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International Planned Parenthood Federation (IPPF)

IPPF is the strongest global voice safeguarding sexual and reproductive health and rights for people everywhere. Today, as these important choices and freedoms are seriously threatened, we are needed now more than ever.

The IPPF European Network is one of IPPF’s six regions. With 40 member associations in as many countries, IPPF European Network increases support for and access to sexual and reproductive health services and rights throughout Europe and Central Asia.

Mission statement

To advance the basic human right of all people to make free and informed choices in their sexual and reproductive lives; to fight for the accessibility to high quality information, education and health services regarding sexuality and sexual identities, conception, contraception, safe abortion, and sexually transmitted infections, including HIV/AIDS.

From choice, a world of possibilities

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Front cover: © Julia Matthews/Women’s Commission
The challenges of access to sexual and reproductive health services, information and contraceptive supplies are often incorrectly interpreted as irrelevant for Europe. The region is often perceived in a 'westernized' manner; the vast majority receiving comprehensive, good quality sexual and reproductive healthcare services and information, with a wide range of affordable contraceptives available.

However, there is a considerable discrepancy in the accessibility of these services throughout the region. In Eastern Europe and Central Asia, many people, predominately the poor and those in rural areas, still lack basic family planning services such as access to modern methods of contraception, and suffer from sub-standard healthcare facilities and services. Health workers are departing their former communist countries to find higher paid employment in Western Europe, leaving a shortage of trained healthcare professionals and a decline in the quality of services available. Furthermore, critical shortages in healthcare funding over the years have created a dismal situation for a great number of people in these countries.

In addition, there is often great inequality in the availability of healthcare services even in countries with well-known, quality healthcare provision. While a majority benefit from wide-ranging services, a small but significant minority’s access to these services falls woefully short. Vulnerable communities such as migrants and sex workers have far less access to family planning services and counselling, even though they show a higher prevalence of sexually transmitted infections (STIs), including HIV/AIDS, and run an increased risk of sexual and gender-based violence. At the core of this issue is the recognition that these communities have specific health needs unique to their status. There are often no services available targeting their sexual and reproductive health requirements, which adds to their feeling of marginalisation in a country where they may already feel ill at ease with the culture and language. When health services are already limited in some areas, and this is coupled with being unfamiliar with the health system or with individual health rights, the capacity of access to services is even less.

The growing influence of the Catholic church in Europe has created barriers in particular to contraception usage, which few governments are willing to counter. With the fall of the communist block, the church has increasingly taken a stronghold in social morality and has growing authority in these former secular countries. This hinders access not only to modern methods of contraception, but the church’s principles on homosexuality and HIV/AIDS also significantly contributes towards stigmatisation of these members of society. Social exclusion is a major factor in people being reluctant to seek the help they need.

It is unfortunately impossible to cover every aspect of access for vulnerable communities in this publication. Young people, for example, often lack specialised sexual and reproductive health services, despite being increasingly affected by STIs, including HIV. Comprehensive sexuality education is also frequently absent in school programmes. However, being such a significant topic, especially for the work of IPPF, it was felt inappropriate to select just one aspect of access for young people in this edition of Choices, but rather to devote an entire edition to young people in the future.

Access to inclusive and unprejudiced services for prevention, treatment and care should be a fundamental human right regardless of age, gender, sexual orientation or socio-economic status. IPPF believes that all people – particularly the poor, vulnerable, socially-excluded and underserved – should be able to exercise their rights to make free and informed choices about their sexual and reproductive health and to have access to these facilities.

By working with a variety of primary and secondary stakeholders, and through partnerships at country level, we can strive to reduce the socio-economic, cultural, religious, political, and gender barriers that limit access for many in our region. In addition, empowering disadvantaged groups will enable them to make educated and responsible decisions on their sexual and reproductive health, and will help them make better use of services provided.

Vicky Claeys
Regional Director
By Gunta Lazdane, MD, PhD, Regional Adviser on Reproductive Health and Research, the WHO Regional Office for Europe

In 1994, the International Conference for Population and Development (ICPD) agreed that one of the main goals in sustainable development is “universal access to reproductive health by 2015”. This includes access to information and education regarding contraception and the ability to use this obtained knowledge. Where are we in Europe in reaching this goal more than 10 years after the ICPD?

The latest publication of WHO Medical Eligibility Criteria for Contraceptive Use presents guidelines on more than 10 different kinds of family planning methods currently available, including different varieties and sub-types, different hormonal components and dosages. The access to these contraceptives varies in the European region and depends on many obstacles.

Factors affecting access to contraceptives in the European Region

- Interest of the pharmaceutical company to enter the market of the country
- System in the country for registration of the contraceptives
- Support of the national authorities (When asked “Why are hormonal implants not available in your country?” one policy maker replied, “They do not need it,” despite a lack of evidence to support this statement.)
- Knowledge of the health professionals involved in information, education and counselling (IEC)
- Level of knowledge concerning the use of contraception in the community
- Support of international organisations
- The system of distribution of contraceptives, for example family planning centres to gasoline stations
- The price of contraceptives, as well as other variables that are unique to more than 50 countries that are considered Europe by the international community.

There are countries, primarily in Western Europe, where only some kinds of contraceptives are not available and/or are just partly reimbursed by the insurance companies. This directly affects contraceptive choice. For example, vaginal diaphragms or female condoms are not always easy to find, despite the presence of women who through informed choice and personal preference wish to use them. Even when a variety of contraceptive choices are available, cost may prove prohibitive. The price of pills, even if partly reimbursed, is quite high for adolescents in many countries. Conversely in certain countries the only available contraception is provided by UNFPA, free of charge through reproductive health centres, where the mention of contraception outside of such centres causes surprise and embarrassment. Fortunately in the above mentioned circumstances non-governmental organisations, often Member Associations of IPPF, are evaluating the situation and trying to help their clients.

One of the 17 global WHO indicators in evaluating and monitoring the reproductive health status of a population is contraceptive prevalence rate; however, the present available data are often unreliable and do not present the real situation. The percentage of women with an unmet need for any contraceptive method ranges from 24% in Georgia to as low as 3% in Belgium and Spain (3, 4). The potential need for modern contraceptive methods in some countries in Europe is as high as 50% of married women ages 15-44 (3).

It is evident that much remains to be done to reach the goal of ICPD and in insuring that personal contraceptive choice, based on information, education and counselling is available and accessible.

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2. Contraceptive Prevalence in European Countries, 2004; http://www.euro.who.int/reproductivehealth/publications/publications

*Includes married, fecund women who say they would prefer to avoid a pregnancy but who either are not using any contraception or are using a traditional method such as withdrawal or periodic abstinence.
As part of the survey, data was collected in four regions of the Russian Federation, namely Ivanovo, Saratov, Orenburg, and Irkutsk. A randomized, household-based, cluster design was used to obtain a representative sample of men and women living in these four regions (including rural and urban populations). The sample consisted of 4,967 respondents between the ages of 14 and 35 years of age. Fieldwork was conducted between February 10 and March 15, 2005. All respondents were interviewed in person. The parts of the questionnaire involving more sensitive questions were self-administered by the respondents to maximize confidentiality and accuracy.

Contraceptive usage in Russia
In our research we compared contraceptive methods used by unmarried and married/cohabiting respondents. Then we compared what methods were used by respondents with regular partners with those with infrequent partners.

- Three quarters of unmarried respondents who had sex within the last 12 months reported that they had used a condom or contraceptive method the last time they had sex. However, men between the ages of 30-35 years and females between the ages of 14-17 years were less likely to have used contraceptives.
- Overall, 55% of married/cohabiting men and 62% of married/cohabiting women reported that they had used a contraceptive method during their last sexual activity with their spouse. Use of contraceptive methods with one’s spouse/partner increases with age among both men and women. Nevertheless, only 44% of men aged 18-22 years reported that they had used any contraceptive method during the last time they had had sexual intercourse with their spouse/partner.
- One third of married men and women reported using a condom with their spouse or regular partner, 20% reported using an IUD, 16% reported using the contraceptive pill and 32% did not use any method.
- The reported usage of contraceptive methods during sexual intercourse with an extra-marital partner was higher than with one’s spouse/partner. More than two thirds of men and three fourths of women reported that they used contraceptives during sex with an extra-marital partner (69% of females and 60% of males used condoms, 19% females report using IUD, 16% the contraceptive pill). While this is high, it is evident that at least one fourth of those who have extramarital relations had unprotected sex.

Attitudes toward contraceptive methods and abortion
Overall attitudes towards modern means of contraceptives were positive but at the same time there were still prevailing prejudices against them. For instance, 78% of men and 87% of women approved of the use of contraceptives, and most respondents did not see any particular obstacles from religious norms and authorities to using contraceptives. However, one third of respondents thought that religious ideologies were against women using family planning methods.

There was a lot of concern about the negative side effects of using various methods of contraception, such as the pill. Fewer than half of all respondents reported that they would rather accept some side effects from contraceptives than take a chance of becoming pregnant. In addition, 75% of respondents believed that contraceptives had dangerous side effects. Therefore, the survey highlighted some worryingly inaccurate attitudes towards some methods of contraception.

As far as abortion was concerned, one quarter of respondents believed that an abortion was the best solution to an unplanned pregnancy. Women who had had an abortion were somewhat more tolerant to this solution for unplanned pregnancies – 35%
agreed that abortions were the best solution for an unplanned pregnancy. However, overall attitudes towards abortion were very negative: 77% of males and 86% of females believed that abortions were much more harmful than any contraceptive method. The attitudes of teenagers towards abortions were similar to the attitudes of adults.

**Risky sexual behaviour**

The survey revealed that risky sexual behaviour was widely practiced. Twenty two percent of male married or cohabiting respondents and 11% of females reported having sex with a non-regular partner during the past year, and one third reported that they did not use any method of contraception with non-regular partners.

However, it is more accurate to look at unmarried and married/cohabiting respondents separately. Sixty eight percent of all unmarried males and 52% of unmarried females reported they were sexually active in the last 12 months. One quarter of sexually active unmarried respondents did not use any contraceptive method the last time they had sex. Most unmarried respondents reported using condoms (73% males and 59% females), followed by smaller proportions of respondents who reported using oral contraceptives or the withdrawal method. Therefore, there appears to be a similar pattern of behaviour for married respondents who report being sexually active.

**Use of reproductive health services**

Along with individual attitudes to sexual and reproductive health, healthcare provision plays a significant role in maintaining reproductive and sexual health. Unfortunately, it was clear that many Russians do not visit reproductive health services to get advice or counselling. Only 13% of males and 51% of females had ever visited such a service, and 7% of males and 28% of females ever discussed contraceptive methods with a healthcare provider. However, 62% of men and 80% of women were willing to visit a healthcare provider for sexual and reproductive health information or services.

The discrepancy between expectations and actual behaviour might be explained by various reasons such as the availability of an individual’s time to visit a healthcare provider, the quality of service provided, and the difficulty of accessing services, especially for rural respondents. As far as satisfaction on quality of services was concerned, only 21% of men and 25% of women who visited healthcare facilities reported being fully satisfied with the quality of help and information they received from the healthcare provider.

As a result of negative attitudes towards healthcare provision, half of males and one third of females who reported a STI in the past year did not seek any professional advice or treatment for their infection. The relationship between teenagers and healthcare providers is apparently even worse. Only 4% of boys and 16% of girls aged 14-17 years old had ever visited a health provider for reproductive health services. We could state as a positive trend that the proportion of those going for advice increases over the time and 20% of male respondents aged 30-35 years and 73% of females start visiting health providers.

**Partner communication on reproductive health**

Both men (83%) and women (78%) agreed that a husband and a wife should discuss family planning together. However, there appears to be a gap between desired behaviour and actual behaviour. Only about half of male and female respondents with a current sexual partner reported that they had discussed contraceptive methods with their spouse or partner in the past year. To correlate their attitudes with real behaviour, we explored the data on communication in relation to STIs. Only 56% of women and 45% of men informed their partners about any STIs they may have or have had.

Partner communication about contraceptives was least common among teenagers; only 22% of both boys and girls with a current sexual partner had discussed contraceptives with their partner in the last year. On the other hand, it was discovered that discussing contraceptive methods with friends and relatives appears to be fairly common. Respondents between the ages of 14 and 17 years appeared more likely to talk about contraceptives with a relative or a friend than with a sexual partner.

**Conclusions**

From the survey, we can determine a number of constraints that prevent the further growth of contraceptive usage in Russia. Russians are widely practicing risky sexual behaviour; for instance, having extra-marital relations without using contraceptives. Among those who are in stable relationships and have an extramarital partner, one third do not use any means of contraception.

Overall, the majority of respondents did not utilise reproductive health services to get and advice or counselling. This was particularly the case among males and adolescents. In general, Russians are reluctant to discuss reproductive health matters, although the majority agreed that a husband and a wife should discuss sexual and reproductive health and family planning together.

To change the situation in Russia and to continue growth of the usage of modern means of contraceptives, it is important to improve counselling skills of healthcare providers, and encourage both men and women to visit healthcare providers. It is clear that hindrances to people visiting these services must be addressed, since it does not seem to be a question of desire but accessibility. Providing widely available and affordable modern methods of contraception is clearly an important issue. It is also vital to continue carrying out awareness-raising campaigns not only on providing accurate and clear information about different methods of contraception, but also on the importance of mutual communication about contraception.

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*Photos: The Healthy Russia Project 2020/Center For Communication Programs of John Hopkins University*
Despite considerable efforts by law enforcement bodies and substantial international support to combat this practice, the number of Albanian girls and women forced into prostitution through trafficking continues to increase, with Albania also functioning as a country of transit for those from other countries such as Bulgaria, Moldova, Montenegro, Poland and Russia.

As well as a serious violation of human rights, it is important to also recognize trafficking as a health issue. Women forced into sex work face serious sexual and reproductive health consequences. In fact, compared to women who choose to work in the sex industry, trafficking victims maintain little control over their own bodies as their work may frequently be conducted under threat of force. During captivity, they experience physical violence, sexual exploitation, psychological abuse, poor living conditions and exposure to STIs and HIV/AIDS.

Young women are particularly at risk to trafficking for sexual exploitation. The most vulnerable come from economically and/or socially marginalized communities, where access to protection mechanisms such as social services, education and income generating opportunities are severely restricted. As a result, women who are trafficked often have limited information and many misconceptions about key aspects of their own sexual and reproductive health, including knowledge of STIs and HIV/AIDS.

Despite the severe health effects posed by trafficking, women's access to sexual and reproductive health (SRH) services and information is extremely limited because of restrictions in trafficked persons' movements, lack of knowledge of available services, cultural and language barriers, or insecurities about immigration status and legal rights which makes them reluctant to seek outside help.

While many organizations work together to address trafficking at national, regional and international level, very few tackle the sexual and reproductive health (SRH) aspect of trafficking, and policymakers rarely acknowledge trafficking as a SRH problem.

Providing medical support and treatment for trafficked women

In order to rectify this issue in Albania, the Albanian Centre for Population and Development (ACPD), started to collaborate with a shelter for trafficked victims in Vlora, a city in southwest Albania, by providing much-needed medical services to the inhabitants. A shelter is a place where trafficked victims are protected in a confidential and secure environment, especially when there are concerns about their safety or if there is the threat of falling victim to re-trafficking. The shelter offers counselling, psychological and social support to help women reintegrate into Albanian society and start a new life.
Through working with the ACPD, the shelter now also offers free medical care for trafficked victims, in private clinics where staff have been sensitized to their particular issues, and provide confidential services. Beneficiaries receive a range of medical and psychological assistance. Many have been exposed to unprotected sexual intercourse with clients, as well as violence and harsh living and working conditions, which have had direct impact on their health and well-being. Almost all request medical care, and this particularly involves gynecological treatment or check-ups. The medical care routinely includes a basic physical examination and testing for sexually transmitted infections (STIs). Trafficked victims are highly prone to STIs, particularly candida, hepatitis, syphilis, and genital herpes, and almost all recipients require treatment for these infections.

Trafficked victims are also vulnerable to HIV. HIV testing is available, free of charge, from health clinics in Albania. The shelter is unable to offer HIV testing but can refer trafficked victims to these clinics. However, as only a limited number of victims have so far been tested, it is impossible to estimate the number of victims at the shelter who had the virus. Anti-retroviral drugs are available and access to such drugs has been improved in Albania over the past few years, and is available free to the public, including those marginalized members such as trafficked women.

Pregnancy tests are also conducted upon request — there are sometimes instances when women have returned from trafficking pregnant or with children born while trafficked. Mothers have specific assistance needs, including the option of accommodation with their children, and programmes that support the development of good parenting skills. Single mothers are often particularly vulnerable, economically and socially, so there is frequently a need to address this with counselling and support. Some of beneficiaries discovered they were pregnant whilst abroad and obtained terminations in illegal, non-hospital settings, which may in turn have contributed to the high number of gynecological complications and infections. Family counselling may also be needed to reconcile families separated by trafficking / migration; guardianship can additionally prove an issue for returning mothers who have relinquished their guardianship rights.

Returning home is hard on all victims of trafficking, but especially on those who were trafficked over a long period of time. The shame and mental scars, including very low self-esteem, create great challenges for reintegration unless there is assistance and help at hand. Women returning to their families and community are confronted with stigmatization, discrimination and marginalization. Access to good quality and confidential health services is crucial, especially since mainstream practitioners vary greatly in their level of information and sensitivity, and women often fear that their personal details may not remain private.

The reality of trafficked women in Albania – a personal testimony

**Kozara* from Bulgiza, Albania**

“I was 13 years old, living in a village in Albania. One day a guy from the village next to mine forced me to get into his car. The guy took me to Gjirokastra, a city in the south of Albania, and kept me in a hotel, not letting me leave. After three long days I was taken to Italy, sold and made to work as a sex worker there.

My life in Italy was horrible… I don’t want to remember what happened. After three years of working as a prostitute in Italy I was sold again to some men in Belgium. I worked there for two years until the police found me and took me back to Albania. Finally I was at home… but nothing was as I had expected. No-one in my family was happy to see me again. They shouted at me and beat me continuously, especially my father. After a few months, I managed to escape the situation with a friend of mine. We decided to leave Albania and go abroad. We went to Fier, in Northern Albania, but I was captured and was sold again to some traffickers in the north of Albania. They took me to Italy for the second time. Two years later I was sent to Belgium again. It seemed that I could not escape; I was back in a situation I dreaded.

However, one day I met a man from Afghanistan. He helped me to escape my life as a sex worker and we began a new life in Holland. After some time together, I got pregnant. From the moment I told my boyfriend, however, everything seemed to change. He started to beat me every night. I hoped that things would be better when the child was born. However, the situation got worse and I was afraid for my child, so one day I left home, but he found me. He told authorities that I had abducted his child — that the child wasn’t mine. Thankfully the authorities did not believe him and I was permitted to keep my child. I was then repatriated back to Albania and consigned to the Albanian police. In the police station, I found out about the shelter in Vlora, for people such as myself. They were wonderful in helping me not only try and get over my past experiences, but also to find a house and a job. Now I am at last happy in Albania, with my new friends and new life.”

*Kozara’s story, though horrific, is unfortunately not uncommon. While it is difficult to stop this practice from continuing despite harsh laws and regulations, it is possible to help victims of trafficking to rebuild their lives, and hopefully prevent them from falling victim again. As part of this rehabilitation, good quality health services are crucial. The contribution of ACPD in collaboration with victim assistance shelters plays an essential role in helping trafficking victims receive vital social and medical support to help them overcome the severe mental and physical effects of this disturbing phenomenon.

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Published with the assistance of the Greek Ministry of Foreign Affairs, 2004 (available in Albanian and English)

* Second Annual Report on trafficking in South Eastern Europe 2004, IOM – Regional Clearing Point

Photo: IPPF EN/Albania
Migrant domestic workers (MDWs) are people who have accompanied an employer to the UK on a ‘domestic worker visa’ to work as part of their private household. A typical role would be as a nanny, housekeeper, cook or chauffeur. The majority of these workers are from South and South-East Asia and Africa. The isolated, dependant and unregulated nature of working in private household, combined with gender-based and racial discrimination means that domestic workers are vulnerable to exploitative practices. They can face physical, psychological and sexual abuse, discrimination, low pay and long hours. Migrant domestic workers are often unfamiliar with the UK system and unsure of their rights in the UK. Kalayaan works with its clients to overcome these barriers and improve their quality of life. In 2004–2005, 92 % of MDWs registered at Kalayaan were women.

Once in the UK, MDW’s are allowed to change their employers so long as they continue to work inside a private household. This is a relatively new rule (1998), and comes as a result of the British Home Office recognising that MDW’s experience ‘abuse and exploitation’. Typically their first visa will be for six months, after which they will be given a renewable one year visa. In order to renew their visa they will need to provide the Home Office with some evidence of their employment relationship. This is usually a letter from the employer confirming they wish to continue employing the domestic worker, and a form outlining the terms and conditions of the job. MDW’s are required to pay tax and national insurance contributions on the money they earn and in turn are protected by UK employment law. They also have free access to primary healthcare.

On paper, it seems that MDWs are protected by law and should enjoy the majority of rights as British citizens. However, in practise, this is not always the case. In 2004, of the 322 newly registered MDW’s at Kalayaan, 74 % reported psychological abuse; 82 % reported working over 15 hour days with no days off; 25 % reported physical abuse (being beaten, kicked, or having things thrown at them); and 5 % suffered from sexual abuse. It is not uncommon for MDW’s to tell us that their bed is a rolled mat on the floor of the children’s room, or even the kitchen floor and perhaps they are not allowed to use the same cutlery and crockery as their employers for fear of ‘contamination’. The psychological abuse is most frequently name calling such as ‘dog’ and ‘donkey’, but it can also become a much deeper form of psychological control that the employers uses over the MDW. MDW’s often have little to no knowledge of the structures that exist in the UK. Many speak hardly any English, and
have had it reinforced to them that they are ‘illegal’, or at least would be were they to leave their employers, and were such a thing to happen the police would catch them and send them home. This problem is magnified when employers withhold MDW’s passports. In many countries this is required by law; however, when an employer withholds a MDW’s passport in the UK, they are prohibiting them from accessing basic services such as healthcare.

Maternity rights and the Migrant Domestic Worker

Kalayaan has recently registered a number of MDW’s who have become pregnant whilst in the UK. As stated above, MDW’s are protected by UK employment law, which includes statutory maternity pay, protection against dismissal and against sex discrimination. They are also deemed as ‘ordinarily resident’ in the UK, therefore as the Department of Health guidelines state, “Any person living in the UK lawfully and on a settled basis is regarded as a resident in the UK and therefore entitled to free primary medical services.” However, they must be in employment at the time they wish to access medical services.

On paper this could seem confusing. Does somebody have to be actually in employment when they have their baby in order to have free maternity care? Accessing protection prescribed by employment law often requires going to an employment tribunal – are these women in a position, physically, psychologically and status wise, to do such a thing? If the employer has not paid tax and national insurance contributions, does this automatically mean they are not entitled to maternity pay? Is it not unfair that MDW’s bear the burden of unscrupulous employers? These individual testimonies highlight the situations many female MDWs face in the UK.

**MDW 1**

MDW 1 was given full maternity care by a hospital in the UK. However, after she had the baby, she started to receive letters asking for approx £3000 of payment to cover the healthcare costs incurred. When she had given birth her visa was still valid. Since giving birth, as a result of not being able to work and being unable to pay for childcare costs, her visa had expired. When enquiries were made to the health trust to understand why these charges were being billed to her, their response was that the visa allows her to access healthcare whilst in employment, and it is reasonable to assume that she was not in employment at the time of giving birth. This was true, her job had been terminated, she was not working anywhere and she was not receiving maternity pay. Immigration lawyers advised that this was inappropriate, even racist, of the health trust to take the hard line. However, they also said in order for her to argue the case it would become public that her visa expired, and she therefore would suffer from the risk of deportation in trying to challenge the health trusts decision. She has now submitted an application to the Home Office to renew her visa.

**MDW 2**

This MDW had her baby in London. She had separated from her partner, she had little to no financial support and her visa had expired before she had given birth. She has not been billed (to-date) for the medical care she received; however the nurses were concerned about her situation and referred her to social services. Social services wanted to help her return to her home country. The MDW did not want to return to her home country and felt like she was being treated like ‘a criminal’ just after she had had her baby. The pressure from social services, combined with fear and a mixture of emotions caused her to run away from the temporary hostel that social services had provided for her. She then came to Kalayaan for help, but was so afraid that she would not leave any contact details and has not been back since. She had no money and nowhere to live. It was obvious that she required support, her mental health had been seriously affected by the pressures she now found herself in. However, she was only assessed by social services on the basis of her immediate immigration status and the only option presented to her was to return back to her home country.

**MDW 3**

MDW 3 was working up until the 8th month of her pregnancy. She had been sleeping on the floor, working 7 full days each week, being given inadequate food to eat. She was paid no money for her work, and was very scared and confused. She had already been to see her doctor and been to an ante-natal clinic. Her employer asked her to leave when she knew MDW 3 had no other support in the UK. Physically she was not in a position to take her employer to the employment tribunal and the priority was her immediate needs: those of food, shelter and money. Kalayaan helped her access a religious organisation that would provide her with accommodation and support. No other organisation would provide any help. Social services were very unwilling to help: she had no right to access their support as they were under the remit of ‘public funds’, however they do have a responsibility to her unborn child. Again, the fear was that once the baby was born they would support her to return to her country of origin as her only option, or potentially separate her from her baby (whilst this only occurs in very extreme circumstances, the fear alone acts as a powerful preventative measure in accessing their support).
Conclusion

On the one hand, there is a lack of continuity in the support provided to pregnant MDW's as in the example of MDW (s) being the only person who was asked to pay healthcare costs. The potential that healthcare costs could be billed at any point must lead to a very different maternity experience and clouds an already emotionally charged event with insecurity. However, the fact which unites all MDW's is that as a result of their immigration status, they were not provided any post-natal support and the majority were so terrified of the consequences of accessing social services support that it has forced them and their baby into the potentially permanent condition of an illegal migrant. This underground world does not even have the pretence of rights or protection and results in abuse and exploitation being commonplace.

A question we may ask ourselves when reading the case studies is whether these women were acting irresponsibly by having a baby in the first place. But as soon as we pose that question, we have fallen into the trap of classification of rights, and the exclusivity of reproductive rights. If someone is British they have the right to choose to have a child, as well as receiving support, but if someone is not a citizen, then they have a different set of rights. Despite the claims that MDW's are protected by employment laws, these are not as easy to access for a migrant as a British citizen, and can easily become illusory.

The British government is currently revising its immigration policy. This will have significant implications for MDW's such as attaching MDW's to their employer – so in cases of abuse and exploitation the only option would be to return to their country of origin, and possibly reducing any free access to the National Health Service (NHS) on the grounds of their non-acquisition of British nationality. If these policies come into practice we are in grave danger of taking all human rights away for migrants in the UK and in particular MDW's. If the rights that exist to protect MDW's are only an illusion, then we can no longer say that they have these rights and we need to collectively understand that MDW's have become a commodity that is only of interest to us as long as it is useful.

Kalayaan is a UK registered charity established in 1987 to provide advice, advocacy and support services in the UK for migrant domestic workers.

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Photos: Kalayaan/UK
Providing sexual and reproductive health counselling for migrant women: the Swiss experience

By Christa Spycher,
PLANeS (The Swiss Foundation for Sexual and Reproductive Health)
(IPPF Member Association)

Due to their living and working conditions, asylum-seeking women and couples, as well as other relatively new migrants, are most vulnerable to sexual ill-health, and in great need of counselling on contraception, pregnancy and abortion. Migrant women should be given the same access to sexual and reproductive health counselling as the rest of a country’s population. However, in many countries, this is not the case. Based on long-term practical experience, a counselling centre in Switzerland – a country with one of the highest percentages of foreigners in Europe – offers an explanation on how this can be achieved.

The Centre for Family Planning, Contraception and Counselling in Pregnancy Complications in Bern has operated for more than 20 years as a small, multi-disciplinary team consisting of doctors and sexual and social counsellors; it falls under the management of the University's women's hospital. At present, migrant women comprise approximately 20% of the Swiss population, and originate from a wide variety of different countries and cultures. Counselling services at the Centre are often fully-booked up to months in advance by, among others, Vietnamese, Kurdish, and Albanian migrant women.

The availability of multi-lingual counselling services and information materials has always played an important part in our family planning services, and translators are called upon for those languages not spoken by the centre’s staff. We are convinced that an important part of counselling services on sensitive issues such as sexuality and pregnancy should be carried out on a woman-to-woman basis, and that the person assisting in translation should also be a woman. It is only at a later stage that the conversation should be expanded to include the partner. Our experiences with such settings are very positive and are backed by objective evaluations.
We engage translators from within the migrant communities in Switzerland. Those women who are interested and willing to function not only as a linguistic translator but also as cultural mediator will almost always step forward. The cultural mediators / translators offer their knowledge regarding cultural intricacies and behaviour, while the staff member offers her expertise as regards to family planning issues. Of course, it takes time and trust from both sides to establish an efficient form of collaboration. Counsellors, doctors and midwives should all be able to understand and grasp the environment, the particular situations and the various differing contexts of these migrant women, and know how to act accordingly.

Programmes for educating female counsellors in German-speaking Switzerland in working with migrant women have been developed, with similar programmes being implemented in the French and Italian-speaking Swiss regions. Some of the main aspects involved in the counselling of migrant women are highlighted below.

CONTRACEPTION

The contraceptive behaviour of migrants is often based on traditional and largely unreliable methods. Explanations for this kind of behaviour often relate to the connection between migration and cultural background. If any contraceptives are used at all, then these consist mostly of methods the woman / couple has had previous experience with, such as the rhythm method or coitus interruptus. Access to other, more reliable contraceptive methods can be difficult for migrant women, as they lack knowledge on the healthcare systems of their host country. This explains why these women only learn about other contraceptive methods and the possibility of counselling when they often first come into contact with the healthcare system – when they are already pregnant, or after birth.

For contraceptives to be used in a reliable manner, it is important to discuss them in great detail in the counselling session. Side effects of some methods, such as irregular bleeding, can alarm women into discontinuing using the contraceptive. Additionally, if Pill use results in unwanted side effects such as headaches or weight gain, a woman might fall back on other unreliable measures and end up taking the pill only every other day, or only periodically hoping that the side effects will disappear. This of course can render the pill ineffective. It is vital that it is made clear to her why the ovulation regulation method is scheduled the way it is, and that contraceptive protection can only be guaranteed through systematic, regular use.

Acceptance of the copper coil contraceptive is difficult, and is also dependent on existing images: we have come across differing perceptions of the localisation and location of this “alien element”, often accompanied by related psychosomatic complaints. Fear-induced comments (such as “the coil will move into the brain”, or “the baby will be born with the coil in the ear”) from close friends are more trusted than explanations from the counsellor / doctor in the foreign host country.

Young migrant women should be carefully questioned about their basic knowledge of anatomy and physiology. These women are often placed in a difficult situation: on the one hand, loyalty to the family, and traditional and cultural practices, and on the other hand to the new world of peers and school friends, and an often very different culture and environment in the host country. How are they to manage when they are to take the pill secretly at home? In such cases professional confidentiality becomes doubly important.

We regularly come across the general assumption that a breast-feeding woman cannot become pregnant. It is also generally believed that a middle-aged woman of about 40 years or more is no longer fertile.

It is important to recognise that efforts as regards to disseminating contraception information to migrant women may sometimes falter, as ambivalence may prevail with these women who can see pregnancy as a source of power and strength in an uprooted situation, and experience this as resource and great hope.
**ABORTION**

The rate of abortion in migrant women in Switzerland is almost four times the number of those among the domestic population. Many explanations exist for this. With unreliable contraception reside the specific psycho-social components of a migrant woman’s reality: insecure residence based on asylum status or judicial aspects for foreign residents, insufficient integration in the host country, and dire financial situation. Add to this the additional strain of a lack of child-friendly work and living without the traditional support of the extended family.

When a woman of around 40 years of age falls pregnant, she is often embarrassed, especially if she already has children in reproductive age. Within the family the husband is generally the only person who knows about the pregnancy. In such situations it would be entirely misplaced to rely on translation provided by one of the woman’s children. If we don’t understand the woman’s language, a different translator will be sought. In most cases the client is very grateful and feels taken seriously in this already difficult situation that she is faced with.

**VIOLENCE**

It is vital to remain attentive and open when an act of violence is being reported. In such situations, the status of the pledge to confidentiality becomes even more important. However, it is of equal importance to point out that any act of violence is against the law, whilst informing the victim that no actions will be undertaken without her agreement. It often takes some time before sufficient confidence has been built before judicial steps can be taken.

Victims of Female Genital Mutilation (FGM) are often only recognised as such during pregnancy or after giving birth. Migrant women rarely address these issues themselves: (“I feel like a Swiss woman, but I have the body of a Somali woman”). Guidelines, that are now applicable throughout Switzerland, have been developed by a multi-disciplinary team in order to sensitise health staff to this practise. Moreover, it must always be stressed that FGM can lead to prosecution and is a criminal act in Switzerland.

**The consultation methodology**

Good collaboration between counsellor and translator is extremely important. “Practise makes perfect” is one thing, but the application of some procedures should be essential. Before a consultation with a migrant woman, the content and goal of the consultation is discussed in a meeting between the counsellor and the translator, an initial scripting of the upcoming consultation is agreed upon, and the translator is reminded that she is bound to confidentiality. It must be clear that the counsellor has the lead and total responsibility for the entire consultation process.

At the start of the consultation itself, the client is first introduced to the translator after which the counsellor explains why this third person was asked to join. The strict adherence to confidentiality is underlined. Responsibility for leading the counselling discussion remains in all cases with the counsellor. It is important to take into account the seating arrangements and the establishment of eye contact with the client. Some counselling techniques specific to such settings include: the counsellor speaks to and with the client, not with the translator; the conversation is conducted in short and comprehensible sentences with many interruptions for translation; possible emotions such as long silences, crying and anger must be permitted and given their place as in all other counselling sessions. The greater the problem of comprehension, the blunter and almost patronising counselling may become. The counsellor must remain alert to prevent this at all times.

If time permits, a debriefing should also be held in which the translator has the opportunity to be asked about important observations and difficulties and what cross-cultural issues were encountered.

When in a new and unknown environment, migrants tend to firmly hold onto their homeland traditions, often making them more conservative than they were in their home countries. During very conflicting or weighted consultations it can be of importance to support the translator in her involvement.

**Conclusion**

In Switzerland, there are competent and increasingly available services for migrant women. Universities and NGOs in the field of sexual and reproductive health organize the education of cultural translators / mediators as well as the training of sexual consultants. The Ministry of Health of Switzerland recognizes the importance of these consultations with the presence of translators / cultural intermediaries throughout Switzerland, and has produced a policy paper on “Migration and Health – Strategic Implementations 2002–2006”. It is vital that other countries acknowledge the importance of making this kind of counselling available for migrant women, who increasingly make up a significant percentage of many European countries.
Disabled people have sexual needs too!

By Elliot Lazerwitz, 
Israel Family Planning Association (IPPF Member Association)

People who are physically or mentally handicapped still have needs and worries concerning sex and love. Many of them grow up suppressing feelings of sexuality and sexual identity. Their tendency for negative self-image and low self-confidence, combined with the ‘special needs’ and requirements of their medical situation, all require the creation of a tailored service for counselling and education on sexual behaviour, sexual health and relationships.

Their ignorance concerning sexuality, combined with a thirst for contact and intimacy, lead many disabled people onto the path of sexual exploitation, unplanned pregnancies and sexually transmitted infections. Statistics show that young disabled people undergo frequent sexual abuse. Coupled with dependence on their families and caretakers, this prevents them from reporting most of these incidences.

In Israel, there are tens of thousands of young people with disabilities. In recent years, there has been a growing awareness of the need for systematic sexuality education for disabled youth. Disabled youth find that their problems of adolescence are increased by their disabilities, and their need for counselling is even greater than that of their able-bodied peers. If they have received sexuality education at all (for example at school), it may not have been in an acceptable, understandable format or may have seemed inappropriate and focused on the sexual needs of able-bodied individuals.

The strong and clear need for a service in Israel specializing in information and counselling on sexuality for youth and adolescents with disabilities inspired the Israel Family Planning Association to establish the ‘Open Door for Disabled People’ Centre in Tel Aviv. The Centre provides disabled youth with sexuality education, information and counselling, discreetly and free of charge. It aims to help young people develop responsible sexual behaviour, and deal with the transition from childhood to adulthood. It also provides them with information on sexually transmitted infections, contraception, fertility and adoption, and gynecological care from doctors specializing in disability medicine. At the same time, parents and staff also receive counselling, for the feelings of helplessness and embarrassment encountered when facing their adolescent children’s struggle with sexuality.

The Centre’s staff consists of one doctor, one social worker, one special gynecologist, one specialist in adolescent medicine and one sexual rehabilitation expert. The staff also includes 30 volunteers – therapists, teachers, nurses and doctors. They have undergone intensive training and provide face-to-face services twice a week. The Centre also has a telephone hotline and a website.

The immediate association between disability, dependency and sickness has formed the prevailing false belief, held even among some medical professionals, of disabled people’s ‘asexuality’. These misconceptions have done damage to all concerned.

Case study:

Vered, a 20 year old girl, was living with SCI (Spinal Cord Injury) and was unable to control her bodily functions. She additionally had no sexual sensations. Outwardly, however, she could walk with no visible disability. She came to the Open Door Network for help after several failed attempts at forming a relationship. She was attractive and intelligent, and was studying at university. She was unsure when to tell her partner about her disability. Up till now, she had delayed this revelation till later in her relationships and generally her boyfriends had panicked and left her.

She also had many questions about sexual functioning, controlling bodily functions, how to have sexual relations, and if she was fertile.

The sexual therapist for disabilities at the Open Door Centre worked with her on how and when to discuss her disability with others, in particular with a partner. Soon after their first meeting, she met a new partner. When she contacted the therapist again, she told of her new, successful relationship and renewed confidence and ability to discuss her sexual feelings and needs.

Individuals with disabilities are frequently targets for sexual abuse, and one aspect of the Centre’s work is to help disabled young people to learn to distinguish between appropriate and inappropriate physical relationships, and to recognize the signs of sexual abuse.

One of the main problems disabled adolescents face is poor self-esteem and lack of confidence. It is vital that they know that their sexual needs are normal and acceptable. The Centre offers the tools they need to develop a more positive self-image so they may enter adulthood confidently, securely and independently.

It is important that disabled people understand that it is their natural right to establish and maintain healthy intimate relations with a partner of their choice. In addition, raising awareness is vital to change prevailing societal attitudes of the ‘asexuality’ of disabled people in order to lessen the marginalization of this vulnerable group.

The Open Door Centre for the disabled is one part of a network of Open Door Centres initiated by the Israel Family Planning Association – the Centres are open to youth and adults of all religions, races, and ethnic groups. An Open Door Centre for the Arab community has also been established, to address the sexual health needs of the Arab community in Arabic.

For more information, visit: www.opendoor.org.il/OpenDoorCenters.htm

Photo: Israel Family Planning Association/Israel
As Vice Chairman of the European Parliament’s Foreign Affairs Committee since 1999, Baroness Nicholson of Winterbourne MEP has been working on these issues for many years. Through her role as Rapporteur for Romania from 1999 to 2004 and in her capacity as WHO Special Envoy for Health, Peace and Development, she has witnessed the critical issues and challenges inherent in healthcare provision in Central and Eastern Europe.

One of the fundamental problems, she argues, is the chronic lack of money spent on healthcare, not only by countries themselves in Eastern Europe, but also by rich, donor countries in the EU failing to target their aid at healthcare. “After the fall of the Berlin Wall,” she says, “health ministers in the European Region failed to make the necessary investments into the former countries of the Soviet Union.” She believes that this is where the bulk of the money to modernise and improve the healthcare systems in Eastern Europe should have come from, and would have made a great difference at the time of the formative shift in power and development of those Eastern European countries emerging from the shackles of Communism.

In addition, EU Member States have decided that health is not an EU competence, so naturally health is one of the highest priorities for national governments. “Therefore,”

Baroness Nicholson explains, “it is very difficult, if not impossible, for health ministers from the wealthy EU Member States to grant large sums of money to their counterparts in Central and Eastern Europe”. Coupled with this, she explains, many of the former Soviet Union states are now, or are on their way to become, Member States of the EU themselves. Further east across the region, countries fall under the wider European neighbourhood policy. “Because of this,” she says, “they are counted out for the development cooperation budgets which traditionally focus on basic need provision such as health.”

These budgets are now primarily directed towards ACP countries, (African, Caribbean and Pacific Group of States), 79 of the poorest nations worldwide. To access these budgets, Central and Eastern Europe states would be competing with other countries around the world who many feel are in more urgent need. Some development ministers already think too much money is being spent on Central and Eastern Europe as it is. “Look at the pressure for aid for Africa,” Baroness Nicholson argues, “correct and proper, but I was at a meeting where Clare Short, then Development Minister for the UK, strongly criticised the EU for the rising proportion of funding we had been spending in

1 List of ACP countries: www.acpsec.org/en/acp_states.htm

Photo shows Baroness Nicholson (centre) with the Romanian Prime Minister Mr Calin Popescu Tariceanu and the winners of the Edelweiss Contest, a Romanian event which celebrates talented children from underprivileged backgrounds.
Baroness Nicholson believes that there has been great ignorance among many EU countries of the intense health needs of Central and Eastern Europe. This has been clouded by the more immediate, desperate and widely televised plight of African countries suffering the consequences of extreme poverty. “Central and Eastern Europe’s health needs have fallen by the wayside,” she argues, “so the position of the people is either no better, or in many instances, considerably worse even than under the Communists. This is because the free market is not an appropriate mechanism for European’s healthcare provision”.

Many countries in Central and Eastern Europe are now either entering the EU or are accession countries – Romania being a case in point. It may be too soon to tell whether healthcare funding and provision have improved in countries such as Poland now they have become EU members. And since healthcare is dealt with on a national rather than EU level, it is not subject to the common minimum standards that exist across many other EU policy areas. “Coming into the European Union takes time – for example, 15 to 18 years in Romania’s case”, says Baroness Nicholson. “As a consequence, Romania’s people have suffered greatly through lack of budgetary provision, intense corruption throughout the health system and significant under provision of health by a wide margin to virtually the whole population”. She adds that much of this budget is not used in line with modern healthcare guidelines, or indeed with transparent and accountable mechanisms.

Therefore, there are many problems inherent in the system which affects the provision of good quality healthcare. “I am gravely unhappy about the situation of health for the people of Romania,” she says, “and just as unhappy about people’s health in neighbouring countries, whose situation is not just the same, but significantly worse - for example Moldova, and Ukraine.” Statistics show that these countries are worryingly comparable to the bottom quartile of the lowest income countries worldwide, in terms of access provision, insufficient healthcare resources and rising levels of serious infections, such as HIV/AIDS. “The situation is very serious”, says Baroness Nicholson. “I have strongly recommended to the new government in Romania that health is one of their topmost priorities, and I want to spread this message throughout other Central and Eastern Europe countries”.

All people, young and old, are affected by these challenges in accessing healthcare, but none more so than women, Baroness Nicholson argues. “Women are by far the largest consumers of healthcare worldwide”, she says. “They bear and look after children, their relations, the elderly; women inevitably consume most of the health provision. In consequence, they are the greatest sufferers from the lack of adequate access to healthcare.” She considers it vital that the EU should be given some authority over health to avoid the significant disparity in healthcare evident in many countries in Central and Eastern Europe. “I very much regret the fact that the EU has not been given a minimum, regulatory competence on health throughout the EU and accession states, and I believe this should come to avoid these dramatic imbalances in health provision”.

As well as the EU, she believes that health regulatory bodies need to be given sufficient power and resources in order to confront the serious situation of health in many countries. The WHO, she says, works tirelessly in tackling the needs of healthcare, but it doesn’t have enough funds to address healthcare problems worldwide. “The money given to WHO each year is a triviality compared to the health needs of the world”, argues Baroness Nicholson. “The WHO works very hard to make things happen, but it isn’t given the money to let it do it’s work to its full potential. It could sort many problems out if it was given substantially more money.”

Healthcare has to be addressed at a national level first and foremost in order to address positive change most rapidly. Baroness Nicholson believes that one of the serious weaknesses in Central and Eastern Europe is a “heavy and outdated focus” on failing hospitals. “Hospital provision should be the last stage of healthcare provision”, she maintains. “Primary healthcare is the key – as was agreed by the world’s healthcare ministers in 19788 – when you swing your budget away from major hospitals to primary health, that’s when you start to see a real improvement in the health of the nation”. She believes this is the model that Romania should follow. “Preventative, curative strategies – immunisation, women’s health, educating healthcare professionals – all these things are tried and trusted methods for rapid improvement in a nation’s health,” she says. “I spoke with the Romanian minister of health about this and I am trying to persuade Romania to adopt this sort of attitude which has been shown to work in other countries. Hopefully then improvements will start to be seen, but most importantly, the people will get the access to good quality healthcare they need and deserve.”

Baroness Nicholson of Winterbourne MEP is Member of the Alliance of Liberals and Democrats for the South East region of England. She is also the Founder and Chairman of the AMAR International Charitable Foundation, which she set up in 1991 to provide emergency aid for refugees in southern Iraq and the Iraqi marshlands in response to the acute humanitarian crisis.

Migration flows from Central and Eastern Europe towards Western Europe in the last decade have encouraged significant changes in the prostitution scene in Europe. In this new international context, prostitution has become an important labour option for a growing number of women. A considerable number of these sex workers are migrants – in the majority of European countries, female migrant workers constitute as high as 70% of the country’s sex workers.

Many of these women are from outside Europe such as Africa and Latin America, but an increasing number are from Central and Eastern Europe and the Balkans, migrating westwards across the region to settle in EU countries. Most are illegal immigrants, with no legal protection and few rights in the country of their residence.

The illegal nature of migrant prostitutes has severe consequences on not only their living and working conditions, but also their health. Sex work, as a result of its characteristics, can isolate prostitutes from any possibility of contact with other social circuits, and added to this are a migrant sex worker’s cultural and linguistic isolation. Faced with not only the difficulty of integration to a new culture and country, but also aggravated by discrimination at being a sex worker, the vulnerability of migrant sex workers becomes critical. Because of their illegal status, migrant sex workers do not have valid health insurance, and consequently have no access to the healthcare system. Additionally, because of their insecure and marginal situation, they have no access to information about their rights and possibilities of getting HIV/AIDS/STI prevention and treatment, even if they are insured. Since health service providers are not often trained to deal with a multicultural population, migrant sex workers are usually discriminated and misunderstood, and therefore are especially vulnerable.

The continuous fear of deportation also limits the motivation of women to undergo STI/HIV tests. In addition, they are often restricted in leaving their working place, or are afraid to move around the city because they are undocumented persons. This clearly shows the extent to which repressive policies affect migrant sex workers, their health and the implementation of STI/AIDS prevention programmes.

The acceptance of prostitution and the process of internationalism are important for effective healthcare and HIV/STI prevention for migrant sex workers. It is vital to establish cooperation across the whole of the region in order to fully address the needs of migrant sex workers in Europe.

TAMPEP is an international project facilitating such networking and collaboration with like-minded NGOs in 25 European countries, promoting the rights of migrant sex workers in Europe. With the increasing expansion of the European Union and the migratory flows of sex workers from East and Central Europe to Western Europe, the involvement and participation of these CEE countries is a must in order to deal with the international phenomenon of prostitution. The network facilitates exchange of knowledge and models of good practice among social, health and civil rights projects for sex workers in the member countries. It has also worked in strict cooperation with relevant international agencies such as UNAIDS in order to harmonize strategies and give recommendations for new policies.

Members use their national networks to disseminate resources and methods for working with migrant sex workers to service providers in their countries. They run targeted projects for migrant sex workers in cooperation with organizations in the countries of origin, transition and
destination. However, promoting safer sex practices alone is not sufficient. Informing migrant sex workers about the safest condoms, instructing them on their use, and teaching negotiation skills with clients needs to be supplemented with direct fieldwork - actual assistance in purchasing condoms, or ensuring that they are supplied with condoms that are adequate. Similarly, informing sex workers of the value of regular preventative medical attention must be complemented with referral to addresses of empathetic doctors. In other words, campaigns will have no effect unless they are combined with services.

Many members have found that outreach / street work is the most effective technique in working with migrant sex workers. Street work must be organised according to the characteristics of prostitution in a country or city. It must be systematic, frequent and intensive in order to build a relationship of trust with migrant prostitutes. It gives a better overview of each specific situation, promoting safe sex practices, carrying out STI/HIV prevention activities in an efficient way, influencing positive behavioural change and building up on migrant sex workers' self-confidence and self-esteem. The direct contact permits the development of grassroots activities tailored to each group, particularly with the involvement of a 'cultural mediator' - go-betweens who appreciate the customs, language and culture of the sex worker, and are capable of eliciting trust from them. They allow a more effective and direct dialogue with the target group and also function as intermediaries between the migrant and health service providers.

The common analysis of the phenomenon of migrant prostitution and the development of effective responses to the identified issues is made through continuous network-wide communication. The organizations keep each other up-to-date on the progress of their projects and compare notes on the pros and cons of various techniques. By doing so, all associated organizations learn from each other and a strong, specialized network of services is created.

Although the situation in each country differs, common comprehensive strategies that include HIV/STI prevention, health promotion and, more generally, a legal and social framework to deal with prostitution are urgently needed. In the health domain, the rationale for providing services should be that sex workers have a right to health services. Delivery of good services, outreach and an involvement of clients, partners, owners of establishments, the police and judiciary, media and policy-makers are all important.

In the social domain, activities should include anti-violence / protective activities through awareness raising in the community, as well as the provision of social and legal support, with the ultimate objective of sex workers' empowerment. In the civic / public domain, existing networks of NGOs that have been active for many years and associated organizations learn from each other and a strong, specialized network of services is created.

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Rape, increasingly used as a weapon of war, as well as sexual exploitation, put refugee and IDP women and girls at risk of sexually transmitted infections (STIs), including HIV/AIDS, unwanted and high-risk pregnancies, unsafe abortions and death. Lack of access to reproductive health (RH) services, including safe motherhood and emergency obstetric services, family planning, protection from violence and care for survivors of sexual violence, and prevention of the transmission of HIV/AIDS and care for people living with AIDS, also put refugees and internally displaced persons (IDPs) to face extraordinary difficulties that affect their reproductive health and rights. Uprooted adolescents, who are especially vulnerable to sexual violence, exploitation and HIV/AIDS, often face multiple barriers to accessing RH services and information.

The Women’s Commission for Refugee Women and Children (Women’s Commission), founded in 1989 under the support of the International Rescue Committee, is an expert advocacy organization which works to improve the lives and defend the rights of refugee and IDP women, children and adolescents. The Women’s Commission first documented the lack of RH services for refugees and IDPs in its seminal report, Refugee Women and Reproductive Health Care: Reassessing Priorities in 1994. The findings from this report were advocated and corroborated by refugee women themselves at the International Conference on Population and Development (ICPD) in 1994 where the rights of refugees and IDPs to RH were specifically recognized in the Programme of Action.

Every year, millions of people around the world flee their homes to escape conflict and violence. Exposure to violence, lack of protection, education and health care, poverty without livelihood opportunities and separation from families and communities cause refugees and internally displaced persons (IDPs) to face extraordinary difficulties that affect their reproductive health and rights.
In 1995, two key consortia, the Reproductive Health Response in Conflict (RHRC) Consortium1, a network of seven NGOs, and the Inter-agency Working Group (IAWG) on Reproductive Health in Refugee Settings2, composed of approximately 40 United Nations, government and international organizations, were established to improve refugee and IDPs’ access to comprehensive good quality RH services. The RHRC Consortium implemented a strategy to address RH advocacy, service delivery, research, documentation, training and small grants support for local and international organizations, while the IAWG developed the Reproductive Health in Refugee Situations: An Inter-agency Field Manual3 which outlined both the initial minimum and comprehensive services in refugee and IDP settings, and also served to coordinate efforts among humanitarian actors to improve refugee and IDP’s access to comprehensive good quality RH services.

Progress, Gaps and Challenges Ahead

A recent UN inter-agency global evaluation of RH for refugees and IDPs shows that significant progress has been made in raising awareness and advancing RH for refugees in all areas of RH in stable camp settings. However, gaps do remain, particularly components of safe motherhood and emergency obstetric care, family planning, treatment of STIs and the newer areas of gender-based violence (GBV) and HIV/AIDS programming. In addition, more services are needed to meet the needs of youth and address male involvement4.

The current US government is taking a more restrictive stance on women’s reproductive health and rights. This is having an alarming effect on refugees and IDPs – some international agencies that receive US funding are avoiding public endorsement of RH. This is particularly evident with any activity that would demonstrate a public endorsement of the RH services that have recently become more controversial, such as emergency contraception (EC), post-abortion care, use of condoms and adolescent RH. Diminished political support for RH combined with reduced funding for these programmes is devastating to the lives of millions of refugees and IDPs around the world.

Safe Motherhood

Every year more than 525,000 women die from maternal causes5. The desperate circumstances of refugee and IDP women fleeing conflict place them at further risk of pregnancy-related illness, disability and death. Childbirth may take place in a ditch alongside the road, in the forest or in a makeshift shelter. Once they arrive in an area of relative safety, whatever health services displaced women were familiar with before their flight are no longer available to them.

A decade of war and ethnic fighting in Bosnia and Herzegovina destroyed a large part of the health infrastructure, health services and systems that existed before the war. The International Rescue Committee, in collaboration with local staff, implemented one pilot project to improve comprehensive emergency obstetric care (EmOC) at Bihac, Mostar and Gorazde hospitals in three cantons of Bosnia and Herzegovina. Specific activities and outcomes included: provision of medical equipment and essential medications; establishment of a sustainable revolving fund for essential medicines; provision of in-service training for health professions on skills such as manual vacuum aspiration and contraceptive services; upgrade of laboratory facilities; and improved systematic data collection. At the end of the project improved utilization of facilities was demonstrated through increased numbers of deliveries and EmOC complications managed by staff at Bihac hospital though the numbers remained unchanged for Mostar and Gorazde hospitals.

Contraception

Recent global evaluations show that contraceptives are much more widely available than a decade ago, particularly for refugees in stable camp settings. However, it is essential to address the remaining challenges of ensuring quality service provision and increased usage, particularly among IDPs. It is also important to plan to make contraceptives available at the start of a crisis, because displaced women are known to request these supplies early in an emergency, as they did in Indonesia following the Tsunami.

1 Refugees have crossed an international border while IDPs have not, but their circumstances are similar.
3 Inter-agency Working Group on Reproductive Health was established by UNHCR, UNFPA and WHO.
Although emergency contraception (EC) is not a form of abortion and does not work if a woman is already pregnant, it is politically controversial in the United States and there is an unfortunate chilling effect on its use in conflict-affected settings where there are even more compelling reasons for its use. For example, displaced populations are vulnerable to sexual exploitation, and unintended sexual intercourse or breakage of a condom could be especially dire for displaced women and their families in the desperate circumstances of emergency settings.

**STIs/HIV/AIDS**

In crisis situations, refugees and IDPs may be especially vulnerable to STIs, including HIV/AIDS, and if not addressed, STIs can spread rapidly among the displaced population. Effective measures for the prevention and treatment of STIs and HIV/AIDS are available but often poorly implemented. The lack of training, skills and user-friendly guidelines for humanitarian workers contribute to the problem.

**Gender-based Violence**

Throughout history, gender-based violence (GBV) has been an integral component of armed conflict. Sexual violence is often systematic, for the purposes of destabilizing populations and destroying bonds within communities and families, advancing ethnic cleansing, and expressing hatred for the enemy. Protecting conflict-affected women from sexual violence and ensuring survivors of sexual violence receive appropriate care is not adequately addressed in humanitarian emergencies.

The Women’s Commission is addressing, in collaboration with the RHRC Consortium and IAWG, RH service gaps such as adolescent reproductive health, emergency contraception, STI/HIV/AIDS and emergency obstetric care by supporting technical capacity-building on RH for humanitarian service providers.

We also aim to prevent rollbacks in US government support and policies, and to increase Canadian and European Union governments’ support of RH for refugees and IDPs. We are working with a broad coalition of partners, deliberately going beyond the “usual suspects” in the RH field to include human rights, faith-based, research and academic organizations to garner a united response in support of RH for refugees and IDPs, as needed. We are also working to increase attention to key RH issues and services at the field level, such as EC and adolescent RH – controversial issues that are vulnerable to cutbacks if pressure is not maintained.

In collaboration with the RHRC Consortium, IAWG and others, the Women’s Commission has produced and continues to globally disseminate numerous advocacy documents, guidelines, training materials and resources that address the specific gaps in the technical areas of RH for refugees and IDPs. Other activities that facilitate RH technical support and services at the field level include piloting “model” projects to demonstrate the feasibility of specific RH programming in humanitarian emergencies in order to facilitate replication by humanitarian actors.

**Conclusion**

Significant achievements have been made in advancing RH for conflict-affected populations over the past decade, yet there are still major gaps in RH technical areas, in RH programming in the early days and weeks of new emergencies, and for IDP populations. The challenging political and economic climate threatens this progress. Scientific-based policies and funding are essential to realize the use of the relevant RH technical resources in the field and to ensure good quality, comprehensive reproductive health services are provided in conflict settings by adequate numbers of well-qualified staff.

For more information about the Women’s Commission for Refugee Women and Children, visit: www.womenscommission.org

Photos: Julia Matthews and Mary Diaz/Women’s Commission
Improving sexual and reproductive health services in Eastern Europe and Central Asia

By Martijn Pakker, Project Coordinator, Quality of Care

During the last four years, IPPF EN has been implementing the Quality of Care project, a global project aimed at identifying the inequalities existing in the quality of sexual and reproductive health services, and strengthening the quality of these services at member association level.

Quality of Care is a concept which is specifically geared at management standards, hygiene standards and service provision, giving service delivery points a more human and a less clinical character. IPPF EN is currently working in five countries in Eastern Europe and Central Asia: Poland, Armenia, Estonia, Albania and Bulgaria. IPPF EN granted funds based on an action plan which is drawn up and submitted after a self-assessment of services. The self-assessment has enabled the member associations (MAs) and service delivery points (SDPs) to give themselves an interim evaluation and the opportunity to address needs, complications and opportunities in their second action plans. The second action plan has been implemented in all countries with the exception of Estonia.

The project is now in the process of its final evaluation and external assessments. The external assessments are aimed to give the opportunity to the MA to receive a fresh and outside opinion. The external assessment team is made up of the QOC project coordinator and an external consultant. The countries already having undergone an external assessment are Poland, Armenia and Bulgaria. All of these countries scored exceptionally well on this assessment and are all adhering to the Quality of Care principles.

When undertaking an assessment, the team revises and checks the level of implementation of the management and individual SDP action plans. The Quality of Care standards have been placed in a checklist and each SDP and the management are scored based on the level of implementation of criteria on this checklist. Since these criteria have been set up to apply to all SDPs in a global sense, most countries in Eastern Europe are already adhering to these health standards due to healthcare reforms in the region.

Poland is exceptionally strong in its quality of care standards. Each SDP throughout the country has its own point of strength. Certain clinics are specialized in HIV counselling and certain centres are dedicated to working with IDUs and sex workers; others are dedicated to catering for the special needs of young people. They are encouraged to share their expertise with other SDPs within the country, to make all of them equally strong and supportive of each other.

Armenia is also very dedicated to improving the standards of healthcare provision. Based on the QOC standards and guidelines, they have created their own “client friendly” standards and certification, where strict criteria are given to the friendliness, cleanliness and medical provision aspects of the SDPs. The management has taken on a large task with this and are coping with it well.

Bulgaria has a wide range of service delivery. They are particularly strong in creating a network of referral for cases which they are not able to handle themselves. They have been able to establish an excellent network of referral and they already offer a wide range of contraceptive and counselling services at their own SDPs. They are encouraged to build on this and to increase their client handling capacity in order to increase sustainability.

Although the QOC funding is finishing at the end of 2005, the aim of IPPF is to encourage MAs to stimulate adherence to the guidelines at all levels. The MAs already having participated in the QOC programme are also encouraged to expand their activities and to become experts in their area, and to share their lessons learned with other MAs. All of the participating MAs are congratulated in their particular commitment to the improvement of the standards of service delivery in the field of SRHR.

Photos: IPPFEN/Bulgaria and Armenia
Standards of sexual healthcare have been established for women, but men have no similar code. Pap tests bring women in for frequent visits to the gynaecologist; there is no equivalent for men. If men wish to get sexual health advice, their doctor is often the only person to turn to, but to whom many men are unwilling to discuss issues of an intimate nature. Any services available for men often fail to see men’s problems from a male point of view, and even manage to exclude or prohibit men from getting help - many family planning centres are situated in obstetrics and gynaecology clinics, and even the names of counselling centres are often targeted at women and motherhood.

Being less used to accessing sexual healthcare than women, men are often unaware of methods for STI and HIV prevention. Services are especially important men with low incomes and minorities, who are vulnerable to contracting these infections, and who are less likely than other men to have access to good medical care.

To meet these needs in Finland, The Sexual Health Clinic of the Finnish Family Federation (Väestöliitto) created the ‘Men’s Moment’ project to help improve male access to sexual health information and services, and to raise awareness of the sexual health and rights of men. In 2000, they organized a national survey for school students aged 14 -15 in Finland, investigating their knowledge of sexual health. The survey revealed that the boys’ knowledge was far worse than the girls’ in all areas of sexual and reproductive health. There can be various reasons for the results. The biological maturation of girls is, on average, about a year ahead that of boys. Therefore, at the age of participating in the survey, boys may not yet be seriously interested in issues of sexuality. In addition, girls often learn more about sexuality than boys from their peers, as well as from their mothers, school nurses and healthcare personnel, especially upon reaching puberty. Boys seldom talk about these issues with their parents, and conversation with their peers often consists of plain boasting. Not being provided with male-targeted, quality sexuality education at a crucial stage in their development means they grow up lacking in knowledge or alternatively use the mass media as their main sexual educator. However, the media often displays distorted or extreme images of men. Men are either seen as violent troublemakers, or successful pop or sports stars. The average man and his sexual feelings and needs does not interest the media, and the life of the family-loving man is pictured as old fashioned or ridiculous. This can all lead to feelings of inadequacy, poor self-image and confusion among adolescent boys, with few people to turn to for help.

Sexuality education

The need for gender balanced, comprehensive sexuality education in schools was clearly needed. Working with the National Board of Education, the Men’s Moment project helped develop a curriculum of sexuality education for schools, as well as creating educational material for it. This curriculum and materials — the Nine Step Model and Human Basic Health — were disseminated throughout schools in Finland to guide teachers in providing sexuality education classes.

An online sexual health clinic

One of the most successful initiatives of the project has been the creation an online sexual health clinic for men, www.seksuaaliterveys.org. The sexual health services can be used by anybody with internet access. In Finland, with its widely scattered population, this is a clear advantage. With this service, Men’s Moment aims to reach as many men as possible and give them the possibility to get answers easily even to difficult and intimate questions.
The clinic provides three essential services: 1) information and articles on sexuality, 2) a question and answer database, and 3) virtual sexuality counselling. The goal is to improve people’s capability to take care of their sexual health and also to provide information for healthcare professionals working in the field of sexual health. Men have found this kind of source for sexuality information extremely useful. The reason may be the lack of widespread, quality information, the anonyymity of using an online clinic, and the ease of access.

Other tools
The online clinic revealed that the average visitor was a 24 year old man with questions about sexuality, and relationship problems such as difficulty in finding a partner. To compliment the service, books focused on these issues were also published. Men’s Moment has published High Voltage – Tales for the Everyman aimed at men aged between 18 and 28 years of age, and also From Lego Blocks to Leopard Skin Boxers - A Journey from a Boy to a Young Man, a sexuality education book aimed at adolescents.

Though the primary attention in this project has so far been given to adolescent boys and young men, the aim is to cover all age groups. Early interaction material for men and their children has been recently developed. Let’s romp together is a book planned to support early interaction and attachment between infants and their fathers. The pictures were designed to visually attract babies aged 0-12 months, and the text gives advice to fathers on how to communicate with an infant. The material supports not only the well-being of the child, but also of the father, and, in the best case scenario, the unity of a whole family.

Collaboration with the Church
It is obvious that with one small project, it is difficult to reach out to the widest possible audience. Therefore, Men’s Moment has collaborated with other organisations working with adults and youth. One such organisation is the Evangelical Lutheran Church. Approximately 90 % of 15 year olds in Finland attend confirmation classes, which are generally followed by a week-long camp session. The central areas in the training scheme are the young people’s own questions about life, which also includes sexuality. The Lutheran Church believes accurate age and culture-appropriate information about sexuality is the foundation for the nurturing of healthy adolescents, adults and relationships. The Men’s Moment sexuality education material has proven particularly suitable for the youth work of churches, and it is widely used. It discusses sexuality as an inner process, developing slowly and step-like – not as a function. It strengthens people’s understanding about their own stage of development, and emphasizes respect between people, while reinforcing the importance of mutual consideration and decision-making when it comes to having sex.

The future
Men’s Moment is a co-ordinating and important acting member of the EU Daphne Programme II 2004-2008, which also involves Estonia and Latvia. The theme of the Programme is the primary prevention of violence through increased understanding of the essence of aggression, and the education of aggression management. The project develops tools for professionals, children, adolescents and parents to understand and cope with emotions, such as aggression as a normal phenomenon, which it is possible to learn to control. Men’s Moment are now writing and testing in schools the comprehensive, age-appropriate, step-like teaching material Steps of Aggression – a model for 0-25-year-old children and young people.

Conclusion
Men’s Moment strives to enforce multidimensional manhood to counterbalance a simplified male image. Online clinic services and educational material are vital, but face-to-face contact is also very important. At the sexual health clinic, doctors and other specialists provide many kinds of medical and counselling services for men as well as women. Direct and intensive interaction with the target group also provides the basis of knowledge which is needed in creating credible materials. Other activities include giving interactive lectures for school groups of adolescent males. We insist on teachers being present at all lectures, so as to also provide them with knowledge on gender-specific issues. Men’s Moment has also arranged several seminars for professionals, the media and general public. These have included collaboration with the Finnish Police (a seminar on aggression), and with the Church (on fatherhood).

During its five years of activity, Men’s Moment has grown to be a noteworthy expert in male issues in Finland. It has succeeded in reaching boys and men by offering a variety of services, and from successful collaboration with the National Board of Education, the Evangelical Church of Finland, and the Helsinki police, other like-minded NGOs, the media, and with teachers and parents. Male attitudes towards gender and sexual relations arise in boyhood, when they are often set for life. This is why it is so important to provide comprehensive sexuality education and support in the concept of sexual responsibility, as well as ongoing education and support in order to experience satisfying, healthy sexual relationships.

For more information about the Men’s Moment Project, contact:
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Photos: IPPF EN/Belgium and Väestöliitto/Finland
Reaching out to refugees

The International Centre for Reproductive Health (ICRH) has reviewed the SRH status, needs and rights of asylum seekers and refugees in *Sexual and Reproductive Health and Rights of Refugee Women in Europe*. A survey among 15 EU member states assessed national policies towards this group. The survey revealed that promoting and improving refugee women's sexual and reproductive health and rights in Europe will contribute to their integration in European host societies. Based on these studies, recommendations to policy-makers were formulated.

To download the studies: [http://www.icrh.org/Documents/literature.pdf](http://www.icrh.org/Documents/literature.pdf)

Reproductive Health Outlook (RHO) has a section on refugee reproductive health giving an overview and lessons learned, key issues and programme examples. It also provides links to other organizations and resources.

Go to the site: [http://www.rho.org/html/refugee.htm](http://www.rho.org/html/refugee.htm)

Reaching out to migrants and minorities

*Bridging the cultural divide in health care settings* is designed to assist healthcare organizations in planning, implementing, and sustaining cultural programmes that mediate between groups or persons of different cultural backgrounds to effect change. It encourages the use of cultural brokering as a key approach to increasing access to, and enhancing the delivery of, culturally competent care.


The *Cultural Competence in Primary Health Care: Self-Assessment* tool helps to gauge the degree to which an organization is effectively addressing the needs and preferences of culturally and linguistically diverse groups.

To download the self-assessment tool: [http://gucchd.georgetown.edu/nccc/orgselfassess.html#benefits](http://gucchd.georgetown.edu/nccc/orgselfassess.html#benefits)

Improving sexual and reproductive health services

The *IPPF Medical and Service delivery guidelines* focus on the concept of 'quality of care'. The aim of these guidelines is to enhance client satisfaction and increase demand for and acceptability of SRH services by guiding health professionals in providing high quality sexual and reproductive healthcare.

Sexual and reproductive health programmes should take the necessary steps to ensure that services will reach all individuals who need them, especially those for whom health services are not yet easily accessible.


Reaching out to trafficked persons

What are the barriers to accessing health services of people that have been trafficked for sexual exploitation? A report (by the London School of Economics and Tropical Hygiene) on *The health risks and consequences of trafficking in women and adolescents* gives us an excellent insight into the difficulties trafficked persons encounter in accessing health services and information. This has an incredible impact on their health status.

Interviews were conducted by researchers in Albania, Italy, the Netherlands, Thailand, and the United Kingdom with women who had been trafficked, health care and other service providers, NGOs working against trafficking, law enforcement officials, and policymakers.

To download the study: [http://www.lshtm.ac.uk/hpu/docs/traffickingfinal.pdf](http://www.lshtm.ac.uk/hpu/docs/traffickingfinal.pdf)

Interviewing a person who has been trafficked raises a number of ethical questions and safety concerns for the person, others close to him/her, and for the interviewer. The World Health Organization developed *ethical and safety recommendations for interviewing trafficked women*. They are intended primarily for use by researchers, members of the media, and service providers unfamiliar with the situation of trafficked women.


Resources

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Reaching out to sex workers

The TAMPEP network has developed a range of resources to support health promotion interventions with migrant sex workers. These resources can be used and reproduced by organisations focusing on sex work and can be downloaded from the CD-ROM *Multi-language information and education for sex workers*. More information on this CD-Rom and an order form can be found here: http://www.tampep.com/order.html

EuroPAP developed *Practical guidelines for delivering health services to sex workers*. They are targeted towards health and social workers who have had formal training in health issues, or developed practical experience through their work, and who deliver healthcare and health services to sex workers.

To download the guidelines: http://www.europap.net/dl/guidelines/layoutENG.pdf

*Hustling for Health, Developing services for sex workers in Europe* is a handbook developed by Europap. It offers a snapshot of various guidelines, projects and interventions from around Europe. It is a practical guide which promotes health and safety in the sex industry through better access to good services. It describes innovative programmes of peer education, outreach, and health promotion schemes for different groups of sex workers, clients and managers in the sex industry.

To download the handbook: http://www.europap.net/dl/archive/publications/H4H%20UK_version.pdf

Reaching out to people with physical/mental disabilities

The *Sexuality and Disability Webliography* aims at meeting the sex education needs of individuals with disabilities, their carers, and professionals with an interest in the topic. It provides readers with easily accessible information, in a variety of formats, including plain language.

To download the webliography: http://www.bccpd.bc.ca/i/pdf/WDI/Sex_DisabilityWebliog.pdf

Reaching out to people with learning disabilities

fpa (the IPPF Member Association in the UK) provides training in sexuality, sexual health and relationships for professionals working with people who have learning disabilities. fpa resources to support this work include:

- *Sexuality and learning disability*, based on fpa’s highly successful learning disability training, a down to earth guide highlighting a range of creative approaches for staff who work with learning disabled people.
- *Talking together ... about contraception*, two user-friendly books: for everyone who works with or supports a young person with a learning disability; and for young people with learning disabilities.
- *Talking together... about growing up*, a workbook to be used in school or at home to help children with learning disabilities learn about the changes that happen when they grow up.
- *Talking together ... about sex and relationships*, the follow-up to Talking together ... about growing up, aimed at school or parents and carers working with young people with learning disabilities.

More information on these publications and an order form can be found here: http://www.fpa.org.uk/about/pubs/index.htm

Reaching out to Injecting Drug Users

*Developing HIV/AIDS Work with Drug Users - a guide to participatory assessment and response* was developed by the International HIV/AIDS Alliance. The handbook describes the steps to designing and carrying out a participatory assessment of the drug-related HIV/AIDS epidemic and other drug-related harms. It uses a participatory assessment and response approach. The ten steps include setting up an advisory group, making contact and building trust, and analysing information.

To download the guide: http://www.aidsalliance.org/sw7369.asp

Reaching out to vulnerable, marginalized and socially-excluded young people

IPPF European Network has developed a *handbook for peer educators to teaching vulnerable, marginalized and socially-excluded young people* - This handbook is intended for peer educators, master trainers and non-governmental organizations (NGOs) that wish to run peer education programmes for young people, especially those from vulnerable, marginalized and socially excluded (VMSE) groups and communities. It provides information on barriers and obstacles, as well as best practices and lessons learned. To download the guide, visit www.ippfen.org/publications
### EUROPEAN MEMBER ASSOCIATIONS

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<td>email: <a href="mailto:mtfp@planning-familial.org">mtfp@planning-familial.org</a></td>
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<td>GEORGIA</td>
<td>Association HERA XXI (FPAGEO)</td>
<td>email: <a href="mailto:ntsul@caucasus.net">ntsul@caucasus.net</a></td>
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<td>GERMANY</td>
<td>PRO FAMILIA Bundesverband</td>
<td>web: <a href="http://www.profamilia.de">www.profamilia.de</a></td>
<td>email: <a href="mailto:international@profamilia.de">international@profamilia.de</a></td>
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<td>GREECE</td>
<td>Family Planning Association of Greece (FPAG)</td>
<td>email: <a href="mailto:stvoskakispag@hotmail.com">stvoskakispag@hotmail.com</a></td>
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<td>HUNGARY</td>
<td>Magyar Család- és Növédelmi Tudományos Társaság</td>
<td>web: <a href="http://www.szxinfo.hu">www.szxinfo.hu</a></td>
<td>email: <a href="mailto:arpad.mezsaros@office.ksh.hu">arpad.mezsaros@office.ksh.hu</a></td>
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<td>ICELAND</td>
<td>Frædslausamtök um kynlíf og barneignir (FKB)</td>
<td>web: <a href="http://www.mmedia.is/fkb">www.mmedia.is/fkb</a></td>
<td>email: <a href="mailto:fk@mmedia.is">fk@mmedia.is</a></td>
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<td>ISRAEL</td>
<td>Israel Family Planning Association (IFPA)</td>
<td>web: <a href="http://www.openepro.org.il">www.openepro.org.il</a></td>
<td>email: <a href="mailto:ifpa@post.com">ifpa@post.com</a></td>
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<td>ITALY</td>
<td>Unione Italiana dei Centri di Educazione Matrimoniale e Prematrimoniale (UICEMP)</td>
<td>web: <a href="http://www.uicemp.org">www.uicemp.org</a></td>
<td>email: <a href="mailto:uicemp@tin.it">uicemp@tin.it</a></td>
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<td>KAZAKHSTAN</td>
<td>Kazakhstan Association on Sexual and Reproductive Health (KMPA)</td>
<td>email: <a href="mailto:center.kmpa@alnet.kz">center.kmpa@alnet.kz</a></td>
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<td>KYRGYZSTAN</td>
<td>Reproductive Health Alliance of Kyrgyzstan (RHAK)</td>
<td>web: <a href="http://www.rhak.kg">www.rhak.kg</a></td>
<td>email: <a href="mailto:rhak@infotel.kg">rhak@infotel.kg</a></td>
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<td>LATVIA</td>
<td>Latvijas Gimenes Planosas un Seksuālas Veselības Asociācija ‘Paradēz Zieds’ (LAFPSh)</td>
<td>web: <a href="http://www.papardeszieds.lv">www.papardeszieds.lv</a></td>
<td>email: <a href="mailto:lfp@mailbox.riga.lv">lfp@mailbox.riga.lv</a></td>
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<td>LITHUANIA</td>
<td>Sėsmos Planavimo ir Seksualinės Sveikatos Asociacija (FPSHA)</td>
<td>web: <a href="http://www.spa.lt">www.spa.lt</a></td>
<td>email: <a href="mailto:ltp@takas.lt">ltp@takas.lt</a></td>
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<td>LUXEMBOURG</td>
<td>Mouvement Luxembourgeois pour le Planning Familial et l’Éducation Sexuelle (MLPFES)</td>
<td>web: <a href="mailto:plannlux@pt.lu">plannlux@pt.lu</a></td>
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<td>MOLDOVA</td>
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<td>THE NETHERLANDS</td>
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<td>email: <a href="mailto:mg@mg.nl">mg@mg.nl</a></td>
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<td>NORWAY</td>
<td>Norsk forening for seksualitet, samliv og reproduktiv helse (NSSR)</td>
<td>web: <a href="http://www.nssr.org">www.nssr.org</a></td>
<td>email: <a href="mailto:post@nssr.org">post@nssr.org</a></td>
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<td>POLAND</td>
<td>Towarzystwo Rozwoju Rodziny (TRR)</td>
<td>web: <a href="http://www.trr.org.pl">www.trr.org.pl</a></td>
<td>email: <a href="mailto:trr@trr.org.pl">trr@trr.org.pl</a></td>
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<td>PORTUGAL</td>
<td>Associação Para o Planeamento da Família (APF)</td>
<td>web: <a href="http://www.apf.pt">www.apf.pt</a></td>
<td>email: <a href="mailto:apfportugal@mail.telepac.pt">apfportugal@mail.telepac.pt</a></td>
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<td>ROMANIA</td>
<td>Societatea de Educatie Contraceptiva si Sexuala (SECS)</td>
<td>web: <a href="http://www.sexdex.ro/sd/index.jsp">www.sexdex.ro/sd/index.jsp</a></td>
<td>email: <a href="mailto:sediu@secs.ro">sediu@secs.ro</a></td>
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<td>RUSSIA</td>
<td>Russian Family Planning Association (RFPA)</td>
<td>web: <a href="http://www.family-planning.ru">www.family-planning.ru</a></td>
<td>email: <a href="mailto:rfa@rdo.lu">rfa@rdo.lu</a></td>
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<td>SLOVAK REPUBLIC</td>
<td>Slovenská spolocnosť pre plánované rodičovstvo a výchovu k rodičovstvu (SSPRVR)</td>
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<td>SPAIN</td>
<td>Federación de Planificación Familiar de España (FFPE)</td>
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<td>SWEDEN</td>
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<td>TURKEY</td>
<td>Türkiye Aile Planlamasi Derneği (TAPD)</td>
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