Ensuring Sexual and Reproductive Health

Conventions and legislation are only the first step.
Entre Nous
The European Magazine for Sexual and Reproductive Health

Entre Nous is published by:
The Reproductive Health/Pregnancy and Gender Mainstreaming programme
WHO Regional Office for Europe
Scherfigvej 8
DK-2100 Copenhagen Ø
Denmark
Tel: (+45) 3917 1341
Fax: (+45) 3917 1850
E-mail: entre Nous@who.dk

Chief editor
Dr Assia Brandrup-Lukanow
Editor
Jeffrey V Lazarus
Editorial assistant
Dominique Gundelach
Layout
KGB Kommunikation, Aarhus
Print
Central tryk Hobro a/s

Entre Nous is funded by the United Nations Population Fund (UNFPA), New York, with the assistance of the World Health Organization Regional Office for Europe, Copenhagen, Denmark.
It is published three times a year. Present distribution figures stand at: 3,500 English, 2,000 Spanish, 2,000 Portuguese, 1,000 Bulgarian, 1,000 Russian and 500 Hungarian.

Entre Nous is produced in:
Bulgarian by the Ministry of Health in Bulgaria as a part of a UNFPA-funded project;
Hungarian by the Department of Obstetrics and Gynaecology, University Medical School of Debrecen, PO Box 37, Debrecen, Hungary;
Portuguese by the General Directorate for Health, Alameda Afonso Henrique 45, P-1056 Lisbon, Portugal;
Russian by the WHO Information Centre for Health in the Central Asian Republics;
Spanish by the Instituto de la Mujer, Ministerio de Trabajo y Asuntos Sociales, Almagro 36, ES-28010 Madrid, Spain.
The Portuguese and Spanish issues are distributed directly through UNFPA representatives and WHO regiona offices to Portuguese and Spanish speaking countries in Africa and South America.

Material from Entre Nous may be freely translated into any national language and reprinted in journals, magazines and newspapers or placed on the Web provided due acknowledgement is made to Entre Nous, UNFPA and the WHO Regional Office for Europe.

Articles appearing in Entre Nous do not necessarily reflect the views of UNFPA or WHO. Please address enquiries to the authors of the signed articles.

For information on WHO-supported activities and WHO documents, please contact the Family and Community Health Unit at the address given above.
Please order WHO publications directly from the WHO sales agent in each country or from Marketing and Dissemination, WHO, CH-1211, Geneva 27, Switzerland

ISSN: 1014-8485

THE ENTRE NOUS EDITORIAL BOARD

Evert Ketting
Netherlands School of Public Health
Utrecht, The Netherlands

Ms Lyn Thomas
Regional Director
International Planned Parenthood Federation (IPPF)
European Network

Dr Malika Ladjall
Senior Programme Specialist
UNESCO/Headquarters

Robert Thompson
Adolescent Health and Development
WHO - Regional Office for the Eastern Mediterranean

Ms Nell Rasmussen, LL M
Senior adviser
The Danish Centre for Human Rights

CONTENTS

Editorial by guest editorialist Adrienne Germain
Implementing the WHO Regional Strategy on Sexual and Reproductive Health by Dr Assia Brandrup-Lukanow
Legal Advocacy of Women's Sexual and Reproductive Health and Rights by Neil Rasmussen
Women's Link Worldwide: Linking Laws Protecting Women around the World by Lise Munn & Julie Flay
The Convention on the Rights of the Child and Rights to Sexual and Reproductive Health by Eric Rogue
The Strategic Action Plan for the Health of Women in Europe by Isabel Yordi
What is gender mainstreaming? by Isabel Yordi
Women: The Next Wave in the HIV Epidemic by Kasia Malinowska-Sempuch
Eliminating sexual orientation discrimination in Romania by Adrian Coman
A National Strategy for Sexual Health and HIV for England by Professor Michael Adler
I Care ... Do you? World Aids Day 2001 by Jeffrey V. Lazarus
Resources
Internet resources by Josh Gross

Page 7
Page 10
Page 12
Page 14
Page 14

women's worldwide
EDITORIAL

Entre Nous is proud to have Adrienne Germain, the president of the International Women’s Health Coalition, as our guest editor for this issue.

Dr Assia Brandrup-Lukanow and Jeffrey V. Lazarus

Understanding the current situation of sexual and reproductive health in the European Region, especially national and international legislation on the issue, starts with a review of the action agreement produced by the world’s governments at the International Conference on Population and Development held in Cairo in 1994. The Cairo Programme of Action was agreed by 179 governments, with unprecedented participation by NGOs, women’s groups and others.

The Programme of Action, based on human rights and fundamental respect for social justice and equality, calls for universal access to sexual and reproductive health services by 2015.

Reproductive health, as it was defined in Cairo, is a much broader concept than we had in the past. Contraception used to be the primary, often sole, emphasis, and control of population growth was the main goal. The Cairo process recognised that we need a comprehensive approach to a wide range of sexual and reproductive health issues that people – especially women and girls – face. The agreement reflects sweeping social changes across a vast diversity of countries, including the emergence of women’s rights and health movements, the large proportions of populations that are young, unmarried and sexually active, and the terrible risks of HIV and other sexually transmitted infections (STIs).

The new, broader definition of reproductive health care includes all of those services and information that people need in order to manage their sexuality and sexual behaviour in a healthy way, such as education and counselling, access to a wide range of contraceptive choices, safe, legal abortion and protection against STIs. It includes work with young people on self-esteem and relationships, and care for women during pregnancy and after delivery. It also includes a concern, increasingly, about the cancers related to reproduction, especially in women: breast cancer and cancer of the cervix. The European Region is large and very diverse. There are vast inequalities between countries and within them. This means that strategies to implement the Programme of Action need to vary.

The articles in this issue of Entre Nous are a clear example of how divergent the legislative situation is between eastern and western Europe, for example. In Romania, Adrian Coman writes on page fourteen that his organization has focused on lobbying to repeal legislation discriminating against citizens based on sexual orientation. They met with a degree of success in June 2001, in large part thanks to international pressure. In Denmark, on the other hand, efforts are commonly focused on legislative problems abroad, as exemplified by the Danish Centre for Human Rights’ support of Women’s Link Worldwide, which will soon be launching an extensive website on women’s rights including legal analyses of reproductive health and rights, violence against women and gender discrimination. And in England, as Michael Adler reports on page fifteen, the first ever national strategy for sexual health and HIV for England was published at the end of July 2001. The strategy attempts to modernise the British approach to sexual health and to deal with a major public health problem in a comprehensive and holistic manner.

Internationally, progress is being made on implementing conventions like the Convention on the Rights of the Child, adopted by the UN General Assembly on 20 November 1989. Its Committee on the Rights of the Child examines the progress made by States Parties in achieving the realization of their obligations, and in the European Region it has expressed its concern about teenage pregnancies, recourse to abortion as a method of family planning when contraception is not easily available, the spread of STIs, particularly syphilis and HIV/AIDS, and discriminatory attitudes towards children with HIV/AIDS, as can be read on page nine. It is clear that it is not enough to just pass conventions and laws, implementation and accountability must be ensured.

Nearly 600 000 women still die every year worldwide because they did not have help during their pregnancies. We know how to help them. We have the technology and we know how to train people. It is a matter of political will and allocating the budgets to ensure that all women have ready access to essential and emergency obstetric care. The global “Making Pregnancy Safer” initiative described in the last issue of Entre Nous, which will be formally launched by WHO in the European Region in Moldova, in February, is a step in the right direction.

But this and other efforts will only be successful if legislation simultaneously provides for comprehensive, quality reproductive health services as defined in Cairo. Further, laws must help create an “enabling environment” for reproductive freedom. They must facilitate girls’ and women’s access to education, employment and other opportunities, and men must understand – and laws must reinforce – that they also have the responsibility to respect, protect and ensure women’s rights and health.

Adrienne Germain is President of the International Women’s Health Coalition in New York.

IWHC promotes health and population policies, programmes and funding for women’s health and rights in Africa, Asia, Latin America and eastern Europe. IWHC is funded by private foundations and European governments. For more information, go to www.iwhc.org.
Implementing the WHO Regional Strategy on Sexual and Reproductive Health

National and international responsibilities

1. Country level

National governments and other national organizations/institutes, including NGOs, will be primarily responsible for the implementation of the strategy. Because improving sexual and reproductive health (SRH) requires the active involvement of different sectors, national networks and mechanisms for appropriate co-ordination are to be established. National governments are encouraged to adapt the strategy and develop operational programmes, in line with national needs and priorities. WHO country offices will support national programmes.

2. Internationally operating specialised NGOs, including IPPF/European Network;

3. Networks of professional organizations, including schools of public health, universities, research institutes;

4. Associations of professionals working in the field of SRH, including the European Association of Gynaecology and Obstetrics and the European Midwives Association;

5. Youth and women's organizations.

Resources for improving SRH

1. Resource needs

The Cairo Programme of Action estimated that in developing countries and countries with economies in transition the implementation of proposed programmes in reproductive health would cost $17 billion in 2000, $18.5 billion in 2005, $20.5 billion in 2010 and $21.7 billion in 2015. Although the cost estimates have not fallen, the contribution has fallen short of demand. Countries in the Region will have to review their needs as part of the new strategies. As stated in the Programme of Action, it is estimated that up to two-thirds of the costs will have to be met by the countries themselves.

Guidance on the assessment of needs and setting priorities may be obtained from WHO.

2. Sources

Governments, as the primary providers of resources, will consider what measures are required to meet the SRH needs, applying the usual options of taxes, insurance and prepayment, user fees, and community support (mainly in kind). The allocation or reallocation of resources may be more important than the mobilisation of new funds.

The private sector has become an important contributor to resources. Private facilities rely on direct payment and should be accepted as part of the resource base for RH care. Similarly NGOs, such as family planning associations, provide services that would not otherwise have been available. In this connection, the different components of the RH programme will have a different resource base with the public sector taking the lead in those aspects, such as public health and data collection, which cannot easily be delegated to private practice or NGOs.

The international ("donor") community have shown their desire to assist countries in their chosen programmes and they remain a critical resource for the implementation of programmes.

The United Nations agencies should be prevailed on to collaborate: UNFPA, UNICEF, UNAIDS and the World Bank have a particular interest in the field. But bilateral agencies and philanthropic foundations have an increasingly important role to play. In the European Region, the European Commission is an important resource.

The World Health Organization has defined its role clearly. It will provide technical support in designing and applying programmes; it will help to develop projects that can be funded by donors; and it will, in some cases, provide financial support, especially when the activities concerned, or lessons there from, have the potential to be extrapolated to other situations. Above all, WHO is a suitable forum for intercountry development of ideas and scientifically sound programmes.

3. Process

The assessment of needs is the first step in the resource mobilisation process. WHO can offer guidelines for this exercise. Training in the costing of programmes can also be provided to a limited extent. Proposals for resource mobilization can receive technical support in their preparation, and if these are sound there are prospects for support internally and externally.

Monitoring and evaluation

Progress in the implementation of strategies and the attainment of objectives needs to be checked on a regular basis. This requires indicators of the status at a given time and each country will have to determine which measurements are appropriate. WHO has proposed a list of 17 indicators for global monitoring (see below) and this may be used as a starting point for selection of national indicators.

Evaluation is the periodic in-depth systematic analysis of experience. It provides opportunities to review the imple-
vention of programmes, identify problems and suggest future directions. The aim is to recall the objectives and to determine the extent to which the objectives are being achieved through the programme activities. This facilitates any measures being taken to increase the chances of attaining the desired outcomes. Several methodologies are available for evaluation and selection will depend on relevance and feasibility.

The Rapid Evaluation Method (REM) has been advocated since 1993 by WHO as a “participatory and motivational” approach in which health service providers from different levels work together on a rapid and comprehensive assessment of the situation. It was applied to maternal and child health and family planning programmes in several countries.

In a survey, information is gathered on selected parameters in a cross-section of a population over a defined period. Several exercises have been carried out on reproductive health in Eastern Europe, for example in Armenia and Georgia. Birth surveys were pioneered in England as early as 1948 and have been repeated in other countries.

Whatever method is chosen for evaluation, the survey is a critical component of any national strategy on reproductive health and should be included in the design of programmes from the beginning, including suggestions for measurable indicators.

Reproductive health indicators for global monitoring

1. Total fertility rate
Total number of children an average woman would have by the end of her reproductive life if she experienced the currently prevailing age-specific fertility rates throughout her childbearing life.

2. Contraceptive prevalence rate
Percentage of women of reproductive age (all women aged 15-49 who are at risk of pregnancy, i.e., sexually active women who are not infertile, pregnant or menorrhagic) who are using (or whose partner is using) a contraceptive method (include female and male sterilization, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and condoms, natural family planning and lactational amenorrhea, where cited as a method) at a particular point in time.

3. Maternal mortality ratio
Ratio of the number of women dying from pregnancy related causes to the number of live births, expressed as annual number of maternal deaths per 100,000 live births.

4. Antenatal care coverage
Percentage of women attended, at least once during pregnancy, by a skilled birth attendant (Doctors, specialist or non-specialist, and/or persons with officially recognized midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications) - excluding trained or untrained traditional birth attendants - for reasons related to pregnancy.

5. Births attended by skilled health personnel
Percentage of births attended by skilled birth attendant (excluding trained or untrained traditional birth attendants) for reasons related to pregnancy.

6. Availability of basic essential obstetric care
Number of facilities with functioning essential obstetric care (basic essential obstetric care should include availability of essential medicines, for example parenteral antibiotics, intramuscular oxytocin and magnesium sulphate for eclampsia and equipment for the manual removal of placenta and retained products) per 500,000 population.

7. Availability of comprehensive essential obstetric care
Number of facilities with functioning comprehensive essential obstetric care (comprehensive essential obstetric care should include basic EOC plus availability/equipment for Caesarean section, anaesthesia and blood transfusion) per 500,000 population.

8. Perinatal mortality rate
Number of perinatal deaths (deaths occurring during late pregnancy (at 22 completed weeks gestation and over), during childbirth and up to seven completed days of life) per 1000 total births.

9. Low birth weight prevalence
Percentage of live births that weigh less than 2500 g.

10. Positive syphilis serology prevalence in pregnant women
Percentage of pregnant women (15-24 years of age) attending antenatal clinics whose blood has been screened for syphilis, with positive serology for syphilis.

11. Prevalence of anaemia in women
Percentage of women of reproductive age (15-49) screened for haemoglobin levels with levels below 110 g/l for pregnant women and below 120 g/l for non-pregnant women.

12. Percentage of obstetric and gynaecological admissions owing to abortion
Percentage of all cases admitted to service delivery points, providing in-patient obstetric and gynaecological services which are due to abortion (spontaneous and pre admission induced, but excluding planned termination of pregnancy).

13. Reported prevalence of women with female genital mutilation
Percentage of women interviewed in a community survey reporting themselves to have undergone FGM.

14. Prevalence of infertility in women
Percentage of women of reproductive age (15-49) at risk of pregnancy (not pregnant, sexually active, non-contracepting and non-lactating) who report trying for a pregnancy for two years or more.

15. Reported incidence of urethritis in men
Percentage of men (15-49) interviewed in a community survey reporting episodes of urethritis in the last 12 months.

16. HIV prevalence among pregnant women
Percentage of blood samples taken from women aged 15-24 and tested for HIV during routine sentinel surveillance at selected antenatal clinics which test positive for HIV.

17. Knowledge of HIV related prevention practices
The percentage of all respondents who correctly identify all three major ways of preventing the sexual transmission of HIV (abstinence, barrier contraceptive methods and avoidance of drug abuse by injection) and who reject three major misconceptions about HIV transmission or prevention.

For more information about the WHO Regional Strategy on Sexual and Reproductive Health, please contact:
Dr Assia Brandrup-Lukanow [abr@who.dk], Regional Adviser Reproductive Health/Pregnancy, Family and Community Health unit WHO Regional Office for Europe.
Many sexual and reproductive rights of women are protected to some extent through national constitutions and legislation as well as international human rights conventions. The fundamental rights include the right to life, personal liberty and security, the right to information and education and the right to equality and freedom from discrimination. Sexual and reproductive rights are much more than merely a health issue concerning contraception. From a legal point of view, they are a matter closely related to personal rights such as the right to bodily integrity, security and autonomy.

Despite the legal obligations that states have taken upon themselves, progress is slow in the realisation of these rights. The amount of law regarding human rights is growing, but the realisation of women’s fundamental rights is lacking and in many countries in the European Region violations still occur.

In order to change this situation, the Danish Centre for Human Rights is part of a new project aiding European reproductive health and human rights organisations to cooperate to advocate to lawyers litigation as a tool for promoting women’s rights in the areas of sexual and reproductive rights, violence against women and gender discrimination. Through the creation of an advocacy tool, the project seeks to promote a wider use of regional and international human rights instruments as part of lawyers’ argumentation. The aim of the project is to promote a rights-based approach to questions of sexual and reproductive autonomy.

The Women’s Link Worldwide project is a joint collaborative effort between the Federación de Planificación Familiar de España (the Spanish Family Planning Association), the Danish Centre for Human Rights and the Irish Family Planning Association and is supported financially by the European Union (EU) through the DAPHNE programme. DAPHNE is an EU action programme set up in 1997 to support programmes on violence against women. Since then, the programme has been expanded to include sexual violence and abuse as well as violence in schools and violence against minority groups and migrants. The trafficking of women for prostitution, an increased concern to European states, is also covered. Furthermore, one interesting modification of the programme is that NGOs can now apply for funding to a greater extent than in the past.

The project’s team of lawyers have conducted research in their respective countries concerning central national and international cases of law regarding, for example, patient’s rights including forced sterilisation and other medical interventions without the patient’s informed consent. The results of the research will be submitted to a database including summaries of and annotations to the cases. The project seeks to provide new and useful argumentation in the promotion of women’s sexual and reproductive rights. The idea is to assist lawyers in a straightforward manner with updated information, thus facilitating the process of taking cases to court. Each researcher will contact national forums and relevant individuals to ensure the usefulness and quality of the database.

There is no doubt that the areas of legal interest of different countries will vary a great deal due to the fundamental differences of the legal systems, for example the question of the right to abortion is of particular interest in Ireland but not an issue in Denmark. Despite these differences, lawyers may find assistance when taking a case to court in the arguments or reasoning of a case from another country. Cases concerning European conventions and interpretation as well as cases brought before international tribunals may be of particular interest in this context. Apart from being a helpful tool to lawyers, the project will also assist victims in the preparation of a case by providing information on filler alia access to compensation or damages.

The treatment of patients by health personnel is largely governed by legislation and it is important that people working in the health sector are aware of the legal aspects of their work. Furthermore, the understanding of the fundamental rights of the individual is a central matter in the practical promotion and implementation of women’s reproductive rights. Although health personnel may not have an equal opportunity to use the information contained in the database, the cases may provide basic knowledge on the situations in which violations of fundamental rights take place - thus raising the awareness of the personnel and providing a more holistic perspective to the treatment of people and especially women. Both the recognition of that awareness and knowledge are core elements in the protection of women’s sexual and reproductive rights.

The Danish project also includes the preparation of a compilation on European human rights law relating to sexual and reproductive health and rights, which will be published and distributed by the Polish Federation for Women and Family Planning in the spring of 2002. It will also appear on the website (www.humanrights.dk) of the Centre in spring 2002 and will be widely announced. The compilation should be a powerful advocacy tool to promote the European Human Rights Convention and Social Charter and to hold governments accountable to their responsibilities.

Further information can be obtained by contacting Nell Rasmussen, Senior adviser, The Danish Centre for Human Rights [nr@humanrights.dk].
WOMEN’S LINK WORLDWIDE: LINKING LAWS PROTECTING WOMEN AROUND THE WORLD
by Lori Mann | lolo123@together.net | co-director, Women’s Link, Tel.: (+34) 91 591 3449
& Julie Kay | msjulie.kay@yahoo.com | Irish Family Planning Association, Tel.: (+353) 1 474 0947

While international conferences such as the Fourth World Conference on Women in Beijing and the International Conference on Population and Development have focused attention on women’s rights around the world, local advocates remain faced with the complex task of developing a legal foundation and culture of rights for women. Litigation at national and international levels remains a key component to advancing women’s rights. Yet advocates in many countries have not yet fully explored the judicial system to assert rights conveyed by national and international law.

Toward that end, Women’s Link Worldwide, a new, collaborative project among women’s rights NGOs in Europe and Latin America, provides a central clearinghouse of legal information on a range of gender-related topics. Via its website, which will be launched in February 2002, Women’s Link provides easy access to legal precedent and creative argumentation in order to inform advocates in developing effective legal strategies to advance and promote women’s rights. The website (www.womenslinkworldwide.org) will provide direct access to case law from national, regional and international tribunals as well as legal analysis on reproductive health and rights, violence against women and gender discrimination. It will also contain links to relevant legislation, international treaties and covenants, and supply background information on additional topics such as sexual violence, trafficking and gender-based asylum by both country and region. Workshops with local advocates will provide a forum for further, in-depth discussions on the practicalities and potential impact of international law and litigation.

Workshops with local advocates will provide a forum for further, in-depth discussions on the practicalities and potential impact of international law and litigation.

Women’s Link is a collaborative effort among partner organizations in Europe and Latin America, including the Federación de Planificación Familiar de España, the Danish Centre for Human Rights, the Irish Family Planning Association and the Comité de América Latina y el Caribe para la Defensa de los Derechos de la Mujer (CLADEM). Its funders include the Daphne Initiative of the European Commission and the Ford and Hewlett Foundations. Designed to advance the use of international law and tribunals to promote women’s human rights around the world, Women’s Link hopes its database and search engine will be used not only by advocates in the countries currently participating, but will serve as a model and resource for advocates in other countries and regions.

In conjunction with the launch of the website, Women’s Link will be releasing a complementary publication to provide additional information to advocates. This publication will include interviews with lawyers and legal advocates who have brought litigation to advance women’s rights in the partner countries, as well as practical advice about strategizing and executing legal strategies to promote women’s rights. Through interviews with lawyers who have successfully brought landmark women’s rights litigation, such as UN Commissioner for Human Rights Mary Robinson, the publication will explore the role of international law and tribunals in advancing women’s rights domestically as well as the practical realities of international litigation.

Those interested in obtaining a copy of the publication or more information on Women’s Link Worldwide should contact Viviana Waismann (vwaismann@fpe.org) at (+34) 91 591 3449.
THE CONVENTION ON THE RIGHTS OF THE CHILD AND RIGHTS TO SEXUAL AND REPRODUCTIVE HEALTH

By Eric Roque

What is the Convention on the Rights of the Child?
The United Nations General Assembly adopted the Convention on the Rights of the Child in 1989, which is one of the most fundamental human rights treaties. Globally, all states ratified or acceded to the Convention on the Rights of the Child, with two exceptions, Somalia and the USA. The roots of the Convention are found in the Universal Declaration of Human Rights which proclaimed that childhood is entitled to special care and assistance. In addition, the Declaration of the Rights of the Child (1959) indicated that: “the child, by reason of his physical and mental immaturity, needs special safeguards and care”.

How is the Convention on the Rights of the Child monitored?
The Convention established the Committee on the Rights of the Child for the purpose of examining the progress made by states in achieving the realization of their obligations. Ten experts are members of the Committee; they are elected by secret ballot by the states, for a term of four years renewable once. Although each state has the obligation to submit a public periodic report on its realization of the Convention, most of states do not report in due time. A pre-session working group between the Committee, some United Nations agencies and NGOs, provides the opportunity to inform the Committee about the implementation of the Convention, and to respond to the questions of the Committee. The representatives of the state thereafter receive a list of issues, which they address. This is followed by a public session between the Committee and the state, in which some representatives of the government are questioned. The summary records are subsequently made public. Finally, the Committee adopts concluding observations addressed to the state, which include recommendations. In this way the Committee interprets and de facto develops the Convention in its review of each report.

The reporting process opens a dialogue with states to agree on common priorities for action, and helps channel support and advocacy to national programmes. The regular reporting process cycle also provides valuable opportunities for monitoring the progress achieved by states in assuring the rights to health and health care of children and adolescents.

The relation to sexual and reproductive health
The Convention aims to improve the health and development of the child. Most of articles relate to health directly or indirectly, for example many articles provide for the right to health (article 24), the right to privacy, the right to access to information and minority or indigenous rights. The Convention does not have many provisions on sexual and reproductive health but treats these issues throughout its examination of state reports. Based on the Convention and recommendations of the Committee on the Rights of the Child, the following lines summarize the rights of the child to sexual and reproductive health.

The Convention recognizes the competences of states in determining the lawful sexual activities and practices of the child (article 34). The Committee has, however, suggested raising the age limit for sexual consent in some countries, expressing its concern with teenage marriages and respect for the principle of non-discrimination (article 2), in particular on the grounds of sex and sexual orientation.

The Committee has expressed its concern with and made recommendations on the issues of teenage pregnancies, the recourse to abortion as a method of family planning, the spread of STIs, particularly syphilis and HIV/AIDS, and discriminatory attitudes toward children with HIV/AIDS in some states. It has also recommended allocating adequate human and financial resources to evaluate the effectiveness of training programmes in reproductive health education, and developing youth-friendly counselling and care and rehabilitation facilities that are accessible to adolescents without parental consent.

States shall take appropriate measures to develop family planning education and services (article 24-2-f). The Committee recommended improving the primary health care system regarding the effectiveness of sex education and family planning. The recommendations of the Committee have developed more specific issues, such as spreading knowledge about modern methods of family planning including the use of condoms, strengthening the promotion of male acceptance of the use of contraceptives and information campaigns on family planning, and developing a programme for the systematic sexual education of adolescents at school.

States shall take measures to ensure appropriate prenatal and postnatal health care for mothers (article 24-2-d). The Committee has expressed its concern at the high maternal mortality rates in some states, and the situation of maternal and reproductive health.

States shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of the child (article 24-2-f). The Committee recommended protecting girls from honour killings, when they are suspected of being unchaste, by reviewing legislation, developing awareness raising and education campaigns, and providing special training and resources to law enforcement personnel. If the Committee welcomed the efforts made within the jurisdiction of a state in protecting girls from female genital mutilation (FGM) carried out outside its territory, it urged the undertaking of strong and effectively targeted information campaigns to combat FGM, and the adoption of legislation with extraterritorial reach to protect children within the jurisdiction of the state from FGM.

WHO cooperates with the Committee on the Rights of the Child and provides expert advice on the implementation of the Convention in health areas, in accordance with article 45 of the Convention. This cooperation has led the Committee to suggest to some States that they seek assistance from WHO in order to implement recommendations on sexual and reproductive health.

For more information please contact: Dr Viviana Mangiatera [vma@who.dk], Regional Adviser, or Dr Mikael Østergren [mmo@who.dk], Medical Officer, Child and Adolescent Health and Development Programme, WHO Regional Office for Europe.
Convention on the Rights of the Child

Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49
For the full text, see: http://www.unhchr.ch/html/menu3/b/k2rc.htm

Article 24
1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.
2. States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:
   (a) To diminish infant and child mortality;
   (b) To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;
   (c) To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;
   (d) To ensure appropriate pre-natal and post-natal health care for mothers;
   (e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents;
   (f) To develop preventive health care, guidance for parents and family planning education and services.
3. States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.
4. States Parties undertake to promote and encourage international co-operation with a view to achieving progressively the full realization of the rights recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.

Article 34
States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:
   (a) The inducement or coercion of a child to engage in any unlawful sexual activity;
   (b) The exploitative use of children in prostitution or other unlawful sexual practices;
   (c) The exploitative use of children in pornographic performances and materials.

Examples of recommendations of the Committee on the Rights of the Child addressed to some European countries with regard to sexual and reproductive health

Teenage pregnancies:
- Reduce the number of teenage pregnancies;
- Promote adolescent health policies and reproductive health education and counselling services.

Abortion:
- Reduce the practise of abortion;
- Strengthen measures to ensure that abortion is not perceived as a method of contraception.

Contraceptives:
- Promote male acceptance of the use of condoms;
- Strengthen sex education including birth control, such as the use of condoms.

STIs and HIV/AIDS:
- Prevent discrimination against children infected by HIV/AIDS;
- Provide counselling to HIV/AIDS infected mothers about the risk of transmission of HIV/AIDS through breastfeeding;
- Ensure access for adolescents to sex education, including information about contraception and STIs;
- Use of the media in relation to awareness raising and education.

- Provide statistical data and other indicators for vulnerable groups (disaggregated data), and multidisciplinary studies on the special situation of children infected by HIV/AIDS.

Teenage marriage:
- Increase protection against the harmful effects of early marriage;
- Amend legislation to ensure that boys are treated as equally as girls.

Honour killing:
- Review legislation;
- Develop awareness raising and education campaigns to combat discriminatory attitudes and harmful traditions affecting girls;
- Develop special training and resources to law enforcement personnel.

Female genital mutilation:
- Undertake strong and effectively targeted information campaigns to combat this phenomenon;
- Adopt legislation with extraterritorial reach to protect children within the state's jurisdiction from female genital mutilation out outside its territory.

Age of sexual consent:
- No gender discrimination with regard to ages of sexual consent and sexual relations;
- No discrimination based on sexual orientation in regard with the age of sexual consent;
- Enact legislation concerning the minimum legal ages for sexual consent.

Family planning services:
- Establish comprehensive family planning programmes;
- Develop youth-sensitive counselling, care and rehabilitation facilities that are accessible, without parental consent;
- Allocate adequate human and financial resources, to increase the number of social workers and psychologists, to evaluate the effectiveness of training programmes in reproductive health.

Reproductive health education:
- Improve the primary health care system regarding the effectiveness of sex education and family planning;
- Strengthen reproductive health education;
- Ensure a programme for the systematic sexual education of adolescents at schools;
- Evaluate the effectiveness of training programmes in reproductive health education.
One year ago, on 5-7 February 2001, the Strategic Action Plan for the Health of Women in Europe (Action Plan) was endorsed by the 34 countries participating in the Third Meeting of Focal Points for Reproductive Health, Women's Health and Gender Mainstreaming in the European Region in Copenhagen. The Action Plan aims to assist Member States in their efforts to achieve greater gender equity in health, health care and the implementation of HEALTH21, ensuring that women's health issues are explicit in any strategies to address inequities in health across Europe.

The Action Plan, now available, has been prepared within the context of HEALTH21. Operationalising HEALTH21 for the health of women is an annex to the Action Plan and it takes as its rationale the need to make the health of women more visible and a priority for action. It contains specific recommendations to Member States, the WHO Regional Office for Europe (WHO/Euro), NGOs and international governmental organizations to strengthen the focus on women's health and to ensure gender equity in all aspects of health.

Prerequisites for improving women's health
In order to promote the health of women, the Action Plan incorporates and builds on policies and legislation aimed at ensuring gender equality in society. Several prerequisites for Member States are to:

- Ensure that human rights legislation and instruments already existing and signed by WHO Member States are implemented;
- Actively promote equity in women's status across the European Region and within the European countries through empowerment, education and women's participation in decision-making processes;
- Address discrimination against women. Implementing the Convention on the Elimination of All Forms of Discrimination against Women and monitoring its implementation;
- Address women's poverty. Introducing and enforcing policies specifically to alleviate poverty among women will have a positive effect on the health of women and of their families;
- Ensure that laws on equal opportunities and equal pay are implemented and that women's employment is promoted and facilitated;
- Introduce bodies/working groups at ministries of health and other public health structures to specifically monitor and address how well the systems are responding to the health needs of poor populations; and
- Ensure that policies for economic regeneration do not undermine social and health services that promote equity and support low-income groups.

Framework for women's health policy
Any action plan on the health of women, which is to be developed at country level, should highlight the following key elements:

- Life course approach
  Throughout the course of their lives, women's health needs vary. Identifying the most important potentials and threats to health at each stage is essential to creating the right prevention and effective interventions;
- Participation by women
  The role of women in all spheres of health should be re-examined. Empowering women and avoiding medicalization are health-promoting strategies that should be integrated into health care organizations;
- Improving health care practice and provision
  All health care services should be sensitive to women's health needs. The partial privatization of health care in the course
of health care reforms has led to an exclusion of certain women's health services from the public health sector. The need for evidence on access and use of services, the role of health services in gender-based violence and the access to health care services of migrant women are some key issues;

- **Research**
  Since the determinants of women’s health have been recognized as stemming both from sex differences and gender differences, undertaking research that appreciates the differences in patterns of health and illness between the sexes is crucial;

- **Involving men**
  Men have a crucial role to play in advancing the cause of women’s health, both providing encouragement for change and having the potential to reduce the risks to which women are exposed.

**Implementation by Member States**

The Action Plan identifies appropriate action to be taken and where responsibility for this action lies. It sets up targets for implementation:

- Starting in 2002, and every two years thereafter, each country in the European Region should prepare and publish a comprehensive report on the progress of plans of action for the health of women and the priority areas for intervention.
- By the year 2003, adequately funded committees for coordinating action for the health of women should be operational for all Member States;
- By the year 2005, adequately funded country-based plans of action for the health of women should be drawn up in all Member States;

**Implementation**

The WHO Regional Office for Europe is distributing the Action Plan to the Member States and its counterparts and will promote and monitor the implementation of the Action Plan. For a copy of the action plan or more information, please contact: Isabel Yordi [lyo@who.dk]

Gender Mainstreaming/ Women’s Health

Division of Technical Support

WHO Regional Office for Europe

---

**WHAT IS GENDERMAINSTREAMING?**

*By Isabel Yordi*

All women and men have the right to live without discrimination in all spheres of life, including access to health care, education, and equal remuneration for equal work. All women and men have the right to the highest attainable standard of health. WHO’s Constitution also states, "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

Fifty years after the Constitution was first formulated, it is evident that factors determining health and the burden of ill-health are not the same for women and men. Women and men play different roles in different social contexts. These roles are valued differently, and those associated with men are usually valued more highly. This affects the degree to which women and men have access to, and control over, the resources and decision-making processes needed to protect their health. This results in inequitable patterns of health risk, use of health services and in health outcomes.

There has been a growing recognition worldwide, and within the United Nations system, that equal opportunities for women and men, and improving women’s status, are necessary for achieving health and sustainable development. This recognition has been articulated in the agreements reached at a number of recent international conferences. The Fourth World Conference on Women, held at Beijing in 1995, specified that in order to achieve the goal of equality between women and men in all spheres of development "it is essential to design, implement and monitor, with the full participation of women, effective, efficient and mutually reinforcing gender-sensitive policies and programmes". This was reinforced in the UN Economic and Social Council (ECOSOC) "agreed conclusions on gender mainstreaming in all activities of the UN System" in July 1997.

All of these agreements have been supported and endorsed by WHO. The new global health policy, "Health for all in the 21st century", adopted by the Fifty-first World Health Assembly, also underscores gender, along with human rights, equity and ethics, as one of the cornerstones for achieving health for all.
The remarkable growth rate of the HIV epidemic in central and eastern Europe and the former Soviet Union (CEE/ISU) among male injecting drug users (IDUs) should alert everyone to the inevitable course of the epidemic. While HIV travels more quickly and efficiently between people who share needles, it is only a matter of time before IDUs transmit the virus to their sexual partners, who are mostly women. Women hold society together. When women themselves get sick and cannot do all the unpaid labour societies rely on, the living standards of households, communities and even national productivity go down. More than ever the region needs its human resources. A generation of children negotiating the difficulties of growing up in newly democratic countries needs its mothers, who are disproportionately vulnerable to HIV biologically and socially.

Women’s biological vulnerability

The crude, biological fact that women are at least four times more vulnerable to HIV infection than men, according to the World Health Organization (WHO), is not widely known. This means that theoretically equal situations, such as intercourse between a woman and a man, are actually not equal. Sperm contains a much higher concentration of HIV than vaginal secretions and the vaginal barrier to infection is less effective if it is not intact. Any ordinary trauma such as childbirth, intercourse or sexually transmitted infections (STIs) can damage the barrier.

While STIs are relatively simple to treat, they are often asymptomatic. Over half of the women with chlamydial cervicitis or bacterial vaginosis, the most common syndromes in lower tract infections, experience no symptoms, according to the United Nations Development Programme (UNDP). It is difficult enough to get a woman to seek gynaecological care but if the STI is asymptomatic she is almost sure not to. And even if she does get treatment, the syndromic management of STIs in women is more difficult than in men.

These are just a few of the biological handicaps women experience because of the way their bodies are structured, no matter where in the world they live and under what circumstances and in what century. Call it biological discrimination when it comes to HIV. We can do things in response to this discrimination – we can try to scrupulously use condoms and stay healthy – but we cannot change our bodies.

Women’s social vulnerability

Gender relations, which oftentimes prove as intractable as biological givens, have biological consequences. When sexual intercourse is forced on a woman her vaginal muscles can tense, she can produce insufficient mucus and her risk of injury and transmission of viral infection are increased.

Violence against women is seldom talked about but is nevertheless very real in CEE/ISU. A study in Ukraine found that 50% of adolescents had experienced unwanted sexual contact; out of all the 1997 divorce cases in Bucharest, Romania, 23% alleged physical abuse by the husband; and an estimated 36,000 acts of domestic violence are perpetrated against women every day in Russia. In spite of these indicators of a widespread problem, the Center for Reproductive Law and Policy came to the conclusion that “the laws and policies of the nations of this region do not recognize domestic violence, nor do they take it seriously as a women’s rights – or even public health – issue.”

Violence comes from women’s lack of power. Fifty years of forced equality under Soviet rule made women equal on paper at the time, particularly in the realms of education and work, but when the enforcements were gone, when the wall came down, the equality was gone. Suddenly, a women’s place was in the home again. After elections in May 1990 in Romania, for example, the number of women in parliament fell suddenly and precipitously from 34.3% to 3.5%. And in Czechoslovakia in June 1990, the percentage fell from 29.5 to 6.

Gender inequality is not just political

The highly personal fact that it is unacceptable for a woman to refuse unwanted and unprotected sex leads to higher infection levels in women. “We can promote condom use from dawn to dusk and back to dawn,” says Stephanie Urdang of UNIFEM, “but unless women
are able to say ‘no!’ and be both heard and respected, these efforts will be limited.”

Women may not say “no,” but when they say “yes” it is considered promiscuous. Since seeking gynaecological care can bring attention to their sexual activity, women may avoid treatment. HIV testing is even more treacherous than treatment. According to the UNDP in Russia, the legal provision that HIV testing should be voluntary and accompanied by counselling is “violated openly and systematically.” Pregnant women, or any woman seeking gynaecological treatment, has reason to fear and avoid it. If she is found to be HIV infected, she often loses her job and income.

**Women at risk in transition**

Broad, impersonal factors can also make women more vulnerable to HIV infection than men. Women have been the biggest losers in the economic and political transition over the last decade in CEE/ISU. Structural adjustment policies have dramatically increased poverty and made previously subsidized health services more costly than most women can afford. A 1997 survey in Poland, for instance, showed that 40% of women had not had a gynaecological exam within the previous year, when under communism exams had been free, frequent, and taken for granted.

Under the transition to a market economy women have been the first to lose jobs and when they are lucky enough to keep their jobs they earn less than men. The Center for Reproductive Law and Policy reports that in Russia in 1996, women earned 69.5% of what men earned, and employment discrimination across the region is rampant. The economic hardship transition has brought to families has only aggravated the region’s historically widespread problem of alcoholism and abuse against women.

The comparatively poor economic status of women leads to their dependency on men and a situation in which they may have to exchange sex for daily survival. Alternatively, if a woman cannot depend on a man for economic stability, she may be forced into other risky behaviours to earn money. Organized criminal rings promise financial opportunity to women and coerce them into the sex trade. Open borders have made both sex workers and their clients more transient, increasing their chances of coming into contact with HIV. The Center for Reproductive Law and Policy estimates that 30,000 Albanian women are trafficked annually.

Women are getting more involved in drug trafficking and dealing. The nexus where women, drugs, and HIV meet is complex. In some cases women are exposed to HIV by taking up injecting drugs as a by-product of entering the drug trafficking or sex work worlds. An Open Society Institute study done in Tajikistan last year discovered that the overwhelming majority (87.3%) of women imprisoned for drug-related crimes said their motivation was to get out of a difficult economic situation.

**Solutions within reach**

The problem of women and HIV is large but it can be broken down into less overwhelming parts. To address the biological disadvantage of women, barriers to the sexual transmission of HIV that women can keep under their control need to be developed and distributed. And a vaginal virucide to protect against HIV transmission should also be available to women.

To address the social factors that encourage the HIV epidemic to spread so virulently, violence against women must be legally recognized, punished and socially condemned. A public education campaign needs to teach the public and health care professionals about the actual risks of HIV so that people with the infection are not discriminated against. HIV infected mothers should be given long-term care and culturally appropriate health care should be easily, if not freely, available to women. Most important and also most challenging to the social status quo, women’s economic independence must be encouraged and supported by laws and common practice.

The UNGASS Declaration of Commitment, adopted by member states of the United Nations on 26 June 2001,

---

**Kasia Malinowska-Sempruch is the director of International Harm Reduction Development, a program of the Open Society Institute.**

400 West 59th Street
New York, NY 10019 USA
(+1) 212 548-0344
[kmalinowska@sorosny.org]
ELIMINATING SEXUAL ORIENTATION DISCRIMINATION IN ROMANIA
by Adrian Coman [adices@fx.ro], ACCEPT [www.accept-romania.ro]

For many people in public and private life, the expression of homophobia is both legitimate and respectable — in a manner that would be utterly unacceptable for any other minority. In an opinion poll carried out in November 2000 in Romania, 86% of the respondents chose homosexuals as a group whom they would not like as their neighbors (Public Opinion Barometer, Open Society Foundation, carried out by CURS, Bucharest, November 2000), ranking third after alcoholics and former detainees. Politicians tend to rather follow than lead the public opinion on this matter, not knowing or ignoring that the state should regulate sexual crimes, and not the (homo)sexual identity of an individual. But Romania's integration into international bodies, first of all into the European Union (EU), is a key factor for social change.

Advocates in Romania rely on international instruments and pressure to achieve equal status with regard to criminal law. This article will briefly present the legal framework of same sex relations and discuss the influence of international pressure on eliminating discrimination based on sexual orientation in Romania.

Two laws are to be taken into account when assessing the legal status of lesbian and gay people in Romania.

Article 200 of the Penal Code — an anti-gay provision which denied lesbians and gays their rights to private life, free association and free expression. While in Romania article 200 was regarded as a natural expression of the Orthodox rejection of unnatural practices, the Council of Europe was the first to point out in 1993 that this law needs to be repealed. The Parliament, Commission and the Council of the European Union included the repeal of the antigay law in their reports on Romania and scheduled the issue on their agenda with the Romanian authorities. As a result of intensive lobbying during the Swedish presidency, in particular by the Embassy of Sweden in Bucharest, article 200 was repealed by the government through an emergency ordinance on 21 June 2001. The parliament confirmed this legal measure in October 2001, although at present the law is still at a conciliation committee between the two chambers of the legislature, because of a different understanding on sexual perversions in another article on sex related offences in the same law.

Surprising for a country with such clear anti-gay provisions, an anti-discrimination law was adopted by the government (Ordinance 137/2000) — before the repeal of article 200 — outlawing discrimination on various grounds, including sexual orientation. This law can find some of its roots in the EU requirements to ban racial and ethnic based discrimination as part of the 'acquis communautaire' — the body of EU law to be incorporated into domestic legislation prior to accession. However, Romania still lacks the institutional arrangements to make this law operational, although the government recently adopted secondary legislation to put it into place. And when in October 2001 the parliament had to confirm this government initiative, the Chamber of Deputies eliminated sexual orientation from the non-discrimination grounds. The law is also in a conciliation committee between the two chambers, since the Senate adopted it in the form submitted by the government. The EU reaction was prompt, and prominent leaders such as Baroness Nicholson of Winterbourne EU Parliament Rapporteur for Romania, criticized the vote and reminded the parliament that the EU will only accept a Romania officially free of discrimination.

ACCEPT and ILGA-Europe (The European region of the International Lesbian and Gay Association) have been key factors in monitoring these legal developments and lobbying for these changes — with financial support from the Open Society Institute and the Dutch government. However, our mission does not end with the two laws, but goes on to discrimination still exercised by law enforcement officials. Gay people rarely file a complaint against abuses by police officials, fearing the disclosure of their sexual orientation through the media and its impact on their families and colleagues, and because they do not believe that there will be a fair resolution of such a complaint. ACCEPT has received many such reports from victims and on 17 January 2001, for the first time in Romania, a gay man publicly broke the silence and accused a non-commissioned police officer with misconduct and an infringement of his right to private life. He filed a complaint following the Romanian procedures and, with the help of ACCEPT, is looking to the Court of Human Rights in Strasbourg, in the event that the domestic judicial system fails to adequately resolve the violation.

Overall, this Romanian story proves that social change is possible even with very sensitive issues and the attitude of politicians, law enforcement officials and society in general has to change in line with international commitments by Romania. Little by little, young people, various institutions and the media have begun to support the repeal of article 200. They join ACCEPT in trying to resolve these problems at the core: changing the public debate from the morality of gay sex to the human rights dimension of the situation of lesbians and gays in Romania.

And as Entre Nous goes to press, the Romanian Parliament has just finalised the two laws, re-including sexual orientation among the non-discrimination grounds.
A NATIONAL STRATEGY FOR SEXUAL HEALTH AND HIV FOR ENGLAND
By Professor Michael Adler, Department of STDs, Royal Free & University College Medical School

The first ever national strategy for sexual health and HIV for England was published at the end of July 2001. England, in common with many other European countries, has seen an increase in all the sexually transmitted infections (STIs), continuing HIV transmission and poor adherence to safer sex. Improving the nation’s sexual health will have major benefits for overall health and wellbeing as well as National Health Service resources. The national strategy for sexual health and HIV for England attempts to do this by proposing a comprehensive and holistic model.

Objectives and scope
The key objectives of the strategy are to ensure that everyone has better access to information on sexual health and to make services more available and accessible to all those who require them at all ages. The aims of the strategy attempt to address these over-arching objectives. These are to reduce the acquisition and transmission of STIs including HIV, the prevalence of undiagnosed STIs and unintended pregnancy rates, and to improve health and social care for people with HIV and to reduce stigma associated with STIs, especially HIV/AIDS.

Information and prevention
The strategy aims to see that clear information is provided so that people can take informed decisions about preventing STIs, including HIV. To achieve this it will be important “to foster a culture of positive sexual health by making sure that everyone gets the information they need without stigma, fear or embarrassment”.

The headline proposals outline the way in which the strategy will attempt to improve on current information and prevention strategies (Table 1). Action to prevent sexual ill-health works best when it is multi-faceted. A new national safer sex campaign will be launched in 2002 and will help to provide the backdrop to more targeted local prevention work. It is recognised that some groups need targeted and specific information, for example young people, and especially those in or leaving care, black and minority ethnic groups, gay and bisexual men, injecting drug users, individuals living with HIV, and other people affected by HIV, sex workers and people in prisons. The evidence base for STI and HIV prevention is still dispersed and unsystematic.

Recognising this, the Department of Health (DoH) has commissioned the Health Development Agency to draw together the available evidence to assess what works and make recommendations by the end of 2002.

Services/access
A comprehensive sexual health service needs to incorporate the areas of contraception and abortion, diagnosis, treatment and prevention of STIs and HIV, and services for psycho-sexual problems/sexual dysfunction. Currently, these are offered by many different parts of the health service with variable quality, availability and coordination. To improve on this requires a new model of working which aims to develop sexual health services around patients needs. The headline proposals address these issues (Table 2). The need to increase access is addressed by widening the role of primary care.

HIV treatment and care services
The treatment of patients with HIV infection is complex and changing rapidly. Clinicians therefore need to be up to date and need professional support to make sure they deliver high quality services. This can be achieved through clinical partnerships, collaborative working and agreed service standards. The introduction of managed clinical networks is seen for other complex areas of clinical medicine such as cancer care. The basic philosophy of such networks is to share patient care and give clinical supervision and support to practitioners in smaller units, thus improving the quality of services and patient’s access to them. The strategy is clear that all those providing HIV care will be expected to work within managed service networks.

Screening/vaccination/targets
Following pilot studies for chlamydia screening, the strategy plans to roll out national screening from 2002 for selected groups of women. The strategy encourages more HIV testing by making people aware of the benefits of knowing their antibody status. Physicians will be encouraged to act more proactively in offering testing, and all STD clinics will be required to offer HIV testing to all those patients attending for first screen for STIs. Targets for reducing undiagnosed HIV and increasing hepatitis B vaccination have been set within the strategy summary.

Information/Prevention
- Develop a new national safer sex information campaign;
- Targeted local prevention campaigns based on local needs assessment;
- More responsive national telephone helplines;
- Develop an evidence base for HIV/STI prevention.

Services/Access
- Widen the role of primary care;
- Improve access to genito-urinary medicine (GUM) services;
- Closer working between primary and secondary care with single commissioning;
- Develop managed clinical networks for HIV and sexual health services;
- Evaluate the benefits of more integrated sexual health services, including pilots of one-stop clinics, primary care, youth services and primary care teams with a special interest in sexual health;
- Begin a programme of screening for chlamydia for targeted groups in 2002;
- Ensure a range of contraceptive services are provided for those who need them;
- Address the disparities that exist in abortion services across the country.

The strategy can be found on the Department of Health website: www.doh.gov.uk/nshs/strategy.htm

Professor Michael Adler
Department of STDs, Royal Free & University College Medical School, The Mortimer Market Centre, Off Capper Street, London WC1E 6AU, The UK
"I care... Do you?"
is the slogan for the second yearof a two-year campaign intendedto create a sustained focuson the role of men in the AIDS epidemic.

The campaign culminated on 1 Decem-ber, World AIDS day. It aimed to involve men, particularly young men, more fullyin the effort against AIDS, to bring abouta much-needed focus on men in nationalresponses to the epidemic and to involveleaders both as politicians and in theirpersonal lives in the response to the HIV epidemic.

UNAIDS/WHO report from November2001) reports, the number of HIV infec-tions in eastern Europe is rising fasterthan anywhere else in the world.

"HIV is spreading rapidlythroughout the entire east-ern European region - aquarter of a million new cases only this year," reports Dr Peter Piot, ExecutiveDirector of the Joint UnitedNation's Programme onHIV/AIDS (UNAIDS).

Albania
In Albania a joint press conference with the Ministry of Health on HIV/AIDS programmes and needs in Albania set the agenda. The day's activities included the distribution of information materials including posters, leaflets, booklets, calen-dars and bookmarks; and a uniqueinitiative: a short message containinginformation about HIV/AIDS to all Vodafone mobile phone users.

Kosovo
In Kosovo a press conference organized by the Kosovo AIDS Committee, UNAIDS Theme Group in Kosovo (chaired by WHO) and Pristina Youth Centre pointed out key issues. These were reinforced by two TV spots, radio mes-sages and the distribution of 100 000 leaflets; 100 000 stickers; 20 000 posters; a30-minute documentary on HIV/AIDS in Kosovo; a concert; t-shirts with theofficial slogan of the campaign in three lan-guages; hats and ribbons.

The Federal Republic of Yugoslavia
The 2001 campaign against AIDS ran from 22 November to 22 December,starting with a press conference held at the Belgrade City Hall and peaking with events organized to mark World Aids Day on 1 December. UNAIDS managed tobring partners together under one umbrella. A joint campaign, with fivepartners, also ran in Montenegro.

Activities included TV advertising, radiojingles, billboard displays and the distri-bution of printed material about HIV/AIDS, disease prevention and access to services in the community. While cam-paign partners were also free to organizeindividual activities to highlight World Aids Day, their use of unified messagesstrengthened efforts across the country.

Moreover, free HIV testing was availablethroughout December.

The Russian Federation
In the Russian Federation, where there are163 623 officially registered cases ofHIV infection, HIV/AIDS awareness wasso particular importance. WHO activities inNorth Ossetia included a public cere-mony with a performance attended byschool children and the Minister of Health. At the event, WHO informedabout global activities and current AIDSdrug research.

Uzbekistan
In Uzbekistan, activities were organized by WHO's Republican Health Centre, Uzbekistan Red Crescent, ZdravPlus-ART associate, UNAIDS, UNESCO"Eshlar", and an Uzbek TV channel.

Despite pouring rain, activities includeda drawing contest; videos on HIV/AIDSrelated topics; handouts by Red Crescent volunteers; basic HIV/AIDS information(UNAIDS, UNESCO, and WHO materi-al); a quiz on the content of the videos;information material; plays; live perform ance; and speeches by representativesfrom the Ministry of Health in Uzbekistan and WHO.

For more information about WHO'sEmergency Preparedness and Response programme and to join the Health Action mailing lists, contact:
Jeffrey V. Lazarus [jla@who.dk]
The WHO Regional Office for Europe
www.euro.who.int/emergencies
Tel: (+45) 39 17 13 41
Integrating Sexual and Reproductive Health and Rights into a Sector Wide Approach to Danish International Development Assistance

By Victoria Frances and Kris Heggenhougen with Tom Barton, Grete Bredstedt, and Sangeeta Mookherji

The aim of this report from 1999 is to map out key issues for promoting the integration of sexual and reproductive health and rights into the planning, implementation, and reviews of Danish International Development Assistance (DANIDA) sector programme support. Most of the documented background information refers to various material from international conferences, UN agencies, and NGOs.

This publication is only available online: http://www.un.dk/danida/befolkning/integrating/

Women 2000


This 540-page report covers 29 countries in central and south-east Europe. Its detailed analysis of each country as well as comprehensive conclusions and recommendations make this work one of the information cornerstones on women's rights, including reproductive rights and access to health care systems.

Contact
International Helsinki Federation for Human Rights,
Wickenburgg. 14/7, A-1080 Vienna, AUSTRIA
Tel: (+43) 1-408 88 22
Fax: (+43) 1-408 88 22-50
[office@ihf-hr.org]
Available online: http://www.ihf-hr.org/reports/women/women2000_cover.pdf

Women 2000:


This 194-page report sets forth national laws and policies in key areas of reproductive health and women’s empowerment in seven east-central European countries: Albania, Croatia, Hungary, Lithuania, Poland, Romania, and the Russian Federation. The report concludes that the privatization of the health care system under structural adjustment programmes has led to decreased spending on health care and a deterioration in women’s ability to control their fertility. Access to comprehensive reproductive health services and basic family planning, such as contraception, is extremely limited across the region.

In spite of a history of egalitarian law under state socialism promoting the equality of women and the adoption of major international human rights treaties including the Convention on the Elimination of All Forms of Discrimination and the Convention on the Rights of the Child, which are equivalent to domestic law, there remains a large gap between the rights granted by law and the ability to exercise those rights.

Contact
The Center for Reproductive Law and Policy (CRLP)
120 Wall St.
New York, NY 10005
(917) 637-3600
(917) 637-3666 (fax)
[info@crlp.org]
Available online: http://www.crlp.org

"Towards a Human Rights-based Contraceptive Policy: a Critique of Anti-sterilisation Law in Poland"


Sterilisation is one of the saddest, most effective and widely used methods of family planning in the world. However, according to Polish law it is illegal and thus inaccessible in Poland. Such regulations impose certain harms, which amount to a violation of human rights, especially the right to respect for private and family life and to equality. The paper also explores this question with respect to the right to health. The challenges to the criminal prohibition of sterilisation require a gender-sensitive perspective on contraceptive policy that recognizes the intimate connection between reproductive choice and the status of women.

To order the journal, contact:
Kluwer Academic Publishers
Distribution Centre
P.O. Box 322
3300 AH Dordrecht
The Netherlands
Tel: (+31) 78 654 6454
Fax: (+31) 78 654 6474
[services@wkap.nl]
www.kluweronline.com

Results of the Eight United Nations Inquiry among Governments on Population and Development

Eight United Nations Inquiry is part of the effort of the UN Population Division to ensure a proper monitoring of the implementation of the goals and recommendations adopted by the UN International Conference on Population and Development, held in 1994 in Cairo.

For more information about the publication or population issues in general, please contact Mr Joseph Chami (population@un.org), Director, Population Division, United Nations.

United Nations publication 2001
ISBN 92-1-151346
INTERNET RESOURCES
Prepared by Josh Gross, Web editor
Links To Sites with Content and Information Concerning Reproductive Health Conventions, Laws and Legislation

IPPF Charter on Sexual and Reproductive Rights

www.mirror.ippf.org/charter/Intro.htm
Source: www.ippf.org
The International Planned Parenthood Federation's Charter on Sexual and Reproductive Rights was approved by its governing body and 127 member associations in 1995. The Charter provides an ethical framework for IPPF's work in the field of sexual and reproductive health and rights. The full document (http://mirror.ippf.org/charter/full.htm) defines 12 rights identified from international human rights as additional rights to which IPPF commits itself.

Article: Health as a human right - the view from Vienna, Cairo, Beijing and the Women's Convention
http://cma.commat.org/files/Commonhealth/health.htm
The concept of health and human rights has been promoted by the recent series of UN conferences. In 1993 the Vienna Declaration and Programme of Action recognized for the first time that women have a right to “the highest standard of physical and mental health throughout their life span” and, on the basis of equality between men and women, “a right to accessible and adequate health care and the widest range of family planning services, as well as equal access to education at all levels” (Para 41).

The Center for Reproductive Law and Policy,
www.crlp.org
An excellent site for all things legal concerning reproductive rights, law policy, and issues concerning women and women's rights, both for the US and abroad. The search engine turned up many results touching on a wide variety of issues such as US and international law pertaining to women's reproductive rights, international charters and conventions and the status of US and international court battles. The site is very simply designed and a pleasure to navigate.

The United Nations Beijing Declaration and Platform for Action
www.un.org/womenwatch/daw/beijing/platform
This UN site includes the full Beijing Declaration and information about the Platform for Action.

The Women's Global Network for Reproductive Rights,
www.wgnrr.org
The Women's Global Network for Reproductive Rights (WGNRR) is a worldwide autonomous network of groups and individuals who jointly aspire to the recognition and protection of reproductive rights for women. The organization is based in the Netherlands. The site appears to have not been updated recently.

ASTRA, Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights,
www.womenaction.org/csw44/astra.html
ASTRA, a network of activist organizations in central and eastern Europe, was established in December 1999. Its main objective is to promote women's sexual and reproductive health and rights in the region and to ensure a prominent place for these issues on national and regional agendas. The site is mostly about the organization, with few of its own resources. There are, however, many relevant links.

The International Digest of Health Legislation (IDHL) online database
www.nt who.int/idhl/en/ConsultIDHL.cfm
The International Digest of Health Legislation contains a selection of national and international health legislation. Texts of legislation are summarized in English. There are, in some cases, links to other websites containing the full text of the legislation in question. IDHL is the definitive resource of international legislation on the net. One can perform a search by country, subject, volume, issue or keyword. The site, however, poorly designed and the frame layout is confusing.

From Tao to Earth, Laws and Legislation page.
http://taotoearth.pmpubs.com/links_lawsworld.html
From Tao to Earth Laws and Legislation page contains records of laws and legislation concerning the practice of acupuncture and oriental medicine and other alternative therapies worldwide. The pages are divided up into regions containing downloadable PDF files of international laws and legislation and a wide variety of other issues concerning acupuncture, oriental medicine and other alternative therapies. There is a large section on European Union legislation. There are also links on the main page that cover a plethora of subjects on alternative medicine for practitioners. Although this is not a very exciting page graphically and possesses a noteworthy lack of interactivity, it is fully worth a visit for its totally unique content. There is also a link to the WHO International Digest of Health Legislation.

Safe Motherhood

www.safemotherhood.org
Safe Motherhood is a coalition between UNFPA, UNICEF, WHO, the World Bank, IPPF and the Population Council. Need I say more? The affiliations speak for themselves. Safe Motherhood contains an almost overwhelming amount of information. It is the best all-around site I have seen on women's health issues, rights, legislation, statistics and much, much more. There are current articles and reports and links to a plethora of other resources. There is also a powerful search engine that turned up many results. Most search
results give an in-depth summary describing the referred link. Safe Motherhood’s design is a simple frame containing a menu with a host of choices such as: Facts and Figures, Action Messages, News articles and mainframe.

UPCOMING CONFERENCES AND SYMPOSIUMS

8-9 March 2002, Nice, France
New Frontiers in Women’s Health: An International Dialogue
The 2nd International Journal Watch Women’s Health Symposium
www.health-symposia.org
Sponsored by the Journal Watch Women’s Health and affiliated with the New England Journal of Medicine, this symposium will bring together experts from the United States and France to present their perspectives on the latest advancements in women’s health research and clinical application. Plenary sessions will cover advances in contraception, hormone replacement therapy and breast cancer prevention and treatment. Specialized tracks for family practitioners and obstetrician/gynaecologists cover a range of topics, including heart disease, depression, high-risk pregnancy, and AIDS in women. For more information, please contact: The Massachusetts Medical Society, 860 Winter Street, Waltham, Mass. 02451 USA; Tel: (+1) 781-893-3000 ext. 5515; [symposiumcust@nejm.org]

10-14 March 2003, Havana, Cuba
World Congress on Sexology - “Sexuality and Human Development: From Discourse to Action”
For information in English, or Spanish, visit www.cubasexologia.com.

14-18 April 2002, Vienna, Austria
Midwives and Women Together for the Family of the World
International Confederation of Midwives 26th Triennial Conference
www.hebammen.at/icm-congress/
Hosted by the Austrian Midwives Association, this congress offers a scientific programme, an exhibition on pregnancy and birth, and discussions on the role of midwives in women’s and global health.
For more information, please contact: Wiener Medizinische Akademie (Vienna Medical Academy), Alser Strasse 4, A-1090 Vienna, Austria; Tel: (+43) 1-405-13-830; Fax: (+43) 1-407-8274; [office@medacad.org]

38-31 May 2002, Washington, D.C.

www.globalhealth.org/
The 29th annual Global Health Council conference will address a range of topics, including health, human rights and advocacy; disasters and conflict; issues in transitioning from disaster to development; infectious diseases and epidemics; urbanization and socio-economic change; environmental threats to health; health policy and financing; health service delivery and behaviour change.

June 2002, Seoul, Korea
The Thirteenth International Conference on Women’s Health Issues
The 13th International Conference on Women’s Health Issues will be held in Seoul, Korea. All abstracts related with Women’s Health are welcome. Abstracts should be submitted by 28 February 2002. For more information or to submit an abstract, please contact the Congress Secretariat, [krshin@mm.ewha.ac.kr]

16-20 June, Limassol, Cyprus
6th Congress of the European Federation of Sexology.
Some 600 participants are expected. There are 31 main topics and papers should be sent to the organizers by 31 March 2002. For more information:
www.eufsexology.org/

July 2002, Barcelona, Spain
XIV International AIDS Conference
www.aids2002.com
For information, please contact: Conference Program Secretariat, Eidifici ApolloX, Blanes 200 at 9,08006 Barcelona, Spain; Tel: (+34) 932-182; Fax: (+34) 932-170-188; [aids2002@bcncservicom.es]

21-26 July 2002, Kampala, Uganda
Gendered Worlds: Gains and Challenges
Women’s Worlds 2002: The 8th International Interdisciplinary Congress of Women
http://www.makerere.ac.ug/womenstudies/congress2/index.htm
The Women’s Worlds Congress is held every three years. This year’s congress is organized by the Department of Women and Gender Studies at Makerere University and will focus on gender research and interdisciplinary scholarship. For more information, please contact: Department of Women and Gender Studies, Makerere University, PO Box 7062, Kampala, Uganda Tel: 256-41-531484; Fax: 256-41-543539; [gender@swiftuganda.com]

11-15 August 2002,
The World Association for Medical Law Congress, will be held in Maastricht, the Netherlands. Meetings of this sort have in the past (the Congress is held every two years) attracted 800 or more participants, and the papers based on accepted abstracts often provide material for publication. Many appear in the WAML Journal, Medicine and Law, but many contributors can also present pieces of appropriate length for other publications.
Contact: Conference Agency Limburg P.O. Box 1402 6201 BK Maastricht The Netherlands Tel: (+31) (0)43-3619192 Fax: (+31) (0)43-3619020 [cal.conferenceagency@wxs.nl]
The Congress Programme and registration information are available online: www.conferenceagency.com/medicallaw.
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
[entrenous@who.dk]