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Profound global political changes in the late 1980s have, unfortunately, triggered a large number of severe socio-economic, civil and military crises in different parts of Europe: wars in former Yugoslavia, the Caucasus and Tajikistan, as well as a critical deterioration of the economy in many countries of Eastern Europe and the former USSR. These so-called "complex humanitarian emergencies" required an immediate and effective response from the international community in order to alleviate the suffering of up to hundreds of thousand and even millions of people in affected countries.

The impact of complex emergencies always includes an increase in mortality and a decline in the general health of a population, which is obviously of concern to WHO, whose global mandate is "to act as the directing and coordinating authority on international health work". WHO has a specific and now already well-defined role in the comprehensive international emergency humanitarian assistance effort, usually implemented by many partner agencies working together.

WHO priority interventions usually include some combination of:

- public health assessment, both rapid and more continuous, working collaboratively with local public health structures wherever possible;
- NGO co-ordination, based upon the WHO competitive advantages of close contact with governmental structures;
- Post-conflict programmes and those at the interface between the humanitarian and development aspects of international assistance;
- Health system reform work set in a humanitarian context, for example, currently in Kosovo and in Tajikistan where structural and functional reforms aimed at increasing the efficiency of resource utilisation within the previously rigid and structurally overburdened health-care system, for example primary care development and pharmaceutical reform, represent very practical and immediately available humanitarian interventions;
- Supplying of drugs and medical and surgical equipment.

Moreover, WHO implements specific public health programmes (water, sanitation and solid waste control, immunisation, communicable disease surveillance and control, mental health rehabilitation, etc.), based upon assessed needs. These needs arise from common features of the adverse impact of an emergency on health, especially in relation to the most vulnerable population groups: women, children and the elderly. These groups suffer the most, and they usually represent the majority among the displaced population during the emergency.

Humanitarian health assistance to women and children as a response to emergency situations is an important area of WHO programmes. Of the refugees crossing borders in Kosovo, Chechnya and other crisis zones in Europe, the majority of the adults are women, most of reproductive age. Yet in the assistance provided, reproductive health care is often forgotten among what seems to be higher level priority concerns: communicable diseases, emergency surgery, and aid against cold and hunger.

It nearly seems as if it is "inappropriate" to consider the provision of contraceptives, for example, in such serious situations. Yet, human relationships continue, also in times of hardship, and sexual relationships are among these, both positive and negative. The range of reproductive health needs is, consequently, very broad – from the need for quality antenatal, perinatal and obstetric care in order to ensure that desired children can be born as safely as possible under difficult conditions (this may mean providing emergency maternity care in refugee camps or strengthening existing health services to cope with larger numbers of patients), to ensuring that women will have access to appropriate contraceptives so that they will not have to resort to unsafe abortions in order to terminate an unwanted pregnancy. In an environment where contraceptives may not be available, the provision of emergency contraceptives, the so-called morning after pill, is particularly necessary.

The issue of sexual violence and rape calls for a differentiated reproductive health service response – from providing the correct medical care to ensuring psychological and social counselling if desired.

The danger of sexually transmitted infections is again an issue which tends to not be highlighted. Providing diagnostic services and early treatment will prevent long-term complications and the further spread of infections.

Older women may also have reproductive health problems – reproductive tract cancers, osteoporosis – problems which at least deserve diagnostic attention and referral.

Many NGOs and UN agencies, notably UNFPA, UNHCR and WHO are increasingly addressing reproductive health needs. In this issue of Entre Nous, the reader will find reports of this work along with descriptions of the situation in some of the most burning places. We hope that this issue will be helpful to those who have to organise health care for refugee populations.

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MALE CONTRACEPTION: Planning for the future

VSC International and Reproductive Health Alliance Europe, in collaboration with the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), convened a symposium in London, in May 1999, to discuss the future of male contraception. Up to 35 biomedical and social science researchers, women's health advocates and service delivery specialists drawn from the international community, came together to deliberate on the status of research on male contraceptive methods. The main objectives of the symposium were to review progress on the research conducted so far on the development of male contraceptive methods; to articulate and better understand the service delivery needs regarding existing and potential future male contraceptive methods; and to develop a draft agenda on operations research aimed at improving service delivery for male contraception.

New contraceptive technology

Plenary presentations covered the status of new contraceptive technology development. In her presentation, Dr Christina Wang, the chairperson of WHO/HRP's Research Group on Methods for the Regulation of Male Fertility, reviewed progress made so far in the development and testing of reversible, hormonal male contraceptives. The mechanism of action for hormonal male contraception is to reduce the levels of intratesticular testosterone and suppress sperm production while maintaining sexual function. Feasibility studies in animals and men have shown that the administration of androgens alone, combinations of gonadotrophin-releasing hormone analogues and androgens, and progestogens and androgen combinations, can suppress gonadotrophin secretion and spermato genesis either completely to azoospermia or to a sufficiently low level of sperm concentration to render the treated individuals infertile. Discontinuation of the treatment leads to full recovery of gonadotrophin secretion and spermato genesis, and a return to fertility.

The advent of a safe, effective and reversible systemic method of contraception for men is expected to provide a valuable addition to the range of methods available to users of family planning and an attractive alternative to the limited options of the condom, vasectomy and withdrawal that are the only methods currently available to men. In fact, in a landmark 15-centre study conducted by WHO/HRP, the contraceptive efficacy of azoospermia induced by injections of an androgen ester was comparable to that achieved by available female hormonal contraception. A high level of acceptability was found among both the recipients and their partners. Other research advances discussed included the development and testing for acceptability of the non-latex condom. Non-latex condoms are more resistant to degradation and are reported to cause fewer allergic reactions.

Improving on vasectomy

There have also been research efforts to improve on vasectomy. The advent of no-scalpel vasectomy has gone a long way toward improving the technology of this male surgical contraceptive method. One of the alternative methods of vas occlusion, which was considered promising, is the percutaneous injection of liquid silicone into the lumen of the vas where it rapidly hardens to form a plug, which prevents the passage of sperm. However, recent studies of percutaneous vas occlusion in the Netherlands have demonstrated a lower incidence of achieving azoospermia, than that previously reported for men in Indonesia.

NEW REGIONAL DIRECTOR FOR EUROPE

Entre Nous would like to welcome Dr Marc Danzon as new WHO Regional Director for Europe

"I strongly believe in WHO and its potential to advocate and support health. I am committed to its ideals and look forward to working together with people throughout the Region and beyond in making access to health for all a reality in the new millennium," stated Dr Danzon.

In 1992 Dr Danzon returned to the WHO Regional Office as Director of the new Department for Country Health Development. In this capacity, he was responsible for the development of the EURO-HEALTH programme for the countries of Central and Eastern Europe. He then became director of the Health Promotion and Disease Prevention Department.

The new Regional Director assumed office in February 2000 and will serve for five years.

Dr Danzon, born in France in 1947, has 25 years of experience in public health. Dr Danzon has worked twice before with WHO at the Regional Office for Europe. From 1985 to 1989, he was responsible for communication and public information. Between 1989 and 1992, Dr Danzon served as director of the Comité Français d'Education pour la Sante (French Health Education Committee). In this capacity Dr Danzon organised national health promotion campaigns, led a research team and developed a national institution in charge of defining and implementing policies and programmes for health promotion and education.
Scientists are exploring a variety of other approaches, including the use of plant material. These approaches still require basic research. The WHO/HRP is also supporting basic research leads towards male contraception. The research being supported is aimed at gaining a clearer understanding of the process of sperm production in the testis and subsequent attainment of fertilizing ability by the mature spermatozoons, as a means of identifying contraceptive targets.

Men As Partners (MAP)

The symposium also provided an opportunity to inform about the AVSC International’s Men As Partners (MAP) initiative. Established in 1996, the MAP initiative has four goals: to improve men’s awareness and support of their partners’ sexual and reproductive health choices; to increase men’s awareness and responsibility for disease protection; to increase men’s use of contraceptive methods that require their participation and cooperation; and to improve men’s access to comprehensive sexual and reproductive health services.

Issues on service delivery of sexual and reproductive health services for men were also discussed. These discussions highlighted the importance of gender issues and roles in reproductive health, including power dynamics; understanding men’s motivations and preferences; knowledge on male clients’ perceptions on service delivery; the need for communication strategies that are sensitive to culture; and how should be informed by experiences from programmes serving women. These have demonstrated the need for ensuring wide access to existing methods and for quality in service delivery.

“Overall, participants shared a vision that included a renewed commitment to expanding access to available male contraceptive methods and supporting research for further male contraceptive development.”

In conclusion, the symposium observed that:

1. There was need for widening the population base of men participating in male contraceptive clinical trials.

2. Studies need to document, for each possible combination, user perspectives and preferences. Such research should include men’s preferences for places from which to obtain contraceptive services and information. They should also identify the level of involvement that women want from men in contraception.

3. Operations research is needed on service delivery systems. This should define the extent to which service providers are prepared to work with male clients, identify provider biases and appropriate counselling approaches.

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An assessment in Kyrgyzstan illustrated the power of participatory, qualitative approaches in determining policy, programmatic and research needs in sexual and reproductive health (SRH) and the potential for addressing the needs of other groups or other countries.

The lack of awareness of the sexual and reproductive health needs of young people and the limited resources available to address them are critical issues throughout the world. In many countries, socio-economic changes have altered traditional patterns of life, young people have become underserved or marginalised and have little or no opportunity to obtain information, help or health care. These changes have resulted in traditional practices and sources of information disappearing without new approaches to life skills and sexual education being provided in schools. In many developing countries, the resources available to governmental departments of health and education have become grossly inadequate to meet the demands placed upon them, making partnerships between governmental and non-governmental organisations (NGOs), critical in addressing the needs of young people.

Socio-economic change in countries of the former Soviet Union has led to many of these countries, particularly the central Asian republics, experiencing such problems for the first time. The 1990s have been a period in which the health, educational and economic status of young people have deteriorated creating significant and increasing problems around their sexual and reproductive health. Health expenditures have been slashed (in Kyrgyzstan, the health expenditure per capita fell from USD156 in 1990 to USD 9 in 1997); the prevalence of STIs has risen dramatically; schooling is no longer universal; and jobs are becoming memories of the past.

Reproductive Health Alliance Europe, London, at the request of the Government of Kyrgyzstan, recently facilitated and provided technical assistance for an assessment of the sexual and reproductive health needs of young people in Kyrgyzstan. This assessment was based on a rapid evaluation methodology developed by WHO (Simmons, Hall, Díaz, Díaz, Fajans and Satia, Studies in Family Planning, 1997, 28, 79-94) and was the first time it had been used to address young people’s sexual and reproductive health. The assessment was designed to define policy and programmatic needs and to identify what research was necessary to explore the feasibility, acceptability and potential impact of implementing such changes. It reviewed existing knowledge and conducted field observations to address specific questions and identify how to answer them, using a participatory planning process that involved stakeholders from all organizations and entities involved in the sexual and reproductive health field. The assessment comprised a preparatory phase, field observation and data collection, analysis and preparation of the assessment report, and workshops for the dissemination of findings and the development of action plans.

The assessment, which was completed in September 1999, was conducted in collaboration with the national NGO, the Association “Family and Healthy Generation” and with representatives of the Ministries of Health, Education and Labour and Social Protection and the State Commission on Family, Women and Youth, NGOs and young people. Field work was conducted in June, with the assessment team traveling throughout the country meeting with young people, parents, teachers, health care providers, community leaders and other relevant people and group. The results were analyzed and the findings disseminated through a national workshop in Bishkek, and regional workshops in Naryn, Issyk-kul and Osh. It was funded by DFID/Know How Fund, the Aga Khan Foundation, AVSC International and Reproductive Health Alliance Europe.

The report of the assessment concluded that young people receive little or no factual information on these issues, either in school or through other channels such as the mass media. They rarely go to health facilities for services and when they do they experience barriers to appropriate reception and treatment.

They have little to do in their spare time, many turning to intravenous drug use and sex. This is exacerbated by the fact that some of them are having to drop out of school because their families have no money. For girls, this can mean turning to commercial sex work, exposing themselves to the dangers of STIs and HIV. Many are concerned about the future and the lack of employment. Some are turning away from the conservative nature of society and the resurgence of religion, something that isolates them from, or creates stresses within their families, while others are seeking the support of new religious sects. Sadly, the overall effect is that young people are experiencing increasing levels of pregnancy, abortion, STIs/HIV, rape, abandonment, suicide and intravenous drug use, as well as appearing more in the crime statistics.
THE HEALTH OF 4 MILLION WOMEN AT RISK IN EUROPE

"The rapidly increased migration, war and unrest during the last decades have put women and their families at a higher health risk all over the world. These health risks also apply to the more than four million women living in Europe who belong to migrant groups or ethnic minorities," stated Ms Efua Dorkenoo, representing the Department of Women's Health at the World Health Organization (WHO) in Geneva.

To address this problem, WHO staff and women's health professionals from around Europe met in Gothenburg, Sweden, in November 1999, to outline actions to tackle the special health concerns of women from ethnic and migrant minorities in Europe. In the European Union (EU) in 1997, Austria (6.6%), Belgium (8.8%), France (6.3%), Germany (8.9%), Luxembourg (34.1%) and Sweden (6.0%) had the largest numbers of non-nationals (both male and female) as a percentage of the total population. From 1985 to 1998, approximately 3.5 million individuals sought political asylum in the member states of the EU.

These numbers, however, do not reflect the heterogeneity of ethnic and migrant minorities in Europe. Minority status may be based on religion, race, class, nationality or ethnic origin, depending on the culture of the country. Overall, the number of non-nationals can be assumed to be a conservative estimate of individuals with minority status residing in EU countries.

Although data on the health of specific immigrant and ethnic minorities in the EU is limited, Mr Wilfried Kamphausen, the European Commission representative, said that research showed that in general the risk of illness was higher for people who had to adapt to the process of migration. These higher risks were in fact reported for all migrant groups, independent of ethnicity, and seemed particularly alarming for certain infectious diseases (mainly tuberculosis), occupational health, women's reproductive health, child health and mental health.

Sweden (migrants from Finland and Eastern Europe) report that suicide rates among children, especially girls, are three times as high as in the host population.

Following the meeting, WHO outlined five areas of work needed to better understand the health needs of minority women in the EU and to best fulfill those needs:

- training of health-care providers who have contact with minority women on how best to overcome linguistic and cultural barriers in communication, and to adapt the provision of services to the needs of migrants;
- improved data collection, taking into account the potential risk of stigmatization or discrimination for the groups covered;
- strengthening health promotion activities by enabling migrant groups to take responsibility for their health;
- assisting the health services to recognize and adapt to the special needs of minority women; and
- continued exploration of the social determinants of health among minority female populations in the EU.

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Action is clearly needed now and funding must be found within the government or from international donors. The immediacy for action is underlined by the complacency surrounding the HIV/AIDS epidemic, which is just over the horizon, and while this does not select its victims by age, children and young people will bear the brunt of its consequences.

The report, which is available in English, Kyrgyz and Russian, identified the most important recommendations and prioritised them in terms of policies, programmes and research. They are aimed at all stakeholders, whether they are governmental or non-governmental; at the national or community levels; service providers or parents; or young people themselves. It also underlined the need to take a multi-sectoral approach to address the problems faced by young people. This was something accepted by the Kyrgyz government, which immediately established a multi-sectoral advisory group run from the President's office.

Higher pregnancy-related morbidity, increased postnatal problems and a greater number of infant deaths and congenital malformations are reported for minority women in all EU countries. Unwanted pregnancy is reported from some member states as being frequent among immigrant women. Also, surveys from Belgium (migrants from Morocco), the Netherlands (migrants from Morocco, Surinam and Turkey), the United Kingdom (migrants from India and Pakistan) and...
The UNFPA intervention during the Kosovo crisis was quite unique and should serve as a model for future UNFPA interventions in emergencies. UNFPA was already operational in the region before the advent of the crisis brought on by the bombing of Serbia by NATO, allowing us to develop a comprehensive reproductive health (RH) approach.

UNFPA was ready to assist Kosovo from September 1998. Two RH needs missions were organised shortly thereafter. A project proposal was submitted to UNFPA for a total of USD 200,000. Three implementing agencies were identified: WHO, Regional Office for Europe, Doctors without Borders (MSF) Belgian and Mother Theresa. Nevertheless, the project was not approved due to the deterioration of the situation and the internationalisation of the internal conflict.

The bombing campaign carried out by NATO resulted in a large influx of Kosovar refugees to Albania. UNFPA, in turn, commenced activities through its office in Tirana. The office was highly instrumental for political, medical and interagency local contacts. It provided basic logistical assistance in terms of availability of personnel, transport, communication and even lodging accommodation as well as becoming more involved in reproductive health activities. At that time, the office was only staffed by a national programme officer. Since the beginning of operations, it has been reinforced administratively, first by a logistician from headquarters then by the UNFPA senior officer in charge of all emergency relief operations. The UNFPA Tirana office became the focal point for all emergencies in Albania and Macedonia and greatly facilitated the implementation of all RH activities in both countries.

At the beginning of the conflict a UNFPA consultant was recruited, the Director of the International Centre for Migration and Health from the International Organization for Migration (IOM). He made an RH assessment needs report and UNFPA took immediate action. On 11 of April, 1998 various RH subkits were provided for all levels of RH activities. These subkits, at a total cost of USD 121,000, cou-
ered the RH needs of 350,000 refugees for a 3-6 month period. They were distributed to maternity hospitals all over Albania through the Ministry of Health. They were also distributed to local and International NGOs such as Medicos del Mundo, Nesmark (local affiliate of Population Services International [PSI]) and the Albania Family Planning Association. It should be noted that sanitary pads and underwear were also immediately procured.

"the provision of RH supplies is not sufficient in an emergency situation"

In Macedonia, basic emergency RH supplies and hygienic products were provided by UNFPA and distributed by UNHCR and UNDP to women refugees. At the beginning of May 1999, UNFPA provided a second batch of RH kits to Albania with requested equipment including examination and delivery tables. Reference maternity centres were equipped with two badly needed ultrasounds machines, donated by Siemens.

But the provision of RH supplies is not sufficient in an emergency situation. UNFPA, having been recognised as RH coordinating Agency by UNHCR, hired an RH consultant for a two-month period to coordinate not only RH activities organised by UNFPA but also to facilitate the implementation of RH services by the national authorities and international and local NGOs

"emergency contraception in this context was useless as women sexually assaulted and raped reached Albania after days of travel"

Next, a psychologist was hired to explore and document the situation of sexual violence and the systematic rape of women and adolescent girls in Kosovo. The dramatic report has been publicised worldwide. It should be noted that emergency contraception in this context was useless as women sexually assaulted and raped reached Albania after days of travel and had a long waiting period before being seen by a health provider. Furthermore, women were highly reluctant about exposing themselves as having been raped.

On the whole, the intervention was successful. It should be underlined that for the first time UNFPA received funding from a UN consolidated appeal. All the needs were financially covered by a number of bilateral donors: Japan, Denmark, Luxemburg, in addition to private donations from Planned Parenthood of America, the Turner Foundation and even the US Committee. A total of USD 1.1 million was obtained.

"Comprehensive RH activities are inexpensive because they are complementary activities of basic primary health-care services"

Although it may seem like a low figure, the amount was sufficient to cover the RH needs of the 600,000 Kosovan refugees for a 3-6 month period. Comprehensive RH activities are inexpensive because they are complementary activities of basic primary health-care services. They should always be included as an integral part of basic services. The presence of an operational UNFPA office was also an essential input to reduce administrative and logistical costs.

After three months, the conflict ended and the Kosovan population rushed back to their province. UNFPA was then confronted by a new challenge: how to respond to the RH needs of the Kosovan returnees and how to rehabilitate a new RH Kosovan Programme. To do this UNFPA opened up a UNFPA office in Pristina with an international representative.

Lessons learnt from the Kosovo conflict

First, we realised that we can be efficient and play an important role in meeting the RH needs of the populations during the emergency phase. Our action was acknowledged by our international partners as we were requested by UNHCR to ensure the coordination of RH activities.

Our operations were greatly facilitated by a series of favourable elements:

UNFPA readiness through preparatory RH missions the previous year, initial funding (USD 200,000), constant assistance from a local UNFPA office with all necessary logistical support, immediate availability of competent consultants, provision of RH subkits, flexibility and adaptation of our supply and equipment inputs.

The long tradition of cooperation with the Albanian authorities should also be noted (UNFPA has been operational in RH through its Technical Support expert and funding via WHO Regional Office for Europe since 1986). The thorough knowledge of the country by two UNFPA staff was also an asset as was the total mobilisation of UNFPA personnel at all levels. However, the determining factor was the positive answer from the donor community regarding funding, which allowed the development of RH interventions. With all these favourable elements the UNFPA intervention in Albania was able to successfully respond to a severe emergency crisis.

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Erratum
The correct name and mailing address of CFFC is:
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Kosovo’s “emergency” is unusual. Although it started in the refugee camps of spring 1999, the real challenges in reproductive health can be found back in Kosovo where, in June, the population and international and local doctors faced not only the traumatic fallout of two years of overt rape and terror, but the accumulated damage to practice and attitudes created by a decade of suspicion, isolation and neglect. This combination has left the territory with some of the worst reproductive outcomes in the Western world, including an infant mortality rate estimated at between 30 and 50 per 1000 births, a high rate of infertility and an enormously high rate of abortion – one for every 1.7 live births.

Unlike more traditional emergency situations where it is war or natural calamity alone that has dramatic consequences on levels of health and health care, in Kosovo the role of the war was to focus international attention on the disastrous health-care situation that had taken 10 years in the making.

As a result the Kosovo crisis has presented humanitarian agencies with some unique problems.

Number one, says Dr Olivier Brasseur, head of mission for the United Nations Population Fund who, along the World Health Organization, NGOs such as CARE, International Rescue Committee, International Medical Corps working in the field of reproductive health care and the vast majority of the almost 1 million Kosovar Albanian refugees, returned to Kosovo in the first few days after the NATO take-over, is that “every single health institution has been left in decay”.

“Of course on top of this there was both systematic and random destruction of equipment coupled with looting of facilities, but the essential structures of the health service are in crisis now, largely because of 10 years of neglect, not warfare”.

Secondly, the Albanians who now almost completely staff the health service, have been excluded from the state health care system, and the rest of the world, for the past 10 years. “They have worked in a parallel system, lacking adequate equipment and information on new practice. And thirdly,” adds Brasseur, “despite the outward impression of very modern young women in the streets of Pristina, Kosovars still largely subscribe to a remarkably outdated status of women in society”.

A fourth factor dogging reproductive health in the province, according to Dr Hélène Lefèvre-Cholay, WHO’s reproductive health adviser in Pristina, is that there has been no development of preventive care in the six hospitals or 20 health houses with gynaecological services.

“The vast majority of women receive no ante-natal or post natal care, no newborn checks, no contraceptive counselling. Even in the very few places it is offered, preventative care is not taken up because the culture is not to visit the doctor before labour. The result is high rates of prematurity, infant death and health complications for women.”

There is also the fact that family planning has in the past been seen by many Albanians as a tool of state genocide. Add to this estimates that between 10,000 and 20,000 women and girls were raped in the two years before NATO’s arrival in the province, and the complicated nature of Kosovo’s reproductive health needs and perceptions requires little further emphasis.

“Reproductive health is a priority right from the beginning of any emergency. But in Kosovo it has been even more of a priority partly because of the amount and intensity of the sexual violence,” says Brasseur.

In these circumstances, humanitarian agencies have a complex role, one which combines the traditional emergency activities of drug and equipment supply and immediate clinical care with those more connected to development, such as training and advocacy.

“A crisis like this is an opportunity because of all the change going on,” says Lefèvre-Cholay, “who has made sure emergency supplies for reproductive health – like condoms or equipment – relatively easily, but when you start thinking about policy and changing attitudes it needs time. Awareness and use of family planning, for example, is a long term process. In emergencies, it is not the first thing people think of. The first is to survive, to take care of their children, not to die in childbirth”.

The latter has been one of the most acute challenges for the international community. Simply getting generators, heating, running water, food blankets into maternity units in health houses where women were giving birth in sub-zero temperatures proved tricky, largely since the drawback of such a large humanitarian influx (some 300 NGOs currently and every possible UN agency) is that everyone thinks someone else is taking care of the obvious and it is easy for early promises to be forgotten.

Other emergency aspects have gone more smoothly. UNFPA and WHO have rapidly distributed large numbers of reproductive health kits with ongoing supplies taken care of by Pharmaciens sans Frontieres and soon United Nations Mission in Kosovo Health Department. Contraceptive drugs and devices were included in the kits and though demand has been low (less than 10 per cent of women are thought to have used contraception due to a combination of lack of knowledge and unwillingness due to past suspicions) according to IRC’s reproductive health nurses, women even at rural level are now eager for information and excited that contraception methods will be available. Emergency contraception, however, has not been a priority issue either in the camps or after the return, despite the level of sexual violence, since most women who were raped in Kosovo ended up walking for days before they reached the border or anywhere that could provide such medication. The kits also included equipment that would, among other uses, facilitate abortion – an important requirement since termination is the main method of controlling family size.

It is advocacy – both to women and health professionals, however, that Brasseur and Lefèvre-Cholay see as the most significant, though longer term, target of attention in this particular
emergency, since the breakdown in services offer a window of opportunity to try and change old practices and attitudes.

Kosovar women, says Brasseur, are right now receptive to talking about reproductive health, not least because they believe it will help them improve their health and their status in society. But advocates need to tread carefully. Gynaecological examination and counseling hold hidden pitfalls for many women related to the systematic sexual and physical abuse committed in the province. Reports also suggest significant numbers of women fear to speak of their experiences due to the risk of being ostracised from their families or communities, while those who do speak out, even supported by their families, expose themselves to danger from revenge attacks or to prevent them becoming potential witnesses for the International Criminal Tribunal for the Former Yugoslavia.

In this area, it is proving crucial for international agencies to work with local organizations, several of whom remained in Kosovo throughout the crisis. The Centre for Protection of Women and Children, for example, with the help of Italian donor ADAS, has opened six centres offering gynaecological and reproductive health services as well as psycho-social support in the areas worst affected by atrocities, and hopes to gain funding for a further eight. Director Sevdie Ahmeti, a human rights worker who spent the bombardment hiding in a cow byre, says trust is the most important factor in offering reproductive health services for these women, many of whom initially may not initially feel able to submit even to a doctor's examination.

Unfortunately, too, women remain vulnerable to violence despite the cessation of hostilities, says Brasseur. "Women have been the targets of a premeditated systematic war strategy that has created a tremendous trauma. But, on top of this, women were the ones who had to stay in the house while their husbands had to run. Many men feel a tremendous amount of guilt which in turn produces anger and aggression within the family."

Unemployment (around 50% currently), loss of purpose, lack of money among a predominantly young male population simply compounds the problem.

Against this background, humanitarian organizations have taken what might be considered unusual steps for an emergency response. Just two months to the day after NATO troops rolled into the country, a group of local clinicians aided by UNFPA, WHO, CARE and others had drawn up a 10-point Kosovo Reproductive Health Policy (see box) aimed at guiding reproductive health in the territory into the 20th century, though probably not before the 21st.

There has been no proper education of women, particularly young women and girls, of what they should expect from reproductive health and their reproductive rights, such as the fact that couples have a right to have as many children as they want when they want them," says Brasseur. "It took five years, not two months in an emergency, to get the international community to agree on a policy anything like as comprehensive as this one which covers everything from political to clinical issues on one side of A4."

Building on this, the key players have established a National Committee for Healthy Families made up largely of nationals and including obstetricians, gynaecologists, neonatologists and representatives of the Institute of Public Health and of local women's groups as well as a sociologist, and a journalist. Its aim is to advise UNMIK and later the elected government on all issues related to reproductive health and to family health with the first priority the development of a strategy to remove the "wishful thinking and approach the most urgent challenges pragmatically."

One element of this strategy must be to start working on unhelpful practices and attitudes. Women have not only had no access to quality reproductive care, but in the past, for Albanians at least, quality care has not been available except in the limited infrastructure of the parallel system. So not only do services need to be built-up, but expectations and understanding.

Kosovo Reproductive Health Policy: Principles
1. Policies, strategic plan and all aspects of the implementation of the reproductive health services in Kosovo shall respect all human rights. They shall protect women and children against violence.
2. Reproductive health services shall be accessible to all ages, gender, ethnic, religious status or other diversities. Reproductive health services shall meet health needs of throughout life-cycle, including the needs of adolescents. They shall address inequities due to poverty, gender and other factors and ensure equity of access to information and care.
3. All relevant sectors, including non-governmental organizations, especially women's, youth and professional organizations, shall be involved through ongoing participatory process in the design, implementation, quality, monitoring and evaluation of policies and programs, to ensure that sexual and reproductive health information and services meet people's needs and respect their human rights, including their right to access to good quality services.
4. All couples and individuals in Kosovo have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so. They shall have the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.
5. Men and women in Kosovo have the right to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law.
6. Reproductive health services shall be available at, and integrated into, all levels of the Kosovo health care system, especially at primary care level. Links should exist with relevant sectors of civil society, including education and social welfare.
7. Reproductive health services shall:
   • reduce maternal and infant mortality and morbidity.
   • provide adequate high quality care.
   • ensure effective referral mechanisms across services and levels of care.
   • provide adequate information, education, prevention and care for reproductive tract diseases, STDs and HIV.
   • prevent violence against women and children during education, care and legal protection.
   • ensure informed, voluntary and free contraceptive method choice.
   • respect privacy, confidentially and comfort.
   • and establish fully functioning information management system.
8. Personnel involved in reproductive health shall undergo appropriate pre-service and in-service training and supervision to fulfill the missions of reproductive health services in Kosovo.
9. An adequate level of funding should be provided through public and/or private sources to ensure sustainable provision.
10. This policy will form the foundation for forthcoming laws and regulations enforcing the reproductive rights of men/women in Kosovo.
Humanitarian work in the area of sexual and reproductive health is a relatively new and growing movement beckoning for the experience and knowledge of women. This is the voice of one woman who has found herself in the highly political arena of sexual and reproductive health in emergency situations.

Q: The new millennium is here. Everybody was, and is, reflecting on last year, the last century and their lives. As a professional working in the area of women's and reproductive health in emergency situations, is there cause for celebration when we look at the past, or do we really need to make some centennial resolutions?

A: Well, we need to do both. You don’t know where you are going unless you know where you have been. Let’s concentrate on the Balkans. Women’s health jump started in the Balkans in 1991. The first comprehensive women’s and reproductive health initiative in the region was implemented in Romania. The initial catalyst for this programme was propelled by the televised coverage of AIDS babies (1990), revealing the hardships of Romanians, particularly women and children. After the creation of this awareness, the first sustainable democracy building initiatives were started, and along with that came the first reproductive health initiatives.

There were approximately ten abortions to every live birth in Russia during 1991, and abortion was the main means of fertility control. Have things changed today? Judging success really requires a specific look at each of the former Communist countries, looking at where we have been and where we are going. One reason to celebrate, however, is that USD ten million was earmarked for women in Kosovo. This reflects a view that women’s health is important, and that skimming the surface is not the way of the future.

f extreme importance, though, if we are really interested in promoting and protecting women’s health, including sexual and reproductive health, is the need to begin a dialogue on the effects of pro-natalism on sexual and reproductive health. Effective policy cannot be created if this dialogue is unspoken; a goal for the future.

Q: Approximately how many non-governmental organisations are contributing to the field of sexual and reproductive health in the conflict regions of the Balkans?

A: There are approximately 285 NGOs in Kosovo and 100 national NGOs. Civil society is being constructed. Many of the NGOs that are in Kosovo were previously in Albania. During the Kosovo war, lasting only 78 days, Albania had approximately 479,000 refugees, the largest number compared to the Former Yugoslav Republic of Macedonia and Montenegro. There were 189 NGOs, of the 189, 34 were coordinated by the coordinating body of UNHCR, of those 34, 12 NGOs were working in the health and sanitation sectors, of those 12, 4 were working...
in Women's and Reproductive Health. [Note: data obtained from UNHCR by interviewer]

Q: What are the major areas of reproductive health being covered?

A: It is difficult to say because governmental and non-governmental organizations have different programmes in the areas of safe motherhood, input to sexually based violence, prevention of STIs and AIDS, and family planning. Coordination in an emergency situation is always a major component of effective interventions, especially in the area of reproductive health, as it is such a new component of humanitarian programmes.

Q: Major areas being neglected?

A: Infusing sexual and reproductive health into health initiatives during emergency situations is a needed step if we are to see reproductive health gain the legitimacy that it needs.

Q: For those NGOs interested in working in the area of sexual and reproductive health in the Balkans, what will be the first obstacle to providing help to the women and girls that need it?

A: Pro-natalism. Additionally, since 1991 the Kosovars have not been allowed to go to medical school; and, given the devastation of the war upon the populations, finding a core group of Kosovars to take responsibility will be a process.

The lives of the women are also unique, both before and after the war. Women often live with their in-laws, and the mother-in-law dictates the life of the young wife. Additionally, the absence of women from many households has placed added pressures on women. These factors will have to be confronted when initiating any programmes in sexual and reproductive health.

Q: Also what are the opportunities presented?

A: Always, when you are in an emergency there are horrible problems but there are amazing opportunities, it is kaleidoscopic. You need to keep your eyes fixed on the open windows and take advantage of the opportunity. The reproductive health consortium (six non-governmental organizations working together, mostly in Africa), has been quite effective in taking advantage of these “windows of opportunity” to influence the lives of women.

Of course, the first thing to do will be to provide the basics: water, electricity, sanitation. However, there is a very literate population of women, as in most former Communist countries. This is an incredible advantage.

Primary health care should belong to general practitioners, as they are the front line physicians, and a high percentage of GPs are women in the ex-Communist countries. However, since these GPs are usually women, their political power is not as established as the male medical specialists, the OB/GYNs. It becomes a question of money, and therefore a complex agenda.

Q: Winston Churchill said of the Balkan peoples: “They have more history than they can handle”. Today, do you see this long history affecting Balkan women’s perceptions of their own reproductive health needs?

A: “One for the family and one to replace who the Serbs killed.” This is a quote I heard while in Kosovo. Also, I heard a story about a young man. He was the youngest of five boys in a loving family. The young man fought with the KLA along with his brothers. After returning from the war, he raped his wife, and she became pregnant. The young wife did not want to have a child because of financial reasons, as there was no roof on the house. So, the young women had to get an abortion. By the way, this guy likes his wife.

As is the case in many countries in conflict, the boy child is favoured. Unless the society celebrates the birth of a girl child we have a long way to go. We need one hundred per cent of Kosovo not just fifty per cent to rebuild the basic fabric of society.

The populations are decreasing in Eastern Europe and this has a significant effect on how women’s roles are defined. It complicates the egalitarian role we want women to have. It is a complex issue. By the way, emergency contraception was used in the Kosovo emergency. Emergency contraception was advertised on the radio and trained personnel distributed it. Humanitarian agencies also gave out 3-month supplies of pills and condoms.

Q: Finally, what phase are we in when we look at the process of fully integrating women’s health into overall humanitarian responses?

A: Women will not have children in a crisis situation. That is the end of the story, they just won’t. There are both Darwinian and social constructionist theories on the fact that women avoid having children when their lives are in danger. Therefore, something else is going on. How can women have equal say or power in a relationship when their voices are muted by their socially ordained roles? Women’s equality is at the root of this issue.

Humanitarian agencies were positioned at the starting gate when the whistle blew in this complex emergency called Kosovo, giving reproductive health an opportunity to inculcate the important tenants: safe motherhood, family planning, prevention of gender-based violence and the prevention of STIs including HIV/AIDS, into the overall primary health-care system currently under design. There was no recipe to follow which offered an open window beckoning us to design how to integrate reproductive health and all its tenants into the baseline fabric of primary health care.

In order for humanitarian agencies to address the sexual and reproductive health needs of a population in crises there has to be a continued effort to realise the broad implications for reproductive health upon a society and how women’s health needs, including reproductive health, when fulfilled, benefit the entire population.

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WOMEN'S HEALTH IN ACTION
Capacity-building through country level training

One of the main aims of The Women's and Reproductive health Programme at the WHO Regional Office for Europe is to develop human resources in the Member States by improving service providers' skills, knowledge and techniques in reproductive health and family planning. We believe that greater emphasis must be given to upgrading pre- and in-service training curricula and strategies, as well as better preparing providers to deliver high-quality services from the clients' perspective.

Our programme provides trainings as a component of joint UNFPA/WHO projects and regular activities in the different countries of the European region. Trainings on clinical as well as public health aspects of reproductive health and family planning (modern contraception) including strategies of design, implementation and evaluation of services are the main area covered. Other areas include minority women, adolescent health and violence as a public health issue. Moreover, countries are regularly updated with current information on reproductive health and family planning.

Some of the trainings and workshops which were undertaken during 1999-2000 are listed below:


- **IEC workshop**, Sarajevo, Bosnia and Herzegovina, September 1999.

- **Training to prepare medical protocol on all contraceptives**, Ashgabat, Turkmenistan, 6-16 September 1999.

- **Workshop on Family Planning, Reproductive Health and STI Prevention**, at the Kazakhstan School of Public Health, Almaty, Kazakhstan, 4-8 October 1999.

- **Workshop on the Role of Paramedical Providers and Counselling Skills in Improvement of Family Reproductive Health**, in Ashgabat, Turkmenistan, 7-13 October 1999.

- **Two workshops on Post-Abortion Contraceptives and Counselling**, in Dushanbe and in Khodjent, Tajikistan, 12-20 October 1999.


- **Workshop on Violence as a Public Health Issue: Training for Health Professionals in Israel**, from 6 to 12 March 2000.

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Estonia is a little country in north-eastern Europe. It is located between Latvia, Russia, Finland and Sweden. Of its 1.4 million inhabitants, about 65% of them are Estonians and the rest are mainly Russians who migrated into Estonia during the Soviet occupation between 1944 and 1991. Estonia restored its independence in 1991 and has been an associated member of the European Union since 1995.

Estonian Family Planning Association, youth counselling centres
The Estonian Family Planning Association (FPA) was founded in 1994 and has been an associated member of IPPF since 1995. Currently, there are 15 youth counselling centres all over Estonia, established and run by local active members of the FPA.

At the start, most of the youth counselling centres’ clients were young females. Boys rarely attended the clinics, be it alone or together with girls.

The main aspects of individual counselling are:
- Contraception;
- Diagnosis and treatment of STIs;
- Counselling in the case of sexual problems;
- Diagnosis and counselling in the case of pregnancy.

In addition to individual counselling, all the counselling centres are involved in sexual education for school children. The groups are varied, including boys of all ages, army recruits, children from orphanages, disabled young people, etc.

In 1996 special counselling hours for boys started in Pelgulinna Youth Counselling Centre in Tallinn, and for a period in Tartu Youth Counselling Centre as well. Boys primarily seek counselling for diagnosing and treatment of STIs, problems concerning the advent of sexual life, premature ejaculation, counselling in the case of sexual problems, doubts (“Am I normal?”), risk factors concerning fertility, etc.

The rate of incidence of STIs is relatively high in Estonia (interestingly, there are few diagnosed cases of HIV infection, only 80 at the end of 1999, see Tables). However, there is good news based on the Nordic-Baltic Military Recruitment Fertility Study (1999). Fertility markers were satisfactory among Estonian participants according to preliminary results.

Since 1996, the FPA has organised educational courses for the youth counselling centres’ workers, one of which was dedicated to boys’ sexual education and counselling (lecturers from RFSU, the Swedish Family Planning Association). During the last three years the reproductive health of boys and men has been one of the topics of several seminars organised by the FPA for different target groups including school health educators, school health personnel, physicians, etc.

Different questions for different age groups:
- In pre-puberty (7-10 years)
  - Gender differences;
  - Sexual anatomy, physiology;
  - Sexual intercourse.
- In puberty
  - Sexual development;
  - Masturbation;
  - Sexual identity.
- In late adolescence:
  - Contraception;
  - STIs and HIV preventon;
  - Starting sexual life.

New developments
In December 1998, Internet and e-mail counselling was initiated by the members of the Family Planning Association who work in Tartu Youth Counselling Centre (www.amor.ee). On the homepage there is basic information about sexuality, sexually transmitted infection (STIs), contraception, youth counselling centres, etc., both in Estonian and Russian. There were about 32,000 hits on the homepage from January 1999, to January 2000. It’s interesting to note that slightly more than half of the questions are from boys, mainly about:
- masturbation 30%;
- premature ejaculation 20%;
- STIs 15%;
- genital infections 10%;
- intimate relations 10%;
- female orgasm 10%;
- other topics 5%.

The Family Planning Association published a leaflet in Estonian and Russian for boys on the following topics:
- Male sexuality;
- Contraception;
- Male sexual anatomy and physiology;
- STIs, etc.
This year, a book about male reproductive health will be published by the FPA. The authors are from the FPA and the book shall be distributed among medical personnel, decision-makers, journalists and educators.

Why special programmes for and about boys and men?

- We believe that involving more men in family planning issues has a positive impact on father-child relations in the future. We can see positive changes in this respect (that men want to be involved) during the last ten years. For example, until the beginning of the 1990s men were not allowed to assist their wives during deliveries, but by now more than half of the babies are born with their fathers present. It is also more common that male partners obtain emergency contraception in the event that a condom ruptures, for instance.

- A better understanding of the changes that boys undergo during puberty enables parents to avoid mistakes when their children are teenagers.

- Better results of (treatment of) reproductive health of women if it is possible to also reach men, especially in the case of sexual problems, genital infection, infertility, etc.

- Men need (in many cases) to have male counsellors who are able to understand certain problems.

- Better awareness throughout society about male sexual and reproductive health (SRH) issues creates an atmosphere where it becomes natural and easy to meet with a counsellor.

- The average life expectancy for Estonian men is 66. This is ten years below that of women. The suicide rate among males is also very high.

- In everyday clinical practice we have better results if we solve problems of sexuality (premature ejaculation, orgasmic problems, etc.) and infertility risk factors as early as possible. The same is true about diagnoses and treatment of STIs. Some international data demonstrate that an enjoyable sex life at a younger age determines the person’s sexual activity at an older age.

Previously, in the case of SRH problems men could only seek advice from urologists, dermatologists or psychiatrists. Now, fortunately, a new specialty – andrology – is rapidly developing in Estonia dealing with men “from birth to death”.

Men need counselling about sexuality and fertility as much as women, and in the future we will have more possibilities to do that in the era of male contraception, improved erectile dysfunction treatment, etc. Hopefully, the need for male sexual and reproductive health counselling will be acknowledged by society and men themselves will become more ready and willing to seek help.

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UN DOCUMENTS

Integrating STI Management into Family Planning Services: What Are the Benefits? (by Karl Dehne and Rachel Snow, WHO 1999) is an Occasional Paper focusing on the increasing global need for better access to quality reproductive health services. The integration of sexually transmitted infections (STIs) and family planning (FP) services is regarded as an important criteria for improving the health of women. Comprehensive RH needs are often not met in family planning clinics. This review, commissioned by WHO, documents current experience with the integration of STI management into FP services, in order to clarify the public health benefit of this integration and highlight the operational changes.

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Providing Behavior Change Among Providers and Communities to Support Safe Motherhood: an Integrated Approach to IEC (Information, Education, and Communication) - A guide for Program Planners (MotherCare 1999, pp 14) is a short document exemplifying the application of a new framework developed by the Department of Reproductive Health and Adolescent Health at WHO in collaboration with the WHO programmes of Child and Adolescent Health, Women's Health, HIV/AIDS and Health Systems. The framework was developed to gain a consensus about how to systematically assess the healthiest behaviours as well as interventions that can promote and support them. The framework is in the process of being applied to behaviours associated with maternal and newborn health and will soon be used in behaviours related to family planning and STIs.

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Reproductive Health Project Coordinators Meeting (WHO 2000, pp 56) was held in Copenhagen at the World Health Organization Regional Office for Europe on 22-24 April 1999. The scope and purpose of the annual meeting was to share experiences regarding project progress encountered in the implementation of reproductive health (RH) projects in countries; to discuss new technical developments in RH; to discuss coopera-
tion between institutions; to discuss future steps of project implementation and to make recommendations for improved execution.

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The Special Programme of Research, Development and Research Training in Human Reproduction Annual Technical Report (WHO 1999, pp 287) covers all aspects of the programme's work including fertility regulation, unsafe abortion, maternal health, reproductive tract infections (including cervical cancer) and programming and integration in reproductive health. The programme also carries out activities to strengthen the capabilities of developing countries to meet their own research needs and to enable them to participate in the global effort in reproductive health research.

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Working Group for Reproductive Health and Family Planning. The meeting's main purpose was to examine what is known about the effects of reproductive health (RH) reforms on access to good quality RH care. Interim conclusions include the fact that reproductive rights and gender equality concerns have not yet become a central part of the health sector reforms discourse, nor a central focus of implementation. Although there is a long case study of Zambia, both the initial overview and the questions for clarification in each section are extremely useful.

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Advancing the Role of Midlevel Providers In Abortion and Postabortion Care: A Global Review and Key Future Actions (Bord et al., IJas: Issues in Abortion Care 6, 1999, pp 30) responds to the challenge of decreasing maternal mortality and bringing health services closer to where women live. This document builds on the recommendations of the World Health Organization regarding skills and responsibilities at the primary level. It reviews the critical components that enable midlevel providers to improve women's access to abortion or post-abortion care, and offers policy and programmatic examples from several countries.

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The Implications of Health Sector Reform for Reproductive Health and Rights (Population Council and Center for Health and Gender Equity 1999, pp 104) is a report of a meeting of the

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Migrants: HIV Testing and Counselling A manual for IOM counsellors (Alessio Panza. IOM) provides information on understanding HIV issues commonly needed in daily counselling and guidelines (accompanied by checklists) for counsellors. The focus is on settings where HIV counselling is mainly addressed to newly diagnosed HIV positive individuals to help them to understand and adjust to their new situation.
Health Considerations in Rural-Urban Migration (Migration and Health 2/1999) draws on UNFPA reports to discuss, among other subjects, reproductive health in terms of rural to urban migration. Although focusing on causes for migration, the article does mention, for example, that “HIV infections may be a greater risk for migrants in urban environments than at their rural origin”. IOM can also be contacted for more resources.

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Prioritizing Reproductive Health for Refugees (Karen Otsea in Initiatives in Reproductive Health Policy Vol. 3 No. 1 September 1999) is a call to action based on the fact that women and children constitute the majority of the estimated 30 million refugees in the world today. It asserts that reproductive health care can save refugee women’s lives and should be given increased importance in emergency refugee assistance efforts.

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Advances in Summer Course on Public Health and Humanitarian Aid (Brussels, 17-28 July 2000) and Optional Course on Computer Publication in Disaster Management (10-14 July 2000) will be organised by the Centre for Research on the Epidemiology of Disasters (CRED). The course fees which include all documentation, software, professor fees (but not travel and lodging) are USD 1500 for the two week course and USD 500 for the computer application module. It is hoped that there will be some fellowships for participants from developing countries.

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UNFPA Provides EC to Countries in Crisis
Since 1994, UNFPA has provided emergency contraception to select countries in crisis through grants of Postinor 1 and 2 from Gedeon Richter and PC4 from Schering. PC4 is included as part of an emergency kit that has been provided to Albania and Macedonia among other countries. Other emergency kits contain combined oral contraceptives and IUDs which both could be used as emergency contraceptives if needed.

In Albania, the climate is highly favourable to the dissemination of emergency contraception, which has recently been explicitly legalised. EC is now officially part of the national reproductive health programme. However, in general there is not a great demand of EC in crisis areas with high rates of reported rape. Often, the time elapsed between the rape and the potential prescription of EC is too long. EC will only reduce unwanted pregnancies due to rape if women are aware of the treatment, know where it is available, and are able to receive treatment in time.

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The Master of Philosophy in International Community Health degree at the University of Oslo is a full two-year programme with admissions every August. The aim of the programme is to train students in International Community Health research and interventions. Theoretical courses include women’s and reproductive health.

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Highlights from The Emergency Contraceptive Newsletter
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TRAINING

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Slide Presentations Modules in English, French or Spanish on the most current information related to reproductive health, designed for use in seminars, workshops, and the training of physicians, nurses and medical students is now online (www.fhi.org/en/ctu/adoltpm/main.html). The material is used and recommended by world-renowned experts in the field of contraception. Family health International (FHI) is committed to helping women and men have access to safe, effective, acceptable and affordable family planning methods to ensure that they achieve their desired number and spacing of children; preventing the spread of HIV/AIDS and other sexually transmitted diseases (STDs); and improving the health of women and children.
British Pregnancy Advisory Service (BPAS) Provides EC to Women in Advance

Following the WHO study that showed emergency contraception was 50% more effective if taken within 12 hours of having unprotected sex, the British Pregnancy Advisory Service (BPAS) launched a program to provide EC to women in advance of need. The program, started in July 1999, advises women to call a special hotline number and book an appointment with a physician where she will be advised about emergency contraception. After receiving this consultation, she can obtain EC supplies to keep on hand in case of need.

The program has become so popular in some areas that BPAS has set up “walk-in” services so that women do not need to make appointments to receive the counselling and EC supply in advance. Previously, women were only able to receive emergency contraception by prescription after seeing a health professional within three days after unprotected sex. For many women whose physicians or clinics do not provide extended hours or are not open over the weekend, the time constraint created a barrier to access. BPAS has a network of 40 clinics around Britain.

The Japanese government, parliamentarians and the UN, are now calling on the next World Population Conference (2004), to be held in Japan. CPE considers this important because Asia is home to two-thirds of the world’s population and has never been a World Population Conference in Asia. Moreover, the experiences of many Asian countries which have reduced birth and death rates provide useful examples for others that are taking the path towards demographic transition.

Reducing Nausea Associated With Emergency Contraception

Family Health International recently fielded a study to determine if treatment with meclizine would reduce the incidence of nausea and vomiting associated with the Yuzpe regimen of emergency contraception. Women were randomised to receive treatment of 50 mg meclizine one hour before the first EC dose, Yuzpe treatment and placebo or Yuzpe alone. The risk of nausea and vomiting dropped significantly if women took the Yuzpe regimen following treatment with meclizine (nausea from 64.2% to 47.2% and vomiting from 12.8% to 4.6%). However, meclizine did significantly increase the rate of drowsiness (from 15.6% to 30.6%). The study found no placebo effect. Brand names for meclizine in the US include Bonine and Dramamine II.

HIV/AIDS in the Baltic Sea Region

A meeting on HIV/AIDS in the Baltic Sea Region was convened on 7–8 December 1999 in Helsinki, Finland, to facilitate a common understanding of the dynamics of the HIV epidemic in the region, assess the capacity to respond as well as improve communication and coordination among the different partners. UNAIDS will play a key role coordinating information exchange and support at the regional and global levels. It is hoped that in addition to combatting HIV/AIDS, the “Northern Dimension” coordination will give a new boost to public health issues in the region. For more information see www.unaid.org.

Women Want More Contraceptive Choices

Two out of three contraceptive pill users in the US, Europe and Japan reported in a survey carried out in 1999 of 2,500 women that they do not like having to take the pill every day. Statistics compiled by the Alan Guttmacher Institute show that use of the diaphragm and the intrauterine device fell to all-time lows between 1988 and 1995. As women age and, presumably, move into monogamous relationships, use of condoms and the pill falls. But the need for family planning continues. Andrew Kaunitz, professor of obstetrics and gynecology at the University of Florida Health Science Center, was lead investigator in a recent study of Lunelle, the newest drug on the contraceptive horizon. Lunelle is an injectable contraceptive that contains both oestrogen and progestin. It is similar to Depo Provera, the other hormonal birth control injection, which has been available since 1992. Lunelle, however, has fewer side effects and permits a quicker return to fertility when a woman stops using it. Lunelle, now being considered by the US Food and Drug Administration for approval, is expected to be available to American consumers by the end of this year.

Women in Scotland Receive Free EC Kits in Advance

The Lothian Primary Care NHS Trust Family Planning and Well Women Service of Scotland has recently begun a programme to provide free emergency contraception kits to women in advance of need. In 1997 researchers found that women were more likely to use the method if they had it on hand at home than if they had to go and see a physician to receive a prescription. Since it must be prescribed within 72 hours of unprotected sex, this policy has created barriers to access for women during weekends and holidays when doctors are not available. In total, approximately 85,000 women ages 16 to 29 will be provided with ECPs to take home for use when needed. This programme will continue for two more years and changes in abortion rates will be evaluated at the end.

Bangladesh TV Drama Promotes Integrated Services

Johns Hopkins University Population Communication Services provided technical assistance for the production of a TV drama which inspired a greater understanding and respect for health workers. A survey revealed that overall health knowledge was significantly related to the number of episodes watched. In fact, married women who saw the drama were 1.6 times more likely to use a modern contraceptive than women who did not watch the show.

To learn more about the Green Umbrella Campaign contact: The Bangladesh Center for Communication Programs (bccp@citecho.net) or Johns Hopkins University (www.jhhccp.org) CPE Proposes Japan to Host World Population Conference 2004

The Council on Population Education (CPE)
A training module on reproductive health issues affecting young adults has been produced by Family Health International (FHI) in collaboration with the FOCUS on Young Adults Project. It is designed for use in seminars, workshops and other training events for physicians, nurses and medical students. The Web version includes 83 colour slides, a narrative, a summary fact sheet, note-taking pages, and a questionnaire to be completed after viewing the presentation on the Web.

"Reproductive Health of Young Adults" is part of FHI's training presentation series on contraceptive technology and reproductive health. Ten additional training modules are also available in English, French and Spanish. For more information on the series, including a list of topics covered, and to order, go to: http://www.fhi.org/en/ctu/ctu.html or contact Ms. Carol Smith, FHI, PO Box 13950, Research Triangle Park, NC 27709, USA (csmith@fhi.org).

WOMEN'S VOICES
http://www.peacenet.org/balkans/index3.html
Peace Net has links to other sites which aim to support women who have been through the Balkan Crises and other humanitarian crises. (See Human Rights Watch for more information about women and violence: http://www.hrw.org/hrw/worldreport99/europe/).

Contributors to this site include Balkan women support groups around the world, women aid groups, films about women and violence, Yugoslav writers and other cultural dimensions of international women's experiences.

World Council of Muslim Women
http://www.connect.ab.ca/~lfahlman/wcfomw.htm
A non-profit organisation dedicated as a living memorial to the women of Bosnia and other women who have suffered the degradation of rape, torture and death.

Muslim Women's Homepage
http://www.jannah.org/sisters/

“I hope the information here will pique your interest and help you to understand the true stance Islam takes on gender issues and the role of women.”

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