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NETWORKING: Beyond the Rhetoric

Since 1989, the field of sexual and reproductive health has expanded in the W HO European Region, in large part due to the increased sensitivity of policymakers to this priority issue. In particular, the new countries which emerged from the former Soviet Union found themselves in need of donor support with regard to funding of the public health care system. To break their isolation a forum for peer review and exchange had to be created. Compounded with the change in government in the eastern European countries, the World Health Organization faced the task of filling in the information vacuum. In 1990, WHO approached UNFPA and together they decided to launch a family planning magazine for the entire WHO European Region, but aware that the greatest need would be in the central and eastern countries.

Ente Nous is now in its tenth year and while the sexual and reproductive health situation is improving in many countries, the recent violence against women resulting from the conflicts in the Balkans and in more eastern parts of the Region is a reminder of the importance of a regular source of information that deals with these issues for health care workers in the field, ministries of health and non-governmental and intergovernmental organizations.

High rates of maternal mortality and morbidity in many central and eastern European countries, very high abortion rates in several countries, the reproductive health of refugees and negative population growth in a number of eastern European countries, in addition to issues like female genital mutilation among migrants, emergency contraception and the advent of medical abortion and Viagra have created a vigorous and often controversial debate. However, the Programme of Action of the International Conference on Population and Development (ICPD) in Cairo in 1994 and the ICPD+5 review in the Hague have provided a forum for defining the issues and implementation strategies.

While specific goals were set, to be achieved by the year 2015, general decisions were made to prioritise reproductive health in national agendas and development aid budgets. And, in response to requests from countries, the Women's and Reproductive Health unit of the WHO Regional Office for Europe expanded activities by forming alliances with strategic partners and creating networks.

These collaborative efforts have had some sustainable effects in research, training and service delivery and bilateral assistance:

- A scientific advisory group on training and research in reproductive health, with 20 members, was established to pinpoint key issues in the Region and help define programmes and policies. To implement these recommendations, a country network was created in cooperation with UNFPA, UNICEF, the European Union (EU), the World Bank and bilateral donors;
- A network of focal points in reproductive and women's health provides a forum for peer review and exchange for all of the Region's Member States;
- Women's and reproductive health has been a central element of the WHO Healthy Cities Programme network that works through mayors and urban administration bodies to improve health. See: http://www.who.dk/healthy-cities/papers.htm;
- Increased bilateral aid: the Netherlands School of Public Health, for example, has now trained more than 173 specialists from the countries of central and eastern Europe and has helped the Kazakhstan School of Public Health to expand its reproductive health section (see article on pages 4-5).

Collaboration with non-governmental organizations, like IPPF with its network of family planning associations, has been the crucial element for many of the sexual and reproductive networks. NGO contact with local players forms an important bridge for donors responding to problems derived from statistical analysis and reports. And while collaboration and discussion is the key to success, NGOs often remind the international community that there needs to be more than just talk.

We, the editors of Ente Nous, have discussed if the above initiatives are sufficient. Where are the gaps? What are the barriers? Networking itself is not just a good way to optimize resources and to support peer review and exchange, and the collection of comparative evidence, it must also result in "working" information. We hope that in this issue of Ente Nous the contributions about joint programmes and projects with a number of donors such as UNFPA, UNICEF, WHO and the World Bank will spark more debate on the next steps to be taken. From central Asia to Hungary to the Netherlands, training programmes and the exchange of knowledge, organized by health experts, are slowly increasing networking with other sectors. But as the article entitled "Why Increase Interagency Cooperation on Adolescent Health?", on page 8, points out, health is intricately tied to a country's overall socio-economic context, which means that sexual and reproductive health programmes must develop and strengthen new alliances with donors such as the World Bank and/or ministries such as the ministry of finance.

In addition to the focus on networking and collaboration, this issue of Ente Nous includes articles on sexuality and aging in an Israeli context, AIDS testing among military conscripts in Austria and the state of medical abortion in Europe. As always, we welcome and look forward to your feedback.

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Women's and Reproductive Health Networks in the WHO European Region

- Scientific advisory group on training & research in reproductive health
- Network for strengthening reproductive health at the country level in cooperation with UNFPA, UNICEF, EU, World Bank & bilateral donors
- CARAK: Strengthening maternal & child health at district level (with Child Health Development)
- Multi city action plan on women's health (with Healthy Cities)
KAzbakh nation and the Netherlands
Sexual and Reproductive Health Training Collaboration

The sexual and reproductive health needs in the central and Eastern European countries and newly industrialized states (CCEE/NIS) are very serious and still largely underestimated. Although many initiatives have been taken over the past decade to improve the situation in these countries, progress has been slow, for the most part, in large parts of the region. Major causes for the relative lack of progress are the persistent economic crisis in several countries in the region, leading to a general lack of resources; a rather low political priority given to sexual and reproductive health (SRH), often caused by a misunderstanding of the issues at stake; health care systems that lack a tradition of prevention and health promotion; and health providers not having had sufficient training in modern approaches to SRH. In addition, cultural factors often make it hard to openly address issues that are perceived as sensitive, in particular sexuality and sexual behaviour. And, finally, international assistance for promoting and implementing the Cairo Programme of Action in central and eastern Europe, including the central Asian republics, has been far too limited given the severity of the situation and the size of the area.

As a result, the SRH situation in the region is still characterized by:

- high maternal and infant mortality and morbidity;
- high abortion incidence;
- a very high prevalence of sexually transmitted infections (STIs), including rapidly rising HIV infection rates;
- increasing adolescent pregnancy rates; and
- poor knowledge of sexuality and sexual health among the population.

A variety of different responses is needed to improve the SRH status of the population, one of them being building national professional capacity. In the past decade, the Netherlands School of Public Health (NSPH) in Utrecht, the Netherlands, has tried to contribute to such national capacity in CCEE/NIS countries, especially Kazakhstan.

Collaborative training efforts: NSPH experience

In 1993, the Netherlands School of Public Health initiated a family planning, sexual and reproductive health (FP/ SRH) training programme, designed especially for health professionals and policy makers working in these fields in CCEE/NIS countries. The initiative was partly triggered by the WHO Regional Office for Europe (Women’s and Reproductive Health unit, at that time called “Sexuality and Family Planning unit”). This unit had suggested better coordination of the different ad-hoc training activities that had been initiated by specialized Dutch agencies in some central and eastern European countries. By bringing together specialized knowledge and experience, available in different institutions, a comprehensive three-week intensive training course was developed by NSPH.

Being a typical “network institution” that is accustomed to hiring experts from different specialized organizations for its educational programmes, it was not unusual for NSPH to involve several external agencies in the development and implementation of this training programme. Expertise on family planning and sexual health was provided by the Rutgers Foundation (Dutch Family Planning Association), on STIs by the Dutch Foundation for STD Control, and on project development and management by the World Population Foundation (an international reproductive health agency). The private sector was also involved, contributing specialized expertise on contraception and on service management. Each of these organizations was already active in central and eastern Europe, and, therefore, all the core facilitators of the training course had practical experience in working with specialists from this part of Europe.

The effort turned out to be very viable; from the end of 1993 until early 2000 a total of nine training courses were given in which 173 specialists from almost all CCEE countries (including some from central Asia) have participated. Feedback from participants, either directly or through follow-up meetings and through follow-up questionnaires, has been overwhelmingly positive, indicating that there is a widespread need to learn how to develop and implement projects and programmes in this field. It should be stressed that the highly interactive approach, through which participants have the opportunity to learn from each other’s experience and develop practical skills has been valued most.

Many former course participants are still working in key positions in the field of sexual and reproductive health in their respective countries, in the government, in universities, in health (promotion) institutions and in non-governmental organizations (NGOs). Through follow-up contacts many of them have been able to build several networks of SRH specialists and institutions in CCEE/NIS countries. The training programme has been financially supported by the United Nations Population Fund (UNFPA) Division for Arab States and Europe and by the Dutch Government, and in some individual cases also by other agencies.

An important factor contributing to the success of this training programme has been the close collaboration, not only nationally with Dutch specialized agencies, but also internationally with a variety of organizations and institutions. The WHO Regional Office for Europe has been closely involved in the process of identifying and assisting in the selection of suitable candidates for the course. It also actively participated in the course itself, and it has been instrumental in supplying some of the course materials, as was the Special Programme on Human Reproduction at WHO headquarters in Geneva. Moreover, the WHO Regional Office for Europe has played an important coordinating role in training for reproductive health by organizing and hosting annual meetings attended by representatives of different European institutions that are involved in this field and that are active in the CCEE countries.

Similarly, collaboration with the International Planned Parenthood Federation (IPPF) European network has been very useful as well. This network has vast experience in working with the NGO sector in the region, and, therefore, it has helped in the process of the selection of suitable course candidates, the supplying of course materials and more.

Collaboration with UNFPA, both the headquarters in New York and regional and national offices, has also been useful. It should be stressed that UNFPA is not only a potential source of financial support, but also has extensive knowledge of the reproductive health situation in the large number of countries where it is represented, and it has extensive networks of national experts that can be used. For example, in the process of the identification and selection of course candidates from the Russian Federation, the UNFPA office in Moscow has always played a crucial role, but it has also been very helpful in solving the practical problems of course participants (such as obtaining a visa). Furthermore, NSPH has built up solid working relationships with ministries of health in most CCEE/NIS countries, which is important for stimulating government commitment to sexual and reproductive health.

The course programme primarily covers the areas of contraception and abortion, sexuality and sexual education, STI control and project/programme management. The objectives are to familiarize partici-
pants with the content and philosophy of the International Conference on Population and Development (ICPD) Programme of Action (Cairo 1994) and to motivate and enable them to implement the programme in their own national or local context.

The NSPH "Working Group on FP/SRH", which implemented the courses, has also initiated a range of related activities in CCEE/NIS countries, including follow-up meetings of the courses to evaluate their impact and to give additional support to the former trainees. In some cases, these follow-up contacts with course participants gained a more permanent character. The collaboration between the Kazakhstan School of Public Health (KSPH) and NSPH is a good example of this. Four reproductive health specialists from Kazakhstan have participated in the NSPH course on FP/SHR, three of them work in the reproductive health unit of KSPH.

The Kazakhstan School of Public Health

KSPH is a relatively new institution. It was established in Almaty in July 1997, with extensive support from WHO Europe. Because it is the only school of public health in Central Asia, it has the potential and the intention to become a regional expert, research and training centre. KSPH has quickly developed and now has a staff of 85, of whom 28 are involved in training. The school has five teaching departments:

- Department of Health Policy and Management;
- Department of Health Economics and Finance;
- Department of Environmental Health and Occupational Hygiene;
- Department of Health Promotion and Social Sciences; and
- Department of Epidemiology, Biostatistics and Information Systems.

The reproductive health unit is part of the Department of Health Promotion and Social Sciences. In Kazakhstan, and the other central Asian republics as well, there is an extensive need for training in public health in general, including reproductive health. Traditionally, medical doctors are the principal health professionals for public health and management related positions in the entire health system, and practically all of them have only a clinical orientation. Moreover, the public health function is almost exclusively focused on the control of communicable diseases, and approaches in these areas need to be modernized. For instance, methods to investigate and control outbreaks of communicable diseases are narrowly based on laboratory tests, with little epidemiological investigation and few policies to eliminate risk factors for infection. Also, few professionals are involved in preventive activities, intersectoral action and promotion of healthy lifestyles. Therefore, there is an urgent need to create a real focus on public health in Kazakhstan and in its neighbouring countries.

In several respects sexual and reproductive health are areas of particular concern in this region. In Kazakhstan, the maternal mortality ratio has increased in recent years to 77-100,000 live births (1997), but according to UNFPA the actual ratio is much higher because Kazakhstan does not use internationally recognized measures. A substantial number of the maternal deaths are probably due to illegal, unsafe abortions, particularly among young (unmarried) women. Although national statistics indicate a substantial decline in the number of abortions, the current official rate of 40-100,000 women of fertile age (1997) is still very high. However, it is doubtful that all abortions are reported to the authorities. Furthermore, the prevalence of STIs is increasing alarmingly. In 1997, the incidence of syphilis had risen to 270-100,000 population. This high incidence has severe implications for the health of infants and children. The high STI rates also increase vulnerability to HIV and eventually AIDS. Adolescent SRH is another serious concern. A significant proportion of young people are sexually active, but sex education is almost completely absent in the country, as are youth oriented sexual health services.

One crucial requirement to effectively deal with these and related SRH problems is the availability of committed professional and managerial staff, both at central and regional (oblast) levels. To meet these needs, KSPH has started to develop an SRH training programme, assisted by WHO Europe and by NSPH.

Collaboration between KSPH and NSPH

Starting from the participation of three KSPH reproductive health staff members in a 3-week NSPH training course, KSPH and NSPH signed an agreement to collaborate in November 1999. The agreement focuses on collaboration in developing a training programme at KSPH in reproductive health management, policy development and administration. Apart from this, the agreement also includes intended future collaboration in the areas of research and consultancy services.

As a first step in this process of collaboration, the reproductive health staff at KSPH has developed a two-week training course, which is largely based on the course given by NSPH. Both the training methodology and the contents and background materials of the KSPH course are used, after having been partly adapted to the specific needs and context in Kazakhstan. The course concentrates on improving quality of care in reproductive health service delivery. In late 1999 and early 2000, the course was held twice, for 20 participants each, and initial feedback from the participants has been positive. KSPH now plans to organize a series of these courses in different oblasts of the country in the near future. In addition, possibilities are being explored to make this course available to participants from other central Asian countries, or to implement the course in those countries.

Concluding remarks

There is not only a need to develop and strengthen technical capacity in the field of sexual and reproductive health in CCEE/NIS countries but also a need to create national and regional training capacity in these countries. Participation of health professionals from CCEE/NIS countries in training activities in Western European countries is generally much more expensive, and, therefore, these training activities should focus on training of trainers programmes, which is also the current policy of UNFPA. However, the collaborative experience of NSPH and KSPH indicates that, particularly at the initial stages, there is need for technical support to institutions like KSPH in developing training programmes and curricula. Support is particularly needed in the areas of modern training methods and in designing curricula that are appropriate for different target groups. Therefore, it would be advisable for international funding agencies to shift gradually from funding participation in training activities abroad to supporting the development of national and regional training capacity.

Promoting and supporting collaboration between specialized training agencies, as has been described here, is a useful mechanism in making national or regional training initiatives in CCEE/NIS countries meet international quality standards.

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STRATEGIC ACTION PLAN FOR THE HEALTH OF WOMEN IN EUROPE

HEALTH21 for the Health of Women

Women in Europe enjoy better health than ever before, and better than that of women in other regions. However, not all health targets set by the World Health Organization for the year 2000 regarding women’s health have been achieved, and there has even been significant deterioration in some women’s health indicators such as cancers of the reproductive tract, cardiovascular disease, mental ill health and depression, and maternal morbidity and mortality. Even in the richest countries in the Region, there are differences and differentials in health for women and men, which are not taken into account.

Although women live longer than men, they suffer a greater burden of morbidity. Women are over-represented amongst the poor and female income is on average only 70% of male income. Women utilize the public health care system more than men do. Women are more likely to experience depression and stress linked to their experience of inequality and discrimination, to experience chronic conditions such as arthritis and osteoporosis and to suffer ill health and death as the result of abuse against them.

Recognizing the need to address these issues more intensively, the Member States of the European Region of WHO are embarking upon the implementation of the Strategic Action Plan for the Health of Women in Europe.

The initiative was developed by the reproductive health unit of the WHO Regional Office for Europe, which, in February 2000, gathered a group of experts, representatives from WHO collaborating centres and members of the WHO Standing Committee for the Regional Committee to discuss the need for, and the content of, a future European women’s health action plan. Participants brought perspectives from nine countries of the region.

The outcome of this two-day meeting was the Strategic Action Plan for the Health of Women in Europe. The action plan is being circulated in its draft version and will be presented during the Regional Committee of WHO, to be held in September 2000.

The action plan revises the 21 health targets for the twenty-first century, endorsed by the Regional Committee of WHO in 1999, identifying their implications for the health of women. It demands to make women’s needs explicit in any strategies to address inequities in health across the Region.

There have been repeated calls through international conventions to ensure greater equality and less discrimination against women with little or partial effect. There is considerable expertise across the Region as to how the impact of these can be improved. The Action Plan requests each European Member State to have a system to ensure that an exchange of this expertise can take place.

The Action Plan aims to assist Member States and local governments in their efforts to achieve greater gender equity in health, health care and in the implementation of HEALTH21, and thus contribute to improving the status of women in society.

The Action Plan recognizes the key role of WHO, working together with its Member States and non-governmental organizations (NGOs), in achieving the goals of improving women’s status and women’s health throughout the Region.

The Strategic Action Plan for the Health of Women in Europe builds upon the relevant recommendations of the World Health Assembly, the recommendations of the International Conference on Population and Development (ICPD) held in 1994 and the Declaration and Platform for Action from the Fourth World Conference on Women held in Beijing, in September 1995.

Before these UN conferences were held, the WHO Regional Office for Europe organized in Vienna, in 1994, the first European conference on women’s health, Investing in Women’s Health, which resulted in a set of recommendations to Member States concerning data collection on women’s health and priority actions to reduce women’s morbidity and mortality in the Region. In 1995, the UN Economic Commission for Europe (UNECE) developed a Regional Platform for Action to improve the status of women in Europe, including a section on action to improve the health of girls, women of reproductive age and elderly women, and specifically addressing the ill-health effects of trafficking and violence.

The action plan contains a Resolution addressed to Member States, WHO, NGOs and international governmental organizations where specific political, financial and structural demands for the implementation of the plan of action are made.

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International Postgraduate Training Courses 1981-2000

Family planning services have existed in Hungary since 1973, when a new population policy came into effect. However, since 1981, the Department of Obstetrics and Gynaecology at the University Medical School of Debrecen (UMSD) has carried out international training courses, in English, funded by the United Nations Population Fund (UNFPA) and executed by the World Health Organization (WHO). There have been three phases in the history of the training programme:

1. Between 1981 and 1987, nearly 90 participants from around 40 countries attended the courses in Hungary. The one to three-week courses focused on basic family planning.

2. In 1988, after a one-week evaluation meeting was organized by UNFPA and WHO in Debrecen, it was decided that the programme should become more specialized. Instead of dealing with basic information on contraception and abortion issues, specific subjects like adolescence, infertility and sterilization were selected. Based on these recommendations, four one-month courses were held in Debrecen in 1990/1991. These were attended by some 60 participants from all over the world.

3) The UMSD then decided to submit a proposal to renew the training programme that was discontinued in 1992 due to financial shortcomings and policy changes. Since the conditions were again found to be acceptable to launch a new programme, and the project proposal was accepted by UNFPA with some modification of the budget, a four-year project was agreed on in 1995. The aim was to organize international postgraduate training courses for service providers from countries with economies in transition (the countries of central and eastern Europe (CCFE) and the newly independent states (NIS)).

Project Objectives
The long-term objective was to contribute to improving reproductive health care/family planning services in countries with economies in transition, and thereby diminish reliance on induced abortion and decrease maternal mortality and morbidity.

- to strengthen the capacity of the department to conduct international reproductive health training courses in the context of intra-eastern European cooperation.

Basic Course
Between October 1996 and November 1999, seven courses were held in Debrecen. They were attended by 143 participants from the following 16 countries: Albania (13), Armenia (15), Belarus (15), Bosnia & Herzegovina (2), Bulgaria (9), China (1), Georgia (6), Hungary (2), Kazakstan (3), Latvia (21), Lithuania (6), Moldavia (8), Poland (2), Romania (20), Russia (6) and the Ukraine (14). Parallel with this programme, a special one-week course on the same topic was organized for Bosnia & Herzegovina for ten doctors in December 1997, at the request of the WHO Regional Office for Europe.

Based on the opinions reported on the evaluation forms, the five-week programme, which included 16 lecture modules and 20 practical training sessions, was very useful for both the present and planned jobs of the majority of the participants. Both the theoretical and the practical portions of the course activities received the highest marks from more than half of the participants. There was great interest in this programme. At the end of the project, 16 candidates were still on the waiting list.

Advanced Training
There was an overbooking for this type of course from the very beginning. Ultimately, 30 participants were selected from the following 11 countries: Albania (1), Armenia (3), Belarus (1), Bulgaria (3), Georgia (1), Latvia (4), Lithuania (5), Moldavia (1), Poland (5), Romania (4) and the Ukraine (2).

Only three days were devoted to lectures and the rest of the programme was left for practical work, primarily carried out in the operating room. The total number of operations the trainees participated in ranged from 40 to 60. The majority of them were laparoscopies including steril-
ization and hysteroscopies, but they also included infertility operations (diagnostic and curative) and microsurgical refertilization procedures as well.

By request, abdominal and vaginal hysterectomies, Wertheim operations and other delicate gynaecological surgeries as well as delivery room programmes and participation in obstetrical surgeries were also scheduled.

**New programmes**

The aim of the projects held over the last two decades has been successfully fulfilled. The large number of trainees who attended the courses (and the long waiting list) and their positive evaluations attest to the importance of training in family planning and reproductive health.

As a result, the involved international organizations have decided to continue financing training programmes, though with some modifications. New topics (emergency obstetrics, neonatal care, management of unsafe abortions), as a result of unfavourable changes (increasing morbidity and mortality of both infants and mothers) in the target countries (NIS), have been included to broaden the coverage of the previous programmes.

Moreover, a new possibility has recently been presented by the WHO Regional Office for Europe for training in research. This programme intends to provide training in learning different aspects of clinical research work. Trainees attending this programme will gain practice in planning, designing, conducting and evaluating clinical studies. In addition to technical aspects, the modules will deal with ethical considerations, preparation of the results for publications and other relevant research-related topics.

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WHY INCREASE INTERAGENCY COOPERATION ON ADOLESCENT HEALTH?

Member States of the United Nations have repeatedly asked the secretariat and the specialized agencies, including the Bretton Woods organizations, to increase their cooperation and to reduce any duplication of efforts. Working within the United Nations system, this plea is very much welcomed. The issue of intersectoral working at the international level is accompanied by a variety of challenges, sometimes barriers, but also tremendous opportunities. An economist has a different approach to health than a sociologist, a medical doctor, a psychologist or a policy analyst. Thus, we have a formidable task in coordinating and planning international health work.

An initiative was started in early 1999 to better coordinate adolescent health work. Based on the recommendation from the international meeting on pilot approaches in adolescent reproductive health, kindly hosted by the Ministry of Health of Portugal in April of that year, WHO, UNICEF and UNFPA started to review the potential of increased cooperation in pilot countries. A major role that the international organizations have is to draw governments' attention to the determinants of health risks which lie, to a great extent, outside the health sector.

A first task that the newly established Interagency Group on Adolescent Health and Development gave itself was to clarify the respective roles of each of the organizations to advocate for adolescent health and address the risk conditions that affect the health of young people. How can we create synergies? And for what use?

Taking the example of children and adolescents, it is clear that comprehensible and sustainable social and economic living conditions are decisive for the healthy development of children. Their life situation in today's social world is comparable to that of adults in that it is characterized by a considerable degree of tension. While on the one hand, children and adolescents have a great degree of freedom to organize their own individual lifestyles, on the other, one price to be paid for these greater opportunities for individuality is a corresponding loosening of social and cultural ties, effecting greater insecurity and an uncertain future. Given the fundamental changes, especially in central and eastern parts of the WHO European Region, children and adolescents, in particular, also have to face contradictory moral and ethical values.

The changing situation raises potentially new forms of stress. However, there is currently no comprehensive scientific evidence on the level of ill health produced through unfavourable changing conditions of societies in central and eastern Europe; the international scientific community so far has been satisfied to study the health behaviour of youth. Like adults, children and adolescents pay a price for the international trends of industrialization, urbanization, commercialization and individualization of everyday life. However, children and adolescents have to pay that price during a period of their lives that is characterized by rapid physical growth and personal development. The changing situation in Eastern Europe since the early 1990s reveals the problem most clearly: The rapid changes in the social macro-structures have been accompanied by changes at the micro-level of social structures and personal relationships. However, these are important for health development. Tense relationships between the parents or partners, financial problems, job insecurity of the father or mother or alcohol problems of one of the parents influence directly or indirectly (via the insecure behaviour of one of the parents) the development of coping skills, behavioural competence and self-esteem.

As the role of the family as the principal socializing authority in moulding health related attitudes and modes of behaviour during childhood changes with regard to cultural heritage, the value system and the social environment, adolescents are particularly affected. The health impacts of divorce on children, for example — a relatively well documented topic — is compounded by other changes in society.

Changes in the living conditions of children, however, are not limited to "split" families. They also concern so-called normal families. An important feature of today's cohabitation of the parents and their children can be described as the relationship of negotiating options and a partnership structure instead of parental disciplinary measures. These "sunny sides" of a great number of freedoms stand opposite many "shady sides": children are confronted with a growing number of behavioural expectations and possible emotional diffusions. This instability is fostered by increasing spatial mobility. Thus, children and adolescents have to cope with an increasing combination of social orientation problems, increasingly unstable family lives. The individual and social protective factors that the family provides must be strengthened if sustainable health improvement is to be achieved.

Whereas this is the case in all societies, the example of the Russian Federation is a striking one, as especially here, these protective factors for adolescent health, by and large, were dismantled. This also had economic consequences which Joseph Stiglitz, a former World Bank chief economist, described very well. Stiglitz argues that "the failures of the reforms that were widely advocated ... [can be explained by] ... a misunderstanding of the very foundations of a market economy, as well as a failure to grasp the fundamentals of reform processes". He argues that at least part of the problem was an excessive reliance on textbook models of economics, especially the neo-classic model.

And since adolescent health has much to do with the overall societal contexts in which health can be produced, economic adjustments, which have caused social adjustments, have taken their toll on children and adolescents. Currently, there are around 300,000 street children in the area of St. Petersburg alone. A strategic and well coordinated World Bank, UNICEF, UNFPA and WHO programme, designed to increase social cohesion, economic security and social safety, would have effects on the health of young people and on positive economic and social development as a whole. There is much at stake and it is high time for the individual players of the international health, economic and social development community to broaden their outlook and increasingly coordinate activities.

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Entre Nous started in 1982 as a four-page bilingual newsletter, and since 1990, it has been published as a proper magazine, now in seven languages. Entre Nous provides a forum for the exchange of opinions and experiences between sexual and reproductive health professionals in Europe, and the growing readership reflects an increasing interest in the magazine. We now reach well over 14,000 readers in the European Region and beyond.

- **A forum for debate**
  Entre Nous serves as a forum for debate or delicate subjects like abortion, emergency contraception, violence against women and sexually transmitted infections (STIs) including HIV/AIDS.

- **Editorial board**
  Members of the Editorial Board of Entre Nous represent the leading United Nations agencies, the European Union and non-governmental organizations (NGOs) working in the field of sexual and reproductive health and women’s health.

- **A voice for UNFPA and WHO policies and programmes**
  In Entre Nous you can read about new initiatives and ongoing UNFPA and WHO projects.

- **Networking with other WHO units**
  Entre Nous has served as an information vehicle for the promotion of several WHO Regional Office for Europe as well as WHO headquarters units. We report on the entire span of reproductive health issues, on women’s health, adolescent health, STIs/AIDS, safe motherhood, reproductive health research and more.

- **Best practice**
  Positive lessons learned are distributed across the Region on integrated RH services, youth centres, sexual education, educational campaigns and the prevention of STIs/HIV/AIDS. These lessons are then converted into training courses and materials by professionals.

- **European network on training**
  Details on training opportunities are regular features in Entre Nous, since the Women’s and Reproductive Health Unit acts as a clearing-house for research and training on RH. The advertisement of courses on sexual and reproductive health (SRH) and adolescents’ and women’s health also contributes to the promotion of European training centres, like the Dutch centre featured in this issue, and to strengthening national capacity-building.

- **Networking of professionals throughout the Region and beyond**
  By ensuring that all articles are signed and by giving all contact details, professionals have been able to contact each other, either directly or sometimes through the magazine.

- **Promotion of publications**
  Entre Nous receives review copies and advertises hundreds of documents and publications on RH and related issues, both from WHO and UNFPA, but also publications from other United Nations agencies and from many NGOs.

- **Internet sites**
  Information on Internet resources has been added since 1999, and Entre Nous itself will be accessible on the Internet this autumn.

- **Free source of information**
  Because of its free distribution, in countries in transition Entre Nous is one of the only sources of information on sexual and reproductive health. The fact that it is available in English, French, Hungarian, Portuguese, Russian, Spanish and from the next issue in Bulgarian makes it accessible to the entire WHO European Region.

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CENTRAL ASIA AND THE CAUCASUS
Collaborative HIV/AIDS Awareness Activities

HIV/AIDS affects everyone, everywhere. The disease has had catastrophic effects in Asia and Africa. Globally, it has been recognized that prevention through education is essential. The United Nations Educational, Scientific and Cultural Organization (UNESCO), working closely with other United Nations agencies, governments and non-governmental organizations (NGOs), has been active in developing and implementing informational and educational HIV/AIDS awareness activities and campaigns in Central Asia and the Caucasus.

The central Asian and Caucasian region presents a unique opportunity in terms of prevention of the spread of HIV/AIDS. To date, the countries, on a global level, have low rates of incidence. However, there is a risk of a rapid increase of infected people. Studies show that intravenous drug use is common throughout the region and that the incidence of sexually transmitted infections (STIs) is increasing at a frightening rate. The most affected are youth. When compounding these factors with the socio-economic difficulties posed to youth today, a bleak picture is painted.

Governments cannot afford to allocate sufficient resources to the education and health sectors and, with the collapse of the Soviet system, a number of gaps have been created. With a long history of cultural, social and economic commonalities, the countries face a number of similar difficulties during the process of transition. Prevention through education is the most effective way to fight HIV/AIDS. As an integral part of its mandate, UNESCO is concerned with education.

Recognizing the potential gravity of the situation, the UN system, governments, NGOs and the private sector joined efforts to work together. In July 1998, UNESCO, WHO and UNAIDS held a regional seminar for the central Asian and Caucasian republics. In keeping with the UNAIDS World AIDS Campaign for 1998, the title of the workshop was “Force for Change – Improvement of Preventive Education and Health Care Services within the School System”. The primary goal of the seminar was to assist governments and NGOs to develop preventive education curricula and to improve health care services for adolescents. Representatives from the government, education specialists and NGOs active in the field of HIV/AIDS education or adolescent health care from Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Mongolia, Tajikistan and Uzbekistan gathered in Almaty, Kazakhstan, for the five-day participatory meeting. This seminar has been a catalyst for a number of activities in central Asia.

“HIV prevalence in Kazakhstan grew 163 fold from 1995-1998”

In Central Asia (Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan) the outbreak of HIV is already known. In 1996, it became evident that HIV infection was rapidly becoming a problem in the city of Temirtau in the Karaganda oblast, Kazakhstan. This period saw a drastic rise in injecting drug use among young people who were unemployed. Estimates indicate that over 10% of the youth in Temirtau inject drugs. Due primarily to the outbreak in Temirtau, HIV prevalence in Kazakhstan grew 163 fold from 1995-1998.

Partially as a result of the seminar, governments in the central Asian republics have begun to recognize the importance of promotion of the health sector, specifically in areas of prevention and STI and HIV/AIDS awareness. National action plans on HIV/AIDS have been developed in each of the republics. Plans have identified a number of priority areas including research, training and development and use of information, education, communication (IEC) techniques to help inform both vulnerable groups and the general public.

UN agencies have been active in assisting governments to identify priorities and have been instrumental in working with relevant ministries, including education and health, in the design, development and implementation of school curricula. As a direct follow up to the July 1998 workshop, UNESCO Almaty worked with the department of education and youth to develop a curriculum addressing healthy lifestyle issues. The curriculum has been integrated into classrooms in Temirtau, Karaganda. In Kyrgyzstan, UNFPA has actively worked with the government, NGOs, youth, teachers and health specialists in the development of a curriculum. In Tajikistan UNESCO and UNFPA have been working with the government to develop a curriculum. UNESCO, alongside UNFPA and the government, have developed a curriculum in Uzbekistan.

And a manual for biology teachers of grade nine students has been developed by UNFPA in Turkmenistan. Teacher training in its use was ongoing in 1999. It was piloted in 17 schools, and is to be integrated into 80 schools in September 2000.

Since 1998, integrated multidonor projects with an aim to fostering a healthy life have been developed regionally and in each of the five central Asian republics. Objectives and priority issues are the same: strengthening governmental response, raising awareness of the general public and specifically among vulnerable groups, advocacy and the national capacity building of civil society organizations. HIV/AIDS has been recognized as a cross cutting issue, and thus UNAIDS, UNESCO, UNICEF, the United Nations Office for Drug Control and Crime Prevention (UNODCCP), UNFPA, the World Bank, WHO, NGOs, bilaterals and the private sector have actively worked together in providing financial and technical assistance to governments.

“The project has not only resulted in agencies committing funds but has been a catalyst for the development of additional activities”

In 1998, UNESCO Almaty was awarded funding from UNAIDS to execute a regional IEC project entitled “STI, HIV/AIDS: A Regional IEC Initiative Along the Silk Roads of Central Asia”. The project has had a number of positive results, including national capacity building, generating additional funding, fostering innovative activities, awareness raising and increasing governmental response. In April 1999, UNICEF contributed financially to the project. The project has not only resulted in agencies committing funds but has been a catalyst...
for the development of additional activities. UNESCO Almaty has worked closely with national partners: relevant government ministries and republican and oblast AIDS centres, in providing technical assistance and in identifying national and regional priority areas in the area of HIV/AIDS prevention.

Through the project, over 150 health care workers throughout Central Asia were trained in communications techniques and over 150 media professionals were trained on HIV/AIDS issues and the significance the media can play to affect change. Networks among these two groups have been formed within each country and on a regional level.

The project has supported the creation of a newsletter with the aim of informing the public and professionals working in the area of HIV/AIDS prevention on developments and to give a situational update of activities in Central Asia. The newsletter, INTO FOCUS, is issued quarterly, in English and Russian, and is disseminated throughout central Asia.

UNESCO Almaty, through its regional responsibility for education and communication in central Asia, has built strong relationships with partners throughout the region. Collaboration has occurred on a number of different levels. Examples include awareness raising events and discos in Kazakhstan, World AIDS Day celebrations in Turkmenistan, media training and peer training in Turkmenistan, and the creation of the Jonathan Mann Award.

Kazakhstan
Through its extensive work with NGOs active in the field of HIV/AIDS prevention, UNESCO Almaty has been able to facilitate cost effective public awareness events on a regular basis. UNESCO was approached by the manager of a local club to see if we would conduct an event using their facilities, free of charge. We then decided to see if our partners were interested in working together – with no provision of funding. The response was positive, the National Healthy Lifestyle Centre, the Republican and City AIDS Centre, Doctors without Borders (MSF), the NGOs ANTI-NAR and “The Times of Change”, and members of the artistic community – dancers and DJs – were all willing to participate. Since this first action, two other HIV/AIDS awareness programmes at popular clubs have taken place in Almaty this year.

Tajikistan
In celebration of the World AIDS Campaign in 1999, the Republican AIDS Centre, the Ministry of Health, UNAIDS, UNDP and UNFPA organized an informational campaign in Dushanbe. One of the highlights of the day was a bus with a loudspeaker that was driven around the city. A popular national figure rode on the bus and spoke on HIV/AIDS issues while distributing condoms, t-shirts and informational materials.

"Within the framework of the World AIDS Campaign, 300,000 people were reached"

Turkmenistan
Collaborative public events included an event for youth in the Ashgabat stadium on World AIDS Day 1999. Within the framework of the World AIDS Campaign, 300,000 people were reached and 27 youth actions were conducted.

Both formal and non-formal educational methods are employed in the process of educating the greatest number of people. UNESCO, working closely with the Republican AIDS Centre and the Youth Union, a national NGO with a network throughout the country, conducted two communication training workshops for youth union leaders outside of the capital. As a result, youth have gained knowledge on HIV/AIDS and contraception, and skills to encourage the sharing of this information have been developed.
HIV/AIDS

How Great is the Danger for Young People?: The Case of the Conscripts

It has long been recognized that young people face a particular risk of HIV infection, which is why they have been a target group for numerous preventative information campaigns. If one attempts to define and assess the risk for young people more accurately, one surprisingly comes up against the problem that there is little or no precise data on the subject. Statements of age on positive HIV tests are by no means representative, since they only exist for some of the tests, and, moreover, it is not clear how many of these are repeat tests.

In Germany, it is known that 38.9 is the average age of all those suffering from AIDS at the time of the diagnosis. In the last 15 years, there have been 506 cases of AIDS in the 13-24 age group (out of a population of 81 million). This age group represents 3.6% of all AIDS cases recorded so far. Precise statements and conclusions on adolescents and AIDS are, however, not possible.

Nevertheless, the analysis of HIV tests for conscripts in the Austrian army is a reliable source of data. Austria is the only western country with an obligatory military service and HIV screening of its conscripts. The results have a high validity as about three quarters of males aged 19-21 have been screened in this programme every year since 1985.

"Since 1985 practically all of the 40,000 annual conscripts, out of a population of eight million, have been regularly tested for HIV"

Although the HIV test is not part of the call-up in Austria, since 1985 practically all of the 43,000 annual conscripts, out of a population of eight million, have been regularly tested for HIV. The basis for this is an agreement between the army, which is seeking a cost-effective method of determining the blood type of its soldiers, and the Red Cross, which is prepared to determine the blood type of non-donors at no cost if it is guaranteed that the majority of conscripts take part in the blood-donor scheme. In order to ensure the motivation of the conscripts for this scheme, they are allowed to take leave for the weekend on Friday, once they have donated blood. Non-donors, however, have to wait until Saturday evening for their weekend leave, and often have no chance of travelling home by public transport.

This procedure, which has been rejected in other European countries as being involuntary, has thus far ensured the almost total testing of Austrian conscripts. As a result, there is now data on the frequency of HIV infection in three quarters of all males aged 19 to 21 for the last 12 years.

A few points need to be taken into account when interpreting the data:

Salzburg (Austria has nine provinces). In view of the fact that the surrounding federal provinces of Tyrol and Upper Austria have so far not had a single HIV-positive blood donor from the barracks, and that their neighbouring province, Carinthia, has only had two, the reliability of this survey is only insignificantly affected by the absence of the Salzburg figures.

All things considered, the data show that blood donors from the barracks are largely representative for homosexually active, non-intravenous drug dependent male youths, after completion of schooling or apprenticeship. The propor-

### HIV positive blood donations from army barracks in Austria

<table>
<thead>
<tr>
<th>Year</th>
<th>HIV-positive results</th>
<th>number of recruits*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>3</td>
<td>49,000</td>
</tr>
<tr>
<td>1986</td>
<td>1</td>
<td>47,000</td>
</tr>
<tr>
<td>1987</td>
<td>1</td>
<td>45,000</td>
</tr>
<tr>
<td>1988</td>
<td>4</td>
<td>44,500</td>
</tr>
<tr>
<td>1989</td>
<td>3</td>
<td>43,000</td>
</tr>
<tr>
<td>1990</td>
<td>3</td>
<td>40,800</td>
</tr>
<tr>
<td>1991</td>
<td>4</td>
<td>39,400</td>
</tr>
<tr>
<td>1992</td>
<td>1</td>
<td>40,100</td>
</tr>
<tr>
<td>1993</td>
<td>2</td>
<td>41,500</td>
</tr>
<tr>
<td>1994</td>
<td>2</td>
<td>38,000</td>
</tr>
<tr>
<td>1995</td>
<td>1</td>
<td>32,300</td>
</tr>
<tr>
<td>1996</td>
<td>2</td>
<td>33,700</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>494,500</td>
</tr>
</tbody>
</table>

*Defence Ministry figures
No data are available from the Salzburg blood bank.

- Members of the groups most affected, homosexuals and intravenous drug users, are, to some extent, in the course of the call up, exempted from military service, as are all haemophiliacs;
- Conscripts who know they are HIV positive might resist the enormous pressure and refuse to take part in the blood donor scheme;
- To a limited extent, professional soldiers also give blood. Some of the positive tests could come from them;
- Young men who have already tested positive for HIV may have attempted to avoid military service by applying for alternative community service instead;
- It was unfortunately not possible to include findings from the province of occupation of homosexuals or intravenous drug addicts seems to be rather limited.

If one were to assume that HIV is spreading among the young heterosexual population, then a significant, and in recent years an increasing, number of HIV positive tests should manifest itself in the group tested.

As is well known, unprotected passive/receptive anal intercourse and the sharing of needles and syringes carries the greatest risk of infection with HIV. It can be assumed that only a small number of the conscripts were exposed to this risk situation. Thus, a low number of HIV positive tests was to be expected in this group, above all in the cities. The average is 2.3 positive results per year.
Almost all cases, 25 of the total of 27, came from the Vienna blood bank, which also covers Lower Austria and Burgenland (Vienna is the only large city in Austria). In Carinthia, since 1985, there has been a total of two HIV-positive blood donors from army barracks. Since the survey began, in 1985, there has not been one single HIV-positive blood donor from army barracks in the other provinces: Upper Austria, Styria, Tyrol and Vorarlberg.

Assuming the participation of about 95% of the conscripts in the blood donor scheme, the result is a rate of six positive HIV tests per 100,000 blood donors. (For all male first-time donors in Germany in 1993, the rate was 11.6).

The studies published by the German and the French ministries of defence also show a similar result. The data there, however, are not as reliable, because conscripts' participation in the blood donor scheme was significantly lower due to its voluntary nature.

The spread of HIV among young males not involved in the recognized risk behaviour cannot be observed on the basis of available data.

In order to assess the risk for young women, it makes sense to draw on the anonymous, unconnected testing of newborn babies. After the birth, blood remaining in the umbilical cord is anonymously tested for HIV antibodies. The results provide information on HIV infection of the mother. Since 1993, this survey has been carried out in almost all births in Berlin, the German city with the greatest number of AIDS cases per capita. In the meantime, similar surveys have been running in Lower Saxony and Bavaria. The Robert Koch Institute in Berlin, which is responsible for the evaluation of the German figures, has come to the following conclusion: "The results - HIV prevalence significantly under one per thousand - among women giving birth confirm the assumption of a low distribution of HIV in the general heterosexual population so far."

"It can hardly be productive, after 18 years of HIV, to warn heterosexual, non intravenous drug-dependent young people by means of undifferentiated and alarmist information"

Against this background, it would appear necessary to rethink sex education and AIDS prevention. It can hardly be productive, after 18 years of HIV, to warn heterosexual, non intravenous drug-dependent young people by means of undifferentiated and alarmist information about a danger that does not exist to any subjectively or objectively provable degree. It is much more likely to endanger the credibility essential to all sex education. On the other hand, most preventative information lacks explicit advice on the dangers of unprotected passive/receptive anal intercourse, for women as much as for homosexual men. For sexually active people, contraception during sex was always an important subject even before the arrival of AIDS. Protection against unwanted pregnancies and sexually transmitted infections should thus be in the foreground of sex education. This should of course be done in a way that corresponds to young people's subjective experiences. Furthermore, any alarmism should be dispensed with, as it has already been shown that no lasting change in sexual behaviour can be achieved in this way.

In this connection, it should be recalled that the Church also attempted to use alarmist information to impose a restrictive sexual morality. The last major campaign of this type took place 35 years ago and was intended to hinder the introduction of the oral contraception pill. The horror scenario employed by the Church, purgatory, "going blind", loss of moral fibre and moral decay corresponded just as little to people's experience as the supposed AIDS epidemic among the heterosexual population today. The Church's insistence on these empty threats has, as we now know after 2,000 years, neither changed our sexual behaviour nor led us to Sodom and Gomorrah. Accordingly, the credibility of the Church and, as a consequence, its influence have shrunk to an extent that was unimaginable at the time.

This research would not have been possible without the support of the Austrian Society for Family Planning and the blood banks of the Austrian Red Cross. I would like to thank them for their cooperation.

References are available from the author.

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SEXUALITY AND AGING

An Israeli Experience

Widespread stereotypes, misconceptions and jokes about old age and sexuality affect negatively and powerfully older people's sexual experience. Younger people sometimes find it difficult to accept that older people are still interested in sex, find one another attractive or enjoy sexual activity. When the elders internalize these attitudes, they function below their actual capacities and their inner needs.

"Younger people sometimes find it difficult to accept that older people are still interested in sex"

Many Israeli healthcare professionals who work with elders share similar ideas and beliefs, thus neglecting sexual aspects of their older clientele. Therefore, they were chosen as the target population for change. This target group included health care professionals in nursing homes, geriatric and psycho-geriatric institutes, sheltered housing and day care centers.

In Israel there is an in-service governmental training programme designed for the professional and personal growth of health care workers. This training created a suitable framework for the insertion of a sexuality education programme, focusing on helping the participants understand and accept the sexual needs and rights of the elders. These rights were clearly defined by the IPPF in 1995: "IPPF recognises and believes that all persons have the right to be free to enjoy and control their sexual and reproductive life. No person should be discriminated against in their sexual and reproductive lives, in their access to health care and/or services on the grounds of race, color, sex, sexual orientation, marital status, family position, age."

During a period of ten years 1,880 staff members participated in the training. This group consisted of 315 directors or managers in geriatric institutes, 580 geriatric nurses, 390 geriatric social workers, 245 care workers and 350 family physicians. In addition, 6 teams (210 professionals in total) attended short training workshops designed to formulate solutions for specific problems regarding the sexual activities of the residents in their own institute.

Through a 12-hour training in small groups, participants could learn about age-related changes in sexuality, practice assertive skills in discussing sexual issues and increase their ability to professionally and ethically confront the sexual behaviour of elders in the various institutes. The objectives of the training were defined on the assumption that helping elders maintain the right to remain sexual human beings will contribute to their quality of life.

During the training the participants were encouraged to raise problems and dilemmas regarding sexuality, which they had to cope with in their daily work with the elders. Due to a strong taboo about speaking about sex, the training became a unique opportunity to talk, share and learn about various sexual problems and dilemmas as encountered by their colleagues in the geriatric profession.

"the training became a unique opportunity to talk, share and learn about various sexual problems and dilemmas"

The next step in the training comprised coping with sexuality at work, by using practical intervention modes. The PLISSIT model was used as a basic intervention model and adapted for the use of the health care professionals. The permission level and the limited information level, which are the first two levels of the PLISSIT model, were converted into two modes: direct permission and indirect permission. For example, a physician who discusses medical issues with an older client could choose to be open and direct in his/her sexual intervention by asking the elder whether there are any questions regarding sexuality or by simply giving the client adequate sexual information regarding an illness or treatment. If the physician is too busy or embarrassed, he/she could choose indirect intervention by using non-verbal encouragement and by creating a positive atmosphere for older clients to ask questions. This may be done by displaying books or leaflets or by hanging posters on sexuality and aging.

In the training participants spoke of problems and dilemmas that they had to face in their professional work with elders. These problems were analysed and solutions for intervention were discussed. The discussion included the following dilemmas:

- Sexual expression in the workplace;
- Sexual expression within the client-professional relationship;
- Concerns about sexual abuse of elders;
- Sexual harassment at work;
- Resistance of staff members, residents and family;
- Dilemmas regarding moral issues.

Conclusion

There seems to be a change in awareness and understanding of professionals of the various issues with regard to sexuality and aging. For example, today there is almost no professional training in the domain of geriatrics which does not include a single lecture on this issue. However, there is still a long way to go until professionals will be able to perceive elders as sexual human beings and endow them with the right to have information, treatment or any other support regarding their sexual problems and questions.

References can be obtained directly from the author.

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Eleven years after becoming commercially available in France, mifepristone (RU 486/Mifepryno) is still being withheld from most potential users in Europe (see Table 1). It is interesting to note that in 1988 the French government gave the pharmaceutical company Russel-Uclaf the choice to either market mifepristone or it would take away the rights and ask another company to produce and sell the drug. The government argued it would be unlawful for a private company to withhold a drug with therapeutic benefits from the population for commercial reasons (fear of boycott).

And resistance to its use continues even 11 years after the first commercialisation, although it has been proved to be safe and effective. By comparison, Viagra was available before its official authorisation and received a licence quickly. It can also be used without medical supervision and outside a hospital, despite a high number of deaths that have been reported in connection with its use (130 US citizens died during the first six months of commercialisation in the US alone; see http://www.fda.gov/). The comparison between Mifepryno and Viagra is just another example of the double standard that continues to exist between men and women, and particularly women facing an unwanted pregnancy.

**What is medical abortion?**
Mifepryno is a hormone that resembles the Luteal hormone progesterone and is taken by the woman as tablets. It binds

<table>
<thead>
<tr>
<th>Country</th>
<th>Availability</th>
<th>Limitations to access</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>Available only in a few institutions in the Vienna area</td>
<td>Approved only for hospitals and clinics, although most abortions are performed in private practice by gynaecologists or GPs</td>
</tr>
<tr>
<td>Belgium</td>
<td>Available since June</td>
<td>Centres have to obtain the product from a reference hospital with a pharmacy</td>
</tr>
<tr>
<td>Denmark</td>
<td>Available since April</td>
<td>Some institutions have used it for over one year</td>
</tr>
<tr>
<td>Finland</td>
<td>Available in May</td>
<td>Strong regional differences in availability</td>
</tr>
<tr>
<td>France</td>
<td>On the market since 1988</td>
<td>The Society of Gynaecologists imposed a &quot;quality standard&quot;: should be used only when cardiac activity is visible (&gt;42 DA); not fully covered by social security, in contrast to surgical abortion</td>
</tr>
<tr>
<td>Germany</td>
<td>Available in some institutions mainly to private paying women</td>
<td>Approved for hospitals and clinics only, although most abortions are performed in private practice</td>
</tr>
<tr>
<td>Greece</td>
<td>Not yet available, although approved in October 1999</td>
<td>No application</td>
</tr>
<tr>
<td>Ireland</td>
<td>Not available</td>
<td>No application</td>
</tr>
<tr>
<td>Italy</td>
<td>Not available</td>
<td>No application</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>Not yet available, although approved since December 1999</td>
<td>Abortion providers judge that women do not need it</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>Not generally available although approved; two clinics are carrying out an acceptance study</td>
<td>Not on the market yet, some institutions have used it the last year</td>
</tr>
<tr>
<td>Norway</td>
<td>Approved since February 2000</td>
<td>No application</td>
</tr>
<tr>
<td>Portugal</td>
<td>Not available</td>
<td>Centres must have a pharmacy or a responsible pharmacist</td>
</tr>
<tr>
<td>Spain</td>
<td>Available since February</td>
<td>Strong regional differences in availability</td>
</tr>
<tr>
<td>Sweden</td>
<td>On the market since 1992</td>
<td>Marketing after a legal debate as to whether Mifepryno is a medical product or not</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Available since December 1999</td>
<td>Strong regional differences in availability</td>
</tr>
<tr>
<td>UK</td>
<td>On the market since 1991</td>
<td>Strong regional differences in availability</td>
</tr>
</tbody>
</table>

Access to medical abortion still depends in all countries on the engagement of individual doctors and counsellors and therefore differs enormously from region to region. DA: Days of amenorrhea
to the receptors in the uterus but exerts no effect. (This is similar to a wrong key blocking a padlock.) The progesterone is vital for the mucous membrane in the uterus for the continuation of the pregnancy. Lack of progesterone or blockage of its receptors by mifepristone results in menstrual bleeding and loss of the pregnancy. A second drug, a prostaglandin tablet is taken by the women two days later to make sure that expulsion takes place.

The course of medical abortion
In the General Public Hospital of Korneuburg, just outside Vienna, we have been carrying out terminations with Mife- egyne® since January 1999. We treat approximately 50 women per month, the demand being very high. Most of the women come from Vienna and its surrounding area. An (after) curettage was needed for three per cent of all women treated. After completion of the treatment, we asked the women, inter alia through a questionnaire, which method they would choose in any future termination. Of those responding, over 90 per cent would choose this method again.

1. First telephone contact
The first telephone contact usually begins with a detailed discussion of information on abortion itself, though also on the details of the various methods. The discussion then proceeds rapidly – according to the situation – to a counselling session. This discussion is often of great importance in the Mifeegyne® counselling, as it lays the foundation stone for the relationship and thus also the course of the process. The telephone calls are often long, or the women rings several times within two or three days.

It is therefore important that the same person also provides the continuing counselling and escort functions. As previously mentioned, the counsellor must go through a selection process with the patient in relation to the medical and psychological criteria in order to choose the most suitable method. If the women seems to be sure of her decision we make an appointment. Often, however, we also provide information on other establishments that are either nearer or which carry out surgical terminations under local or full anaesthetic. Despite the interest in Mifeegyne and the frequent calls to our advice line, only approximately 20 per cent of the callers actually go on to termination with Mifeegyne®.

The period from first contact to the taking of Mifeegyne®
In this phase, women are confronted with unrealistic worries and illusions. Questions repeatedly arise as to what is really going to happen to me, what have I let myself in for, have I made the right decision? Seen as a whole it is the most uncertain and problematic phase.

2. Counselling at the hospital
The first personal contact in the hospital is divided into the medical examination and the counselling. Teamwork between the doctor and the counsellor is crucial in this. They must divide the consultation and reciprocally accept their competences in order to guarantee the best possible care. Detailed information on the method and the process should, where possible, deal with any misconceptions. Women are particularly relieved when there are (still) no embryonic structures, and in particular no heart activity, visible on the ultrasound scan. Furthermore, it should be emphasised that the taking of Mifeegyne® is the actual termination of the pregnancy. This is the point of no return. The prostaglandin two days later serves only to support the expulsion of the already terminated pregnancy. As already mentioned, an exact prediction of the further course of the process is not possible because of the great individual variations. The women should be advised of this. In particular, the varying courses of the process do not allow any conclusions to be drawn on whether the method functions or not.

In our experience it is particularly important and helpful for the woman if the partner or a contact person is integrated into the course of the process, so that he/she can have a supportive effect. Naturally, this can only happen with the agreement of the woman concerned.

The period from the taking of Mifeegyne® to the taking of Prostaglandin
In this phase, the problem with the body comes to the fore. The decision for termination has already been implemented. Now, the uncertainty over the further course of the process and the waiting for the period are the main issues.

3. Care after the taking of Prostaglandin
The atmosphere is now essentially more relaxed than at the previous contact. The woman knows the doctor and counsellor and knows at least theoretically what awaits her. Further, there is no longer any decision to be made, only the continuation of a process that has already been started. For some women, morning sickness has already receded and in a few cases the women have already ejected the amniotic sac and bring it with them (in these cases the treatment is thereby concluded).

Most women are worried about possible pains after the taking of the Prostaglandin. The offer of an appropriate escort by a trusted person is therefore very important. As far as possible this should, however, remain an offer, and not be seen as a compulsory measure. Some women are hardly affected by the termination and therefore have no need of an escort. This should also be taken into account in the organisation of the process. In this phase, medical care recedes into the background, in favour of escort by the counsellor and the partner/friend. Some 20-40% of the women require mild analgesics.

From the taking of Prostaglandin to the check-up
Heavy bleeding and cramps can occur in this phase. The main concern is the uncertainty as to whether the method has worked or not. Future fertility is suddenly also an important issue again.

4. After-care
The further medical check-up after a week to ten days is seen by most women as a great relief and the definitive conclusion of the process. For many women the period up to the check up is stressful because of the uncertainty over whether the pregnancy has actually been terminated. Most women are thus all the more pleasantly surprised if everything has gone well.

Occasionally, a second or third medical check-up is necessary, and in about three per cent of cases a curettage. For these women, too, appropriate counselling should be envisaged. As always, there is the question of psychological-psychotherapeutic after-care, which is, however, only rarely taken up after a medicinal termination.

Conclusion
Medical abortion does not essentially change the counselling in the conflict case of an unwanted pregnancy. The previous counselling only has to be supplemented when it comes to the specific implementation. Here, good information and counselling with sufficient time are necessary, so that each woman can arrive at the best decision regarding the method for her. This makes medical termination with Mifepristone a sensible alternative for many women. Moreover, we have the experience that the treatment proceeds essentially more calmly and less dramatically than the public debate.

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POLICY AND PRACTICE
The UNFPA project TUK/96/P02 "Improving RH Services in Turkmenistan" was initiated in May 1997 and implemented by the Ministry of Health and the Medical Industry of Turkmenistan, and the World Health Organization.

Long-term objectives of the project:
- Improvement of reproductive health conditions;
- Guarantees that pregnancy be made safer;
- Improvement of national and family health, and the preservation of women’s health;

Immediate objectives of the project:
- Increasing the birth space intervals from 1.5 years to 2 years for more than 20% of Turkmenistan’s women;
- Further upgrading performance and skills of health personnel after having trained approximately 300 specialists;
- Ensuring a decrease in maternal and infant mortality rates by upgrading reproductive health services.

A UNFPA project, implemented by the Ministry of Health (MOH) and the Medical Industry (MI) of Turkmenistan and WHO has:
- Resulted in collaboration between the United Nations Population Fund (UNFPA), the MOH & MI of Turkmenistan and WHO;
- Established reproductive health services in Turkmenistan;
- Improved the contraceptive supply system (determination of needs, conditions of storage, distribution, use control);
- Trained twice as many specialists as originally intended;
- Trained specialists so that they can train others;
- Coordinated a system of supervisors;
- Initiated research according to WHO standards;
- Achieved the mutual understanding on basic directions of cooperation with organizations such as WHO, UNFPA and UNICEF;
- Initiated the exchange of national personnel between regions; and
- Established the necessary conditions for the successful beginning of a new programme cycle.

Reproductive health services have existed in Turkmenistan since the beginning of 1997, when an order to establish six reproductive health centres (a centre in each velayat and in Ashkhabad, the capital of Turkmenistan) was issued. Reproductive health sub-centres were opened in each etrap. Today, there are 98 in total.

In January 1999, an order of the Ministry of Health of Turkmenistan was issued calling for the establishment of affiliated branches of the reproductive health departments, the aim of which was to make reproductive health services available to all of Turkmenistan’s citizens, including those who live in remote areas of the country.

Reproductive health centres in each velayat and in the city of Ashkhabad were first established in mother’s and children’s hospitals. UNFPA provided both the principal reproductive health centres and their branches with the necessary equipment for holding training courses. In addition to training equipment, UNFPA equipped health-care institutions with gynaecological Instruments, delivery beds, floor balances, heated infant’s beds, etc.

In 1998/1999, UNFPA financed two research projects reflecting the state of women’s reproductive health, their attitudes to reproductive health and contraceptives, problems of teens and the structure of infection pathology in women. This research was vital for strategy implementation.

From 1997 to 1999, contraceptive use among women increased from 14% to 29.2%. The birth space interval increased from 1.5 years in 1997 to 2.5 in 1999. The abortion rate has decreased and the maternal and infant mortality rate has also decreased: maternal mortality was 64.5 per 100 000 population in 1998 and 42.2 in 1999.

Training of specialists in reproductive health issues

The training of specialists in reproductive health has involved several stages. First, six heads of centres were trained in Hungary as master-trainers. Then, in collaboration with WHO, UNFPA and the MOH of Turkmenistan, training workshops were conducted in February and December 1998. As a result, there are 34 master-trainers in the country. In total, 500 specialists (ob/gyns, family planners and midwives) have been trained.

In 1999, UNFPA provided all the master-trainers with training programmes in Russian and Turkmen. Each training course is designed for 18 participants, the selection of which is conducted by the velayat health care departments with regard to regional requirements. The whole training process is conducted under the supervision of skilled specialists from the first master-trainers, who monitor the training process and assist trainers in conducting courses. In addition to lectures, training courses include role games, which promote the better mastering of the material. After finishing courses, the participants are tested and, if successful, receive certificates.

Before 1999, UNFPA prepared and organized training courses, and beginning from 1999, local coordinators were appointed to independently manage training courses. UNFPA is now only responsible for financing and providing curriculum materials. 340 gynaecologists, 108 family doctors and 108 nurses have been trained in RH issues. About 200 ob/gyns have been trained by local master-trainers. In total, more than 50% of all the obstetricians-gynaecologists have been trained in reproductive health issues, and the training of family doctors and paramedical personnel has started.
tive health service activities accompanied training courses. In 1999, a number of missions were conducted with specific aims: control of the work of the reproductive health sub-centres, stock-taking and storage of contraceptives and an evaluation of maternal and child health. During the monitoring mission, different international materials were distributed such as articles, posters, booklets and pamphlets.

**Future reproductive health work in Turkmenistan should seek to:**
- Collaborate with UNICEF on breastfeeding and reproductive health activities;
- Improve the health of women by decreasing the birth space interval (specific attention should be paid to infections of the genital tract, anaemia and other non-genital pathology);
- Give specific attention to reproductive health during the perinatal period;
- Establish effective RH services for adolescents;
- Train RH master-trainers for adolescents;
- Improve the system of compiling medical statistics;
- Train specialists including specialists from MOH & MI and velayat departments of health on medical statistics;
- Develop activities for AIDS prevention jointly with UNFPA and UNAIDS;
- Expand RH training courses for family doctors and paramedical personnel involved in the field coordinators;
- Systematize regular monitoring involving high level specialists from MOH & MI;
- Continue the practice of short-term (including field trips) seminars as an effective method of information distribution for doctors and middle level staff;
- Organize field trips for obstetrician-gynaecologists from RH centres and sub-centres to study the experience of neighbouring countries; and
- Strengthen the knowledge of project specialists by studying the experiences of different countries that have achieved positive results in improving the RH of their population.

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**Information work**

Besides informing large groups of the population of urgent reproductive health problems, advanced training courses for medical personnel are of considerable importance. Such courses were held at 16 short-term workshops (3-5 days) in 1997-99 at which doctors found the reproductive health issues to be the most interesting. In November 1990, WHO conducted a workshop in the rapid evaluation method of results for the improvement of evaluation methods and monitoring techniques. This workshop was of great use for supervisors and heads of health care departments providing regular monitoring.

Every year, with the help of an international expert, a workshop in the management of informational systems and the planning of procurement is held for heads of reproductive health centres and all specialists taking part in the process of preparation of orders for contraceptives. These workshops have helped in the development of a system to manage procurements and collect information. At the end of each year, a national conference is held to sum up activities dealing with the reproductive service for the year and to define problems to be solved in the future. The conference allows the personnel of the reproductive health services to network. At each conference, an international expert is present. In addition, UNFPA reports on new information sources from WHO and other organizations.

**Monitoring**

In 1998, an evaluation of the reproductive health service activities accompanied training courses. In 1999, a number of missions were conducted with specific aims: control of the work of the reproductive health sub-centres, stock-taking and storage of contraceptives and an evaluation of maternal and child health. During the monitoring mission, different international materials were distributed such as articles, posters, booklets and pamphlets.
UN Documents

Charting the Progress of Populations (Population Division, Economic and Social Affairs, ISBN 92-1-151344-8) provides information on 12 key socio-economic indicators related to the goals of the UN global conferences held in the 1990s on economic and social issues of international concern. The indicators include access to health services, contraceptive prevalence, maternal mortality and infant and child mortality. The data are the latest available as of September 1999. Contact the director of the Population Division directly if you have questions (population@un.org).

Contact
United Nations
Sales Section
New York, NY, USA
www.popin.org

Findings of the Survey on the Reproductive Health of Women in some Towns and Rayons of Khatlon Oblast, Republic of Tajikistan (UNFPA, WHO, pp 46, 2000). The results of the RH survey are based on the examination of 400 women and interviews with 3,000 women of different age groups. Survey results showed that nearly 22% of the respondents could not name at least one birth regulating method. The second survey showed that abortion remains a major means of birth regulation in Tajikistan. Finally, 72% of the surveyed women have little knowledge of what an STI is.

Contact
WHO Regional Office for Europe
Women's and Reproductive Health Programme
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DK-2100 Copenhagen 0
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E-mail: entre nous@who.dk

Handbook for Legislators on HIV/AIDS, Law and Human Rights: Action to Combat HIV/AIDS in View of its Devastating Human, Economic and Social Impact (1999, pp 152). More than 90% of the 33.6 million people living with HIV/AIDS at the end of 1999 were in the developing world. The purpose of this handbook is to assist parliamentarians and other elected officials in promulgating and enacting effective legislation and undertaking appropriate law reform in the fight against AIDS. The handbook provides examples of best legislative and regulatory practices gathered from around the world.

Contact
UNAIDS
20 avenue Appia
CH-1211 Geneva 27 Switzerland
E-mail: unaidsl@unaidsl.org
www.unaidsl.org

Health Issues of Minority Women Living in Europe (1999, pp 198, cost, USD 20). Based on a meeting in Gothenburg, Sweden, in November, 1999, this beautiful publication is the essential document on minority women and health. Well-written and interesting articles cover the spectrum on this subject, from FGM in Europe and justice and equality issues to country case studies and examples. The Gothenburg conference and this report are an example of a successful partnership between WHO, a "Healthy City" and a national public health institute.

Contact
Margareta Acherhans
Gothenburg Healthy City Project
Tel: (+46) 31 4000 885, or
E-mail: marianne.hallberg@stadshuset.goteborg.se

HIV in Pregnancy: A Review is a summary of what is known about HIV during pregnancy, transmission of HIV from mother to child and interventions to prevent transmission. Appropriate management of HIV-positive women during pregnancy delivery and postpartum is discussed. The publication includes guidelines for infection control and safe practices while working with HIV-positive women.

Contact
Documentation Centre
Department of Reproductive Health and Research
World Health Organization
CH-1211 Geneva 27, Switzerland
Tel: (+41) 2 791 4477
Fax: (+41) 2 791 4189

Programming for Adolescent Health and Development (Report of a WHO/UNFPA/UNICEF Study Group on Programming for Adolescent Health, ISBN 92-4-120886-4, price Sw. fr. 56-) describes the guiding concepts and major interventions that are necessary components for country programming for adolescent health and development. The report makes it clear that there is value in collaborating to address the health and development of adolescents simultaneously. Most importantly, the report calls for all three international actors to collaborate in helping adolescents.

Contact
Marketing and Dissemination
World Health Organization
CH-1211 Geneva 27, Switzerland

Reduction of Maternal Mortality - A Joint WHO/UNFPA/UNICEF/World Bank Statement identifies the issues involved in the selection of the appropriate interventions and outlines the policies and legislative actions that are essential. One of the most significant conclusions of this joint effort is that it is possible to reduce maternal mortality significantly with limited investment and effective programme and policy interventions.

Contact
Marketing and Dissemination
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Review and Appraisal of the Progress Made in Achieving the Goals and Objectives of the Programme of Action of the International Conference on Population and Development (Population Division, Economic and Social Affairs, ISBN 92-1-151339-1) contains the key actions adopted by the General Assembly at the special session and the opening statement of the Secretary General. The reproductive health section is 6 pages long with sections on reproductive rights, family planning, STDS/AIDS and adolescents.

Contact
United Nations
Sales Section
New York, NY, USA
www.popin.org

The WHO Reproductive Health Library No. 2, the second issue of a WHO diskette on reproductive health in developing countries, is now available. It updates many of the 27 reviews that appeared on the first diskette and also contains an additional 13 reviews as well as commentaries with practical recommendations. The diskette, available in English and Spanish, is free to health workers in developing countries.

Contact
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AVSC International publication series. AVSC’s latest publication is a package of materials on voluntary sterilization. While working primarily in the field of reproductive health and family planning services, AVSC also retains a specialized expertise related to safe, voluntary sterilization and counseling services.

Contact
AVSC International
440 Ninth Avenue
New York, NY 10001
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www.avsc.org

Another cross-posting from health-i@hivnet.ch

Moderators note: Distributed at no cost to policy makers and program planners worldwide.

Helping Involve Men (HIM)
USAID Working Group and Johns Hopkins Center for Communication Programs releases “HIM” (Helping Involve Men) CD-ROM. The new Helping Involve Men (HIM) CD-ROM brings together for the first time hundreds of documents from around the world about men’s participation in reproductive health. Designed mainly for use by policy makers and program planners in developing countries, the CD provides easy access to an “essential library” of important research and programmatic findings and guidance.

Documents on the CD are organized to address major aspects of men’s involvement in reproductive health. Categories include: Gender, Couples, Men & Reproductive Health, IEC & Men, Institutional Influences and Future Research. Each category lists topic questions or statements to make it easy for the browser to seek out relevant documents. For example: What do we know about men’s knowledge and opinion of family planning? Adolescent males: What special attention do they need? What influence do men have on women’s health? Communication to involve men in reproductive health. What institutional obstacles prevent men from participating in healthy reproductive lives?

Also, the CD-ROM features a resources section that lists materials, organizations, LISTSERVs and web addresses for follow-up information. For example, the section on future research includes articles about operations research, research gaps, indicators of men’s participation, less-than-successful men’s participation projects, lessons learned and recommendations from conferences and literature reviews. JHU/CCP will distribute the CD at no cost to people in developing countries.

Meeting the Cairo Challenge: Progress in Sexual and Reproductive Health, Implementing the ICPD Programme of Action provides documentation that many of the 179 countries which took part in the 1994 International Conference on Population and Development (ICPD) in Cairo are working to implement the gathering’s Programme of Action. The report describes country-level progress and problems in each one. The main problems, however, are that donor countries at large are not meeting funding commitments; women are still undervalued and suffer ill health and the economic and social effect of discrimination in many places; and poverty is hampering expansion of public health services. Developed in collaboration with the London School of Hygiene and Tropical Medicine and the Karolinska Institute.

Contact
Family Care International
588 Broadway, Suite 503
New York, NY 10012
Fax: (+1) 212 941 5563
E-mail: fcppubs@familycareint.org

Network (Family Health International, Vol. 20, No. 1, 2000) focuses on intrauterine devices (IUDs) including a detailed article on how the levonorgestrel contraceptive system offers several non-contraceptive benefits, for example a substantial decrease in menstrual blood loss and pain. It can also stop the development of endometriosis. Additional articles include IUD use and the risk of STIs, how to minimize PID risks and the Copper T IUD, safe, effective and reversible. The journal is available in English, French and Spanish.

Contact
Family Health International
P.O. Box 13950
Research Triangle Park, NC 27709, USA
Tel: (+1) 919 544 7040
Fax: (+1) 919 544 7261
www.fhi.org

Population Reports: Ending Violence Against Women (Series L, Number 11, pp 44). Around the world at least one woman in every three has been beaten, coerced into sex or otherwise abused in her lifetime. Most often the abuse is a member of her own family. Gender-based violence is a major public health concern and the topic of this issue. This is without a doubt one of the most important documents on the subject.

Contact
Population Information Program
Center for Communication Programs
The John Hopkins University School of Public Health
Sida Info Service, a European HIV/AIDS prevention network regarding women of southern European countries, was founded under the aegis of the European Commission. The "Mediterranean network listening to women" publishes a newsletter as part of their efforts to improve the social, psychological and medical care of women confronted with HIV/AIDS. The newsletter is published in English and French.

Contact
Siège national
190, boulevard de Charonne
F-75020 Paris

E-mail: reseauim@club-internet.fr
www.sida-info-service.org

WIN (Women's International Network, Vol. 27, No. 1 winter 2000) has a number of useful web sites as well as articles on women and health, FGM, Beijing + 5 and women and violence.

Contact
Women's International Network News
187 Grant St.
Lexington, MA 02420-2126, USA

Training/Congresses

29th British Congress of Obstetrics and Gynaecology (10-13 July 2001) will be held at the International Convention Centre, Birmingham, UK. Keynote lectures will be on: fetal-maternal medicine, oncology and reproductive medicine.

Contact
29th BCOG Secretariat,
Congress House
65 West Drive, Cheam, Sutton
Surrey SM2 7NJ, UK

Fax: (+44) 20 661 9026
E-mail: info@conorg.com

European Institute of Women's Health: Promoting Gender Equity In Public Health in Europe (9-11 September, Dublin). Topics will include reproductive health, STIs/AIDS and violence against women.

Contact
Conference Partners Limited
8-9 Haddington Road, Ballsbridge
Dublin 4, Ireland
Tel: (+353) 1 667 7188
E-mail: info@conferencepartners.ie

The World Health Report 2000 is like no other WHR previously released. For the first time ever, a comprehensive analysis has been made of the world's health systems. Five performance indicators were used to measure the health systems in 191 member states. France, Italy, Spain, Andorra and Austria from the European Region all ranked at the top.

The report presents an analysis of the four main functions of health systems and outlines a number of policies on provision, financing, input generation and stewardship that seem to be associated with better performance. It also presents the main failings of health systems and provides recommendations. But what is truly unique with this report is that WHO broke new methodological ground by employing a technique not previously used for health systems. It compares each country's system to what the experts estimate to be the upper limit of what can be done with the level of resources available in the that country. It also measures what each country's system has accomplished in comparison with those of other countries.

In Europe, for example, health systems in Mediterranean countries such as France, Italy and Spain are rated higher than others in the continent. Norway is the highest Scandinavian country at 11th. Slovenia is the highest ranking Eastern European country at 38th, followed by Croatia at 43rd, and Kazakhstan at 64th is the highest ranking NIS country.

Responsiveness of health systems, fairness of financial contribution, overall level of health, distribution of health in the populations and distribution of financing were the performance indicators employed, and they are discussed in detail in the WHR.

How do the country rankings reflect sexual and reproductive health care in your country? Send comments or feedback to Entre Nous.

Contact
World Health Report
World Health Organization
CH-1211 Geneva 27, Switzerland
Fax: (+41) 22 791 6870
E-mail: whr@who.int

Copies of the publication can be ordered from: bookorders@who.int
Price: 15 Swiss francs (10.50 Swiss francs in developing countries)
ISBN 92.4.156198 X
The full report is available on www.who.int/whr/
http://www.agi-usa.org/  
The Alan Guttmacher Institute site provides information on sexual behaviour, pregnancy and birth, contraception, abortion, STIs, youth, and law and public policy, both domestic and international. This site also contains select current volumes of the organization's publications including Family Planning Perspectives and International Family Planning Perspectives, and the Guttmacher Report on Public Policy. Selected articles are full text.

http://www.arhp.org/  
The Association of Reproductive Health Professionals (ARHP) represents a group of professionals who provide reproductive health services or education, or conduct research or influence policy concerning reproductive health. The site provides information on future conferences. Recent editions of the organization's publications, including Health and Sexuality, Clinical Proceeding and the quarterly newsletter, ARHP Update, are available full-text online.

http://europa.eu.int/comm/development/aids  
HIV/AIDS – European Union is a new web site. The primary goal is to raise global awareness of HIV/AIDS issues in developing countries and to facilitate the exchange of information. It also provides comprehensive information and relevant documentation relating to all aspects of the EU HIV/AIDS programme in developing countries.

http://www.hivatis.org/glossary/index.html  
This site, sponsored by the U.S. Department of Health and Human Services, provides definitions of HIV/AIDS-related terms, the pathogenesis of and associated treatments for HIV/AIDS, and medical management of related conditions.

http://www.intrah.org/lof.html  
Compiled by INTRAH, this annotated bibliography includes more than 1,200 items that are available free to individuals and organizations in developing countries. The list is organized into a number of sections, including reproductive health, maternal and newborn health, family planning, family and community health, reproduction and sexuality, STIs/RTIs and HIV/AIDS, and gender. The list of materials can be searched online in English, French and Spanish. Information on ordering all of the materials is included.

http://www.ippf.org/  
IPPF's site contains an updated news section and a section on regional projects. The resources section describes the available publications, including a Sexwise Guide, the X-Press; The IPPF Newsletter for Young People, and bibliographies. IPPF also provides over 60 country profiles, and there are links to IPPF affiliates all over the world, organizations concerned with family planning, population and reproductive health issues, other international organizations and other related sites.

http://www.jhuccp.org/netlinks  
Johns Hopkins Center for Communication Programs provides a searchable database of over 1,100 Web sites of organizations and government agencies that deal with issues of population, health and development. The site can be searched by country, subject or organization, and provides direct links to Web sites around the world.

http://www.planeto.com/aidsvi/index.html  
The AIDS Virtual Library provides links to organizations concerned with social, political and/or medical aspects of HIV/AIDS.

www.safemotherhood.org/smguide  
Implementing the Safe Motherhood Action Agenda: A Resource Guide is a comprehensive annotated bibliography of publications, periodicals and web-based materials. Released by the InterAgency Group for Safe Motherhood (IAG), the guide lists and describes a range of available materials and resources, including concise summaries of materials related to each of the ten Safe Motherhood Action Messages and a list of relevant journals focusing on topics relevant to reproductive health. This Web resource will help ensure that individuals and organizations responsible for supporting, designing and implementing safe motherhood programmes in developing countries are aware of the most effective and cost-effective strategies, and know-how to access existing resources that can help them implement these strategies. A CD-ROM version of the Guide will be available in the autumn of 2000.

www.rho.org  
Reproductive Health Outlook's (RHO) Web site, managed by PATH, is designed for reproductive health programme managers and decision-makers working in developing countries. The site provides summaries of recent research findings and programmatic information, including sections on adolescent reproductive health; gender and sexual health; HIV/AIDS; infertility; reproductive tract infections; and safe motherhood; links to other reproductive health information on the Web; and "community forums" through which users can ask questions of, post a notice for or discuss issues and exchange information with international experts and peers working on reproductive and maternal health.

http://www.who.int/hpr/RLH/index.html  
WHO. This library offers reviews of evidence-based studies. It is a subset of the Cochrane Collaboration, which focuses on reproductive health problems in developing countries. The Library is available on CD-ROM through WHO and portions may be available online by subscription. Abstracts are available free of charge. The Cochrane Library Information can be found at: http://www.cochrane.dk/cochrane/revabstr/ccabout.htm

Report on the global HIV/AIDS epidemic. UNAIDS's second comprehensive report is sobering reading indeed. For the first time, the impact of AIDS on young people has been calculated, and the report concludes that up to half of all fifteen-year-olds in the most severely affected African countries (primarily sub-Saharan) will eventually die from HIV/AIDS regardless of whether rates drop substantially in the near future. Worldwide, the report finds that some 34 million people are infected and that life expectancy in the affected countries has been reduced by 20 to 30 years on average. The full text of the 135-page report is available in .pdf format in its entirety or by chapter in English, Spanish, and French. Country-specific estimates and data are offered in Excel format, and a number of PowerPoint slides are also available.

www.un.org/womenwatch/daw/beijing/platform  
This United Nations Web site provides the full text of the Beijing Declaration and the Platform of Action. It treats comprehensively all issues related to women and provides links to sites containing information about other UN conferences dealing with women.

This publication contains the latest population estimates, projections and other key indicators for all geographic entities with populations of 150,000 or more and all members of the United Nations. The data are broken down by standard variables such as birth and death rates, infant mortality and total fertility rates, life expectancy, percentages of populations with HIV/AIDS, population of rural vs. urban, increases in population rate, "double time", current rate, projected population totals for 2010 and 2025, and more. These variables may also be examined by region.