented and run by the Bulgarian Family Planning and Sexual Health Association (BFPA) with technical assistance and monitoring from the International Planned Parenthood Federation (IPPF). The project started in August 1998 and will continue for a two-year period. The main goal of the project is to promote reproductive health information, to reduce the high level of abortions, the high level of unplanned births and the risks of STIs among the Roma community. In three towns, Sofia, Plovdiv and Pleven, in the Roma districts, BFPA will establish family planning cabinets where the Roma people will obtain information, services and counselling.

The teams in these cabinets (gynaecologist, midwife and technical assistant) will be composed of Roma and Bulgarian people experienced in working with this community. The needed information will be provided in the appropriate language. The project will include workshops, trainings for the staff and the volunteers and a series of sex education sessions in the Roma schools as well as printed materials.

The production of a video film, which will look at the main stages of the project, will be one of the results of this two-year process. This film will be useful for similar projects in other European countries. Moreover, the project will ensure the continuation of a whole range of services as well as the volunteer committees, which will continue to work after the termination of the project.

The majority of Roma NGOs and community leaders are involved in the volunteer part of the project among the community. Two workshops were already held by BFPA as a part of this project. The first one "How to work together: effective strategies for working with the Roma people" helped us and our constituency to know the problems that can arise in the process of implementation, and the effective strategies for overcoming them. We all learned a lesson: the difference between the ethnic groups and the generations are not so problematic, and we can live and work together.

The second workshop was designed especially for the staff of the cabinets and the volunteers involved in the field work: "Contraceptives, Quality of care, Counselling." were the main themes. Three regional workshops will be held at the local level as well. BFPA is planning to hold seminars for teachers, journalists and volunteers.

Is it easy to work with the Roma community? For us this project is a significant challenge. The overcoming of communication gaps and the already strictly defined stereotypic way of thinking from both sides and the understanding and acceptance of "another culture" are the main issues. In spite of these obstacles we are still optimists; we have to consider our country as our common home. The first steps have been taken, let's go further!

Valentin Blageev,
BFPA (Bulgarian Family Planning Association)
67, Dondukov bul., Sofia 1504, Bulgaria
Tel/Fax: (+359) 2 943 30 52, 943 37 10
E-mail: bfpa@online.bg

istry of Health and the UNDP. The first step was the development of a national HIV/AIDS strategy, initiated in September, 1998. The project is to further develop a national HIV/AIDS strategy.

In 1998 two AIDS-awareness films were made. The broadcast rights to the first film, "Test of Humanity" were bought by the Ministry of Health (MoH). Many brochures and a number of visual materials have also been produced. MoH has long-established traditions of collaborative work and support of all NGOs involved in AIDS prevention and providing support to people living with HIV and AIDS.

Three national anti-AIDS campaigns have been carried out. These were connected with the Day of Love, the opening of the Summer anti-AIDS campaign and on December first, the World Day for the Fight Against AIDS. In addition to MoH, a number of NGOs, the private sector, daily newspapers, Bulgarian National Television, Bulgarian National Radio and almost all the private radio and television stations from the entire country took part in these campaigns. 1998 marked the first year in which the Council of Ministers approved Bulgaria's participation in the European Union (EU) health programme, "Prevention and the fight against AIDS". The participation of Bulgaria in the programme will contribute towards its integration with the EU and the harmonisation of Bulgarian and European legislation. The same resolution provides the necessary funding for the programme from the national budget. It is understood that now is the time (while there is a low percentage of HIV infection in the country) to invest money in the prevention and control of AIDS as this will avoid the necessity of the state later investing huge sums of money for the treatment and social assistance of persons suffering from AIDS and their families.

Taking into account the fact that AIDS is not only a medical problem but an even greater social, demographic, moral-ethical and legal problem, a National Committee for the Prevention of AIDS and STIs of the Council of Ministers has been established. It involves representatives of twelve ministries and committees and will adopt the National Programme for the Prevention and Control of AIDS and STIs.

Dr. T. Varleva:
(National AIDS co-ordinator) Ministry of Health
5, Sveta Nedega sq., Sofia 1000, Bulgaria
Tel/fax: (+359) 2 59 21 93
E-mail: tvarleva@aster.net
Georgia is bordered to the west by the Black Sea, to the north and east by Russia and to the south by Turkey, Armenia and Azerbaijan. The country covers 69,000 km² and the capital is Tbilisi. The official language is Georgian, but Russian is widely understood. The main religion is Georgian Orthodox, but there is also a minority of Muslims. There are major areas of concern with regard to the reproductive health of women in Georgia. There has been over reliance on abortion as the basic method of fertility regulation. Often, these abortions have been carried out in unsafe conditions. Since the implementation of a UNFPA project in 1997, this rate has taken a significant decline, from 41.1 per 1,000 women of fertile age in 1992 to 24.0 in 1995.

Furthermore, there have been difficulties in accessing modern and reliable forms of contraception and a shortage in supplies. Use of contraceptives are now rising. UNFPA and IPPF are both providing contraceptives which are distributed via clinics. We should also note a very high maternal mortality rate in Georgia, which continues to increase. In 1990 the maternal mortality rate was 20.5 per 100,000 live births. This rose dramatically to 46.8 per 100,000 live births in 1995.

In the 1995 edition of Women’s Health Highlights (WHO), it was stated that some 96% of all maternal deaths in Georgia were directly connected to problems related to pregnancy and delivery. Hospitals lack intensive care units, sufficient equipment, anaesthesia services and the professional level of the personnel has been unsatisfactory. At deliveries, physicians do not have the basic resources for emergencies (essential drugs, surgical equipment). These problems have also led to a high infant mortality rate.

Again, there has been a lack of modern equipment and qualified neonatologists. There has also been a low rate of caesarean sections performed. In 1994 only 4% of all births resulted in caesarean sections. The general population has little knowledge of family planning (FP), reproductive health (RH), sexually transmitted infections (STIs), HIV/AIDS, etc. Georgia has one of the highest STI frequencies in the NIS. There is also a high infertility rate which again is often due to infection. Providers lack knowledge in how to prevent or diagnose STIs. They also have little experience in RH/FP management. All these topics have or are being addressed with the implementation of the UNFPA project. The main objectives of the project have been identified as follows:

1. to develop a basic KAP (knowledge, attitude and service) survey;
2. to develop and implement a national reproductive health programme in conjunction with the Ministry of Health (MoH);
3. to assist the MoH to implement a management information system (MIS);
4. to assist the MoH to extend access to RH/FP services.

Activities started with the “National Forum on Family Planning”. This Forum was not based around lectures and speeches, etc., but a need to reach out to the population (particularly the adolescents) on the subject of FP, contraception, STIs, HIV/AIDS and education. The Forum was a success and was widely talked about by both media and politicians. Between 1997 and 1999 a total of 160 doctors and 145 midwives were trained. It is hoped to train a further 40 doctors and 30 midwives by the end of 1999. Fellowships have been provided in the topics of information, education, communication (IEC), public health management and statistics.

Contraceptives have been received from UNFPA and distributed in five regional centres and forty-three RH/FP centres which have been established under the project. It is hoped for a further twelve to be founded by the end of 1999. Medical equipment has been received and is currently being distributed.

The IEC component has been playing a crucial role. There have been TV and radio clips, newspaper and magazine articles, five education/information booklets (100,000 copies of each) distributed, a telephone hotline was established for three months, lectures and a special education programme.

It has subsequently been decided to extend the project to the end of 1999. Future projects have been identified as follows:

1. A new KAP survey should be undertaken with the help of a WHO consultant;
2. A national reproductive health programme is being developed, the MoH proposal needs to be evaluated. In the meantime IEC components are to continue;
3. The management information system needs to be further studied;
4. Extending access to FP/RH services continues.

Prepared by the Women’s and Reproductive Health Programme, WHO Regional Office for Europe

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<th>PRESENT DATA</th>
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POLICY AND PRACTICE

CATHOLIC SUPPORT FOR THE ICPD PROGRAMME OF ACTION

Five years ago in Cairo, the world's nations came together at the United Nations' International Conference on Population and Development (ICPD) to endorse a 20-year plan for dealing with those crucial and complex issues. In Cairo delegations crafted a rights-based approach that linked population and development and put the needs of women and men rather than demographic targets at the heart of public policy initiatives. While the vast majority of nations favoured Cairo's Programme of Action, a handful of UN member states, the Holy See the most vocal among them, joined by a few Muslim-influenced states and three or four countries with large Catholic populations, endeavoured mightily to block consensus. In the end, these member states had to settle for stating reservations to the final document. After Cairo, however, they did not simply fold their tents, and their continued attempts to undermine Cairo agreements has caused many to especially question the Vatican's international policy role at the United Nations.

Vatican opposition
In the years since Cairo, Roman Catholic church leaders have worked in public policy arenas around the world to block implementation of the ICPD programme and other policies they have suspected of expanding access to reproductive health care. And, during the recently ended ICPD+5 process, a review of progress made toward implementing the ICPD's plan in its first five years, the Holy See delegation was among the most active.

While Permanent Observers, such as the Holy See, cannot vote in the General Assembly, in most UN conferences they are granted the full status enjoyed by UN member states, including not only a voice, but also a vote on any question that is put to a vote. During debate, the Holy See, alone among the world's religions, can make as many interventions as the member states it sits with. Historically, there has appeared to be little reason to question this unusual arrangement. Over the years the Vatican has often engaged in the role of peacemaker on the world stage, and it has been a positive participant in the United Nations on basic health and humanitarian efforts worldwide.

At the same time, the United Nations has become in recent years an important venue for policy discussions on public health issues, including sexuality and reproduction. The church's religious tenets regarding sexuality and reproduction make it next to impossible for the Holy See to participate in the policy debate with the same public health concerns that are at the forefront of most states' interests. With its UN seat on par with governments, the church attempts to conform public policies to its religiously-based views. For example, the Vatican opposes the use of condoms to help protect against the transmission of HIV/AIDS. It opposes the use of contraception even for married couples, and refuses to recognise sexuality outside lifelong, monogamous, heterosexual marriage.

"...the vast majority of nations favoured Cairo's Programme of Action"

Nowhere were these problems more evident than in the ICPD process. During ICPD+5 the Holy See pushed against the tide, just as it had done in Cairo. Its delegation opposed numerous proposals, including those that would call for the provision of emergency contraception to refugees, the promotion of education and use of condoms for safeguarding against HIV/AIDS, the protection of adolescents' right to privacy and confidentiality in reproductive health matters, the inclusion of sex education in school curricula, and the training and equipping of health care workers to ensure that where abortion is legal it is safe and accessible.

The Holy See's attempts to bar general agreement on these matters were joined by only a few countries, principally the Sudan, Libya, Morocco, Iran, Argentina and Guatemala. Notably, however, a number of countries with large Catholic populations - including Mexico, Brazil, Bolivia, Paraguay, Venezuela, and Peru - spoke out in favour of policies that directly contradicted church positions and Holy See interventions.

"See Change"
Non-governmental organisations (NGOs) also challenged the Vatican. Both the Youth Delegation and a wide coalition of women's organisations issued open letters questioning Vatican positions in light of the church's teachings, especially its strong commitment to the poor and marginalised, many of whom are women. And Holy See attempts to block consensus fuelled an already active campaign by NGOs to change the Vatican's status at the United Nations. The "See Change" campaign has been endorsed by hundreds of NGOs. With the premise that the Roman Catholic church should participate in the United Nations in the same way as the world's other religions - as a NGO - the campaign is calling on the UN Secretary-General to review the church's current status.

With NGO status, the Vatican would still be able to add its voice to the public policy debate. But it would no longer be on par with countries that have a genuine citizenry - women, men and children who are directly affected by the healthcare policies of their governments. It would no longer, for example, so easily be able to impede decisions by the United Nations to work to prevent 600,000 women from dying during pregnancy and childbirth and to make condom education and use a major tool in the prevention of HIV/AIDS. International health issues like these are too important to allow the leaders of one religion to sit with governments at the policy table.

Frances Kissling
President, Catholics for a Free Choice
Catholics for a Free Choice
1436 U Street NW Suite 301
Washington DC 20009
USA
Tel: (+1) 202 986-4244
Fax: (+1) 202-332-7995
E-mail: cffc@igc.apc.org

www.seechange.org

N O. 4 3 - 4 4 - S U M M E R / A U T U M N 1 9 9 9 - P A G E 1 3
For the last ten years, IPPF European Network (IPPF EN) has been working intensively to promote sexual and reproductive health (SRH) in countries with economies in transition in central and eastern Europe. Ostensibly, IPPF works through independent and autonomous family planning associations, helping to create non-governmental organisations (NGOs) and build up the third sector contribution to reproductive health development. The challenge facing IPPF EN in central and eastern Europe was not dissimilar to that of the pioneers who began the global reproductive health movement in the early 1950s. In the tradition of these pioneers, family planning associations have been set up to build a national family planning advocacy movement through the third sector; small-scale multi-sector demonstration projects have been implemented; and expertise in the field of sexual and reproductive health has been developed among medical and non-medical professionals.

The uniqueness of SRH work in this region lies in the fact that for the most part, the needs in this part of the world are invisible to the world at large. Where special attention is called for in countries with economies in transition, texts tend to convey neither the urgency nor the extent of the need in the face of more pressing priorities be they in other parts of the world or in the countries themselves. The thrust of investment over the last ten years has been to other sectors, especially those that appear to have a clearer and more direct link to the country's drive for economic development and buoyancy. As a result, choices, rights and the heath of people has suffered because of insufficient investment in the area of sexuality and reproduction.

Sexual and reproductive health worsened before it improved and the lack of widely available and affordable modern contraceptive choices is making women poorer in health, in their economic situation and socially by reducing their ability to compete equally in the public sphere. While donor countries are stepping up their efforts to accelerate the access process of many of these countries into the European Union (EU), it is now all the more important to ensure that health, specifically SRH, continues to receive assistance amidst a larger agenda of structural and institutional development. Failure to ensure choice and respect rights in this area will contribute to an increasing impoverishment of women in their economic status, their health and in their reduced public sphere participation, especially at the policy level.

Abortion instead of contraception
In terms of SRH, access to modern contraception is insufficient and women are kept hostage to an abortion culture, having to pay “under the table” for their abortions. For gynaecologists, abortions provide a means of supplementing their income. It is therefore not in their interests to promote modern contraception. Women are known to borrow money in order to pay for their abortions, even though these are either free or virtually free of charge in most of these countries. When we compare the cost of abortion to modern contraception, it can be cheaper for women to have the former rather than the latter.

With little income, women face the dilemma of having to choose between meeting basic family subsistence needs and attending to their own health. Faced with this sort of choice, contraception can often appear to be a luxury and therefore dispensable. With privatisation of the pharmacists, contraception may be increasingly available on the market place, but it is unaffordable to the majority.

In addition to privatisation, it has been important to expand service delivery beyond the gynaecologists. This has meant training midwives and GPs as well as psychologists and social workers to participate in outreach, counselling and education work. While official figures in some countries may be showing a decline in the reported number of abortions, there does not appear to be a corresponding rise in the use of modern contraception. Furthermore, it is widely known that private medical practice is proliferating and abortions carried out by this sector are not reported. The reality is that fertility is declining in most of these countries, indicating that women are regulating their fertility and indicating a desire not to have children while the socio-economic climate is poor.

Women are poorer in health because the health systems are themselves deteriorating in a number of countries; the health budget allocation is falling as a proportion of overall investment. Furthermore, with inflation and a devaluation of the currency, the buying power of this budget is less. As a consequence health providers are unable to provide quality services to anyone keep up with advances in their specialised fields. As the health sector is unable to replenish old with new equipment and maintain the necessary supply of clinical materials, practice is compromised and skills are lost. Many eminent OB/GYNs have expressed their concern at the de-skilling of their specialists. This decline in quality of care has led to more post-abortion complications. Women's morbidity also increases as a result of repeated abortions and the lack of access to early abortion, vacuum aspiration or medical abortion services. In the same way, emergency contraception is not generally available and post abortion services rarely incorporate contraceptive education.

These factors compound the problem of lack of choice and women find no alternative but to continue relying upon abortion for fertility regulation. In most countries modern contraceptive usage is low and comparatively lower than that in many developing countries. The birth rate is still declining and abortions are equal to the number of births or outnumber the births by 2:1 or even more. This ratio can become higher when national figures are disaggregated by the country’s regions. In addition, there is an alarming increase in the number of sexually transmitted infections (STIs) across the region, especially among young people. The economic benefits of mass health promotion and preventive education to both individual and state have yet to be fully appreciated, though inroads are being made in the trend away from a curative approach towards a primary health care and public health focus in a number of ministries.

Finally, many women are negatively affected by the transition to a market economy and democratic state. Unemployment is higher among the female
population and women are the hardest hit by job losses. Women's voices are heard less and less in parliament and in government. Child care facilities have been withdrawn in many work places and communities, adding to women's lack of ability to participate in work. Women's groups have tended to be viewed as part of the old regime or have a party political bias. Therefore, some governments and women's groups are promoting high natality as a means of asserting their new national identity and independence. Women are particularly vulnerable in these circumstances to the anti-choice lobby.

**IPPF's response**

IPPF European Network's strategy in helping to improve the situation and ensure a reproductive health presence in as many transition countries as quickly and effectively as possible, has been to create and enter into a variety of partnerships in order to improve services.

Partnership has been a fundamental aspect of NGO work in the countries of central and eastern Europe to help achieve both financial and programme sustainability. These have involved Family Planning Associations (FPAs) building alliances in different areas, for example with the media, young peoples groups, teachers, health professionals, the private sector, policy makers and parliamentarians and donors.

**Media partnerships**

The media partnerships have been built with the television, radio and written press. The strategy has been to focus primarily on developing the skills of journalists to enable them to consider feature stories as a means for public education and information dissemination, while news stories have helped raise the profile and have served as public relations tools for the association itself. Some associations have a collaborative agreement with journals, providing answers to readers' questions on sexuality and reproduction, thus entering into direct dialogue with members of the public. This has been particularly successful with young people.

With television, the FPA role has been to exploit the power of the image by bringing forward key personalities and experts to present the case for sexual and reproductive health and contraception in the country. Radio has enabled listeners to openly contribute while guaranteeing them anonymity while discussing or presenting a view on sensitive and personal sexuality-related subjects. Journals and newspapers have been used to enter into further depth on the debate and reinforce public awareness and education.

**FPA activities**

The FPAs work extensively with young people and schools and this has been absolutely vital to enable young people to understand their sexuality, have autonomy over their bodies and learn about love, intimacy and relationships. Five years ago many young people spoke about their confusion about their bodies and their sexuality when they were bombarded with pornography and had no other way to learn about their sexuality positively. Furthermore FPAs have undertaken much work in bridge building in the relationship between parents and young people.

Many FPAs have been at the forefront of introducing up-to-date and correct information about modern contraception to the country. They have taken a leading role in teaching health professionals and teachers about modern contraception as well as SRH issues. In this IPPF have collaborated closely with other agencies. This aspect of IPPF EN's work has been particularly intense and has required considerable investment in order to correct the widespread mis-information that existed about contraception. Often, the importance of education in terms of improving women's status and their autonomy in making choices is emphasised. However, the situation in the CEE and NIS brings in a new dimension to our work. It is not sufficient to just have education. The most important question to ask is what type of education? IPPF EN works with health professionals, schools and communities to ensure that all people have access to the information that will enable them to make the right sort of choices for their lifestyles.

**Private sector**

The IPPF EN involvement with the private sector is growing. One significant activity is the social marketing of the pill and condom, whereby a company agrees to take on manufacture, packaging and distribution in return for IPPF undertaking the product marketing. The success of this initiative has been fivefold. It has made modern contraceptives more widely available in country, reduced the market price of those products, increased contraceptive usage, improved quality and, finally, it has generated income for the project, thus contributing to financial sustainability.

Another example has involved a partnership whereby a large international company agreed to underwrite a sex education initiative in which the FPA produced education materials for distribution in the schools and taught the teachers, in exchange for including a sample of the company's product in each education package.

**Policy Making and collaboration**

Partnership at the policy-making level has involved FPAs interacting with different ministries and different parliamentary bodies. IPPF EN has collaborated closely with UNFPA and WHO in its efforts to influence policy opinion and bring about change. This collaboration has helped ensure that scarce resources are put to the most effective use, joining forces for example in training professionals rather than duplicating work. This has also strengthened and united efforts to integrate sexual and reproductive health into the training of both undergraduate and post-graduate medical and non-medical disciplines. Standard setting in quality of care issues for health professionals and in the production of information, education, communication (IEC) materials have also been a frequent feature of such collaboration initiatives.

In the last five years there has been a shift in the position of many donors towards investing in sexual and reproductive health programmes in this region. Though advances have been made to improve sexual and reproductive health and make it part of national programmes, this cannot be sustained without external assistance in the medium term. As with other sectors, there can be no quick fix for the health situation. The process of becoming a market-led economy will indeed take much longer than was perhaps first anticipated. The assumption then that the cost of sexual and reproductive health (SRH) will be offset by health insurance schemes or national health programmes is still a far and distant prospect. Meanwhile, the rights, choices and health of people need to continue to be protected and supported.

**Janet Jackson**

Programme Manager IPPF European Network
Tel: (+44) 171 487 7952
Fax: (+44) 171 487 7823
E-mail: jjackson@ippf.org
POVERTY, INCOME & ILL HEALTH

Health and poverty are intricately related and the gap between socio-economic conditions in Central Asia and Western Europe clearly reflects this. In addition to socio-economic conditions, political and environmental factors are also key components of initiatives aimed at improving the population's health. As Dr. Mahler stated in his speech at the twentieth anniversary of the Alma-Ata Primary Health Care Declaration in November, 1998, unemployment and underemployment, economic poverty, social apathy and other socio-economic factors and conditions must first be removed or alleviated before we can expect any substantial improvement in the health of the population.

The World Bank in its 1993 World Development Report confirms that those at the bottom of the socio-economic scale have poorer health than those at the top. "The higher a country's average income per capita, the more likely its people are to live longer and healthier lives. Of course, this effect tapers off as income rises. Because poverty has a powerful influence on health, it is not just income per capita that is relevant, the distribution of income and the number of people in poverty matter as well."

From Table 1 we can see the differences between the Central Asian and the Western European countries in terms of maternal and child health indicators. Countries with higher per capita gross national product (GNP), for instance, Denmark and Norway, tend to have lower infant and maternal mortality. Moreover, findings from various studies conducted in the different countries showed that the more polarised the income, the worse the population's health status. However, some of the countries (for example China, Sri Lanka, Costa Rica, Kerala, and India) that have achieved low mortality rates, especially infant mortality rates, despite their low levels of per capita GNP, attribute the result to "non-health factors" such as the spread of education and the drive to provide access to other basic needs, in addition to low cost health services.

A direct relationship between income inequality and mortality has now been established. For example, in a combined analysis of rich and poor countries, it was found that comparing countries where the income of the poor is equal, regardless of the per capita GNP, there was a higher incidence of infant mortality in the poorer the individual. However, it is not exactly clear how this relationship works. It is going be much harder to prove conclusively than, for example, the relatively clear link between tobacco use and cancer. However, higher income may, for instance, lead to a higher level of education, resulting in lower mortality rates. Another hypothesis include: higher income may alternatively lead to greater expenditure on health-related investments (private or public) leading to lower mortality and good health; and higher income may lead to improved nutrition or other consumption-related variables, resulting in lower mortality.

Why the poor are unhealthy
Every minute, forty-seven additional people join the millions living in poverty. No matter where people live in the world, those who live below the poverty line are often forced to live a subsistence existence, easy prey for diseases, malnutrition and despair. In poor countries, due to extremely low income or unemployment, the majority of people treat health care as a low priority. Poor socio-economic conditions may lead to cutbacks in expenditure on food and thereby increase susceptibility to disease. It is believed that people from deprived backgrounds may be less likely to seek medical attention. Moreover, restricted access to health care, different perceptions of symptom severity or a negative view of health-care services may account for lower utilisation of the health services by the socially deprived.

High income inequality may also create an antagonistic atmosphere and ultimately lead to violence. Income differences between households can create psychological stress for the poor and may have health implications. Furthermore, inequality seldom stops at the doorstep of the household; intra-household distributional processes are also key determinants of personal welfare.

Poverty and Women's and Child Health
Different international agencies recognise that poverty is sexist. About seventy per cent of the world’s poor are female, according to international aid experts. A study in 1996 by the International Labour Organisation (ILO) concluded that the negative impact of economic reform and transition to market economics has tended to hit women harder than men. In a situation of poverty, women often have the least access to food, health

<table>
<thead>
<tr>
<th>Country</th>
<th>GNP US Dollar</th>
<th>Maternal mortality rate/100,000 live births</th>
<th>Infant mortality rate per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Central Asia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kazakhstan</td>
<td>1680 per capita</td>
<td>53</td>
<td>25</td>
</tr>
<tr>
<td>Kyrgyzstan</td>
<td>810 per capita</td>
<td>43</td>
<td>31</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>870 per capita</td>
<td>34</td>
<td>25</td>
</tr>
<tr>
<td>Uzbekistan</td>
<td>860 per capita</td>
<td>42</td>
<td>36</td>
</tr>
<tr>
<td>b. Western European</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denmark</td>
<td>26,000 per capita</td>
<td>7.38</td>
<td>5.4</td>
</tr>
<tr>
<td>Austria</td>
<td>22,380 per capita</td>
<td>4.2</td>
<td>7.5</td>
</tr>
<tr>
<td>Norway</td>
<td>29,082 per capita</td>
<td>6.55</td>
<td>5.1</td>
</tr>
<tr>
<td>Ireland</td>
<td>12,210 per capita</td>
<td>7.50</td>
<td>7.6</td>
</tr>
</tbody>
</table>

Source: Women’s Health Profile series, WRH unit, WHO EURO, CPH
education and employment, which in turn violates the right of control over their reproductive function. Social injustice such as violence against women often leaves them powerless, less able to participate in development decision making or even to access education. Poverty is clearly a major cause of death and misery of children and women both in developed and developing countries. Poverty undermines the physical, social, intellectual and emotional development of children. According to the World Bank, children born into poor families have a higher chance of dying before their fifth birthday than children born into better off families. An Australian College of Paediatrics literature review found that children in the 0-4 year old age group had a range of health problems associated with low socio-economic status, including prematurity, low birth weight, poor nutrition and development delay.

Low birth weight is an important indicator of the reproductive health status of the population. In particular, it is associated with infant mortality and with health in later life. A recent study in England and Wales also showed that a strong relationship has been found between socio-economic status and the risk of low birth weight.

Poverty and Stress
To become poor is to experience not only financial stress but also to confront a greatly-increased risk of stress-related ill health. The lack of adequate economic resources and a sense of deprivation associated with poverty can lead to situations of psychological stress and produce a loss of self-esteem. That loss, when combined with the emotional and psychological stress associated with the constant struggle to make ends meet, ultimately leads to stress related ill health.

In the Semipalatinsk region (the former nuclear test site territory) of Kazakhstan, there are claims that stress associated with poverty has also been a contributing factor to the increased number of reported cases of violence, divorce, suicide and crime. At present, the collapse of the former Soviet political system, the worsening socio-economic situation, and poor and slow development of a new organisational structure of public life, have increased the vulnerability of women, children and young people.

WHO Response
WHO is helping its member states into their health care reform process by providing new and updated guidelines on health care programmes for poor mothers and children. In addition, the agency is promoting the development of community-based programmes.

"LET US SPEND MORE MONEY ON PROGRAMMES THAT HELP POOR CHILDREN, FROM NUTRITIONAL AND MEDICAL PROGRAMMES FOR POOR MOTHERS UP THROUGH AID TO DISTRESSED SCHOOL DISTRICTS. LET US ALSO RAISE THE INCOME SUPPORT GIVEN TO POOR FAMILIES. ALL OF THIS WILL COST MORE MONEY. BUT NOT THAT MUCH MORE BECAUSE OUR POOR ARE SO POOR THAT IT ONLY TAKES A MODERATE AMOUNT OF SPENDING TO MAKE THEM BETTER OFF."

PAUL KRUGMAN, 1995

be formulated and implemented with the participation of groups directly affected by poverty. WHO also emphasized the importance of intersectoral collaboration and cooperation in dealing with the complex non-health factors, in terms of policy development and service provision.

Recommendations
Social policies should be more focused and aimed at low income groups. They should also direct more resources and programmes to these groups. Advocacy is required to raise the voices of people affected by socio-economic inequality. This needs to be done at both local and national levels.

Steps should be taken in support of a new public health strategy, particularly in the area of poverty and health. A range of action that health services could take includes ensuring distribution of resources in proportion to relative needs, responding appropriately to health care needs of different groups and encouraging a more strategic approach to developing healthy public policies. At the national level this means interdepartmental action, intersectoral initiatives, health impact assessments of all public policies and equity-oriented health targets. At the local level promoting structural links between agencies so as to better assess and improve their policies and practices impact on health is essential.

Tarek Mahmud Hussain, MD
Short Term Professional World Health Organization Regional Office for Europe Programme of Women's and Reproductive Health E-mail: tmh@who.dk Tel: (+45) 39 17 12 53
RUSSIA

A new approach to the treatment of STIs

Sexually transmitted infections (STIs) are widespread all over the world and a serious problem for many countries, amongst them both for Russia as a whole and for St Petersburg especially. In an average year more than 75,000 cases of infections belonging to the STI category are registered in St Petersburg: trichomoniasis, chlamydial infections, ureaplasmosis, Gardnerella vaginalis infections, urethral candidiasis, venereal warts and genital herpes. These diseases are of great socio-economic significance, as they are the cause of infertility, premature births and the birth of children with symptoms of infection and result in the development of encephalopathy, pyo-septic infections after birth or abortions and cervical cancer in infected women (see table 1).

Active diagnosis was launched in 1990 and registration of STIs in the second generation (chlamydia, ureaplasmosis, Gardnerella vaginalis infections and others) began in 1993. Registration, however, is incomplete owing to the insufficient number and quality of diagnoses. STIs facilitate the transmission of HIV from one person to another. Infections such as herpes, chlamydia, gonorrhoea, syphilis and trichomoniasis can increase the risk of HIV transmission by 2-9 times (according to WHO).

Until recently, the general approach in the treatment of STIs was to identify the etiological factor by using laboratory tests in order to identify the infectious agent. The etiological diagnosis provides an ideal method, although it does entail a range of problems, mainly the high cost and the time-consuming aspect of this method. This means a delay in treatment.

In addition, there is the clinical method, based on the clinical experience of the doctor who identifies symptoms that are typical for a certain STI. Nevertheless, this method also has its drawbacks as it makes the diagnosis of mixed infections more difficult, while each infection needs to be treated separately.

WHO suggests a new syndrome-based approach for treating patients with STIs. The fact is that although there are more than twenty different types of STIs they have similar symptoms. For example, vaginal discharge or genital ulcers are the most frequent symptoms of STI. The combination of objective and subjective symptoms is called a syndrome.

Table 2 lists the complaints experienced by female patients, symptoms of the main STI syndromes and their etiology. It demonstrates that every syndrome can have several causes. In order to answer the question which microorganism has caused a certain syndrome, a well-equipped laboratory is an essential part of all medical establishments. That is why WHO recommends the syndrome-based approach for the treatment of patients with STIs. This means that when a patient has a particular syndrome, you have to treat him/her for all the most commonly encountered STIs connected to this syndrome. In order to identify syndromes, it is essential to construct a flow chart for each one of them.

This flow chart precisely indicates to medical staff which essential decisions and actions have to be taken and what is required for treating the patient. The flow chart is the basis for any decision or action taken and consists of three blocks:

### Treatment of vaginitis
(seen in cases of trichomoniases, candidiasis, bacterial vaginitis)

For the treatment of trichomoniases and bacterial vaginitis the following is prescribed:
- tinidazole (Fazigyn) 2.0 orally, one dose (WHO, StP); or
- metronidazole (Trichopol, Flagyl) 500mg, twice a day, orally for 7 days (WHO, StP); or
- Tiberal 0.5g, twice a day, orally after food for 3 - 5 days (StP); or
- African 0.25 mg, twice a day, orally after food for 4 days (StP).

For the treatment of vaginal candidiasis the following is prescribed:
- Betadine (pessaries) one at night for 14 days (StP); or
- Pimafucin (pessaries) one (0.1g) at night for 6 - 10 days (StP); or
- Clotrimazole (pessaries, tablets) one at night for 6 days (WHO, StP).

### Treatment of cervicitis
(gonorrhoea, chlamydial infections)

For the treatment of gonococcal cervicitis the following is prescribed:
- ciprofloxacin 500-750 mg, one dose orally, (WHO), in chronic cases 500mg twice a day for a complete course of 3.75 - 5.0g (WHO, StP); or
- ceftriaxone one dose of 250mg (WHO, StP), in chronic cases 250mg, once a day, for a complete course of 7.5g (StP); or
- pefloxacin (Abakal) one dose of 0.6g orally, in chronic cases 600mg per day for a complete course of 2.4g (WHO StP), or
- spectromycin (Trobicin) one dose of 2g, intra-muscular injection (WHO), or 4.0g, (2g in each buttock); or
- kanamycin one dose of 2.0g, intra-muscular injection (WHO), in chronic cases 1 million units over 12 hours for a complete course of 6 million units (StP). Simultaneous administration of other preparations with oto - or nephrotoxic actions is contra-indicated; or
- trimethoprim 80mg/sulfametoxazole 400mg (Biseptol) 10 tablets orally, once a day for 3 days (WHO).

For the treatment of chlamydial cervicitis the following is prescribed:
- doxycycline 0.1g twice a day orally after food for 7 days (WHO, StP), in chronic cases for 14 - 21 days (StP); or
- azithromycin (Sumamed), one dose of 1.0g one hour before food or two hours after food, in chronic cases in subsequent days 250mg once a day for a complete course of 3.0g (StP); or
- norfloxacin 400mg twice a day orally for 7 days, in chronic cases for 14 days (StP). It is not advisable combining with other 4-quinolones; or
- Rulid 0.15 g twice a day orally for 7 - 10 days (StP). In chronic cases of gonorrhoea and chlamydiases immunotherapy, physiotherapy and local treatment are recommended.
Clinical manifestations (symptoms indicated in the flow chart);
• decisions which must be taken;
• actions which must be taken.

Arguments for the use of the flow chart:
• Prompt treatment in primary level health-care establishments (women’s outpatients facilities);
• ability to begin treatment directly after first consultation;
• wider access to treatment, owing to the possibility of providing it in a larger number of establishments;
• possibility of taking preventive measures, such as information and the distribution of condoms.

The etiological and clinical methods can only be used for the treatment of one disease, whereas the syndrome-based approach allows for fast treatment of the most common infections. If all the essential medicines are available, then the syndrome-based approach can rapidly help to cure the patient, so that they are no longer contagious.

Remember: fast and effective treatment of STI is the best way of breaking the transmission cycle of infections. The best way of controlling STI is to use the syndrome-based approach.

The aims of the syndrome-based approach are to:
• use the flow chart in order to establish precise diagnoses of STIs;
• correctly prescribe treatment for each specific diagnosis;
• give advice and inform patients about certain important issues

Treatment of all STI patients has to be started from their first visit to a medical establishment. During 1998 the WHO consultant on STIs, together with the St Petersburg Health Care Administration Committee, carried out a study into the implementation of the syndrome-based approach and the behaviour of patients with STIs. In June 1998 the question of holding an extended meeting of the committee with the participation of venereologists, obstetrician-gynaecologists and urologists was discussed. In 1998 the Health Care Administration Committee issued a regulation on "Urgent measures for preventing the spread of sexually transmitted infections and implementing the syndrome-based approach for the treatment of STIs in St Petersburg".

In November 1998, the syndrome-based approach for the diagnosis and treatment of STIs (excluding syphilis) was implemented in obstetrics/gynaecology, urology and dermo-venereology facilities in the Kalinin and Kirov districts, as well as the municipal venereology facility (including syphilis).

From the beginning of 1999 the syndrome-based approach to STIs will be implemented in the Leningrad region. The syndrome approach to the diagnosis and treatment of patients with syphilis will only extend to the municipal venereology facility.

The following groups of potential patients are excluded from the use of the syndrome-based approach: pregnant women, minors, people with reinfections, people in professions requiring regular mandatory medical check-ups, and those suspected of having syphilis. Patients still have the right to choose their treatment of STIs after an examination to determine the etiological factor.

Following the positive results in the two areas of the city, the syndrome-based approach will be implemented in the whole of St Petersburg. According to prognoses made by WHO, the syndrome-based approach will help to reduce the prevalence of STIs as well as gynaecological and reproductive health problems in women.

Table 1. STIs in St Petersburg (1996)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number of patients</th>
<th>Number of cases per 100,000</th>
<th>% of total number of STIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trichomoniasis</td>
<td>21.081</td>
<td>439</td>
<td>22.1</td>
</tr>
<tr>
<td>Gardnerella vaginalis</td>
<td>15.159</td>
<td>316</td>
<td>15.9</td>
</tr>
<tr>
<td>Infections</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ureaplasmosis</td>
<td>12.066</td>
<td>251</td>
<td>12.7</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>8.487</td>
<td>177</td>
<td>8.9</td>
</tr>
<tr>
<td>Urogenital warts</td>
<td>1.791</td>
<td>37.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Urogenital herpes</td>
<td>1.054</td>
<td>21.9</td>
<td>1.1</td>
</tr>
<tr>
<td>Syphilis</td>
<td>11.401</td>
<td>237.0</td>
<td>12.0</td>
</tr>
<tr>
<td>Total</td>
<td>95,257</td>
<td>2,179.3</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 2. Complaints experienced by female patients, the symptoms based on STI syndromes and their etiology.

<table>
<thead>
<tr>
<th>SYNDROME</th>
<th>COMPLAINTS</th>
<th>SYMPTOMS</th>
<th>MOST FREQUENT CAUSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal discharge</td>
<td>Vaginal discharge</td>
<td>Vaginal discharge</td>
<td>Vaginitis: - trichomoniasis, candidiasis, cervicitis, gonorrhoea, chlamydial infection</td>
</tr>
<tr>
<td></td>
<td>Vaginal itch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dysuria, pain during sexual intercourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain in the lower abdomen</td>
<td>Pain in the lower abdomen</td>
<td>Vaginal discharge</td>
<td>Gonorrhoea, Chlamydial infection, Mixed anaerobic infection</td>
</tr>
<tr>
<td></td>
<td>Pain during sexual intercourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital ulcers</td>
<td>Erosion or ulceration of the genitals</td>
<td>Genital ulcers</td>
<td>Syphilis, Genital herpes</td>
</tr>
</tbody>
</table>
ARE "EMBRYO" AND "FETUS" DIFFERENTIATED IN LAW?

The answer is of great significance with regard to abortion legislation and emergency contraception.

Law created by legislation often sets its own definitions. The distinctions made by legislation on abortion often refer to the stage of gestation when abortion is lawful or when particular consent requirements must be observed. Legislation of this sort does not refer to embryos or fetuses, but to gestational stages such as 12 weeks of gestation or the first trimester. Gestation is usually measured from the beginning of the woman's last menstrual period without any biological description being given to the product of conception. Further, because of historical difficulties in obtaining evidence of materials unlawfully taken from the uterus, legislation in many countries, particularly those following English legislation, provides that abortion is the crime committed when any person acts on a woman in order to "procure her miscarriage" whether the woman was actually pregnant or not. That is, the crime is committed by interference with her uterus with the intention to end any pregnancy that may exist. Accordingly, whether she bore an embryo or fetus would not be material.

Where legislation specifies that the crime is committed if the woman is pregnant, prosecuting authorities bear the burden of proof of pregnancy. This is a necessary but may not be a sufficient condition of conviction, because many systems of criminal law accept the defense of mistake of fact. That is, criminal defendants are judged in light of the facts as they honestly saw them, in contrast to how prosecuting authorities can show that the facts actually were. A defendant who claims the honest intention to prevent the beginning of pregnancy may accord-ingly not be convictable of an abortion related offense. Legal systems differ on whether the defendant must prove the honest intention, or whether the prosecuting authority must prove the defendant's wrongful intention, that is the intention to end rather than to prevent pregnancy.

"Where legislation prohibits acting to end an actual pregnancy, the prosecution must prove pregnancy."

Pregnancy is usually taken to begin at completion of the process of implantation of the embryo in the uterine wall. Where legislation prohibits acting to end an actual pregnancy, the prosecution must prove pregnancy. Where legislation punishes acting with the intention to abort whether pregnancy actually exists or not, proof of pregnancy is obviously unnecessary.

"Legal views differ on how long after intercourse action may be taken that does not amount to abortion."

However, it is legally recognized that proof or evidence of conception is not necessarily proof of pregnancy. The Attorney General of England has authoritatively stated that human conception precedes pregnancy. He applied the experience of in vitro fertilisation to show that an ovum may be fertilised and conception accordingly occur before implantation in a woman, who is therefore not pregnant. Destruction of that product of conception would accordingly not amount to abortion. The same is true when a product of conception is destroyed or wasted in vivo, such as by actions designed to prevent implantation of the product of conception in the woman's uterus.

This legal recognition opens the way to emergency contraception. Legal views differ on how long after intercourse action may be taken that does not amount to abortion. It is widely accepted that action taken within about 10 days of unprotected intercourse (or for instance a condom breaking) will not interfere with pregnancy, because pregnancy will not have commenced yet. Reproductive biologists consider pregnancy to commence at about 12-16 days after fertilisation, when the fertilised egg has implanted in the uterus. Courts are likely to be influenced by expert evidence from reproductive biologists. However, for purposes of criminal law, the key element is the honest intention of the person accused of criminal abortion. Honest intentions may be mistaken about scientific facts, but if the accused is a physician or otherwise scientifically qualified, it may be hard to show that an intention was honestly held that is contrary to prevailing scientific understanding. Nevertheless, the test of honesty of intention is reasonableness according to available scientific knowledge, not according to folklore or religious doctrines on the commencement of human life or on ensoulment. That is, religious views on the beginning of human life are not influential when contradicted by scientific evidence on implantation.

For further explanation see, the article entitled "Antiprogestin drugs: medical and legal issues", Family Planning Perspectives Vol. 21, #6 pp 267-272 (1989).

Rebecca J. Cook, JD, JSD
Bernard Dickens, PhD, LL.D
Faculty of Law
University of Toronto
84 Queen's Park
Toronto, Ontario Canada M5S 2C5
Tel: (+1) 416-978-6849
Fax: (+1) 416-978-7899
Annotated Bibliography on Violence against Women: A Health and Human Rights Concern (commissioned by the Global Commission on Women’s Health and prepared by Rights and Humanity, WHO 1999, pp 45) is vital to assisting health policymakers in developing a greater understanding of some of the causes of violence against women and strategies for its prevention and redress. Violence is a major health issue and a violation of human rights.

Contact
Global Commission on Women’s Health
World Health Organization,
CH-1211 Geneva 27
Switzerland
(UN/歌声/99.3)

Annual Review of Population Law, Volumes 21-22 (UNFPA & Harvard Law School 1999, pp 950) is a detailed presentation country by country of international resolutions and agreements, constitutional provisions, legislation, regulations, judicial decisions and legal pronouncements on contraception, women’s health, sex education and more.

Contact
UNFPA
220 East 42nd St,
New York, NY 10017 USA
www.unfpa.org

Harvard Law School Library
1557 Massachusetts Avenue
Cambridge, MA 02138 USA
www.harvard.edu/programs/annual_review

Summary of International and Regional Human Rights Texts Relevant to the Prevention and Redress of Violence against Women (commissioned by the Global Commission on Women’s Health and prepared by Rights and Humanity) (WHO 1999, pp 30) is a useful tool for policymakers and researchers working to prevent violence against women.

Contact
Global Commission on Women’s Health
World Health Organization,
CH-1211 Geneva 27, Switzerland
(UN/歌声/99.3)

Emergency Contraceptive Pills (ECPs):
WHO, USAID and Family Health International (FHI) have made a colour poster about all aspects of ECPs.

Contact
Family Health International
PO box 13950
Research Triangle Park NC 27709 USA
Fax: (+1) 919 564-7261
www.fhi.org

Health and Mortality: a concise report (United Nations 1998, pp 46) is a part of the ICPD Programme of Action assessment process. This report provides a summary of recent information on selected issues including health and mortality, women’s health and safe motherhood; HIV/AIDS; health and development.

Contact
United Nations Publications
Sales Office and Bookshop
CH-1211 Geneva 10, Switzerland
Telephone: (+41) 22 917-2614
Fax: (+41) 22 917-0027
E-mail: unpublish@un.org.

Health Systems and Community Health Strategy (WHO 1999, pp 20) explains the mission, goals and strategy of the Cluster on Health Systems and Community Health (CHS). CHS works to ensure that health interventions for children, for adolescents and women, for reproductive health, HIV/AIDS and sexually transmitted infections (STIs) are delivered through functioning health systems.

Contact
Health Systems and Community Health
World Health Organization
20 Avenue Appia
CH-1211 Geneva 27, Switzerland
Fax: (+41) 22 791 4830
E-mail: chs@who.ch

Listen, Learn Live! World AIDS Campaign with Children and Young People presents key issues and ideas for action from the 1999 world AIDS campaign (UNAIDS 1999, pp 22).

Contact
UNAIDS
20, avenue Appia
CH-1211 Geneva 27, Switzerland
Fax: (+41) 22 791 4898
E-mail: rensudt@unaids.org
www.unaids.org

Moldova, Romania, & Russia: Reproductive Health Survey: Moldova 1997. Final Report (Moldovan Ministry of Health, UNFPA, CDC, USAID, UNICEF; pp 338, 1998) is a comprehensive review of all aspects of RH in Moldova based on a national RH survey. During the period of transition to an independent state, Moldova was no longer able to sustain an adequate health-care system. This report sets out to improve the accountability, efficiency and effectiveness of programmes targeting the health of women and children.

The 1993 Romanian Reproductive Health Survey (reprinted) and the 1996 Young Adult Reproductive Health Survey in Romania are now available.

The 1996 Russia Women’s Reproductive Health Survey: A Study of Three Sites is available.

Available from
Division of Reproductive Health (MS K 35)
Centers for Disease Control and Prevention(CDC)
1600 Clifton Road
Atlanta, Georgia 30333, USA
Fax: (+1) 770 488 5665
E-mail: LXMIDC.gov


Contact
United Nations,
Sales Section, Geneva
Women and occupational health (Issues and policy paper prepared for the Global Commission on Women’s Health) (WHO 1999, pp100) includes the article "Sex Workers and Health": Case studies point out the problem of sexually transmitted infections especially HIV/AIDS among sex workers and their clients.

Contact
Global Commission on Women’s Health
World Health Organization,
CH-1211 Geneva 27, Switzerland
(WHO/EHS/GCWH/99.3)

A Guide to Research Findings on the Cairo Consensus (Population Reference Bureau and Population Council, pp 68, 1999) is a detailed, extremely useful guide to organisations, agencies, etc. working with all aspects of reproductive health (RH): family planning, emergency situation, human rights, adolescents, aging, etc.

Available from:
Population Reference Bureau
Fax: (+1) 202 328 3937
E-mail: kdarwin@prb.org
www.prb.org
Population Council
Fax: (+1) 212 155 6052
E-mail: pubinfo@popcouncil.org
www.popcouncil.org

List of Free Materials in Reproductive Health (INTRAH, University of North Carolina pp 276, 1999) is an extensive guide to booklets, newsletters, videos, fact sheets, books and other RH materials. Complete with full addresses and web sites, this book is essential for reproductive health-care professionals and libraries.

Contact
Program for International Training in Health (INRAH)
The University of North Carolina at Chapel Hill
School of Medicine
1700 Airport Road, Suite 300
Chapel Hill, North Carolina 27514, USA

Prevention and Health Promotion for the Excluded and the Destitute in Europe (Pierre Chauvin, ed., pp 221, 1999) is the result of a collaborative effort started in 1997 in eight European countries. The aggravation of health inequalities in Europe demands new responses and articles look at different aspects of health care systems, poverty and health, etc.

Available from
Institut de l’Humanitaire
1 rue Cabanis
F- 75014 Paris, France
www.humanitary.org

CONTRACEPTIVE PREVALENCE AND METHOD MIX AMONG YOUNGER WOMEN (In per cent)

Source: FFS Comparative Research Project No 45 (Macura, 1997)

<table>
<thead>
<tr>
<th>Using...</th>
<th>France</th>
<th>Hungary</th>
<th>Latvia</th>
<th>Lithuania</th>
<th>Poland</th>
<th>Spain</th>
</tr>
</thead>
<tbody>
<tr>
<td>... no method</td>
<td>0.4</td>
<td>1.3</td>
<td>16.5</td>
<td>32.4</td>
<td>34.4</td>
<td>1.2</td>
</tr>
<tr>
<td>... abstinence</td>
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The Population Activities Unit (PAU) of the United Nations Economic Commission for Europe (ECE) initiated in the late 1980s a long-term sample survey research programme focusing on fertility and family change.

The objectives of the programmes are to:
- Conduct comparable Fertility and Family Surveys (FFS) in ECE member countries;
- Create FFS standard Recode Files (SRF) and archive them at the PAU;
- Prepare national FFS Standard Country Reports (SCR); and
- Carry out a programme of cross-country comparative studies.

The ECE, United Nations Population Fund and participating national organisations have provided funding for the programme.

The following FFS Country Reports are published so far: Norway, Sweden, the Netherlands, Poland, France, Latvia, Finland, Austria and Spain.

United Nations Publications may be obtained from bookstores and distributors throughout the world. Consult your bookstore or write to: United Nations, Sales Section, New York or Geneva.
CONFERENCES

FIAPAC (International Federation of Professional Associations in favor of Abortion and Contraception) is going to hold its third seminar on 15-16 October 1999. The conference languages will be English and French and topics will include: the current situation regarding the training of the medical and paramedical personnel working in abortion clinics in different countries; second trimester abortion "tourism"; and antibiotics and abortion.

Contact
France: Elisabeth Aubeny (+33) 1 42 89 16 67
Belgium: Arlette Bondage (+32) 4 337 89 13
Netherlands: Maria Franças (+31) 20 528 98 90
Other countries: Marjolein Aalbers (+31) 43 321 13 99

INTERNATIONAL CONFERENCE OF THE EIFLE
(European Institute of Family Life Education) will be held on 28 June - 2 July 2000 in Milan, Italy. Topics will include: cervical mucus, new technologies, fertility awareness and infertility treatment, education on sexuality and fertility and more.

For programme details and submission of abstracts contact:
Camer: Scientific Secretariat
Attn: Gabriella Bozzo
Via S. Antonio 5
20122 Milan, Italy
Fax: (+39) 2 58391 363

POVERTY NET

This World Bank site provides information about poverty in a magazine format: simple for beginners, and laden with information for those who have a desire to research. An electronic newsletter by Poverty Net covers: heavily indebted poor countries (HIPC), influence of the poor on policy and World Bank Development report highlights. The Poverty Net library also provides access to data on poverty, literature and reports dealing with contemporary issues in the international community. You can also connect to NGOs, academic institutions, poetry and other poverty resources from the "Web Guide" link. This site is a great place to start.

GRAMEEN: BANKING FOR THE POOR
http://www.grameen-info.org/

"Grameen Bank (GB) has reversed conventional banking practice by removing the need for collateral and created a banking system based on mutual trust, accountability, participation and creativity. GB provides credit to the poorest in rural Bangladesh, without any collateral." In June 1998, Grameen Bank's total of loans disbursed topped US$ 2.44 billion. This site contains excellent resources for understanding how the financial sector can contribute to improving the lives of poor peoples a site for the financially minded.

CEPS/INSTEAD (Centre d'Études de Populations, de Pauvreté et de Politiques Socio-Économiques / International Networks for Studies in Technology, Environment, Alternatives, Development)
http://www.ceps.lu/

CEPS/INSTEAD has expertise in scientific, research-driven social and economic data production, with high-quality control both at the national and the international comparative level. CEPS/INSTEAD maintains close links with many major research institutes through-out the European Union, Central and Eastern Europe, the US, the Former Soviet Union and elsewhere. This site is an excellent resource for academics and researchers interested in access to international dialogue, academic resources and research about the relationships between social and economic structures and public policy. Look here for professional networks.

WOMEN'S WATCH
http://www.un.org/womenwatch/

Described as the UN Internet gateway on the advancement and empowerment of women, this site is an excellent resource for understanding how women's status is integral to alleviating poverty, improving public health, and achieving equity. Be sure to read the UN radio show for women, "Women's news and women's views from around the globe". This site is an unmatched resource for connectivity to the international world of women's health.

It was posted here that on 15 October, 1999, UNHCO, Economic and Social Affairs (ESA) will be sponsoring the International Day for the Eradication of Poverty: "Women and Poverty Eradication." For more details: http://www.un.org/esa/

WOMEN'S HUMAN RIGHTS RESOURCES
www.law-lib.utoronto.ca/diana/docs.htm

Bora Laskin Law Library, University of Toronto, has a web site which provides an extensive list of international women's human rights documents. Topics include Reproductive Freedom and Family Planning, Female Genital Mutilation and Violence Against Women.

Compiled by Ken Legins, WHO-EURO

KENNETH E. LEGINS
Technical Adviser, Information, Education, Communication (IEC) Women's and Reproductive Health Programme WHO Regional Office for Europe

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NEWS

Mifepristone Effective for EC in Range of Doses
February's Lancet contains the results of a WHO study reporting that mifepristone is equally effective in preventing pregnancy when taken in doses of 600 mg, 50 mg or 10 mg. The drug can be taken up to 120 hours after unprotected intercourse. The study took place at family planning clinics in six countries. Over 1700 women participated in this randomised double-blind trial. The failure rate for each group was about 1.2% and the women experienced no major side effects except a dose-related delay in next menses.

Contact:
Helena Von Hertzen
World Health Organization
20 Avenue Appia
1211 Geneva 27
SWITZERLAND
Tel: (+41) 22 791-3307
Fax: (+41) 22 791-4171
Email: vonhertzen@who.ch

The Sooner the Better: Yuzpe and Levo-only Regimens of EC Are Most Effective Within 12 hours of Unprotected Sex
A research letter from WHO published in February's Lancet reports that emergency contraception works better the sooner it begins after unprotected sex. The study found that with both levonorgestrel-only and Yuzpe regimens when treatment was given between 61 and 72 hours following intercourse rather than 12 hours after, pregnancy rates more than doubled.

Contact:
Gilda Piaggio
Special Programme of Research, Development and Research Training in Human Reproduction
World Health Organization
20 Avenue Appia
1211 Geneva 27
SWITZERLAND
Tel: (+41) 22 791-2082
Fax: (+41) 22 791-4171
E-mail: piaggiog@who.ch

Cairo Plus Five: Vatican calls Emergency Contraception Abortion and Warns against Use in Family Planning Programs
Following the Hague Forum (ICPD + 5) the Vatican released a statement cautioning members against implying a right to abortion while promoting access for women to family planning services.

In this statement, Vatican representatives mistakenly consider emergency contraception abortion. Family planning advocates responded by explaining that it has been widely accepted in the medical society that emergency contraception is not abortifacient and that this misunderstanding can result in limiting safe family planning options for women around the world.

Client Materials on EC for Diverse Audiences on the World Wide Web
PATH has produced a booklet containing two sets of materials: a brochure called Emergency Contraception: It's Not Too Late To Prevent Pregnancy and instructions for use of emergency contraceptive pills. The brochure is designed to increase people's awareness and provide a simple explanation of emergency contraception, how it is used, possible side effects and where to get it. The information sheets are individual instruction sheets that provide simply written, detailed information on different brands of oral contraceptives that can be used for emergency contraception, when and how to take the pills, the correct doses, and possible side effects. The brochures and instructions for use are prototype materials designed to be photocopied directly from the master copy. They can also be adapted as needed. No permission is needed to copy or adapt them. Each set of materials is available in thirteen different languages, including Arabic, English, Portuguese, Russian and Spanish.

Contact:
Barbara Crook
PATH
4 Nickerson Street
Seattle, WA 98109, USA
Tel: (+1) 206 285-3500
Fax: (+1) 206 285-6619
Email: bcrook@path.org