From Research ... to Action
During the past decade, and especially after the International Conference on Population and Development, in 1994, much has been done in the European region to improve the sexual and reproductive health status of the population. Still, too little is known about the best ways to provide quality services with respect to interventions and care provision. And too little is known about the specific vulnerable groups. There is a clear need for quality research that focuses not only on biomedical issues and the best ways to improve reproductive health drugs, but also on best practices, quality of care and policies. And this research must be carried out both globally, regionally and within the context of the particular member state.

In our region, unacceptable discrepancies in the sexual and reproductive health status of the population in western, central and eastern Europe remain. Indicators still show relatively high maternal and infant mortality and morbidity rates, a high and rising incidence of sexually transmitted infections (STIs) and high abortion rates in contrast to the low prevalence of contraceptive use.

Within this disproportionate burden of ill-health, certain population groups are at particular risk. First and of greatest concern among these groups are young people, particularly affected by unwanted pregnancy and STIs. Migrants and sex workers constitute groups at high risk of reproductive morbidity, and there is a high rate of violence against women, including sexual assault.

In light of this, the World Health Organization has approved the establishment of a European Regional Advisory Panel to the Department of Reproductive Health and Research to work with WHO on identifying central research questions and the links to sexual and reproductive health programmes. The Regional Advisory Panel takes over from the Regional Scientific Advisory Group on Training and Research in reproductive health. Large investments have already been made by WHO and collaborating centres in capacity building in this field, the fruits of which are now being harvested.

The first meeting of the European Regional Advisory Panel was convened in Copenhagen, in September 2001, to determine priorities in the search for further scientific evidence in sexual and reproductive health. One overriding factor affecting this task is the huge inequity in access to services, essential drugs, family planning and antenatal and obstetric care, which we are observing across the region, including between rich and poor populations within the wealthier countries.

In this issue of Entre Nous, you will read about a number of research initiatives supported by the Regional Advisory Panel. Among these is the new regional programme of Gender Mainstreaming of Health policies, which is already beginning to shape the thinking of policy makers in a way that will be beneficial to the sexual and reproductive health of the populations of Europe. More about this programme and the results of its international meeting in Madrid, in September, can be found on pages 16 to 18.

Likewise, following the initiative of WHO headquarters, the Regional Office for Europe has developed a programme on making pregnancy safe. The regional adviser will initially implement activities in the Republic of Moldova, while developing an action plan for the rest of the European Region (see pages 14-15).

In the light of the growing STI epidemic and the rise in HIV infection, WHO has embarked upon revising its global sexual health strategy, initially written in 1973 (see pages 11-13). Contributions from our region will play an important role in shaping this policy document, which will provide specific strategies for promoting sexual health at national level. Moreover, the Reproductive Health/Pregnancy and Gender Mainstreaming programme of the Regional Office for Europe has prepared a detailed strategy on how to deal with sexual and reproductive problems according to the degree of the problem in the individual member state. A summary of the strategy follows on the next pages.

We look to all of our readers for recommendations on how the challenges can best be tackled scientifically and how the task of resolving the issues can best be shared among partners in science and implementation.

One concrete step Entre Nous is taking is to increase its distribution to the Russian-speaking countries in the region, in addition to a new design and editorial board. Future issues will include a focus on sexual and reproductive health legislation, sexual and reproductive health in emergency situations, adolescent sexual and reproductive health, making pregnancy safer and gender mainstreaming.

Dr. Assia Brandrup-Lukanow  
[abr@who.dk]  
Chief editor

Jeffrey V. Lazarus  
[jla@who.dk]  
Editor
In recent years, the challenge to health policy makers and programme managers in the European Region has been to maintain and improve upon health care delivery in the face of increasing demand and diminishing resources. Countries have also had to respond to global initiatives such as "Health for all," the International Conference on Population and Development (ICPD, 1994) and the Beijing Conference on Women, 1995. Therefore, the need arose for a regional framework to facilitate the formulation of policies and strategies for different health programmes.

The purpose of this strategy is to provide guidance to Member States collaborating in the development of policies and delivery of programmes towards improving the sexual and reproductive health (SRH) of their populations. The WHO Regional Office for Europe recommends use of this strategic framework by governmental, inter-governmental and non-governmental agencies and institutions in developing policies and programmes in the field of SRH, setting priorities for implementation and technical cooperation together with monitoring and evaluating progress.

Sexual and reproductive health are areas of special concern in the European Region, particularly in central and even more in eastern Europe. In the process of social and economic transition, several countries have experienced rising unemployment, increases in poverty, the disintegration of social networks and severe budget cuts for the health and social sectors, all of which are having a devastating impact on the health of their populations. At the same time, problems like adolescent pregnancy, sexual abuse, the sexual and reproductive health needs of refugees, migrants and other vulnerable groups need to be addressed throughout Europe. Therefore, this strategy is designed by and for all 51 European Member States.

Key programme areas
The strategy addresses key programmes areas in the field of sexual-and-reproductive health. For each area, a number of objectives and specific targets for the period 2000-2010 are identified. The targets are differentiated in relation to the degree of the problem in the country. Below, only the key programmes areas are presented.

Maternal Mortality: The maternal mortality rate in the newly independent states (NIS) countries is still around 40 per 100,000 live births, compared to the EU where the level is below 10. Although abortion is legal in almost all of Europe, many women do not have access to safe services. It is estimated that 25-30% of maternal deaths in NIS countries are due to (unsafe) abortion. Furthermore, lack of access to essential obstetric care and low quality of service provision lead to otherwise preventable maternal deaths.

Perinatal and Neonatal Mortality: Perinatal mortality varies in Europe from 5 to 20 per 1,000 births. Neonatal mortality (per 1,000 live births) ranges from 6 to 21 in the NIS region; from 3 to 7 in the central and eastern European (CCCEE) region, and from 2 to 5 in western Europe.

Induced Abortion: Central and eastern Europe show the highest abortion rates in the world. In the Russian Federation, 2.8 million abortions are reported annually. Even these high reported numbers are often an under-estimation of reality as the coverage of the reporting systems is generally diminishing. In Armenia, for example, the reported rate in a recent national survey, conducted by the WHO Regional Office for Europe, exceeded the rate reported to the Ministry of Health five times.

Contraception: The high incidence of abortion reflects the very low level of knowledge about modern contraception, limited access to contraception and poor quality of services. Modern contraception is also hardly affordable to large parts of the population in central and eastern Europe. Contraceptive prevalence rates in Europe range from around 10-70%.

Adolescent sexual and reproductive health: This is a serious issue, both in the central and eastern parts of Europe and in the west. For example, the adolescent pregnancy rate now tends to be between
that more studies be carried out. It has also been suggested that a standardized approach be adopted in the management of the infertile couple. It will be necessary for countries to take steps to assess and manage the problem. The high cost of diagnostic and treatment interventions add to the need for public health efforts to prevent infertility.

Refugees and displaced persons: During the last ten years, wars in nine European countries have caused large increases in refugee and internally displaced populations. These are often women and children. Traditionally, humanitarian assistance has focused on food, shelter and prevention of communicable diseases. Only recently have efforts started to focus also on their sexual and reproductive health needs.

Migrants: In western Europe between 5% and 10% of the population are migrants. Usually their sexual and reproductive health needs are much more pressing than those of the rest of the population, as can be concluded from several essential SRH indicators.

Sexual abuse, violence against women, and trafficking of women: Even though these have always been serious problems, there is growing evidence that the worsening of social and economic conditions in large parts of Europe have led to increases in forced sexual contacts, prostitution and trafficking of women.

Sexual and reproductive health of aging people: In most European countries, the percentage of elderly people in the population is substantially increasing. Health services should respond to the sexual and reproductive health needs of ageing women and men. This includes problems related to menopause, andropause and reproductive tract cancers appearing later in life. Also, lack of social coverage excludes many people from taking the necessary preventive measures against complications due to hormonal decrease.

All the problems mentioned demonstrate that sexual and reproductive health should be given explicit attention in national and regional health policies and programmes within Europe.

Strategies

Improving sexual and reproductive health requires a wide variety of activities, at different levels, and by a multiplicity of actors. Apart from the health sector, other sectors of society have to be involved. The following strategies are recommended:

1. Strengthening health promotion

   Develop personal skills

   The objective of health promotion is to enable women and men, boys and girls, "to increase control over, and to improve, their health" (Ottawa Charter, 1986). People should be enabled, through information and education, to acquire and maintain behaviour that promotes their own reproductive health.

   Rearrange health services

   Health professionals, health service managers and health policy makers should work together to orient the health system in favour of the positive pursuit of reproductive health as much as the treatment of ill-health.

   Strengthen community action

   Communities should be empowered to set priorities, make decisions, plan and implement strategies which help them to achieve optimum reproductive health.

   Create a supportive environment

   An atmosphere should be created in which self-protection is an established practice. In the case of reproductive health, cultural practices become particularly important and should be taken into account.

   Develop suitable public policies

   Policymakers in all sectors and at all levels should be aware of the implications of their decisions for (reproductive) health. In particular they should seek to promote the status and health of women through such measures as human rights legislation and financial credit facilities.

2. Strengthening health systems and services

   Health care reforms

   Two types of reforms will be needed in the health system: those that respond and adapt to overall health reform actions and those that are directed at sexual and reproductive health services. The broad measures taken in the process of health care reforms have been applied differently in different countries, but the main themes of reform are decentralization and privatization.

   Within the SRH services the critical organizational issue is whether or not to
integrate the provision of the various components of the service. Specifically, the traditional separation of family planning (FP) from STI services should be re-examined with a view to providing the two in one setting. This is particularly appropriate where dual protection (from pregnancy and from STIs) is envisaged. Similarly, family planning should be integrated in abortion and in delivery of services. It will require reorientation of current staff and some adjustment in facilities.

General practitioners, not hitherto involved in providing SRH services in some countries, will need reorientation and training. Primary health care will assume a central positioning within the system and the community.

Legal reform
Effective delivery of reproductive health care often depends on the national legal setting, which may directly or indirectly enhance or hinder access. The removal of obstacles to access to services is therefore a principal approach in improving health care.

Accessibility and quality of services
The primary purpose of approaches in this area is to ensure access of clients to good clinical care by securing privacy and confidentiality, removing cultural barriers and providing special services for vulnerable groups such as adolescents, access is assured and maintained.

Standards of care need to be reviewed to achieve improvement, and guidelines for this may be obtained from WHO.

Training and retraining are essential for the private as well as the public sectors.

Information, education and communication (IEC)
Within the strategy of strengthening sexual and reproductive health systems and services special attention will be given to IEC. Much experience has been accumulated in introducing sexual and reproductive health education in schools, and in the use of various techniques and technologies, including electronic media, to disseminate information and increase widely the awareness of the community about sexual and reproductive health issues and services.

Capacity building: training of professionals
The training and retraining needs of professionals, in both education and service delivery, arise from the reorientation of the reproductive health service, in particular the integration of family planning with STI services and the delegation of sexual and reproductive health responsibilities to the primary level. Specific areas of (re)training will therefore include public health measures, clinical practice and new laboratory methods.

3. Building partnerships
Public sector: intersectoral collaboration
Education is the most important public sector area of collaboration in support of sexual and reproductive health. There is overwhelming evidence that formal education holds the key to the assurance of equal status for women. Formal education also provides clear access to young people at the time when they are vulnerable but receptive to guidance in matters of sexual and reproductive health and development. Other sectors should also be involved, such as social services and labour.

Private sector
The private sector, including NGOs, is an important partner. Private medical care and NGOs are both relatively recent additions to the health sector in the newly independent states.

4. Research
The generation of knowledge is an essential element in strategies to improve health promotion and care. Countries are encouraged to examine their health research systems to improve upon and strengthen their capacity to establish a sound knowledge basis for policy and practice. A viable health research system should be able to achieve:
- knowledge generation;
- knowledge management;
- financing of research; and
- capacity building for research.

Fortunately, in the European Region, east and west, the infrastructure for research is already advanced in most cases. There is, however a need for capacity building in some parts and these needs should be identified and addressed.

Gender equity
Inequalities in health status can result from belonging to one or other sex if attention is not paid to gender equity. Public education and services for reproductive health therefore need to take into account the needs of both women and men.

Monitoring and evaluation
A national system to monitor progress in the implementation of the various strategies is necessary. Periodic surveys on reproductive health and related issues will give an insight into the effectiveness and efficiency of the different approaches adopted and may lead to reformulation of policies.

For more information about the Regional Strategy on Sexual and Reproductive Health, please contact Dr Assist Brandrup-Lukanow (abr@who.dk), regional adviser of the Family and Community Health unit at the WHO Regional Office for Europe.
The first World Health Organization course on Operations Research in Reproductive Health took place in Targu Mures, Romania, on 1-12 October, 2001. The workshop was organized by the Department of Reproductive Health and Research, WHO, Geneva, Switzerland in collaboration with the Population Council FRONTIERS PROJECT and the East European Institute of Reproductive Health (EEIRH), Targu Mures, Romania.

The purpose of the course was to train researchers and health managers from countries in central and eastern Europe including the newly independent states (NIS) and central Asian republics (CAR) in designing and conducting operations research (OR). OR in reproductive health employs systematic research techniques drawn from business, social science and health to improve reproductive programme effectiveness, quality and efficiency. It is distinguished from other research because it studies factors that are under the control of programme policy makers and managers. OR is used both to design new programmes and to improve existing services. Policy makers and managers participate in all phases of the research from problem identification to the implementation of the solution to the programme problem. The ultimate objective is to establish one or more centres in central and eastern Europe, NIS and CAR that are able to conduct operations research and to train others how to carry it out. As Jim Foret of the FRON- TIERS PROJECT puts it: "The countries at the workshop are making the transition from one type of health system model to another. That is where OR can help."

The main objective of the course was to prepare a detailed proposal on operations research in reproductive health for possible funding as part of capacity building and networking in eastern and central Europe, the central Asian republics and the newly independent states. There were two representatives from eight countries of these regions: the Czech Republic, Kazakhstan, Latvia, Lithuania, Moldova, Romania, the Russian Federation and the Ukraine (only one participant): Kazakhstan, for example, was represented by specialists from the Kazakhstan School of Public Health (KSPH). Saule Nukusheva, Head of the KSPH Reproductive Health department, found the course content "practical" and the opportunity to network with international colleagues very stimulating. She comments that "Although the workshop is now finished, our work is just starting because we have to make our adolescent sexual education project proposal in a WHO format and send it to Geneva by 30 November 2001."

Other selected project proposals were:
- Reduction of Caesarean section rate (Czech Republic);
- Improving adolescent reproductive health services (Latvia & Republic of Moldova);
- Adolescent sexual health counselling using peers (Lithuania);
- Introducing obstetric and perinatal best practices (Russian Federation);
- Breastfeeding education of primary health care physicians (Romania);
- Introduction of medical eligibility criteria for family planning methods to primary health care physicians (Romania);
- and Introduction of partogram in obstetric care (Ukraine).

The OR course, a first for many researchers in the region, lasted for two weeks, with three 90-minute sessions daily.

Key topics included:
1. What is operations research?
2. Identifying programmatic variables/Role of the manager in OR
3. Identifying the programme problem
4. Experimental designs
5. Process and contents of an OR proposal
6. Ethical issues in an OR proposal
7. Making a good presentation
8. Introduction to cost analysis.

The projects will be reviewed by the end of the year and the organizers feel that there is a very good chance that the majority will secure funding in early 2002; a follow-up workshop is scheduled for 2003, in Moscow, the Russian Federation.

For more information about operations research in reproductive health, visit:
http://www.popcouncil.org/frontiers/frontiers.html or contact Jim Foret (jforet@pdc.org), FRONTIERS PROJECT and/or the Department of Reproductive Health and Research, WHO, Geneva, Switzerland.
The rationale for addressing the sexual and reproductive health needs of adolescents and young people — defined by WHO as the age group 10-19 and 10-24 respectively — is compelling. In general terms, adolescence is considered a time of transition from childhood to adulthood, during which individuals experience physical changes following puberty, but do not immediately assume the roles, privileges and responsibilities of adulthood. The period of adolescence is both a period of opportunity and choice as well as a period of vulnerability and risk. Adolescents are increasingly spending more time in school, experiencing puberty at younger ages, and marrying and having children later. It is a time characterised by vulnerability to health risks, especially those related to unsafe sexual activity and related reproductive health outcomes, and by obstacles to the exercise of informed sexual and reproductive choice. Adolescents and young people are not a homogeneous group; their lives vary enormously by age, sex, marital status, class, region and cultural context.

There are as many as 47.8 million adolescents and 71.3 million young people in eastern Europe, representing 16% and 23% of the population of this region, respectively. And there are a total of 14.4 million adolescents and 17.8 million young people, representing 25% and 31% respectively of the populations of the five central Asian republics: Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan (United Nations, 2001). Increasingly, governments and researchers in this region have begun to shed their traditional ambivalence towards young people’s sexual and reproductive health. Yet, there continues to be a dearth of information on the sexual and reproductive health needs of adolescents, and on strategies that best equip adolescents and youth in different settings to overcome these risks and obstacles.

Nevertheless, some facts are well accepted. As a recent synthesis of case studies supported by WHO (Brown et al., 2001) has demonstrated, large proportions of unmarried adolescent females and especially males have experienced sex and early sexual debut; casual sex and multiple partners are reported, especially by young males; and condom use is reportedly irregular. A look at findings from a recent survey of young adults in Romania confirms these risky behaviours.
A study in the Russia Federation, likewise, reports that only 39% of young people who became sexually active before age 18 used any form of contraception, compared to about half of those who initiated relations at 18 or older (All Russian Centre for Public Opinion and Market Research and others, 1998).

Consequences of risky sexual activity are evident in the form of unwanted pregnancy, sexually transmitted infection (STI) and unsafe abortion among adolescents. Moreover, the risk of STIs including HIV is disturbingly high among young people in this region. For example, 75% of the 33,000 registered cases of HIV in Russia were young people aged 15-29 (Ketling et al., 2001). Unwanted pregnancy is also widespread. Reports from Romania suggest that 4% of unmarried women aged 15-24 had experienced one or more pregnancies, and of them, 18% opted for a live birth; 71% underwent an induced abortion; and 76% reported the experience of at least one unwanted pregnancy (Serbanescu and Morris, 1998). Bankole et. al. (1999) report abortion rates drawn from 34 countries for which data on abortion are available, and conclude that abortion experiences are pronounced among young women in this region: Of 34 countries for which data are available, the adolescent abortion rate is high (over 30 per 1000) in a total of seven countries, four of which – Bulgaria, Hungary, Romania and the Russian Federation – are located in eastern Europe. Typically, the abortion rate for women aged 20-24 is considerably higher than that reported among adolescents, and in several countries in this region is higher than or equal to that reported for older women (30-34).

Despite such behaviour, relatively few young people consider themselves to be at risk of disease or unwanted pregnancy. Awareness of safe sex practices seems to be superficial and misinformation regarding the risks of unsafe sex and its consequences is widespread. Gender inequalities are apparent and double standards concerning the acceptability of male and female premarital sexual behaviour are evident in attitudes and behaviours of young people; and gender power imbalances further exacerbate the inability of females to exercise informed choice and negotiate safe sex.

While the fact that adolescents engage in unsafe and perhaps unwanted sex is increasingly accepted, what is poorly understood are the factors that contribute to positive sexual and reproductive health outcomes. Filling these and other knowledge gaps requires in-depth case studies that explore the nature of sexual relationships among young people, and the kinds of factors that place adolescents at risk or protect them from unsafe or unwanted sexual activity. Conducting research on a topic as sensitive as premarital sexual relations of young people is quite different from research on less sensitive topics and on adult populations. It requires designs and methodologies that inspire reliable responses from youth as well as questions that are sensitive to fears about disclosing sexual activity status. Finally, it requires the building of rapport with community gatekeepers and policy makers.

HRP Research initiative

In view of the urgent need to fill these knowledge gaps, the UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP) at WHO launched a research initiative in 1999 to encourage research on this topic in developing countries and in the countries of eastern Europe and central Asia. The initiative received an enthusiastic response of over 400 proposal submissions. All submissions are peer-reviewed by a panel of scientists, and awards made on the basis of their evaluation. As of late 2001, a total of 42 projects are ongoing, in some 29 countries in Africa, Asia, the European Region and Latin America. Topics are wide-ranging: sexual risk

Source: Bankole, Singh and Haas, 1999
behaviours and their determinants; risk behaviours of vulnerable groups such as migrants and refugees; perspectives on dual risk and protection; unwanted sex and sexual coercion; gender roles and sexual attitudes; health-seeking, quality of care and provider perspectives; consequences of unwanted pregnancy; and interventions seeking to explore innovations in the provision of information and services to adolescents.

Three of these projects are currently under way in European countries: Croatia, Poland and Turkey. While all three focus on the nature of sexual relations among adolescents, underlying factors that place adolescents at risk or protect them from unsafe and unwanted sexual relations, and obstacles to effective health-seeking, each adopts a somewhat different perspective.

Croatia

In Croatia, traditional sex roles continue to be reinforced - conservative attitudes to sex and women persist, sex education is rare, and activities for youth are limited. Gender imbalances foster sexual risk behaviours among youth: poor awareness of sexual and reproductive health, accompanied by early sexual debut and considerable experience of risk behaviour is documented. Research explores gender perceptions and attitudes of adolescents aged 16-17 in four cities, and the ways in which these influence sexual risk behaviour. The study employs a mix of qualitative and quantitative methods, and focuses on adolescent females and males currently in a variety of educational institutions.

Findings are intended to inform sex education programmes, and specifically the ways in which they address gender norms and behaviours, and to raise the consciousness of youth to the ways in which gendered attitudes and expectations affect sexual risk behaviours, and the ability to protect themselves from unsafe sex.

Poland

In Poland, adolescents are faced with conflicting messages on sexuality: the church and the conservative political leadership on the one hand, and popular and youth culture on the other. The study investigates the ways in which adolescents deal with these conflicting messages; and the extent to which the confusion created by these mixed messages influences their views on sexuality and risky sexual behaviour (early debut, multiple partners, unprotected sex). It explores the source, content and credibility of messages, awareness of contradictions, their influence on sexual risk behaviours, self-esteem, gender roles and feelings of guilt. It is conducted among adolescents aged 16-18 studying in schools in Warsaw, using qualitative methods. Perspectives are assessed of both adolescents and key adults, including parents, teachers, church representatives, officials from the ministries of education and health, individuals from the media and youth representatives.

Turkey

In Turkey, sexual and reproductive health services remain generally unavailable to university students. Research is currently underway that explores the sexual and reproductive health needs of first-year university students and the public and private sector providers serving these students in two provinces: Ankara and Diyarbakir. Risk behaviours, perceptions, attitudes and their underlying socio-cultural factors are identified, use of sexual and reproductive health services assessed and knowledge, attitudes and practices of health personnel from whom students currently obtain services are identified. A combination of qualitative and quantitative methods is used. Findings will form the basis for an intervention to provide youth-friendly services at university level.

Undoubtedly, many other unanswered questions need to be investigated in this region. What we know about the sexual and reproductive health needs and behaviours of adolescents and young people in the countries of central Asia is particularly sparse. What is available from both eastern Europe and central Asia suggests, however, that STIs and unwanted pregnancy and experience of induced abortion characterise the sexual lives of far too many adolescents. Priority areas of research thus include: (a) factors enhancing sexual and reproductive choice among adolescents and the extent to which such factors as parental involvement and self-esteem can enhance the exercise of informed choice among young people; (b) unwanted pregnancy and pathways to abortion experienced by adolescents; and (c) obstacles faced by young people in acquiring information and services and the quality of care experienced by them in their quest for information and services.

References are available from the author.
The new document will attempt to reflect the diversity of perspectives on sexuality and sexual health through a broad collaborative process between WHO Geneva, the regional offices of WHO and civil society organizations and associations specialized in sexual health. Country and regional views have been gathered through a broad consultative process, which included the commissioning of background papers and regional "roundtable" discussions. This collaborative process will culminate in January 2002 at a technical consultation on sexual health to be held at WHO in Geneva, where the new consensus document will be reviewed.

Reflecting perspectives from the region
In the European Region, experts in Latvia, Turkey and the Russian Federation have written papers, based on the literature, identifying the key sexual health problems in their country or sub-region, the underlying determinants of those problems (e.g. social, cultural etc.) and the background factors that influence behaviour and attitudes such as globalisation and the media, religion and poverty. The papers identify specific barriers to addressing the problems as well as appropriate strategies for overcoming them. In addition to the commissioned papers, WHO has compiled a large body of evidence from other European countries that will also serve as background material. The purpose of the background papers has been to provide a critical review of the most important issues in the region so that they may be appropriately reflected in the global monograph.

In preparation for the January global consultation, the European Region took up these issues at the recent Regional Advisory Panel (RAP) Meeting for Sexual and Reproductive Health held in Copenhagen on 20-21 September 2001. The writers, special advisor Dr. Larrissa Remennick from the Russian Federation, and two other RAP members, Dr. Ayse Akin of Turkey and Dr. Gunta Lazdane from Latvia, presented their findings on sexual health from their respective sub-regions.

The Russian Federation: glamorisation and commercialisation
Dr. Remennick summarized what she concluded were the most critical barriers to the promotion of sexual health in Russia today. First, and most significant, has been the breakdown and even reversal of traditional gender roles since the demise of the former Soviet Union. Economic instability and increasing poverty in some regions has resulted in an increased dependency on the sex trades. The opening of the cultural divide between east and west has also led to a commercialisation and glamorisation of sex and the sex trades, making prostitution more socially acceptable and in many cases even desirable as a career choice. Recent surveys have indicated that commercial sex work (high rank prostitution and escort services) ranks high among desired occupations for young women. This defining and glamorising of women as sex objects, Dr. Remennick concludes, is one of the most striking results of the post-Communist era.

Linked but not limited to the commercialisation of sex and the objectification of women is the increasing sexual liberty young people are claiming in and outside of the traditional marriage union. A recent study of Leningrad youth, for example, reports that 80% of the boys and girls have had sex prior to marriage. These changes in early sexual experiences have not, however, been accompanied by increased knowledge and understanding of risks associated with unsafe sex. This "sexual illiteracy," Remennick points out, is further exacerbated by lack of communication with families and society more generally about sexual behaviour, the function of the body and how to act responsibly in one's sexual practices. This growing division in attitudes and sexual behaviours between parents and their children is evidenced by a recent study that shows that 15-20% of parents has never discussed sex with their children (Ketting et al. 2001).

Remennick summarizes the changes like this, "The results of several consecutive surveys among young Russians - high school and college students - (Golod, 1996; Cherviakov and Kon, 1998, 2000; Ketting et al., 2001) have confirmed the view that their patterns of sex conduct are very similar to those found in
the US and western Europe two to three decades earlier. The key difference is that gradual changes in sexual norms and practices that stretched over several decades in the west are happening in the matter of years, if not months, in Russia. Therefore, Russian society has had very little time to digest and incorporate these fundamental shifts in the lifestyle of its younger generations.”

The result of this inter-generational tension, she concludes, has not only left young people without sufficient guidance and information to make appropriate choices, it has also served as a catalyst for conservative political and religious voices against what they see as the proliferation of “western values” on the children. This current in Russia today has successfully limited wide-scale efforts to introduce sexual health education into the school as an inappropriate western concept. In addition, research on sexual health problems such as syphilis and HIV has also been met with similar resistance despite growing numbers of infections each year.

Dr. Remennick argues that only through a broad public coalition for the promotion of sexual health education can we tackle popular sexist messages in the media. Considering the current difficulties in advocating for widespread sexual health education, it might be best to begin with the training of health and education professionals to address the issue appropriately with their clients and students. Finally, she argues for the need to support national NGOs and professional associations in terms of funding and skills in order to enable them to work more effectively outside of traditional channels.

Turkey: taboos and traditional beliefs

Dr. Ayse Akin noted that after the 1994 International Conference on Population and Development to which Turkey was a signatory, the government began a process of transforming the maternal child health department of the Ministry of Health to address the broader field of sexual and reproductive health. Despite this new emphasis, however, in the national strategic plan, reproductive health stands virtually alone. Little mention is made of sexual health except in relation to disease prevention. This “oversight,” Dr. Akin pointed out, shows that health policy makers and providers continue to have difficulty addressing sexual health issues. Traditional taboos around discussing sexuality clearly impact on the availability of sexual health services.

Dr. Akin identified a lack of information and communication about sexuality and sexual health as an important barrier to the promotion of sexual health. The silence around the issue she attributes to rooted gender inequalities that have been difficult to overcome. In Turkey, for example, early and forced child marriage, virginity examinations before marriage and polygamy are common in rural areas and not unheard of in urban centres. She noted that there are still “honor killings” reported, which she feels can scarcely be addressed where knowledge of rights and responsibilities are poor and IEC materials are non-existent.

She stressed that “because sexuality is seen as a taboo, most of the parents continue the traditional belief in regard to their relationship with adolescents and do not talk about sex with their children even though they may be coming from different strata of the society and have different cultural and ethnic or educational backgrounds. The tradition of silence continues for those going to school and adolescents cannot acquire adequate information during their formal education.”

Strategies for addressing these barriers included the following:
1. Public awareness of sexual rights;
2. Empowerment, including legislative changes to give more rights, of women;
3. National guidelines of measurable indicators;
4. Formal sexual health education programs ensuring political commitment;
5. Provision of IEC materials through the network of primary health care services.

Latvia: “naughty” folk songs

Dr. Gunta Lazzane pointed out that despite perceptions, in her region, traditional conservative cultural and social values and behaviors around sexuality have not always been the case. She recounted that a series of traditional Latvian folk songs from the 11th-13th centuries portray positive attitudes about sex and sexuality. It was not until much later that these songs became branded as “naughty songs,” clearly a reflection of changing social mores and values. She
noted, however, that the positive attitude around sexuality that had formerly been widespread was eliminated first by the church and much later by communism. She writes: "Married men and women sang these songs during the wedding when the young couple was accompanied to the bedroom. In these songs, all genitalia were called by their real names. These songs provide a great amount of useful information like different ways to attract the other gender, different size of genitalia and its role during intercourse, postures during intercourse, prostitution etc."

Dr. Lazardne also pointed out that the economic difficulties the region is facing have put incredible pressure on both men and women to find sources of income. The result has been increased transactional sex of all kinds including trafficking. She suggested that the only way to reasonably address these issues is to begin by training and equipping health professionals and others such as teachers.

**Towards a global document**

There is still very little evidence on many sexual health issues, for example infertility. A recent population-based survey reported that one-third of all women of reproductive age stated that they believe they are infertile, and it hypothesized that this was a strategy to avoid addressing/using contraceptives. Such a hypothesis can be entertained only when we have sufficient qualitative data, an issue that WHO should be addressing in the future. Another issue of special interest in the European Region is how sexuality should be taught in schools. Who should teach such a course and to what age group needs to be resolved before efforts begin. It has been suggested that since doctors and teachers are often very conservative, coalitions need to be forged between NGOs, youth groups, parents, religious organizations and appropriate government ministries to move the issue forward.

Intervention strategies tailored to the cultural and social needs of the countries where they take place should not be underestimated. An issue such as sexual abuse and violence against women needs to be addressed very carefully. One major concern is how best to present the issue so as not to alienate the older generation (parents, teachers, health providers, religious leaders etc.), which continues to hold very conservative views of sexuality particularly among young people. Given the prevalence of STIs and HIV in the European Region, WHO must take measures to advocate and develop appropriate strategies for the promotion, prevention and care of the sexual health of both adolescents and adults. The WHO regional office for Europe Sexual and Reproductive Health Strategy, approved by the panel in the final session of the RAP, has outlined a number of appropriate strategies for the region that the group concluded should be incorporated into the global document (for more information see pages 5–6). It is anticipated that the final document will be available by mid-2002 for regional distribution.

**References are available from the author.**

---

**SEXOLOGY ON THE INTERNET**

- The website of the archive of sexology

[www.sexology.cjb.net](http://www.sexology.cjb.net)

The website of the Archive for Sexology in Berlin is the best, fastest, and most economical gateway to sexological information. It contains, among other things, a global directory of sexological institutions, organizations, resource centers, scientific journals, and training programmes (including their curricula). Moreover, the website offers a critical dictionary of sexology and an online library of scientific papers and books, among them two encyclopaedias. It also provides preselected links to other websites covering a great variety of topics, from women's studies, gender and trans-gender issues, religion, and cultural history to reproductive health, STIs, and sexual violence. At the moment, the website provides its information in both English and Spanish. However, German, and Turkish versions are in preparation. Other languages may follow, if the necessary funding can be obtained.

From the very beginning, the archive has taken its cue from the recommendations of a 1975 WHO report on the sexological training of health professionals (full text available on the website). All of this was made possible by the Robert Koch Institute, a German federal research institution for infectious and non-infectious diseases.

For more information, please contact: Haeberle@rki.de.
Of the approximately 180 million women who become pregnant annually, more than 20 million women experience ill-health as a result of pregnancy; for some the suffering is permanent. The lives of eight million women are placed in jeopardy, and close to 600,000 women die as a result of causes related to pregnancy and childbirth; around 117,000 of them are adolescent women. Women from the world’s poorest households (income of less than US$ 1 a day) are at least 300 times more likely to suffer in this way than those who are better off. Over three million newborns die within the first week of life; more than three million babies are born dead.

Quality maternal care is vital to ending this travesty. The majority of this suffering and death is preventable through affordable actions at national and community levels, even when adequate resources for health care are lacking. Intense efforts, during the last ten years, have led to significant improvements, though worldwide progress has been limited. It must be ensured that pregnancies are wanted and that women can obtain the care they need when they need it.

Many European countries are still struggling with health sector reform and other health system changes as a result of new forms of government, fiscal constraints, growth of the private sector and deteriorating quality of care in the public and private sectors. These changes have profound impacts on resource development and use, and on the delivery of services including services that contribute to making pregnancy safer, especially to disadvantaged groups.

Specific health interventions are needed to reduce the incidence and severity of major complications associated with pregnancy and childbirth. For example, the use of the partograph, basic obstetric care ensuring the presence of a skilled attendant with the necessary equipment at every childbirth, an adequate referral system and support for the management of complications should reduce the number of maternal and perinatal complications and deaths.

It should be noted that a significant number of maternal deaths are still related to abortion. Interventions aimed at preventing unwanted pregnancies (promoting contraception) and abortion complications (making it safe and legal) as well as improving clinical management when complications arise are urgently needed.

The Making Pregnancy Safer Initiative

The Making Pregnancy Safer Initiative (MPS) was launched by WHO in 1999 to confirm the organization’s strong support for the international Safe Motherhood movement. MPS aims to refocus WHO’s strategies and efforts in Safe Motherhood and maintain the issues firmly on the international development agenda.

Alberta Bacci, the WHO Regional Office for Europe MPS coordinator, clarifies that “Broadly, the goals of the Safe Motherhood Initiative and MPS are the same: protecting and promoting reproductive and human rights by reducing the global burden of unnecessary illness, disability and death associated with pregnancy, childbirth and the neonatal period. However, WHO’s Making Pregnancy Safer Initiative will work specifically with the health sector, stressing the need to focus on effective evidence-based interventions, strengthening national health systems and promoting necessary actions at community level.”

The principal MPS interventions are:

- prevention and management of unwanted pregnancy and unsafe abortion;
- skilled care in pregnancy and childbirth;
- access to referral care when complication arise.
Concretely, WHO will help countries reduce maternal and perinatal mortality by:

- Advocating support among interested parties at global, regional and country levels to increase resources and promote consistent, ethical and evidence-based policies;
- Building effective partnerships among global, regional, and national partners in order to maximize available resources and ensure better coordination of maternal and newborn health plans and initiatives;
- Providing technical and policy support and strengthening governmental capacity to plan, design and implement effective evidence-based technical and health system interventions, as well as to identify the necessary actions at community level to improve maternal and newborn health;
- Establishing or updating national policy and standards for maternal and newborn care (including postabortion care), family planning, induced abortion care (where legal) and developing tools for maternal and newborn health care, and supporting countries and partners in adapting them for local use and special circumstances;
- Promoting and coordinating research and disseminating findings in areas that are crucial to improve maternal and newborn health; and
- Monitoring and evaluating implementation of the work, including assessments of maternal and newborn health programmes.

In short, WHO will strive to reduce pregnancy-related maternal mortality by 75% of the 1990 level by 2015 and infant mortality to below 35 per 1000 births by 2015, in addition to ensuring that skilled attendants are present at 80% of all births by the year 2005.

As a result of WHO’s support, 20 participating countries, of which 2-3 are in the European Region, will have developed:

- Co-ordinated plans for making pregnancy safer, including monitoring and evaluation;
- Strengthened health systems with coordinated policies, strategies and plans, improved human resource development and referral and supervisory systems established for maternal and perinatal morbidity and mortality reduction;
- Improved quality and coverage of maternal and perinatal health care through evidence-based interventions; and
- Home/family and community-based messages and interventions to improve maternal and perinatal health practices and fertility regulation.

Specific challenges in the European Region

The European Region faces a unique challenge due to the heterogeneous health care systems. Official data regarding maternal mortality in 1998 in western Europe was around 16:100 000, while in eastern Europe and the central Asian republics it was approximately 40:100 000, with some countries reporting figures as high as 50 or more per one hundred thousand live births.

The perinatal mortality rate in the same year in western Europe was 7:1000, in eastern Europe and the central Asian republics it was 13:1000, with some countries reporting 20:1000 or more.

The main issues facing the European region are:

- Gaps in equity (within and among countries);
- High maternal and perinatal mortality and morbidity;
- Lack of access to available services;
- Legislative constraints;
- Lack of decentralization and an integrated network among different levels of care;
- No multidisciplinary approach to perinatal care;
- Excessive medicalisation (focus on inpatient care, inappropriate interventions);
- Inappropriate use of drugs and an inappropriate use of technology.

Therefore, work in this region will focus on central and eastern Europe and the newly independent states. The first country for the implementation of MPS in the region is the Republic of Moldova. Two to three countries in total will be chosen for the implementation of the MPS initiative during 2002-2003, according to the following criteria: high maternal and perinatal mortality, ability to develop a bilateral partnership, previous Safe Motherhood and similar activities in the country.

Work in Moldova began in early autumn 2001. The first activities included auditing (reviewing clinical obstetric cases) to determine how to improve the quality of care. However, additional research is needed in order to fully implement the initiative. Some preliminary topics for research, following an assessment of the situation and previously held trainings at country level, are:

- Determining appropriate indications for Caesarean sections, setting standards according to scientific evidence and reviewing clinical cases;
- A trial on the use of different methods for performing Caesarean sections including the Misgav-Ladach method (as compared to the travcational method);
- An audit with clinical teams on the appropriate use of drugs in the perinatal field (setting standards, reviewing practices, implementing changes and evaluating);
- Following recent evidence published in a WHO study on antenatal care in the Lancet ("World Health Organization paternograph in management of labour," Lancet 1994, June 4, 343 (8910):1399-404) regarding the number and content of antenatal care visits and outcomes, there is a need to review existing antenatal care practices in order to develop recommendations for improvement;
- Effective interventions to prevent repeated induced abortion;
- Quantitative and qualitative research on the use and awareness of emergency contraception among specific sectors of the population including adolescents. This research will also address use of emergency contraception for rape victims and awareness among care givers and police in emergency situations.

For more information, contact:
Dr Alberta Bacci [aba@who.dk]
Regional Coordinator of the Making Pregnancy Safer Initiative
World Health Organization, Regional Office for Europe
“We are committed to the ethical concepts of equity, solidarity and social justice and to the incorporation of a gender perspective into our strategies.”

-World Health Declaration, May 1998

The UN system is implementing the decision that a gender approach must be mainstreamed into all policies and programmes. In health, the aim of this approach is to identify and address inequalities in health and health care related to gender roles and power relationships between women and men.

At present, mechanisms exist in some WHO programmes to work on the integration of a gender perspective. However, the integration of a gender perspective has depended on individual initiatives rather than on organization-wide policies and mechanisms. The same applies, with exceptions, to Member States.

Recognising the need to move from commitment to implementation, the WHO Regional Office for Europe together with the Spanish Ministry of Health and the Spanish Institute of Women, jointly organized the Seminar on Gender Mainstreaming Health Policies in Europe, held on 14 September, in Madrid. Representatives from over 30 European countries together with representatives from relevant European institutes met in Madrid to discuss the current status of gender and health.

The seminar was an opportunity to achieve consensus on the need to move forward and to agree on common basic steps in order to gender mainstream health policies in our Region. It provided a unique chance to discuss gender on a technical basis with policy makers and representatives of ministries of health. The main outcome of the seminar was the Madrid Statement, which include specific recommendations to WHO and its Member States to mainstream gender into their health policies.

**Gender - The word “gender” is used to describe those characteristics of women and men, which are socially constructed, while “sex” refers to those which are biologically determined. People are born female or male but learn to be girls and boys who grow into women and men. This learned behaviour makes up gender identity and determines gender roles.**

**The benefit of gender mainstreaming**

“Why, in spite of political commitment to universal resolutions, is gender mainstreaming not a reality in European health policies and programmes?”

**Mainstreaming gender in health**

- Integration of gender concerns into the analyses, formulation and monitoring of policies, programmes and projects with the objective of ensuring that women and men achieve the highest health status. A mainstreaming strategy does not preclude initiatives specifically directed toward women or toward equality between women and men. Such positive initiatives are necessary and complementary to a mainstreaming strategy.

There are plenty of examples of the existing gap between international commitments and implementation at the country level. To fill in this gap is the main challenge.

The first step is to develop an understanding of the benefit of mainstreaming gender into our policies and programmes: benefit from an equity perspective, from a human rights perspective, from a health outcome perspective and from an efficiency perspective.

Strategies may differ but the goal is the same: to integrate gender concerns into the analyses, formulation and monitoring of policies, programmes and projects, with the objective of ensuring that women and men achieve the highest health status.

In most of the countries in the European Region, policy makers and health workers do not see the relation between gender and their area of work. The existing evidence on the relation between gender and health must be conveyed.

How do we gender mainstream health?

A clear strategy or action plan to mainstream gender at country level is needed. Whether this is translated into a formal policy, or not, will depend on the country/institution’s needs and resources.

**WHO**

- requires political commitment;
- requires allocation of resources, including funds;
- involves different sectors, which need to be coordinated under a common goal;
- requires structured mechanisms for implementation and evaluation;
- needs to be visible until the mainstreaming process is achieved.

The global gender policy for WHO has been developed to ensure that all research, policies and programmes/projects in WHO are designed from a gender perspective, and that this is accomplished in a systematic and sustainable manner. This will, in turn, increase the effectiveness and impact on equity of health interventions and contribute to achieving social justice, thus enabling WHO to carry out its mandate in providing global leadership in health.

One of the specific objectives of the global policy is to ensure that WHO policies, programmes and projects provide information and policy advice to Member States on the influence of gender on health and health care, based on both quantitative and qualitative data.

Do we have the right tools to mainstream gender?

Due to its origins as a gender in development strategy, much of the work done on mainstreaming gender applies to developing countries. There is, therefore, an urgent need to adapt existing tools to the health sector in the European Region.

However, some tools for gender analysis are already applicable to our Region. Gender analysis examines the differences and disparities in the roles that women and men play, the power imbalances in their relations, their different needs, the constraints and opportunities they face,
and the impact of these differences on their lives. In health, a gender analysis examines how these differences determine differences in exposure to risk factors, in manifestation, severity, and frequency of disease, and in social and cultural consequences of disease. It also highlights inequalities in access to the benefits of technology, information, resources and health care, and the realization of rights. A gender analysis must be done at all stages of an intervention from priority-settings and data collection, to the design, implementation and evaluation of policies or programmes.

WHO has produced a review of existing tools for mainstreaming gender and their applicability to health. A further document: will summarize those that were found to be most useful for health and show their application to different health concerns and topics. The Gender and Health Equity Resource Guide (Gender and Health Equity Network, April 2001) provides a comprehensive overview of the existing tools. This guide is available online at:
http://www.ids.ac.uk/ids/.

Can we monitor progress and evaluate impact?

To be able to monitor progress of mainstreaming gender into policies and to evaluate the impact of that on health outcomes, there are three main prerequisites:
- Sex disaggregated data: To understand the specific situation of women and men, and to plan in ways that take these differences into account, we need to have statistics disaggregated by sex. To achieve this, special care is needed both in the collection of data (morbidity, mortality, health determinants) and its analysis and its presentation (health reporting);
- The existence of gender relevant information in routine data collection (gender sensitive indicators);
- Health workers and policy makers must be educated to understand the importance of gender into their work.

“In comparison to other areas of health, the development of indicators of gender equity is relatively new and undeveloped.”

In comparison to other areas of health, the development of indicators of gender equity is relatively new and undeveloped. Many of the developed indicators have not been tested for their ability to effectively measure change over time. The indicators should be adapted to the health situation in each country and to the available data. International compendiums of health statistics require comparability and therefore tend to focus on a small set of widely available and well-defined indicators. But individual countries are likely to have a greater range of information available and this information should be utilized to the extent possible.

While indicators are useful for describing the situation in a country with respect to health policy, health status, resources devoted to health and utilization of health services, it is important to recognize that they are only descriptive tools that can be used to detect patterns. Indicators cannot explain the causes behind the patterns observed. In depth analysis is usually needed to shed light on these causes.

The relation between political will and evidence

Gender mainstreaming is both a technical and a political process. To move from awareness to implementation of gender sensitive policies, policy makers, health managers and health professionals need to clearly see the positive implications of integrating a gender perspective into their work. As long as this does not happen there will only be more isolated experiences based on the commitment of the individual.

An effort has to be made to convey the existing evidence to the policy makers and health managers and to use evidence and technical debate as awareness raising tools.

Gender equality will have a twofold effect on policies. On the one hand, it will serve to ensure political commitment and resources and, on the other hand, it will serve to promote good evidence-based policies.

If policy is to be based on solid evidence then gender-based analysis has to be part of that evidence.

Can we provide gender equality?

In order to bridge the policy-implementation gap, WHO needs to be able to convey the existing evidence. Evidence on gender inequalities and inequities; evidence on positive experiences and innovative approaches with mainstreaming gender; and evidence on improvements in health outcomes or on better access to health services as a result.

Gender equality - Absence of discrimination on the basis of a person's sex in opportunities, allocation of resources or benefits or in access to services.

As a first step, countries and health programmes need to identify critical areas for gender analysis in their health sector priorities.

Does gender need to be mainstreamed into research?

There is increasing evidence from all fields of health research, both the biomedical and social side, that the risk factors, biological mechanisms, clinical manifestation, causes, consequences and management of disease differ in men and women. In such cases, prevention, treatment, rehabilitation and care-delivery need to be adapted according to sex. The consequences for not doing so are profound on the health of both men and women. Undertaking research that appreciates these differences in patterns of health and illness between the sexes is crucial.

There should, additionally, be greater recognition of the need for qualitative research methods to document and explore some of the more structural aspects of gender inequalities in health.
The inclusion of women in clinical trials should be ensured through close scrutiny of research design and funding allocation dependent upon the demonstration of relevance for both sexes where possible.

There is also a need to include the male perspective in gender research. The interaction of gender with other categories, such as age, ethnicity and class needs to be integrated into research protocols.

The European Panel for Gender Mainstreaming Health

A growing demand to understand the process and objectives of gender mainstreaming health was made visible through several consultations with representatives of the health sector in European countries. There was also a clear request to define a common European approach that will allow us to move forward and fill in the gap between international commitments and national implementation.

As a response to these needs, in February 2001, the European Panel on Gender Mainstreaming was established. The panel met for the first time in Basel in June 2001. Representatives of seven European countries, six European institutions working with gender issues and the WHO Regional Office for Europe participated in this first meeting.

The European Panel on Gender Mainstreaming indicated the following areas as priorities for gender analysis:
- Gender differences in risk behaviour: smoking, drug use, alcohol consumption, nutrition, violence etc;
- Intergenerational effects of gendered interventions on selected health related behaviours (i.e. tobacco prevention on young women);
- Causes of excess premature male mortality;
- Sexual and reproductive health: preservation of fertility; male and female reproductive health; and prevention and treatment of STIs;
- Gender differentiated impact of major socio-economic changes;
- Gender differences in health care seeking behaviour and the use of drugs;
- Gender and parenting and its impact on health;
- Analysis of the impact on the health of professional and reproductive gender roles;
- Gender and the quality of life of elderly people;
- Gender-based violence; and
- Gender differences in mental health and access to services.

A need to move forward

In order to promote the benefit of mainstreaming gender into health policies in Europe, we need clear guidelines on how to proceed. Although these guidelines will have to be designed at the country level, agreement on the main steps to follow at the European level would facilitate this process.

It is not a question of making gender mainstreaming a priority in the health agendas; it is a question of looking at gender as a determinant of health as important as social and economic background and ethnicity.

A prerequisite for gender mainstreaming to be a reality is that both men and women are actively involved in the design, implementation and evaluation of health policy changes and that men, as well as women, be actively involved in mainstreaming gender in health.

Terms of reference of the European Panel for Gender Mainstreaming Health

In February 2001, the European Panel for Gender Mainstreaming Health was formed to assist Member States and the WHO Regional Office for Europe on:

- Defining a new approach on gender and health, which introduces the concept of the benefit of gender mainstreaming;
- Developing a practical flexible framework for the process of gender mainstreaming health programmes at the country level;
- Identifying critical areas for the health of men and women, in different programmes;
- Identifying and documenting examples of good practice at the country and community level, which will feed the flexible framework;
- Piloting new approaches on gender and health;
- Facilitating the exchange of experiences and approaches among European countries;
- Developing a set of main indicators on gender and health.

For more information, please contact:
Isabel Yordi
Gender Mainstreaming
Division of Technical Support
WHO Regional Office for Europe

This article is adapted from a discussion paper presented at the seminar on Gender Mainstreaming Health Policies in Europe, 14 September 2001. It is based on the WHO Global Policy on Mainstreaming Gender in Health, 1999 and on the Gender and Health Technical Paper, WHO 1998.
One hundred and fifty representatives of governments, national and international youth NGOs and international organizations convened in Sofia, Bulgaria, in early October, for the Youth Policy Forum. The forum was organized by the European Youth Forum in partnership with the European Commission, the Council of Europe and UNICEF. It was hosted by the National Youth Council of Bulgaria and the State Agency for Youth and Sports of Bulgaria. The objective was to "encourage government decision-makers to work with youth organizations and young people in the creation of youth policy in south east Europe".

The participants concentrated their efforts on determining the key elements of national youth action plans according to the special needs and characteristics of the south east European region. In order to accomplish this goal they were divided into five working groups, each with a separate topic for discussion: Youth Participation and Inclusion, Youth Employment, Promoting Healthy Lifestyles, Education and Youth Development, Individual Independence and Housing. The working groups identified the main problems that young people in south east Europe face and provided possible ways on how governments, together with youth organizations can work together to solve these problems. The discussions clearly revealed that in spite of some differences, the young people of south east Europe face similar problems.

After the participants identified areas to be included in the national youth action plans, they focused on determining the role of the different actors in youth policy development. It was concluded that government representatives, youth organizations and international organizations should cooperate in the process of creating and implementing national youth action plans. Needless to say, a special emphasis on the participation of youth in the process was stressed.

Marta Diapalma, a programme officer at UNFPA in Bulgaria, saw the forum as a unique opportunity to address the sexual and reproductive health issues facing young people today. "The issue of youth participation and inclusion is vital for any reproductive health policy. Young people must not only be the target of these programmes, but should also contribute to the formulation of them. Bulgaria, as one of the countries with the highest adolescent pregnancy rate in Europe, is in need of urgent action. UNFPA is assisting the Government of Bulgaria in addressing young people's needs through the development of SRH educational programme, strengthening peer education, teacher training courses and youth services."

On the last day of the forum, the participants had to present their view of the process of the actual development of a policy geared towards youth. Lachezara Stoeva, a Bulgarian participant at the Forum, stressed "that national youth action plans can only become a reality if there is serious political will. And in order to ensure that these policies address the needs of young people, national youth organizations should be actively involved in both their development and implementation."

To develop national action plans on youth policy in the countries of south east Europe and to actively implement them is a long process. The Youth Policy Forum provided the ideas and the vision for how this can be done, and the initiative has now been passed onto the governments in the region.

For more information, please see: www.youthforum.org
AIDS RESEARCH RECOMMENDATIONS:  
An African Perspective 
by Heidi Holland

African AIDS research is still steering clear of a number of sensitive but vital issues, despite millions of deaths from the pandemic. With notable exceptions, too few are studying the crisis of AIDS orphans, for example. And far too little use is being made of cross-cultural psychology or medical anthropology in the struggle to understand and influence sexual behaviour on the continent. In South Africa alone, one in nine people is HIV positive.

Africa’s orphan crisis

Although there will be 40 million African AIDS orphans by 2005, the prevailing wisdom among many donors and public health activists abroad is that the grandmothers of Africa will somehow cope with the problem. This view is not spoken as much as inferred by the paucity of projects focusing on alternative family structures, as well as the deep western sighs emitted in honour of Africa’s extended family system.

Africa’s enduring sense of community is indeed a spiritual strength but the continent’s grandmothers have inadequate resources to cope with the orphan crisis. They need financial help, creative ideas and psychological support.

We should be doing more than rolling our eyes heavenward at the thought of 40-million loveless children growing into 40-million forlorn and possibly vengeful adults. As Emma Guest, author of CHILDREN OF AIDS, says: “Africa after AIDS will be an unpredictable place. What will happen to the minds of a generation that grows up alone, poor and ashamed? The stigma of the disease that killed their parents? Some will suffer depression. Others may lash out.”

Understanding sexual behaviour

There has been a movement away from statistical research and condom promotion towards understanding sexual behaviour in Africa but, all too often, existing epidemiologists seem to be the ones reinventing themselves as social investigators. There must be armies of gifted cultural psychologists and anthropologists in the west who are better equipped to find out why people behave in the way they do in terms of unsafe sexual practices. This may be a tricky area of research in the wake of post-modernism, but researchers from other cultures have to try to gain insight in order to seek behaviour change. Cultural standoffs in the politics of knowledge might someday be viewed historically as acts of genocide in the war against African AIDS.

Westernising the problem

One way in which westerners waste time in African AIDS research is in their need to westernise the problem. This intellectual process may help the researcher frame the questions but it does not necessarily elicit the right answers.

Tough calls on aid allocation

Although the American government believes AIDS is treatable with drug cocktails, USAID is unwilling to spend its money on the drugs since monitoring of drug delivery by African physicians and by the patients themselves is failing.

At a time when important battles have been fought and won against the giant drug manufacturers of the world to secure access to AIDS medications, lack of infrastructure to deliver these accessible drugs remains a huge obstacle. There must be solutions, given the scale of the AIDS catastrophe, even if delivery comes down to bicycles and donkeys. At least one malaria project in KwaZulu-Natal relies on hitherto unemployed cyclists to deliver emergency treatment to far-flung villages throughout the region.

Heidi Holland, a South African journalist and author, runs The Melville House, a B&B in Johannesburg (e-mail happy@afrrica.com). Informally known as the Reproductive Health House, her establishment attracts international professionals working in NGOs, academia and the media.

UNAIDS - the International Partnership Against AIDS in Africa

Efforts to roll back the AIDS epidemic in Africa simply have not kept pace with the epidemic itself. For many, the answer lies in the International Partnership Against AIDS in Africa - a coalition of actors who have chosen to work together to significantly scale up efforts in Africa to put a stop to the spread of HIV, reduce its impact and halt the further reversal of human, social and economic development. In international development, never before has such a multilateral group joined forces to fight a single disease. By providing national leadership, African governments are spearheading broad-based national responses. UN organizations are coordinating the global response and providing programme and financial support to country-level efforts. Donor governments are also supporting action at all levels, providing input into substantive development of the Partnership in addition to financial assistance. The private sector is providing expertise and resources to help turn the epidemic around in the business community and beyond. And, finally, the community sector is working to ensure ownership of the Partnership within local civil society and to strengthen regional and country networks.

See http://www.unaids.org/africapartnership/index.html
INTERNET RESOURCES
Prepared by Josh Gross, Web editor

The Reproductive Health Outlook
www.rho.org
The RHO website provides up-to-date summaries of research findings, programme experience and clinical guidelines related to key reproductive health topics, as well as analyses of policy and programme implications. An important objective of RHO is to help users link with quality online resources and collaborate with colleagues around the world. This is an excellent resource on all aspects of reproductive health. It has a great links page.

International Rescue Committee (IRC)
www.intrescom.org
This non-profit aid organization provides relief, protection, and resettlement services for refugees and victims of oppression and violent conflict and is a founding member of the Reproductive Health for Refugees Consortium. Check out the field reports (www.intrescom.org/health/publications.cfm) analysing the challenges and achievements of some of IRC's reproductive health programmes. The reports are mostly in PDF format with high-level graphic content.

Reproductive Health Gateway
www.rhgateway.org
RHG gives you quick access to relevant, accurate information about reproductive health on the Web. RHG lets you search a group of websites carefully selected for accuracy, authority and relevance - much quicker, easier and more trustworthy than either a Web-wide search, which can yield many irrelevant or unreliable sites, or a time-consuming site-by-site search. This is an excellent portal covering all areas of reproductive health. It has a fast and convenient search engine linking the user to relevant articles and Web pages. It has advanced, multi-subject search capabilities.

Population Reference Bureau
www.prb.org
The Population Reference Bureau is the leader in providing timely and objective information on US and international population trends and their implications. An excellent site with current reports and statistics. Easily navigable and clearly designed. Take a look at PBA's World Population Data Sheets. The "Data Finder" contains data on 85 demographic variables for 221 countries, 28 world regions and sub-regions.

LINKS TO SPECIFIC ARTICLES AND REPORTS:

Family Health International - Russian Federation Programme Overview
Source: www.fhi.org
In 1996, FHI translated into Russian its entire contraceptive technology training module on injectable contraceptives with funding from the Pharmacia & Upjohn company. The link leads to a synopsis of FHI's Russian Federation programme. Although brief, there are current statistics for the Russian Federation.

The Emergency Contraception for Diverse Communities Project
Source: www.path.org
An excellent resource on emergency contraception for clinical and non-clinical providers presented by the organization PATH. Included is the Emergency Contraception Tools Notebook, which contains information files in PDF format and free downloadable Powerpoint presentations on EC. The material is written for use in the USA but its argumentation and practical information is universal.

Links to three online issues of Choices, published by the International Planned Parenthood Federation European Network:
http://www.ippf.org/regions/europe/choices/index.htm
Choices is an excellent resource for current European sexual health and family planning. The articles below contain current statistics.
- Issue 28 no. 1, 2000 Sexual and reproductive health in Europe today
- Issue 28 no. 2, 2000 Abortion in Europe
- Volume 27 no. 1, 1999 The new role of FPAs in Europe.

The European NGOs for Sexual and Reproductive Health and Rights, Popula-

http://www.euronsos.org
A rather confusing and dumby designed site but many useful links to member organizations and their links page is also very good.
A Global View of HIV Infections

This poster, produced by UNAIDS and WHO, contains three maps. Each conveys an important message on the different HIV epidemics around the world. Together, they present an illuminating picture of the magnitude, impact, and recent trends of HIV spread in regions, countries, and societies.

To obtain a copy and other resources on HIV/AIDS, please contact:
UNAIDS
20, avenue Appia
CH-1211 Geneva 27
Switzerland
Tel: (+4122) 791 3666
www.unaids.org

Improving Access to Quality Care in Family Planning - Medical Eligibility Criteria for Contraceptive Use

This document is one important step in the process for improving access to quality of care in family planning by reviewing the medical eligibility criteria for selecting methods of contraception. It provides recommendations for appropriate medical eligibility criteria based on the latest clinical and epidemiological data and is intended to be used by policymakers, family planning programme managers, and the scientific community. It aims to provide guidance to national family planning reproductive health programmes in the preparation of guidelines for service delivery of contraceptives. It is a collaborative document between WHO's department of Reproductive Health and Research and a large number of international agencies and organizations.

For further information or to obtain a copy, contact:
Dr QM Islam (rhrpublications@who.int)
WHO Department of Reproductive Health and Research
Tel: (+41) 22 791 4447

Meeting the Challenge: Securing Contraceptive Supplies

Meeting the Challenge is a resource pack- et which identifies the causes of problems in global availability of reproductive health supplies in order to stimulate effective action and meaningful collaboration among donors, national governments, and other stakeholders. The pack contains nine studies on topics such as donor funding, future need projections, country case studies, financing options and awareness of and attitudes towards contraceptive shortfalls. It is a collaborative effort of: John Snow Inc., Population Action International, PATH and the Wallace Global Fund. See www.nostockouts.org for more information or to receive the material.
UNFPA 2000

A Practical Approach to Gender-Based Violence: A Programme Guide for Health Care Providers and Managers

This guide contains step-by-step guidance on how reproductive health facilities can start their own Gender-Based Violence projects. We know that a sizeable proportion of women experience domestic violence. Yet, few health providers have been trained to address these difficult issues and give a sensitive and helpful response. The guide is also meant to help a wider range of readers to understand the connections between sexual and reproductive health and violence. While the programme guide is targeting primarily health service providers, it can also be used as a reference guide for advocacy purposes. The approach will be tested in Romania and Lithuania in our region.

The guide is available at www.unfpa.org.

UNFPA ASSISTANCE BY GEOGRAPHICAL REGION

Learning to Live: Monitoring and evaluating HIV/AIDS programmes for young people

This 210-page handbook is a practical guide to developing, monitoring and evaluating practice in HIV/AIDS-related programmes for young people. It focuses on recent learning from work with young people in peer education, school-based education, clinic-based service delivery, etc. Examples of good practice are included throughout. For development workers in HIV/AIDS programmes, this is an invaluable aid.

Available from:
Save the Children Publications
17 Grove Lane
London SE5 8RD
UK
www.savethechildren.org.uk

Sexual Relations among Young People in Developing Countries: Evidence from WHO Case Studies

By Anjum Aziz Khan, Shireen H. Jafargholi, Aihua Shih, Katharine M. Yount

Although this occasional paper reports on young people from outside of the Eastern Mediterranean region, the findings reflect the situation in our region. For example, sexual activity begins during adolescence among many young people and is often characterized by risky behavior including erratic contraceptive use.

The paper reviews the implications of the findings for policies and programmes and highlights research gaps.

Available from:
WHO Department of Reproductive Health and Research
CH-1211 Geneva 27
Switzerland
E-mail: rhrpublications@who.int

TRAINING

Advanced Course on Sexual and Reproductive Health
(Utrecht, Netherlands, 18-30 March 2002)

organized by the Netherlands School of Public Health, Rutgers-NISSO Group (Voyage Incentives), World Population Foundation and the Dutch Foundation for STD Control

Target groups: STD project managers and project staff (two optional modules).
Course focus on young people's needs.
Fee: 2,995,- (± USD 2,660) includes lodging and all other costs, except round trip to the Netherlands and incidentals.

For further information and an application form visit:
w www.mph.nl/eng/education/index.htm

Contact: SRH Course Secretariat at WPF:
Mrs. Martha Roes
Amperestraat 10
1221 GJ Hilversum
The Netherlands
Tel: (+31) 35 6422304
Fax: (+31) 35 6423713
E-mail: projects@wpf.org

The UNFPA 2000 annual report reports that the development of a new global strategy for reproductive health commodity security was prioritized during the year. Adequate supplies are needed to meet the international goal of universal access to reproductive health care by 2015 and to prevent unwanted pregnancies and the spread of HIV. Moreover, the year saw the strengthening of emergency reproductive health services as millions fled from armed conflict and natural disasters. This 30-page report also presents UNFPA assistance by region, function and amount.

To obtain a copy contact:
UNFPA
Information, Executive Board and Resource Mobilization Division
220 East 42nd Street
New York, NY 10017, USA
www.unfpa.org
ISBN 089714-600 x

TOP 20 GOVERNMENT DONORS TO UNFPA IN 2000 (IN US $)

Government Contribution Contribution to General to Supplementary to General Resources Resources Resources
Netherlands 50,583,784 52,544,641
Japan 48,285,000 1,000,000
United Kingdom 22,290,673 4,589,496
Norway 22,994,053 3,473,847
Denmark 23,884,919 1,536,994
United States 21,500,000 1,179,000
EntreNous

The European Magazine for Sexual and Reproductive Health

WHO Regional Office for Europe
Family and Community Health unit
Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark
Tel: (+45) 3917 1451 or 1341
Fax: (+45) 3917 1850
E-mail: entre nous@who.dk