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The forgotten women of western Europe

Migration is by no means new to Europe, a continent shaped by successive waves of conquerors and refugees. What is novel about migration in the late twentieth century is the sheer number of people involved. The unprecedented upheavals of the Second World War were followed by unprecedented prosperity in western Europe, creating a high demand for migrant labour. Even with the economic slow-down of recent years, the region remains a magnet for people fleeing from conflict and crisis as far away as Africa – or as near as the Balkans.

There are now an estimated 17.5 million people living as immigrants in western Europe, making up roughly 4% of the total population. More than half will have migrated from neighbouring countries, but may feel no less displaced than those who come from distant continents. Language difficulties often prevent immigrants from making good use of mainstream health and social services. Many are not even aware of the services on offer, nor of the social benefits to which they may be entitled. Women who follow working spouses to a foreign country may be among the most marginalized, particularly if the home culture discourages them from mixing with strangers.

The health needs of migrant women become most apparent when they are referred for antenatal or obstetric care. The lack of family or community support networks, and of early prenatal care leads in many cases to complications during pregnancy. Studies comparing pregnancy outcomes in different population groups show significantly higher rates of complication among immigrant women. The same women often lack access to culturally appropriate information about family planning.

Mental health is another area of enormous need. Most immigrants suffer at least a temporary sense of dislocation and loss of status, while women in particular may feel isolated and torn between conflicting value systems. Unrelieved stress often manifests itself in psychosomatic illnesses or even substance abuse, yet for linguistic as well as cultural reasons, many immigrants find it difficult to seek help.

Slowly but surely, communities in western Europe are coming to recognize that local health services must reinvent themselves to meet the diverse needs of a diverse population. The most effective changes are not necessarily the most costly. Often it is a case of redesigning existing services to reach out to immigrant women, and encouraging them to get involved as volunteer or professional health workers, educators and interpreters.

In this issue of Entre Nous, we review innovative strategies from several west European countries, and we set out the recommendations agreed at a recent WHO working group on health issues for immigrant women. There is no doubt that implementing these recommendations will require considerable ingenuity. But the costs will be modest compared to the benefits of reducing social exclusion and promoting the health of whole communities.

Health rights of immigrants

Member States in the WHO European Region have committed themselves to promoting the rights of all patients to adequate and appropriate health care. Signatories to the 1994 Declaration on the Promotion of Patients’ Rights in Europe resolved that:

- Everyone has the right to have his or her moral, cultural, religious and philosophical convictions respected (article 1.5)
- Information about health services and how best to use them is to be made available to the public in order to benefit all those concerned (article 2.1)
- Information must be communicated to the patient in a way appropriate to the latter’s capacity for understanding... If the patient does not speak the common language, some form of interpreting should be available (article 2.4)
- Everyone has the right to receive such health care as is appropriate to his or her health needs, including preventive care...
- Services should be continually available and accessible to all equitably, without discrimination... (article 5.1)

In 1996 Member States adopted the Ljubljana Charter on Reforming Health Care, pledging themselves to this key principle:

Reforms, with primary health care as a philosophy, should ensure that health services at all levels protect and promote health, improve the quality of life, prevent and treat diseases, rehabilitate patients and care for the suffering and terminally ill. They should reinforce joint decision-making by the patient and care provider and promote the comprehensiveness and continuity of care within their specific cultural environments (article 5.6)
Migration and public health in the European Union

The pattern of migration in western Europe has changed rapidly over the past twenty years. In the early 1970s, many labour migrants were men without families. Calls for family reunification, backed up by new legislation in many receiving countries, allowed families to join working migrants, placing unexpected demands on health and social services with limited experience of multicultural practice. Another shift occurred from about 1980, as traditional countries of emigration in southern Europe began to attract immigrants from Africa, Latin America, and eastern Europe. Growing unemployment in northern Europe has also encouraged Greek, Italian, Spanish and Portuguese immigrants to return home.

The European Commission is attempting to track the health and social implications of migration, which seems likely to remain a characteristic feature of life in modern Europe. Directorate-General V (responsible for employment, social affairs and public health) is calling for a regional effort to ensure that services are better equipped to respond to changing needs in immigrant and host populations.

However incomplete our current understanding, it is clear that reproductive health services will be central to that effort. Migrant communities tend to have higher fertility rates than host populations in western Europe, where fertility has been in marked decline over the past 25 years. Evidence from Belgium, Germany and the UK indicates that perinatal and infant mortality rates are also higher among non-nationals, although rates vary between different immigrant communities. Yet health authorities in Sweden have shown that when culturally sensitive services are provided, pregnancy outcomes of Turkish immigrants move into line with those of Swedish nationals. Innovative work with immigrant communities in many European countries demonstrates that multicultural outreach services can be crucial. Recruiting volunteers and professional staff from immigrant backgrounds, and training them to seek out women and families in their homes and neighbourhoods, helps to ensure that the most vulnerable members of society do not slip through the net of mainstream health and social services.

More information on public health in the European Union is available from Dr W. J. Hunter, European Commission, Directorate-General V, Bâtiment J. Monnet, Plateau du Kirchberg, L-2920 Luxembourg

Immigrants in France forge their own links

by Michèle Mendoza

Since the early 1980s, women from immigrant backgrounds in France have been working alongside health and social welfare professionals, providing outreach services in areas as varied as education, health, housing, community relations and the law. Firmly rooted in immigrant communities but with the confidence and skills to deal with mainstream institutions, these femmes-relais, or "link women", help their neighbours in the slow process of understanding the French system. They act as community mediators, resolving problems, preventing conflict, and negotiating on behalf of people unable to speak for themselves.

A French government circular of 19
Mainstream services in many countries often fail to address the needs of minority communities, and the most recent immigrants are usually the least well served. Dislocated, disoriented and often disenfranchised, new arrivals find it difficult to understand what services are available and how to access them. They may be unable to communicate in the language of the host country. Even when interpreters are available, immigrants may present physical conditions and mental attitudes which are poorly understood by professionals with limited experience of other cultures.

At a meeting in Copenhagen from 24-25 November 1997, participants from six countries of the WHO European Region reviewed the health needs of women in immigrant communities, which now make up approximately 4% of the total population in western Europe. Representatives from health ministries, NGOs and minority groups in Denmark, Italy, Norway, Sweden, Switzerland and the UK discussed innovative and cost-effective ways to meet their special needs.

Arguing that the social inclusion of minorities is essential to the well-being of the whole community, the working group made a series of specific recommendations. National and local authorities are urged to ensure:

- that resources are allocated to address the special needs of immigrant women
- that sensitization to cultural differences and the specific needs of migrant women is included in medical and paramedical training
- that services are made accessible to all, without cultural, racial or class barriers
- that services are sensitive to gender relations within target communities
- that every effort is made to facilitate the professional accreditation and employment of health professionals from migrant communities
- that women from minority communities are directly involved in planning services

The working group also urged national health services to follow the example set recently by the General Medical Council of the United Kingdom, which has put the issue of racial inequality within the National Health Service high on its agenda.

The working group called on the World Health Organization to support Member States in meeting the needs of minority women by encouraging research, collating data and identifying best practice in different countries and communities. A larger meeting on this topic in 1999 should involve WHO member states, the International Organization for Migration, the European Commission, the International Federation of Gynaecology and Obstetrics (FIGO), representatives of national medical and paramedical associations, minority groups, refugee associations, and experts on immigration law.

This first meeting identified the most significant health needs of immigrant women. Reproductive and sexual health come top of the list, which goes on to cover female genital mutilation, changing patterns of nutrition, infectious diseases including tuberculosis, HIV/AIDS and other sexually transmitted diseases. Mental health needs are also significant, in particular depression or stress disorders resulting from migration, torture, domestic violence, or flight from catastrophe or war in the home country.

Recommended strategies include training interpreters and cultural mediators in terminology specific to all these conditions, and working closely with women within target communities to develop linguistically and culturally appropriate information materials. Local authorities should offer financial and structural support to community organizations, which have a crucial role to play in health education. Wherever possible, professional members of immigrant communities should be involved in the provision of health services and the training of other health workers. The cost of health services for immigrants should be covered by governments, and individuals should be informed of their rights within the social security system of the host country.

Without a timely investment in health promotion and disease prevention, host countries will face a rising toll of untreated disease, pregnancy complications, and incalculable stress for some of the most vulnerable members of modern society.

Acting against racism in the UK National Health Service

As an independent professional association, the General Medical Council in London is determined to play a leading role in the fight against unfair discrimination in medical practice. Last year the GMC signed the leadership challenge issued by Britain’s Commission for Racial Equality, issuing a clear statement of standards for doctors and commissioning a new study of GMC procedures.

The United Kingdom has a long tradition of welcoming medical and dental students, as well as practising doctors and dentists, from overseas. The government recently issued a Guide to immigration and employment of overseas medical and dental students. But racial bias is a reality within the National Health Service, as it is elsewhere in British society.

The GMC’s position is very clear: doctors must not discriminate against colleagues, including doctors applying for posts, because of their lifestyle, culture, beliefs, race, colour, sex, sexuality or age. The Council is committed to a system of professional regulation which is open and accountable, and to procedures and processes that are fair, objective, transparent and free from discrimination. The annual review of GMC activities in 1997 reports a number of new initiatives designed to improve handling of registration applications and complaints and to allow more effective monitoring. An independent study will investigate potential bias in procedures for determining fitness to practise.
WHO policy on FGM

In 1994 a series of international agreements on female genital mutilation culminated in the adoption by the World Health Assembly of WHA 47.10, urging governments to take measures to eliminate traditional practices harmful to the health of women and children, particularly FGM. WHO has accordingly strengthened its technical support to countries in promoting public education and cooperating with non-governmental organizations and community groups. WHO has also consistently and unequivocally advised that FGM, in any of its forms, should not be practised by health professionals in any setting, including hospitals or other health establishments.

FORWARD against female genital mutilation

by Rahmat Mohammad

For the past fifteen years FORWARD, the Foundation for Women’s Health, Research and Development, has been leading the campaign against female genital mutilation. With health and education projects underway in the UK as well as in Gambia, Nigeria, Ghana, Egypt, Kenya and Uganda, FORWARD is now recognized internationally as the organization which has brought the issue into the limelight.

The practice is so deeply rooted in traditional culture that any campaign against it requires enormous sensitivity. We may condemn the practice as a violation of the child’s basic human rights, but traditionalist parents justify it as an act of love, convinced that a daughter who is not circumcised will be regarded as unclean and ineligible for marriage. Policymakers may tend to avoid the issue for fear of being seen to impose western value judgements on other cultures. Yet to do so is to ignore the plight of millions of girls too young and too power- less to protest against a practice which has devastating consequences for their physical and mental health.

FORWARD’s campaign strategy in the UK combines health care and counselling for women who have undergone FGM with public education and professional training. FORWARD supports African Well Women Clinics at three hospitals in greater London, where experienced doctors and midwives, supported by interpreters, offer obstetric and gynaecological services to affected women. Confidential professional counselling is also arranged. FORWARD distributes a free information pack, as well as priced publications and videos, and has just received funding from the UK Department of Health to produce health education materials on FGM for more general distribution through health centres. Since 1994 FORWARD has been working to involve men from immigrant communities as activists and peer educators.

FORWARD has become the principal source of FGM awareness training for British professionals in health, education and social services. The organization runs an average of two training sessions per month, with most requests coming from London and a few other cities where there are significant numbers of African immigrants. The training focuses not only on how to help women who have undergone FGM in their country of origin, but also how to persuade parents and professionals not to continue the practice. FORWARD provided information and advice to the producers of a television documentary, “Cutting the Rose”, which was broadcast on Channel 4 in October 1997. Shockingly, the programme revealed that at least one licensed doctor has carried out FGM in the UK in direct violation of the Prohibition of Female Circumcision Act 1985.

More information on the organization’s activities worldwide is available from

FORWARD, 40 Eastbourne Terrace, GB-London W2 3QR.

“Even though cultural practices may appear senseless or destructive from the standpoint of others, they have meaning and fulfil a function for those who practise them. However, culture is not static... People will change their behaviour when they understand the hazards and indignity of harmful practices and when they realize that it is possible to give up harmful practices without giving up meaningful aspects of their culture.”

WHO/UNICEF/UNFPA statement on FGM, 1997

What is female genital mutilation?

Female genital mutilation (FGM) constitutes all procedures which involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or any other non-therapeutic reasons.

Type I Excision of the prepuce with or without excision of part or all of the clitoris.

Type II Excision of the prepuce and clitoris together with partial or total excision of the labia minora.

Type III Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).

Type IV Unclassified: includes pricking, piercing or incision of clitoris and/or labia; stretching of clitoris and/or labia; cauterization by burning of clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishirin cuts) of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure which falls under the definition of FGM given above.

All of these procedures are irreversible and have lifelong effects. Types I and II account for up to 80% of all female genital mutilation. Type III (infibulation), the most extreme form of FGM, constitutes 15% of cases worldwide, but in Djibouti, Somalia, and northern Sudan it is the most common practice. It is estimated that between 100 and 132 million girls and women worldwide have been subjected to FGM, and that a further 2 million girls are at risk every year.

ENTRE NOUS 38, Spring 1998
How a midwife can change attitudes
by Lisbet Nybro

As a midwife at Frederiksberg Hospital on the outskirts of Copenhagen, I have been working with Somali women ever since they began migrating to Denmark. It started off as a kind of family obligation, after my brother-in-law married and settled down in Somalia in 1981. In 1985 I spent a summer with him and his wife in Mogadishu.

As a result I speak a little lousy Somali, maybe a hundred words. When I put them together I can say things like: Hello, how are you today? Show me where it hurts. Have your waters broken? I have to take a blood sample. Thank you. Goodbye.

But a hundred words can work wonders. Somalis have a wonderful sense of humour, and if I have a go at their language, they will have a go at Danish. Once they have accepted me, I can tell them anything, and they take my word for it. But I choose my words carefully, especially when I talk to them about female circumcision: I never say female genital mutilation.

About 20 Somali women come to Frederiksberg Hospital for maternity services every year, and they are all sent to me. So far all but one have been infibulated (as are 98% of women in Somalia). They need and deserve to be cared for by midwives who understand their condition. Empathy is important. Getting a good female interpreter is also important. This is not easy in Denmark, where the demand for Somali interpreters has grown rapidly in recent years. I always use the same one. I try not to rely on the husband, and I never ask a woman’s children to translate for me.

When a Somali woman comes to me, I tell her that together we are going to plan her delivery. We talk about her circumcision and any problems she may have had as a result, such as repeated urinary tract infections, difficulty passing urine, or excessively painful periods. I explain that these are not typical women’s problems. I ask her when she was infibulated, and who performed the operation.

Then I ask if I can see it. I judge the extent of the circumcision and test the elasticity of the tissue. I examine the old scars. I offer de-infibulation early in the pregnancy to every Somali woman, but I particularly urge it on those who are still completely infibulated. In such cases I tell the woman that her labour may be longer and more painful. I explain that if we cannot examine her properly to determine whether delivery is progressing normally, she may risk an unnecessary Caesarean. Most women are more than happy to be de-infibulated as soon as possible.

I use drawings of a normal and an infibu-

lated adolescent vulva to show her how she has been cut, and what will happen if she has to have an episiotomy during delivery. We discuss the natural birth process, and the uses of local anaesthetic. I also show her drawings of a de-infibulated and a partially restitched vulva. I explain the consequences of each choice, and the risks of complete restitching.

Then the woman has some decisions to make. Some go home to think about it, but others know exactly what they want once they have seen the pictures. Their husbands usually agree. Often they say: I want what is best for my wife.

Once a woman has made up her mind, I enter the decision in her case record, describing precisely how to administer the local anaesthetic, how and where to cut, what to do if the woman wants to be de-infibulated, and what to do if she wants to be restitched. I make drawings in her record, showing them to her so that she is confident her wishes will be respected. Finally I remind my colleagues that circumcised women need extra amounts of post-partum analgesic.

I believe it is important to respect the woman’s choice, even if she wants to be restitched. My experience from Frederiksberg Hospital indicates that all women who are completely infibulated want de-infibulation before the delivery, as do most partially infibulated women who are expecting their first child. A woman who has already given birth and was only partially restitched may prefer to deliver this child without further cutting and stitching. Others opt for a medio-lateral episiotomy, particularly if that worked well for them in the past. Finally, some women seize the opportunity to be completely de-infibulated.

After we have planned the delivery I raise the issue of the unborn child. Again I bring out my drawings. I talk about the hymen, the natural sign of virginity. I show her what is cut when you are infibulated. I describe how the labia majora are stitched together, and how they form a “hood of skin” which covers the urethra and most of the vagina. We talk about how the scars may obstruct urination and menstruation, leading to blood clots, infections, even reduced fertility.

Many of the Somalis I see believe that circumcision is actually good for women’s health. They are confused by what I tell them, but they listen. If they want, I give them photocopies of my drawings. I also give them a Somali-language pamphlet about female circumcision from the Danish Refugee Council. Even if they cannot read, most of them know someone who can.

Finally, I ask husband and wife what their intentions are, should she give birth to a girl. Most of them smile indulgently and tell me that of course their daughters will not be circumcised. The men often say they never wanted their daughters circumcised anyway.

I am aware that my results may be affected by the relatively settled status of the Somali women I see, all of whom have already been granted asylum. Nonetheless I often wonder why this method of health education is so effective. Is it the timing? During pregnancy, the woman is highly motivated to reconsider the issue of female circumcision, firstly because she has to face the consequences of her own condition. But as she goes through the transition to motherhood, she is increasingly receptive to information about the wellbeing of her child.

It seems to me that health education provided by the midwife during pregnancy, clearly describing female anatomy and the effects of female circumcision, might prevent many mothers from passing on this harmful tradition.

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Women doctors campaign against female circumcision

by Vibeke Jorgensen

Female genital mutilation is no longer confined to the 28 African countries where it has been prevalent for centuries. As recent immigrants and refugees have carried the practice to their new homes in Europe, North America, and Australasia, several countries have passed specific laws condemning the practice. Sweden was the first to outlaw FGM, in 1982; the United Kingdom followed suit in 1985, and Norway in 1995. Danish doctors were barred from performing FGM in 1981, and in 1992, following a campaign by the Medical Women’s Association, the practice was forbidden under our penal code. Canada, Finland, France, the Netherlands and several other countries have also banned FGM.

In the last two decades almost 9,000 refugees have fled Somalia to settle in Denmark. The new community includes 1,200 girls under 14 years of age, some of whom will have been circumcised already. We estimate that at least 1,000 girls are still at risk, particularly those from more traditionalist families.

At the Danish Medical Women’s Association we believe that information about female genital mutilation must be aimed at Somali refugees and at all professionals who work with them. Since 1992 we have been running workshops on FGM for health professionals and refugee organizations in many parts of Denmark.

Our workshops are led by Dr Margrethe Möller and Dr Fatuma Ali. Dr Möller stresses how important it is for obstetricians and midwives to discuss circumcision with Somali patients and their husbands. Professional interpreters are indispensable. Dr Ali, a Somali psychiatrist who is herself circumcised, explains the tradition, describing the different forms of circumcision and the resultant complications. She insists that there is no religious law requiring Muslim women to undergo circumcision. Dr Ali also regularly leads discussions for Somali women in their own language. She finds it is very important to involve the men, who have been taught to believe that only circumcised women are marriageable, without knowing what actually happens, nor what the consequences may be. It is not just a woman’s problem, but a problem for the whole family.

Some midwives in Denmark have adopted the practice of stitching over the urethra after delivery as is customary in Somalia. This procedure is prohibited in Sweden. Current guidance from Danish health authorities recommends that midwives inform the patient and her partner of the health risks involved, replacing the stitch only if both of them insist on disregarding medical advice. Here again it is essential to use professional interpreters. We find that very few women request the stitch once they understand the consequences.

To date we have no evidence that FGM has been performed in Denmark. But there are indications that girls from refugee families have been taken elsewhere to be circumcised. If the operation is performed in a country where it is not illegal, no action can be taken in Denmark against the parents. We have suggested to the Ministry of Justice that a team of educators be established to seek out and educate parents who might be contemplating circumcision. The team would need legal expertise, excellent contacts within the Somali community and an understanding of Somali culture. Representatives from the community should be recruited as peer educators, able to explain not only the general health risks, but also the problems faced by a circumcised girl living in a country where the practice is little known. Painful menstruation may cause her to miss school on a regular basis. She may feel forced to give up sports to avoid revealing her scar. Above all, she will be considered abnormal, and the older she is, the more acutely she is liable to feel this stigma.

The stated purpose of female genital mutilation is to prepare a girl for marriage within the Somali community. But if she falls in love with someone outside her community, she will find it hard to explain why she is not “normal”. If we do not succeed in stopping this harmful practice, at least among African women living on other continents, we will see a growing number of women with psychological problems, trapped in a tradition which most societies find abhorrent.

Dr Vibeke Jorgensen can be reached at the Medical Women’s International Association, 37 Hgingsvej, DK-2830 Nærum

What about male circumcision?

The word circumcision was originally coined to describe the practice of cutting around the base of the penis to remove the foreskin. Jewish and Muslim boys are traditionally circumcised, sometimes just days after birth. The practice may be less dangerous than female “circumcision”, but like any surgical procedure it is not without risk, while its medical benefits are not clear. It therefore raises difficult questions for health professionals asked to perform circumcision or to deal with any after-effects.

In 1996 the British General Medical Council invited comments from religious organizations, anti-circumcision groups, professional and patients’ organizations and civil rights organizations. Some strong views were expressed, though many acknowledged the difficulty of balancing the rights of the child with the rights of individuals to practise their religion. Noting that British law currently gives no definitive guidance on male circumcision (whereas female circumcision is prohibited under legislation passed in 1985), the GMC has now published standards of practice for doctors asked to circumcise male children.

The GMC guidance requires that doctors who agree to perform circumcision have the necessary skills and experience, that they keep up with developments in the practice of circumcision (including when the procedure is and is not medically indicated), and that they discuss the benefits and risks carefully with those who have responsibility for the child. Doctors who decide not to perform circumcision except for therapeutic reasons should inform parents that they have the right to consult another practitioner.

Guidance for Doctors Who are Asked to Circumcise Male Children is available from the General Medical Council, 178 Great Portland Street, GB-London WIN 6JE.
When disaster strikes: Caring for mothers and babies in conflict and disasters

The most vulnerable persons in any society suffer most when disaster strikes, whether it is natural or man-made. Women and newborn infants are among the most vulnerable. In many countries women are poorly nourished and have a high rate of reproductive health problems at the best of times. In times of war and disaster their vulnerability soars.

Most of the world’s refugees and displaced persons are women and children. Fleeing from home may be safer than facing conflicts or other disaster, but it is usually very dangerous nonetheless. Possessions and food supply are limited to what can be carried, and pregnant women or those encumbered with small children move slowly and can carry very little. The disaster that caused the displacement may have reduced food supplies anyway, but during displacement the availability of food is likely to be zero. Huge numbers of women refugees are malnourished. During the exodus and emergency phases (see box), many are starving.

Severe malnutrition in a pregnant woman causes fetal malnutrition. The newborn infant of a malnourished mother has a low birth weight and, if it stays in the same deprived environment as the mother, will grow up malnourished with limited potential for physical and mental development. When there has been war, women are often left to care for their children without the help of a husband or other male relative. Households headed by women tend to obtain the least food and the children of such households tend to be poorly nourished.

Following war or disaster, displacement has four phases:

Exodus. Leaving home is usually spontaneous, unplanned and chaotic. 
Emergency: huge numbers of persons arrive, ill-equipped and often ill-nourished, in an area that is ill-prepared to receive them.
Stabilization: the refugee camp becomes a long-term home.
Return: the refugees return to their original towns and villages, often after being away for years.

A refugee is a person who seeks refuge in another country. An internally displaced person is one who flies from home but stays within the same country.

Refugees in Bosnia and Herzegovina

During the exodus and emergency phases, disease, exhaustion and violence take a heavy toll of pregnant women and infants. After the emergency phase, the main causes of death among women refugees of childbearing age are the complications of pregnancy and delivery.

Rape and coerced sex are frequent during conflict and displacement, leading to a rise in unwanted pregnancies, sexually transmitted diseases and HIV infection. In many emergencies, women have been systematically subjected to sexual violence: the crisis in former Yugoslavia was no exception. Refugee camps can also be dangerous places. Violence and exploitation directed against women and girls lead to health problems, as well as unwanted pregnancies, abandoned babies and unsafe abortion. Many women are forced to offer sex in exchange for food, shelter or protection. In addition, in many areas where war has broken out, blood transfusion services have been unable to check for HIV.

Conflict: reducing the damage

It is impossible to prevent suffering when war or disaster drive people from their homes. Yet that suffering can be reduced by being prepared and by reacting quickly when an emergency happens.

Armed conflict is associated with massive social upheaval that has a profound impact on reproductive health. Attitudes to sex and childbearing may change. The erosion of women’s social and economic power may lead to an erosion of power in relationships as women lose the freedom to make decisions (such as condom use or family planning) that can protect their reproductive health.

These changes in relationships take place as society becomes more militarized. Non-military needs, such as social welfare and development, become less of a priority and women carry the burden of the decrease in spending. Men as fighters may have preferential access to health care over women and children.

During armed conflict and emergencies, even the most basic reproductive health services may not be available. Organizations that offer aid in emergencies usually focus on saving lives. Other serious but less obvious problems such as sexually transmitted diseases, unsafe abortions and sexual violence may go unnoticed.

There has to be more concern for the factors that affect women’s health, more attention to the inequalities between men and women, and more notice taken of what women have to say.

Even before outright conflict begins, you can often see it coming. While still hoping for the best, it is always wise to plan for the worst. Often this task falls to nongovernmental organizations. Reproductive health risks can be identified and measures planned to protect women’s health if the situation deteriorates. Efforts can be made to keep family groups together as they flee, and international observers should be stationed at border crossings to make sure that vulnerable persons are not exploited.

In order to set priorities at this stage,
Coping in an emergency

Amid the chaos of a sudden and unexpected influx of refugees, the first tasks are to ensure adequate shelter, sanitation, clean water and food for everyone. But efforts can also be made to help mothers and infants, as soon as the refugees or displaced persons arrive at a place where they can be reached with humanitarian aid.

During the emergency phase, the health of displaced people may deteriorate further as epidemics spread through the crowded camps. Health services may be rudimentary at this stage and many people are likely to be malnourished. Women may still be subject to sexual violence. WHO is planning to include reproductive health material in the new emergency health kit.

First, the refugees' reproductive health needs have to be rapidly assessed. This means locating the pregnant women, nursing mothers and women who are lone heads of households to make sure they get support. It means finding out beliefs about pregnancy, childbirth and nutrition to help plan health education campaigns. It also means assessing nutritional status, finding out what foods the refugees are used to eating, and giving supplements to women who are undernourished.

Causes of sickness and death should always be recorded, for this information shows what health problems are prevalent. It is the basis for planning health care for mothers and infants - and others too - and for finding out if they are the victims of violence.

The local environment should be studied so the camp can be planned in a way that gives protection to women. The refugee community will often have the remnants of a social structure that can be used to protect vulnerable people and disseminate information about health services. Food, shelter and relief supplies should be distributed equitably; distribution should not be left only to men. If there are doctors and nurses among the refugees they should be enlisted to set up a clinic. Special efforts should be made to employ female health workers. And existing local health services should be expanded so that they are not swamped with demand from the refugees and left unable to meet the needs of the local community.

Midwives and nurses with midwifery experience should be identified and encouraged to arrange training for other staff within a month of health services being established. Training should include information on breastfeeding, prevention of sexually transmitted diseases, the use of condoms, and clean delivery practices. All staff in the refugee camp should be briefed about women’s risk of sexual violence and exploitation, and trained in counselling techniques.

As soon as possible, health workers and midwives should be at work both in the clinic and in the camp community. Health services should give priority to pregnant women, nursing mothers and children under five years. If a delivery unit is set up, it must have good sanitation and a source of clean water. Referral services can also be established if there is a hospital in the locality that can respond to an increase in demand for services. Referral should be available 24 hours a day, seven days a week, and will require a covered vehicle and fuel, as well as a driver and midwife or doctor on call, and a means of contacting these people urgently. Health workers should be able to recognize haemorrhage, infection, eclampsia, obstructed labour, the complications of unsafe abortion and other reasons for immediate referral.

An inter-agency manual to assist all concerned parties - governments, NGOs, academic institutions, the UN and its specialized agencies - in promoting the integration of reproductive health services in refugee and other emergency situations.

Available from: UNHCR Programme and Technical Support Section, Case Postale 2500, CH-1211 Geneva 2, Switzerland.
E-mail: bopandan@unhcr.ch
Living in a refugee camp

Many refugee groups have among their children who have fled along with the rest but have become separated from their parents. In some cases one or both of the parents may be dead. These children need to be identified so that any remaining family members can be traced.

As the situation stabilizes, and life in a refugee settlement becomes routine, fertility rates often go up, sometimes to surprisingly high levels: women may want to replace lost children. As epidemic diseases are brought under control, sexually transmitted diseases - including AIDS - may become significant in illness statistics. The breakdown of family ties and community controls in refugee settlements often leads to increased unprotected sexual activity among young persons. As men lose their traditional roles and status and have little work to do, excessive drinking and violence may result. The numbers of women with the complications of unsafe abortion may be high, especially if rape was common in the early states of the emergency. There may be many abandoned babies.

Reproductive health services at this stage should aim to be as comprehensive as possible. They should include integrated services directed at adequate nutrition, safe motherhood, sexual violence, family planning, and sexually transmitted diseases.

Reproductive health services should be accessible to all refugees. Culturally appropriate education about reproductive health should be targeted at those who make the decisions in families and communities. Clinics should be located as close as possible to the people they serve and all services should be available daily. If this is not possible, all the services for women and children should be offered on the same day so that clients do not have to make unnecessary journeys. Opening times should suit women and health workers should visit women who cannot leave home because they are disabled, or for any other reason. Staff should be nonjudgmental and prepared to provide reproductive health services to all clients - married and unmarried, old and young. Referral for emergency obstetric care should be available to all who need it, and referral will also be needed for family planning services, such as the insertion of intrauterine devices.

Discussions with health workers must be confidential. They should take place where they cannot be overheard, and they must never be the subject of gossip. The system of record-keeping should also ensure confidentiality. If interpreters are used, they should be chosen carefully and must understand that they should not repeat client’s discussions. Women who have been raped may need to be given health services and counselling in the context of a safe and confidential setting.

The value of psychological and social support cannot be underestimated. Women who have undergone multiple traumas of loss of family members, loss of home and belongings, a long and frightening journey to a new environment, hunger, exhaustion, exploitation and - in all too many cases - rape, need all the support they can get. Women who survive all this have shown they are determined to win through. They are likely to be strong and resourceful but experiences like these take a heavy toll on their health - both physical and mental. Health services that take care of their physical health can help them stay alive. Psychosocial support through counselling, self-help groups and caring companionship can help them overcome the nightmares of the past and face the uncertainties of the future with a will to live.

Extracted from Safe Motherhood, issue 23, 1997 (1)

The Reproductive Health for Refugees Consortium

The Reproductive Health for Refugees Consortium consists of CARE, the International Committee of the Red Cross, John Snow. Research and Training, Marie Stopes International and the Women’s Commission for Refugee Women and Children. The consortium hosted a technical meeting in New York in April 1997 for field workers and representatives of nongovernmental organizations and United Nations agencies. The Consortium’s Reproductive health: guide to needs assessment and evaluation has been field-tested in over 12 refugee sites in the past year. Feedback was used to prepare five reproductive health tools for use in refugee situations: questions for refugee leaders; group discussion questions for refugee men or women; health facility questionnaire and checklist; and two surveys (for analysis by computer and for analysis by hand). The participants in the technical meeting revised these tools which will be made available soon. In several countries with significant refugee populations the Consortium plans to review reproductive health programmes to assess what progress has been made and what barriers still exist. Potential sites for the study are Armenia, Ethiopia, Georgia, Guinea, Kenya, Lebanon, Pakistan, Rwanda, Sierra Leone, the Thai/Burma border, the former Yugoslavia and Zaire.

ENTRE NOUS 38. Spring 1998
Bosnia-Herzegovina: a case study in service collapse

by Fedja Omeragic, WHO Tuzla

The recent crisis in Bosnia and Herzegovina exposed a fatal flaw in the established system of reproductive health care. Rates of perinatal and maternal mortality, and of prematurity, soared during the conflict: in Sarajevo alone, the infant mortality rate virtually doubled between 1991 and 1994, rising from 15.8 to 30.8 deaths per 1,000 live births.

The fatal mistake was the concentration of reproductive health care services in city hospitals. Even in peacetime this caused unnecessary delays, and many women chose to miss appointments rather than wait long hours for routine examinations. General practitioners and community nurses were not even allowed to prescribe contraceptives. When war erupted, the system proved disastrous. Many hospitals were destroyed or seriously damaged, expensive equipment was lost, and there was soon a critical shortage of basic medicines. Specialist health professionals often fled the country, while those who remained were overwhelmed with the needs of war wounded. Family planning and antenatal services were suddenly a very low priority.

During the war, as few as 20% of pregnant women in urban areas received regular check-ups; in rural villages, the situation was even worse. The result was a range of easily preventable problems which soon escalated to chronic levels: untreated urinary tract infections contributed to EPH gestosis and chronic renal disease; inadequate nutrition further affected renal functioning; untreated anaemia increased the risk of maternal and newborn mortality. The rise in infant death rates was swift and dramatic.

Maternal mortality rates also soared, rising as high as 57 deaths per 100,000 live births in Sarajevo in 1992-4. Even at Tuzla Hospital, which remained accessible and adequately equipped, the maternal death rate rose from 20 per 100,000 pregnancies before the war to 50 per 100,000 during the conflict.

General practitioners and other community health workers should be trained to advise on family planning, prescribe contraceptives, monitor women through pregnancy, assist normal deliveries, and refer complicated cases to specialist care. If it is all left to the specialists, there may be no one to help in a crisis.

Dr Fedja Omeragic
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From emergency assistance to sustainable reproductive health care

From 1998 onwards, UNFPA and WHO will be providing financial and technical assistance to further strengthen family planning and reproductive health services. The project will focus on information and health education activities for the public and on training health professionals in cervical cancer screening techniques. Contraceptives and other essential drugs for reproductive health care will be provided by UNFPA.
Peer education in Portugal

by Teresa Telleria

Since 1976, immigrants from former Portuguese colonies around the world have flocked to the Amadora district of Lisbon. Living conditions are cramped and often unsanitary, despite local government efforts to improve housing and to identify illegal immigrants. Even those who have valid resident permits are sometimes reluctant to use official health services. The Portuguese Ministry of Health believes that the best way to help marginalized immigrant communities is to develop innovative outreach services, taking health information and education out of formal health centres and onto the streets.

The Amadora peer education project, launched in 1990 as part of the Healthy Cities initiative, now involves 160 "health promoters" between 16 and 25 years old. Public health nurses began by identifying potential volunteers at community centres used by young people from Cape Verde, Sao Tomé and Príncipe, Guinea-Bissau and India. Interested young people were invited to discuss the health problems faced by their communities and to learn about prevention strategies. A typical workshop would begin by exploring the concept of risk and would move on to symptoms of illness participants might have encountered, linking them to risk factors in the environment and in human behaviour. Hygiene, nutrition, family planning and HIV/AIDS feature prominently in the health education materials developed by young volunteers in collaboration with doctors and nurses in charge of the training programme. Many of these materials are written in "creolo", the Cape Verde dialect used also by immigrants from Guinea and Sao Tomé.

Armed with their leaflets and posters, young health promoters go out into the community, leading sessions for their friends and relatives. Newly trained volunteers are supervised by professional health workers, but soon they are ready to work on their own. As integral members of fast-changing communities, they are able to reach people whom the professionals never see. When they report back to the community centre, they bring news of their achievements and their difficulties. They also bring new volunteers, so that the network of health promoters is constantly expanding as well as adapting its strategies to meet local needs more effectively.

In 1995 overall responsibility for the project was shifted to a single community centre, which now coordinates the work of health promoters throughout Amadora. The centre conducts an annual evaluation of the project, which is considered a success, despite the volume of need in these slum areas of urban Lisbon.

Dr Teresa Telleria is based at the Maternal Child and Adolescents Health Care Division, Directorate General for Health, Alameda Dr Afonso Henriques 45, 1056 Lisboa Codex, Portugal.

Slipping through the safety net

by Lucia Spada

Counting the number of immigrants in any country depends on how you define an "immigrant" and whether you attempt to count people who have slipped past border controls. In Italy, if you limit your measure to people of foreign nationality who have official permission to reside in the country, you come up with 683,600 individuals, representing 1.2% of the total population. Most of these immigrants have limited tourist, student, or working visas. Many, however, stay on after their permits expire, at which point they may disappear from official statistics.

The Italian constitution recognizes that all citizens have a fundamental right to health, and the 1978 law which governs the health care system accordingly guarantees the provision of adequate health care without discrimination. But the so-called Martelli Law passed in 1990 limited this right for non-nationals living in Italy: they must show proof of employment and residence every 31st of December to obtain a new "sanitary card". A new law passed in February 1998 guarantees regular health care to every non-national legally working or studying in Italy, living "in a family context", and with no criminal record.

Given this legal background, it is not surprising that statutory health services for the 12,500 immigrants living in Genoa are inadequate. Nongovernmental organizations like the Red Cross and Caritas attempt to fill the gaps. 2,000 women visit the Red Cross clinic in Genoa every year, most of them aged between 18 and 30 years. The great majority (at least 60%) come from Latin America, while 20% are from eastern Europe, and the remaining 20% from North and sub-Saharan Africa. Many need emergency help (usually after violent incidents at home or at work), but most others want reproductive health services, including contraception, abortion, and help with the menopause. Some present psychosomatic problems.

Users of the UICEMP (Italian Family Planning Association) clinic tend to be relatively well-adapted legal immigrants. But in 1995 the central hospital in Genoa treated 1,143 nonnationals: it seems significant that almost 20% were admitted for psychiatric emergencies. Clearly there are many immigrants slipping through the net of basic primary health care, at considerable cost to themselves and to the community at large.

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ENTRE NOUS 38, Spring 1998
Norwegian lessons

by Dr Berit Austveg

In 1975, Oslo’s Health Commissioner opened a Health Service for Immigrants. Funded by central government, the centre aimed to provide health care to people whose access to ordinary health services was limited by linguistic and cultural barriers, and to increase professional competence in providing multicultural health care. The service was geared towards immigrant women in particular, as the group least likely to benefit from mainstream services.

From 1975 to 1988 the Health Service for Immigrants provided health care, conducted research, trained health professionals, gave advice to health care providers, and distributed information to the general public. Staff from the centre also provided health education in the community, visiting women’s groups and religious centres, and working with immigrant media. In the early days about 90% of clients were of Pakistani origin, but as the centre increased its outreach, the proportion of Pakistanis fell to about 60% of immigrants using the service.

In 1988, after a difference of opinion with clinic staff, the newly appointed Health Commissioner decided to shut down the centre. Another clinic for immigrants has opened recently, with similar aims but more limited resources. Meanwhile the central government has attempted to improve health services for immigrants by issuing guidelines on the care of newly arrived immigrants; distributing training kits for health professionals, and developing health education materials in appropriate languages. There is also a Psychosocial Centre for Refugees with regional teams counselling immigrants with symptoms of trauma.

Over the years we have learned a number of lessons from our clinical work with immigrant women. For instance, we found that a targeted service need not restrict itself entirely to female staff, as many immigrant women will accept male doctors and nurses. On the other hand, professional interpreters are indispensable, not only for newly arrived immigrants but even for long-established residents, many of whom still face considerable language barriers. In over twelve years we treated only a few tropical diseases, none of them particularly exotic. Much more common were conditions resulting from micronutrient deficiencies, especially anaemia, but also rickets and osteomalacia. Conditions common among Norwegian women, such as diabetes and pelvic pain, were considered exotic by our users. We saw a number of patients with psychological problems, but in many cases it was difficult to distinguish the physical and psychological aspects of a patient’s condition.

That was only one of the unexpected challenges we faced. Advising patients from diverse backgrounds on reproductive choices, such as contraception or sterilization, was an extremely delicate process. Racial prejudice, on the part of both patients and staff, had an insidious tendency to affect power relations throughout the service. Sometimes such prejudice was linked to a fear of HIV infection. Again and again we were confronted with the trauma of migration. Patients who had experienced torture needed particularly sensitive handling in any medical examination or treatment.

A new service for minority women in Copenhagen

Since January 1998 the Prevention and Counselling Clinic in central Copenhagen has redoubled its efforts to reach minority women across the city. Run by the Danish Family Planning Association with funding from the city council, the clinic already attracts a few clients from immigrant communities, but hopes to encourage many more to come in for regular advice and medical check-ups.

For a two-year trial period, community nurses will carry news of the clinic to women in their homes and local neighbourhood centres. Targeted funding and training will allow the nurses to offer advice on family planning and to invite clients to the clinic for more specialist services. Women who prefer to consult a female doctor will be encouraged to come in on Thursdays, when a woman gynaecologist is available from 4.00 to 6.30 p.m. The centre also plans to arrange group sessions for migrant women on Thursday afternoons, when clinic staff will answer questions and encourage discussion on issues of particular interest.

Hanne Gylche, a midwife on the board of the Family Planning Association, explains that the clinic will target women from a wide range of communities, including Arabs, Turks, Pakistanis, Somalis and refugees from the various countries of former Yugoslavia. Basic leaflets on women’s health and family planning are currently available in Arabic, Turkish, Urdu, Serbian and Croatian. This year the materials will be improved and translated into additional languages. While there are no interpreters currently available, the clinic will be monitoring clients’ language requirements.

Contact: Hanne Gylche, c/o the Danish Family Planning Association, Skindergade 28, 1, 1159 Copenhagen K, Denmark.
Multicultural health promotion: are we getting it right?

by Margareta Ackerhans

Immigrants and refugees in Sweden

Immigrants have been settling in Sweden for the last 150 years, but until recently most came from European countries, including Greece and Turkey. Over the last two decades the pattern of immigration has changed dramatically, as it has in most countries of western Europe. A rapid influx of migrants and refugees from Latin America, the Middle East, southeast Asia and sub-Saharan Africa led to restrictions in immigration policy, with many newcomers refused asylum or granted only temporary leave to stay. As recently as 1975, nine out of ten immigrants living in Sweden were from other European countries; within twenty years, the proportion of non-Europeans had swelled to 35%. By December 1994 10.5% of the Swedish population were first-generation immigrants, a total of 992,000 residents born in other countries.

The incidence of HIV/AIDS among immigrants generally is low: in one group of 45,000 refugees and asylum-seekers, just 0.22% tested HIV-positive. Again, there are particular groups at greater risk: a 1995 study indicated that more than 20% of refugees and asylum-seekers from certain African countries were HIV-positive, while none of the 130,000 new refugees from the former Yugoslavia carried the virus. Persons of foreign origin now account for 42% of all registered HIV/AIDS cases in Sweden.

A healthy city project in Gothenburg

The Multi-City Action Project on AIDS is a European healthy city project launched in 1990 which aims to strengthen local HIV/AIDS prevention and treatment. Sixteen cities are now involved, with Gothenburg coordinating the action group on black and ethnic minorities. In November 1996, we hosted a workshop at which women from immigrant communities across Europe presented their own health projects. On the basis of their shared experience, participants agreed a series of recommendations on HIV/AIDS work with ethnic minorities.

Evaluation is essential

In 1995 I co-authored a study on the effectiveness of HIV/AIDS information distributed to immigrants in Sweden. Birgit Westphal-Victor of the School of Advanced Nursing Studies, Univeristy of Aarhus, Denmark, worked with me to develop a questionnaire aimed at county council and local authority officials running HIV/AIDS programmes. Our survey revealed that while most large towns and cities had developed some sort of health education programme, most county councils had done little. None of them had undertaken a systematic evaluation of how immigrant groups responded to information aimed at the general public. Interviews with immigrants themselves revealed that few felt such information had anything to do with them.

We concluded that an effective health prevention strategy involves targeting specific groups with culturally appropriate information, while ensuring that all population groups are covered. Mechanisms to assess health information needs, and to evaluate the effectiveness of information provided, are equally essential. Immigrant organizations and community groups must be genuinely and visibly involved in health prevention efforts.
Health needs of menopausal women

IPPF International Medical Advisory Panel

The menopause is the time in a woman’s life when menstruation ceases permanently and natural reproductive capacity comes to an end. Perimenopause, or the climacteric, is the transition period beginning about two years before the menopause and ending one year after. The various physiological changes women go through at this time can be attributed to reduced secretion of ovarian hormones, mainly oestrogens, as well as to the ageing process.

A woman’s health during the perimenopause will be largely determined by previous health status, reproductive patterns, lifestyle and environmental factors. Many women experience disturbing symptoms, usually not threatening to life, but nonetheless unpleasant. In addition, the transition from regular menstrual periods may generate anxiety. Some women fear pregnancy at a late age; others who have been trying for a child may regard the menopause as their final failure.

Physiological events

The only menopausal change common to all women is the cessation of menstrual periods. Some women experience changes in periodicity and amount of menstrual flow. Other possible symptoms include hot flushes, night sweats, vaginal dryness, vaginitis, dyspareunia, urethritis, urge incontinence and urinary frequency.

Loss of bone tissue accelerates in the years immediately after the menopause, the principal cause being low oestrogen production. Other factors may include smoking, prolonged immobilization, adrenocortical hyperfunction, hyperthyroidism and calcium deficiency. The risk of fractures increases progressively with age.

During the reproductive years more women die from malignancy than from cardiovascular disease, but this order tends to be reversed beyond 60 years of age. On average, women develop coronary heart disease about ten years later than men. It may be the loss of protection by oestrogens that accounts for women’s increased susceptibility in later years.

The incidence of cancer also increases with age. Reproductive cancers often arise during the perimenopause and early postmenopausal years, and early detection can improve the outcome.

General service issues

Health in the perimenopause is determined largely by health status in childhood and during the early reproductive years. Family planning provides caring for young women can therefore play a significant role in preventing problems associated with menopause and ageing. Wherever possible, perimenopausal counselling and care should also be provided within sexual and reproductive health services, to ensure that the needs of older clients are addressed.

The most important factors affecting women’s health during the menopause are behavioural. Information should be provided about the influences of nutrition and behaviour in the years before the menopause on the quality of life thereafter. The length of the interbirth interval is also important. Even with adequate calcium intake, bone density lost during pregnancy and lactation is not recovered for several months after weaning. If the interval between pregnancies is short, the calcium content of the skeleton will diminish and women will have a smaller reserve to face bone loss after menopause. Malnourished women may need even longer intervals. Regular exercise promotes cardiovascular health, and weight-bearing physical activity such as brisk walking and aerobic exercise slows bone loss and stimulates regeneration of bone tissue. Moderate bouts of exercise three or four times a week should be recommended. Women should also be counselled to give up smoking.

Misconceptions and fears about the menopause may influence women’s response to physiological changes and therapeutic measures. The best preparation is to help women see the menopause as a
normal stage of life, and to make sure they know what to expect. Educating men about the menopause is also important to ensure that they can be supportive.

**Contraception for menopausal women**

Because ovarian function fluctuates during the perimenopausal years, contraception is necessary until the woman has been amenorrhoeic for one year. Those women who, after proper counselling, choose to use a hormonal method up to the menopause, should be advised to discontinue this method at the age of 50. They must use other methods of contraception (mainly barrier methods such as condoms) until they are sure that they have reached the menopause. Women who have an IUD in place should have it removed one year after the last menstrual period.

**Hormone replacement therapy**

Hormone replacement therapy aims to restore circulating levels of oestrogen to average premenopausal levels. HRT originally consisted of the administration of oestrogens alone, but when the uterus is intact such unopposed therapy leads to a high risk of endometrial hyperplasia or cancer. Regimens that combine oestrogen with cyclical progestagens induce regular endometrial transformation and withdrawal bleeds, thus preventing the development of endometrial abnormalities. New continuous regimens offer the advantages of a combined preparation without withdrawal bleeding, which many perimenopausal women find unacceptable. Hysterectomized women, with or without ovaries, may use unopposed oestrogen replacement therapy.

In many women, HRT relieves the symptoms of oestrogen deficiency.

### Demography of the menopause

For most women, natural menopause takes place between the ages of 45 and 55. As life expectancy increases, more women spend a larger proportion of their lives in the postmenopausal state. In 1990, some 467 million women were aged 50 or over, 40% of them living in industrialized countries. By the year 2030, there will be an estimated 1200 million women over 50 years old around the world. Growing numbers of women can expect to live for several decades after the menopause.

The average age at menopause is about 51 years in industrialized societies. Women who smoke and those who have not had children tend to be younger, and there is some evidence that low socio-economic status is related to lower age at menopause. Analysis has shown that women with menstrual cycles averaging less than 26 days reach the menopause 1.4 years earlier than those with longer cycles. A woman’s age at menopause may be a biological marker of ageing, with later menopause associated with greater longevity.


Furthermore, women who have significant risk factors for either osteoporosis or cardiovascular disease (especially myocardial infarction) may benefit from its long-term protective effects. However, HRT is not without side effects or long-term risks (particularly breast cancer) and the individual decision to start it and continue it will depend on how the woman herself perceives the balance of risks and potential benefits.

The full statement on the health needs of perimenopausal women, drawn up by the IPPF Medical Advisory Panel (MAP) in October 1996, appears in the IPPF Medical Bulletin, volume 31, number 3, June 1997.

### ERRATUM

We would like to thank Dr Olaf Meirik, Chief, Epidemiological Research, HRE/HRP in WHO Geneva for pointing out that in the last issue of Entre Nous (No 36/37) there was a mistake in the headline chosen for the article on page 21: “Oral contraceptives not a risk factor for cardiovascular disease”. The heading should read: “Oral contraceptives not a risk factor for heart attack in healthy women”.

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**Abortion and breast cancer: good data at last**

Induced abortion does not increase a woman’s risk of breast cancer, according to new research recently published by M. Melbye, J. Wohlforth and five colleagues in the *New England Journal of Medicine* (1997; 336:81-5). In a study of unprecedented size, the authors linked data from the Danish Cancer Registry and the National Registry of Induced Abortions to compare the breast cancer and abortion experience of 1.5 million Danish-born women from 1935 through 1978. 10,246 women in the sample developed breast cancer over that period, while approximately 281,000 underwent one or more induced abortions.

Uniquely in this study, registration of abortion was entirely unrelated to the occurrence and registration of cancer in later years. Studies which rely on women reporting their own history are subject to recall bias, particularly if abortion is illegal or stigmatized in their communities. There is evidence that healthy women may be less willing to report a history of abortion than women who have just been diagnosed as having breast cancer.

Melbye and colleagues found that “overall, the risk of breast cancer in women with a history of induced abortion was not different from that in women without such a history”. They were able to adjust for parity and for timing and number of abortions as well as to examine any effect of gestational age at the time of abortion.

Summarizing these results in the *IPPF Medical Bulletin* (31:2, April 1997), Dr Carolyn Westhoff concludes that the causes of breast cancer, and the health effects of abortion, can now be assessed without unnecessary distraction.

“It should come as a great relief to clinicians, as well as to women everywhere, that these two big issues in women’s health are unconnected.”

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Books

The Essentials of Contraceptive Technology by Hatcher, Rinehart, Blackburn & Geller (Johns Hopkins Population Information Program, 1997).

This comprehensive reference work, fully endorsed by WHO, UNFPA and USAID, includes practical, scientifically-based guidance for clinical staff on family planning methods and STDs/AIDS. The 352-page book incorporates WHO medical eligibility criteria and Technical Guidance/Competence Working Group recommendations, while the accompanying wall chart for clients covers important points about family planning methods. Available for US $5 (free of charge to developing countries) from the Population Information Program, Johns Hopkins School of Public Health, 111 Market Place, Baltimore, MD 21202, USA, fax +1 410 659 6266

Documents

International Migration Policies (UN Population Division, 1998) gives an overview of current international migration policies in both developed and developing countries. Part one is devoted to three major policy issues in international migration: a) family reunification; b) citizenship, nationality and naturalization; and c) social, political, economic and cultural integration of migrants. Part two reviews policies and programmes targeting specific types of migration as well as national, regional and global instruments in regard to permanent migration, labour migration, refugees and undocumented migrants. Available from UN Publications, Sales Office and Bookshops, CH-1211 Geneva 10, fax +41 22 917 0027, e-mail: unpubli@unog.ch (ISBN 92-1-151320-0).


The first in a planned series of 20 comparable country reports examining new trends and patterns of partnership and reproductive behaviour in Europe and North America. Produced by the United Nations Economic Commission for Europe with support from the United Nations Population Fund, the reports are essential reading for policy-makers, administrators, researchers and students. Available for US $25 each from United Nations Publications, Sales Office and Bookshop, CH-1211 Geneva 10, fax +41 22 917 0027, e-mail: unpubli@unog.ch

The International Migration Bulletin is published twice a year, in May and November, by the Population Activities Unit of the Division for Economic Analysis and Projects of the United Nations Economic Commission for Europe. The Bulletin presents and analyses comprehensive data on international migration throughout the region collected by the Rapid Information System, a PAU project funded by the United Nations Population Fund. For the most recent issue contact United Nations Publications, Sales Office and Bookshop, CH-1211 Geneva 10, fax +41 22 917 0027, e-mail: unpubli@unog.ch

International Migration in Central and Eastern Europe and the Commonwealth of Independent States (United Nations, 1996).

Containing previously unpublished data from a variety of sources, obtained and analysed by national experts, this report provides an overview of major migration flows throughout the region, then gives a more detailed picture of migration in 11 selected countries of central and eastern Europe.Edited by Tomas Frejka for the United Nations Economic Commission for Europe and UNFPA, it is available from United Nations Publications, Sales Office and Bookshop, CH-1211 Geneva 10, fax +41 22 917 0027, e-mail: unpubli@unog.ch (Economic Studies No. 8)

Community Participation in Designing and Monitoring Reproductive Health Programmes (UNFPA Technical Report no. 36, 1996) analyzes community participation strategies in reproductive health programmes and UNFPA support for involving community members, particularly women, in the design, implementation and evaluation of projects. Available for US $5 from UNFPA, 220 East 42nd Street, New York, NY 10017, USA (ISBN 0 89714 383 3)


STD Case Management Workbook 6: Partner Management (WHO, 1995; Russian-language edition 1997). This final workbook in WHO’s six-part series on STD case management demonstrates how to work with patients to identify and treat their sexual partners. Now available in Russian from World Health Organization, CH-1211 Geneva 27 (WHO/GPA/TCO/PMT/95.18A)

Women who have terminated a pregnancy through abortion, whether or not it is a legal procedure in their local jurisdiction, are in critical need of appropriate family planning services to reduce the risk of future unwanted pregnancy. This manual provides concrete suggestions for modifying and coordinating services (e.g. between emergency abortion treatment and family planning services) to improve quality of care and ensure informed decision making. Available from the Division of Reproductive Health (Technical Support), Family and Reproductive Health, World Health Organization, CH-1211 Geneva 27 (WHO/RHT/97.20)

Shared Rights - Shared Responsibilities: European consultation on collaboration between government sectors, non-governmental organizations in AIDS prevention, support and care (WHO Regional Office for Europe, 1996).

This report of a consultative meeting held in London in October 1995 highlights the importance of involving community-based ethnic minority organizations in AIDS prevention and care. Participants stressed that ethnic minorities do not form a homogenous group, and that uniform structures for community-based ethnic minority organizations cannot be prescribed. Yet involving ethnic minority communities in decision-making at all levels, and acknowledging their specific cultural, religious and linguistic circumstances, is essential to the success of HIV prevention, support and care. The report and recommendations are available free of charge.

from: WHO Regional office for Europe, Scherfigsvej 8, DK-2100 Copenhagen, fax +45 39 17 18 18, e-mail postmaster@who.dk (EUR/ICP/AIDS 9402/C004)

Medical Methods for Termination of Pregnancy (WHO, 1997).

This report of a WHO Scientific Group reviews medical methods for the termination of first- and second-trimester pregnancy, examines their relative efficacy and acceptability, and discusses the factors that cause women to seek abortion services. The report makes a number of recommendations on the service environment required to provide medical termination of pregnancy, and calls for further research in this controversial field. Available for Sw. fr. 23 from Distribution and Sales, World Health Organization, CH-1211 Geneva 27 (ISBN 92 4 120871 6)


This paper identifies research priorities for the broader reproductive health programme, encompassing scientific, ethical and service management issues, as well as gender perspectives and developing country needs. Available from Family and Reproductive Health, World Health Organization, CH-1211 Geneva 27 (document no. HRP/PCC(10)/1997/9)

The Female Condom: an information pack (WHO/UNAIDS, 1997) describes the only method of protection from pregnancy and infection by STDs which is available for use by women themselves. Inserts discuss what the female condom is, why it is important, what is known about its safety, effectiveness and acceptability, and what is needed to make it more widely available. Available free of charge from Reproductive Health Technical Support, WHO, CH-1211 Geneva 27

Preclinical and clinical requirements for approval to market non-latex condoms (WHO, 1997).

On 13-15 May 1996 WHO gathered international condom manufacturers, drug regulatory authorities and condom experts at a consultation to discuss the development of safe and effective non-latex male condoms. The resulting recommendations are available free of charge from the Special Programme of Research, Development and Research, Training in Human Reproduction, WHO, CH-1211 Geneva 27 (WHO/HRP/TDA/97.1)

Communicating Family Planning in Reproductive Health: Key Messages for Communicators (WHO, 1997).

This indispensable handbook for health care providers and communicators presents eight key messages on reproductive health, backed up by essential supporting information. Available free of charge from the Family Planning and Population Section, World Health Organization, CH-1211 Geneva 27, Switzerland (document no. WHO/FRH/FPP/97.33).
RESOURCES

Videos

Reproductive Health in Refugee Situations—What can you do? (UNHCR, 1996)
This 12-minute training and awareness-building video is designed to encourage non-health staff working in refugee situations to promote reproductive health. The facilitator's guide which accompanies the video suggests activities to generate discussion on safe motherhood, sexual violence, STIDs including HIV/AIDS and family planning. Available on request from the Programme and Technical Support Section, UNHCR - C.P. 2500, CH-1211 Geneva, 2 Depot.

DIARY

Second meeting of focal points for reproductive health/health of women and children in the European Region, WHO Regional Office for Europe, Copenhagen, 11 to 13 May 1998.

The conference is organized jointly by the Kiev Research, Family Planning, Sexology and Andrology Center, the Eurasian Sexologist Association and the Ukrainian Family Planning Association and will focus on male, female and adolescent sexual dysfunctions, infertility of a couple, family planning in the sexual and reproductive health, sexual education, sexual identity disorders, sexual abuse.

TRAINING IN EUROPE

The Sir David Owen Population Centre at the University of Wales offers two Masters courses:
• MSc in Reproductive Health and Family Planning Management
• MSc in Population and Development
Short intensive courses are also available in various reproductive health management and communication topics, including IEC and management skills. Any specific requirements needed for your projects can be discussed with the Director of the Centre, Professor Tom Gabriel.
Enquiries to: Sir David Owen Population Centre, University of Wales, PO Box 915, Cardiff CF1 3TL, United Kingdom, tel. +44 1222 974794, fax +44 1222 874372, e-mail: Bournejth@cf.ac.uk

The Centre for Population Studies at the London School of Hygiene & Tropical Medicine offers two Masters courses:
• A new MSc Reproductive & Sexual Health Research. This new course aims to equip individuals with the knowledge and skills required to contribute to the improvement of reproductive and sexual health policies and programmes in developed and developing countries.
• MSc and Diploma in Medical Demography. The course offers a broad training in the theories and methods of demography and the population sciences and in their application to health, social welfare and economic development.
In addition, the Centre offers a four-week Short Course in Reproductive Health Research. The course introduces participants to the principles and methods of effective social and demographic research in this field, and concentrates on the design of policy-oriented research and methods of evaluating the impact of programmes. The course, which will start on 22 June and end on 17 July 1998, is suitable for those with research interests in this field, and for managers and others who wish to commission or use research results.
Enquiries to: Registry, London School of Hygiene & Tropical Medicine, Keppel Street (Gower Street), London WC1E 7HT, United Kingdom, tel. 144-171-9272239, fax +44 171 323 0638, e-mail: registry@lshtm.ac.uk

The Liverpool School of Tropical Medicine and the Royal College of Obstetricians & Gynaecologists run jointly a course for the Diploma in Reproductive Health in Developing Countries from April to July each year. The focus of the course is on reducing reproductive mortality and morbidity through an integrated community-oriented approach, appropriate to developing countries. The course is aimed at doctors and midwives and provides training in maternal and obstetric care, computers, management, health economics, epidemiology, research methodologies, family planning and abortion, adolescent health, infection and sexually transmitted diseases. Further information from:
The Course Secretary, Liverpool School of Tropical Medicine, Pembroke Place, Liverpool L3 5QA, United Kingdom, tel. +44 151 708 9393, fax +44 151 708 8733, e-mail: agordon@liverpool.ac.uk

Family Planning/Sexual and Reproductive Health (FP/RH) Course, 19 October to 7 November 1998, Netherlands. This 3-week training programme is organized by the Netherlands School of Public Health, the Rutgers Foundation and the World Population Foundation to familiarize health professionals and policy makers with strategies and approaches currently used in western countries in the areas of FP/RH, and to explore the possibilities of applying or adapting them to their local or national situation. Further information from: Henk Roink, World Population Foundation, Amperestreet 10, 1221 GJ Hilversum. The Netherlands, tel:+31-35-6422304 fax: +31-35-6421462, e-mail: wfp@xs4all.nl

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