

IS IT ALL ABOUT SEX?

GENDER *Sex* *Gender*
CULTURE *Rights* *Culture*
TRADITION *TRADITION*
Men/women *Women/men*
IDENTITY *Identity*
Trafficking *Trafficking*
Health outcomes *Health outcomes*
VIOLENCE *Violence*
Adolescents *Adolescents*
POWER RELATIONS *Power relations*
Relationships *Relationships*



Entre Nous

THE EUROPEAN MAGAZINE FOR SEXUAL AND REPRODUCTIVE HEALTH



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Midway in the countdown to 2015, we have to face the reality. Of all the Millennium Development Goals (MDGs), the health-related goals are the least likely to be met. Of all the health-related goals, those related to sexual and reproductive health, including reducing maternal mortality, pose the greatest challenge globally.

This should come as no great surprise. The determinants of maternal health are especially broad and very closely linked to social, economic factors and gender inequality.

We know the close association with poverty. Ninety-nine percent of these maternal deaths occur in low- and middle-income countries. We know the impact that malnutrition has on pregnancy outcomes.

We know how education contributes to the health of women and their families. We know how gender can limit access to health services, including life-saving obstetric care. And we know that while gender roles impact both men and women, women remain more affected by gender inequities and inequalities, especially in sexual and reproductive health.

Globally, the challenges presented by gender inequality and inequity regarding gender and sexual and reproductive health are well known. Each year 536 000 mothers die from complications during childbirth, many of which are preventable. An estimated 14 million girls aged 15 to 19 give birth each year. Their risk of dying from pregnancy related causes is

twice as high when compared

to 20 to 29 year old

women. Cervical

cancer remains

the second most

common cancer

among women

worldwide

with about 500

000 new cases

and 250 000

deaths every

year. Between

13-61% of

women around

the world report

that they have

been physically

abused by an inti-

mate partner at least

once in their lifetime.

Worldwide, sex work-

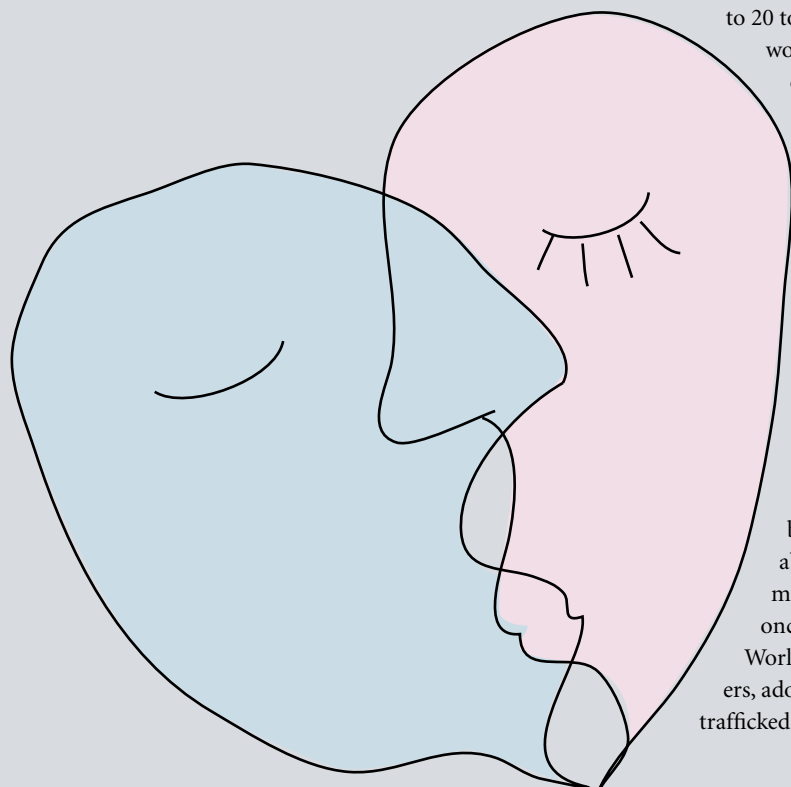
ers, adolescents, migrants, trafficked individuals and

injection drug users are particularly vulnerable to sexual and reproductive ill-health due to gender inequities and inequalities. Although, worldwide, approximately as many women as men are living with HIV, gender inequalities as well as biological factors make women more vulnerable to HIV and to the impact of AIDS than men.

Consensus agreements and declarations, such as the Cairo Programme of Action and the Beijing Platform for Action, have highlighted the direct connection between gender equality and women's empowerment and health, including sexual and reproductive health. They also emphasize the importance of achieving gender equality for both individuals' health and well being, and for sustainable development.

Here is the conclusion. To achieve the MDGs related to sexual and reproductive health, the need for a well-functioning and equitable health system, with access to sexual and reproductive health services is absolute. The link between gender equality and sexual and reproductive health needs to be recognized and acted on. Communities must be engaged in addressing gender inequities. Relevant, appropriate gender sensitive data and information is required to influence policy. An integrated approach that recognizes that our ability to meet the health-related MDGs is also related to our ability to achieve MDG 3 "promote gender equality and empower women" is required.

Dr. Margaret Chan
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WHY IS IT RELEVANT FOR SEXUAL AND REPRODUCTIVE HEALTH IN EUROPE?

In May 2007, the World Health Assembly of the WHO approved the Strategy for integrating gender analysis in the work of WHO 2008-2013. The Strategy aims to integrate gender equality and equity into the WHO's overall strategic operational planning and implementation, and in its support to countries. The Strategy requests Member States of the WHO "to formulate national strategies for addressing gender issues in health policies, programmes and research, including in the area of reproductive health" (1).

Reproductive health (RH) is specifically mentioned due to the major role gender inequalities play in health outcomes in this area. Gender inequalities in society are directly linked to the way men and women live their sexuality. The roles that women and men are assigned in different societies, and the social expectations of how women and men should live their own sexuality, determine the way they behave, the risks they take, the factors that will protect them from illness, their access to RH services and the responses they will have from RH services. Inequalities in access to financial resources, decision making power, levels of education and in values assigned to men and women have consistently put women in a subordinated position with regards to their sexuality and the control of their RH. At the same time, in spite of the concept of male responsibility for the health of themselves, their partners and their children developed in the Cairo and Beijing conferences, in most sexual and reproductive health (SRH) programmes and policies men and boys' needs are neglected by the health services and addressed only when related to HIV, STIs and condom use.

The implementation of the Strategy consists of a three step process that acknowledges the need to have sex disaggregated data, recognizes the added value of performing gender analysis in policies and programmes and highlights the need to design and implement specific actions to address gender inequalities in health.

Specifically applied to SRH, a gender analysis enables:

- Understanding how gender norms and values impact risk and protective factors in SRH;
- Highlighting inequalities between men and women in access to resources to promote and protect health, in responses from the health sector and in the ability to exercise the right to health;
- Understanding how health services need to address men and women's needs differently.

Engendering SRH policies and programmes in the European Region

The implementation of the WHO Gender Strategy in the area of SRH will be done under the framework of the following existing WHO policy and strategic frameworks:

- The WHO European Regional Strategy on Sexual and Reproductive Health (2001). The implementation of the Gender Strategy will seek to achieve the systematic use of sex disaggregated data and gender analysis to address gender inequalities in SRH policies and programmes.
- The European Strategy for Child and Adolescent Health and Development (2005). The Gender Tool developed to accompany this Strategy provides guidance on how to address gender in the implementation of the Strategy. The section on adolescents' health, one of the Strategy's priority areas, addresses the gender issues that influence the SRH of adolescents.
- Improving Maternal and Perinatal Health: European Strategic Approach for Making Pregnancy Safer (2007). This document calls attention to the maternal and perinatal ill-health situation in the Region and acknowledges women's empowerment and men's responsibility as means to achieve maternal health.

Priority areas

The European Regional Strategy on Sexual and Reproductive Health identified the following programme areas as

priorities: maternal mortality, perinatal and neonatal mortality, induced abortion, contraception, adolescent sexual and reproductive health, sexually transmitted infections, HIV/AIDS, cervical cancer, infertility, sexual violence, and vulnerable groups such as refugees and displaced populations, migrants, trafficked women and elderly people.

Among these programme areas, a gender perspective can be applied to certain select topics. Some of these issues will also be dealt with in depth in other articles of this volume of *Entre Nous*.

Maternal health

Maternal and perinatal health continues to be a problem in Europe (2). The health of the woman is closely connected with perinatal health outcome, as maternal mortality and morbidity can have a negative impact on the survival chance of the new baby. The determinants of good perinatal and maternal health and survival are multifaceted. However, it is clear that, especially where women are from poor or marginalised communities, they are not able to make healthy decisions and act upon those decisions, including the decision to seek care when needed. Gender constraints may prevent some women from expressing the need for and obtaining care from their own household members. Working with the role of men and families in taking crucial decisions and in providing support and care for the women has been one of the gendered interventions in the area of maternal health.

Adolescents' SRH

In many societies and communities in Europe double standards still prevail regarding sexuality of boys and girls. Data from the Sexual Awareness for Europe project indicates that boys report that sexual education in schools focuses on negative aspects of sex, or on female reproduction. Boys and young men are also subject to higher psychological stress in relation to their "sexual performance". The project shows that preventing pregnancy is perceived by young males as a "girl's issue" while girls still have a problem in negotiating the use of contraceptives (3).



Gender based violence

Gender based violence is deeply rooted in gender inequalities that place women in a subordinated status in relation to men. There are special circumstances that may increase women's vulnerability to violence, such as sex work. Also, although boys are affected, it is girls who are disproportionately victims of trafficking of human beings. Female genital mutilation imposes young girls at risk to a practice conducted in the name of tradition and cultural practice.

Violence against women from an intimate partner is prevalent in all countries of the European Region and it is manifested in many different forms. In population based demographic and reproductive health surveys in eastern and central Europe between 15 and 29 % of women reported to have ever suffered abuse and 8 to 10 % reported abuse in the previous year (4). It is also important to note that partner violence during pregnancy has important consequences to maternal health.

HIV and AIDS

Injecting drug use and unsafe sex between men have been the primary routes of transmission for HIV in the WHO European Region. However, in countries across the Region, prevalence statistics now suggest that most new HIV infections are attributable to heterosexual transmission. The trend is evident in France, Italy, Portugal and Spain; at least one quarter of new infections are due to heterosexual sex in the Caucasus countries of Azerbaijan and Georgia, and nearly one half in Armenia (5). A gender analysis needs to be done to define programmes that address differences in behaviours determined by gender norms, values and unequal power relations when deciding on protective measures. As long as condoms remain the main way of protection from HIV, women will be in a disadvantaged position since, in most cases, it is men who make the decision to use them. There is also a need to make a gender analysis of the factors, societal norms and inequalities that drive men and boys into unprotected sex and drug use.

Migrants

Women from ethnic minority groups and migrant communities may encounter even greater difficulties in reporting violence, sexual exploitation and trafficking and are at greater risk of facing RH problems, including HIV/AIDS infection.

Challenges

Specific challenges in implementing the Gender Strategy in SRH include:

- Systematic use of sex and age disaggregated data. Although quite an improvement has been seen in the European Region in recent years, in SRH we face a double challenge. There is still a lack of data on very basic indicators on SRH, and the gaps are even bigger when we look at sex disaggregation.
- Building capacity among health care providers on the impact of gender in SRH, including gender based violence.
- To further study and address the connections between gender, sexual health and different cultures in the European Region, including ethnic minorities and migrant populations.
- Involving men in gender equality, in SRH issues and services across the Region and targeting men to address underlying risk factors for violence against women. To develop services that address the SRH of young men.
- To understand and address the gender dynamics that influence and determine adolescents risk and protective factors.
- Using a gender approach to look at the interlinks between SRH and other areas of health. For example, the links between SRH and mental health, nutrition, physical activity, chronic illnesses, and violence (6).
- Links between gender and other determinants of health, such as education, ethnicity and economic power. Gender is just one of many factors that influence couples and affect their reproductive decisions. Education level, family pressures, social expectations, socioeconomic status, exposure to mass media, personal experience,

expectations for the future, and religion also shape such decisions. Wherever possible, social inequities in health should be described and analyzed separately for men and women (7).

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WHAT GENDER IS THE RESEARCH?

The concept of sexual health first appeared in the 1970's, but it has only been relatively recently that it has become seen as essential for all questions and aspects related to human sexuality. Its use has increased drastically over the last 15 years. In fact, sexual health has become so popular that at its congress in Montreal in 2005, the World Association for Sexology made the decision to change its name to the World Association for Sexual Health.

The WHO definition from 2002 served as a reference for this change. This definition of sexual health focuses on the multifactorial aspect of sexual health, as well as, the dimension of human needs and how these are essentially linked to sexual rights and equity. However, the common tendency of publications dealing with sexual research, as we will see, has been less sensitive and holistic towards gender inequalities. This type of research followed predominantly 2 paradigms, that of the public health paradigm, whose interest derived from the HIV/AIDS pandemic, and that of the sexual medicine paradigm, whose major interest focused on sexual function. It is this last school of thought that will be the focus of this article. In this field, the discovery of pharmaceuticals that maintain male erection and the ongoing development of similar pharmacological substances for women, have accentuated a particular vision of human sexuality; a vision that pushes aside the socio-cultural aspects of sexuality and avoids the questions of gender by presenting a model of sexuality that is pseudo universal, ahistorique and individual.

For many years, researchers and clinicians have critiqued and analysed the establishment of a sexual medicine that serves to turn the sexuality of individuals, especially that of women, into something pathological. Take, for example, a study published in the *Journal of the American Medical Association* that received much media attention, which concluded that “sexual dysfunction is an important public health concern”, because it affects 43% of American women and 31% of American men (1). If we take a step back and examine these results, it is interesting to examine the construction of the criteria of health and normality. In the sexual medicine paradigm, theories on functionality of sexuality refer nearly always, implicitly and explicitly, to one model of human sexual response: the human sexual response cycle (HSRC). This model was developed in the 1960's by Masters and Johnson (2) based on observations of sexual activities (primarily masturbation) in a research laboratory. It presents

sexuality as a series of steps which all merge towards orgasm, which is implicitly understood to be the climactic point of the sexual experience.

This model describes a decontextualised sexuality, summed up principally by a group of behavioural and physiological reactions. It describes a certain number of steps that are supposed to correspond to a “normal” sexual response. At the same time, this “reference of normality”, permitted the establishment of criteria for problems or trouble. Leonore Tiefer has proposed a critical and methodological analysis of HSRC (3). She raises the issue of selection bias in the selection of subjects, who are not representative of the population at large, but rather are representative of the characteristic in the model.* She also emphasizes the tautological aspect of the construction of this model.

“‘Normal’ sexual response is whatever results from effective sexual stimulation and effective sexual stimulation is what ever produces ‘normal’ response. Another way to put this is Masters and Johnson (and the American Psychiatric Association after them) defined sex as what occurs during the response cycle and produces orgasm.” (3).

In this way we participate in the construction of a vision of sexual health that is reduced to sexual function only; a function that only follows an exact sequence and a function that is not at all sensitive to gender differences. Worse, when we evaluate female sexuality based on criteria accepted as being universal, but that ignores differences in culture or gender, we also contribute to making female sexuality pathologic. The problem with using these criteria, as well as, the standard means of evaluation used in research, have finally been brought to light.

If we study more attentively the way women and men live their sexuality throughout the different steps described for sexual function, the gender differences are striking. Sexuality is often presented from a masculine perspective as a need or spontaneous sexual motivation. Sexual desire for women is presented as either



a response, or a willingness, to engage in a sexual encounter. This willingness depends overall on the quality of the relationship; feelings of security, love, intimacy, previous experiences (good and bad); of self body image; of desire for children; of anxiety over pregnancy; of the interaction between pleasure, stress and other preoccupations from family and professional life (4,5). Regarding sexual excitement, the way in which 'normal' women experience their excitement is also significantly different from men. The work of Ellen Lan showed that women's subjective experience is not strongly tied to that which produces the physiologic response (6). Orgasm is another sensitive topic. Clinical sexology and research on female sexuality takes into account experience that permits us to see that female sexuality is not truly 'orgasm oriented' as it is for men. However, the emphasis placed on orgasm has helped to create a performance anxiety, which makes sexuality sometimes more tyrannical than pleasurable.

After the criticisms, suggestions and proposals have also been made. Rosemary Basson proposed an alternative model to understand female sexuality and desire that places importance on positive and negative experiences of sexuality in terms of relationships and that speaks of 'responsive desire' more so than 'spontaneous desire' (6). A working group also proposed we reconsider the definition of female sexual dysfunction (7). Going one step further, a new classification for sexual difficulties based more on aetiologies than symptoms and that is sensitive to women's experiences has been elaborated (8). 'A new view of women's sexual problems' defends a definition of sexual problems from a perspective focused on women, taking into account satisfaction in a larger context, including the emotional, physical and relational aspects of sexual experiences.

As this article has attempted to present, the notion of gender has been eluded in the advancement of research on sexual health. Finally propositions have been made to integrate a vision of sexual

well being and equity between men and women, and to not measure the sexuality of women solely on tenuous universal criteria. The critiques and propositions recently made on women's sexual health are improving our understanding of sexual health and reducing gender biases in research and interventions. However, society is still thinking of gender in a dual perspective, which is a perfect adequation with sex. Through this society has reproduced the classic dichotomies and separation of sex into male and female. Yet gender is more variable and fluid. Feminine and masculine are not the only genders and are not monolithic identities. Individuals can live as being more or less feminine or masculine, a fact which impacts the manner in which they live their sexuality and that can be independent of their physiological function. Sexual health still has number of challenges to overcome to integrate an understanding that is sensitive to gender, in all possible genders and to develop an approach in accord with sexual rights that makes sense for individuals and their own experience of their sexuality and sexual, physical, emotional, mental and social well being.

** satisfying orgasms were not considered the norm for American women in the 1960's, according to the work of Kinsley and his collaborators.*

"Sexual health is a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."

Source: *Defining sexual health: report of a technical consultation on sexual health 28-31 January 2002*, Geneva. Geneva: WHO; 2006.

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BRINGING MEN INTO THE STORY

What should be done about men in terms of sexual and reproductive health (SRH)? For years the response to that question was limited, with an equally limited programme and research base. The last 10 years have seen a shift in that story. While there are still far too many obvious examples of lack of action and of the harmful results of the behaviour of men, there are reasons to be hopeful. Most importantly, there is evidence of men's changing behaviour (and of changing social norms related to masculinities) and evidence of the kind of programme and policy interventions that promote change.

The international policy level

A key component of the shift is the numerous international declarations that have called attention to the realities and needs of men in terms of SRH. Both the Programme of Action of the 1994 International Conference on Population and Development and the agreed conclusions from the 2004 Commission on the Status of Women are revolutionary in what they suggest and propose on the role of men and boys in achieving equality. Both affirm the need for changing how societies, states and individuals view and socialize men and boys. They are not simply a collection of unconnected statements or a "to-do" list, but a call for engaging men and boys in new, different and far-reaching ways to achieve gender equality, and for ending patriarchy and the unequal power relations behind it. Most importantly these statements do not make men and boys into the "bad guys", or present men as inherently callous, dominating or violent. They affirm that men, and masculinities, can change.

A growing research base

Concomitant with these international declarations, there has been an increasing research base that has provided a better understanding of the nuances and local contexts of men's behaviours in terms of their relationships, their identity formation and their sexual behaviour. Research with men and boys in various settings worldwide has shown how inequitable

and rigid gender norms influence the way men interact with their intimate partners on a wide range of issues; HIV/STI prevention, contraceptive use, physical violence (both against women and between men), domestic chores, parenting and men's health-seeking behaviours. Similarly, sample survey research using standardized attitude scales has found that adult and younger men who adhere to more rigid views about masculinity (e.g. believing that men need sex more than women, that men should dominate women, that women are "responsible" for domestic tasks, among others) are more likely to report having used violence against a partner, to have had a sexually transmitted infection, to have been arrested and to use substances.

These and other studies affirm that both men and women are made vulnerable by specific norms related to masculinity. In some settings being a man means being tough, brave, risk-taking, aggressive and not caring for one's body. Men's and boys' engagement in some risk-taking behaviours, including substance use and unsafe sex, are often ways to affirm their manhood. Norms of men and boys as being invulnerable also influence men's health-seeking behaviour, contributing to an unwillingness to seek help or treatment when their health is impaired.

The gaps are still large

Research has confirmed that there is still much to do. Women continue to bear the responsibility for family planning. Worldwide, among women using contraception, about one in every four, or 26%, say they are relying on a method used by their male partner. 7% rely on vasectomy, another 7% on condoms and 12% rely on either periodic abstinence or withdrawal. Globally, the majority (74%) of currently married couples who use any contraceptive method use a female contraceptive method. Of these, female sterilization is the most common at 33% (1).

According to numerous household surveys, including the recent WHO-sponsored multi-country study, 13-61% of women worldwide have suffered physical violence at least once from a male partner

(2). In addition, WHO estimates that there are approximately 536000 maternal-related deaths each year, the majority preventable. Relatively little is being done to engage men, who often control women's access to health services, to reduce this number. Furthermore, in terms of child care, women spend on average 3 to 4 times the amount of time caring for children than men do worldwide, even in countries where women have entered the workforce (outside the home) in numbers close to or equal to those of men.

Looking specifically at HIV/AIDS, there were 39.5 million living with AIDS by the end of 2006; 63% live in Africa and 90% are infected through sexual transmission. Regardless of whether the epidemic follows a generalized or concentrated model, the gendered patterns are clear. Men's behaviour and the power dynamics behind sexual relations (the power of individual men over women, the economic power in cases of transactional sex, or the power related to stigmatizing men who have sex with men) drive the epidemic.

There is some good news in terms of HIV. The epidemic is leveling off in some countries, and at least part of the story in those countries seems to be changes in men's behaviour; increased condom use, reduction in number of partners, and increased use of VCT and STI treatment.

There are other opportunities in the field of HIV/AIDS as well: male circumcision and microbicides. The emerging evidence related to male circumcision finds a dramatic impact on HIV risk for circumcised men (it decreases), but limited evidence of reduced transmission to women partners of circumcised men. Both WHO and UNAIDS have affirmed the effectiveness of male circumcision in reducing HIV, but at the same time have noted the complex cultural, ethical and programme considerations involved.

Microbicides are another area where progress is being made. Several substances and methods are currently in trials to create an effective female-controlled, topical STI and HIV prevention microbicide. If such trials produce results, the implications for the lives of women



Gary Barker



Peju Olukoya

and for promoting new discussions about male sexuality are important.

What works to engage men: new programme evidence

The last few years have seen a growing base of evidence that engaging men and boys in gender-specific, relevant programmes leads to positive results. WHO and Institute Promundo recently reviewed 59 evaluation studies of programmes working to engage men and boys in health interventions in the areas of SRH, HIV/AIDS prevention, gender-based violence, fatherhood and maternal, child and neonatal health. The review ranked the programmes in terms of their gender approach (gender neutral, gender-sensitive or gender transformative) and reviewed overall effectiveness, which combined both the kind of impact (behaviour, attitude or knowledge change) and the rigor of the evaluation design (3).

The key finding from the review is that well-designed programmes with men and boys show compelling evidence of leading to behaviour and attitude change. Men and boys can and do change attitudes and behaviours related to SRH behaviour, maternal and child health, their interaction with their children, their use of violence against women, questioning violence with other men, and their health-seeking behaviour as a result of relatively short-term programmes. Overall 28.8% of the 59 programmes were assessed as effective in leading to attitude or behaviour change and 39% showed reasonable evidence of at least some attitude change. The rest showed only knowledge change or limited evidence of impact.

Programmes that were ranked as being gender transformative showed a higher rate of effectiveness. Among the 28 programmes assessed as being gender transformative, 42.9% were effective, compared to 28.8% of the 59 programmes as a whole which were defined as effective. Programmes with men and boys that include deliberate discussions of gender and masculinities, with clear efforts to transform such gender norms, seem to be more effective than programmes that merely acknowledge or mention gender norms and roles.

Integrated programmes (providing both one-on-one interaction with men, together with community mobilization or media-based messages) showed the highest rate of effectiveness. This highlights the importance of reaching beyond the individual level, to the social context – including relationships, social institutions, gatekeepers, community leaders and the like – in which men and boys live.

The downside is that relatively few programmes with men and boys go beyond the pilot stage or a short-term time frame, ranging from 16-week group educational sessions to one-year campaigns. In a few cases (10 of the 59 programmes) projects represent long-term efforts to engage men, communities and form alliances to go beyond or scale up the relatively limited scope and short-term interventions.

The missing pieces

While the findings on engaging men are positive, there is still a long way to go. The glaring reality is that while we have evidence that programme and policy interventions can lead to important changes, the scale has been extremely limited.

Policy action at the national and local levels (and research on the impact of such policies) is urgently needed. Apart from paternity leave policies in some European countries (which show evidence of increased participation by men in child care, or at least increasing take-up of paid paternity leave), there has been limited implementation of policies, legal structures or laws in developing country settings to engage men in achieving gender equality.

If we seek to identify ways to change gender inequities at a society-wide level, understanding the impact of such policy-level changes must be a priority for future research. Europe offers some potentially good news on this front. Data from western Europe (mostly Nordic countries) where paid paternity leave has been offered for more than 10 years has confirmed that increasing numbers (and proportions) of fathers are using such leave. This is particularly true when paternity leave is paid and when it is non-transferable to the mother. One of the few

examples from a developing country setting is Costa Rica's Responsible Paternity Law, which includes awareness raising campaigns and public support for mothers to request DNA testing from men. The law led to a decline in the number of children with unrecognized paternity, from 29.3% in 1999 to 7.8 % in 2003 (1).

The emerging conclusion from these efforts – at the programmatic and policy levels and from research – is that gender norms are at the heart of the matter. There is increasing evidence that gender norms, as well as the social reproduction of these norms in institutions and cultural practices, are directly related to many of men's health-related behaviours, including SRH. Programme planners have understood this. The next revolution will be to take this understanding to the policy level.

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INVOLVING MEN IN PREGNANCY AND CHILDBIRTH

-On paternal support and positive health outcomes

Around 15 years ago the International Conference on Population and Development established the importance of involving men in the challenge of improving sexual and reproductive health (SRH). Above all, emphasis was placed on developing efforts which would increase men's involvement in parenting and measures which could lead them to take greater responsibility for their own sexual and reproductive behaviour.

Parallel to this development there has been a growing interest from the academic world in how men live their lives, create their male identities and form relationships within family life. The result is that a number of questions have been raised about men's parenting, mirroring positive as well as problematic issues. The challenging and difficult side of men's parenting has mostly been framed in discussions about "deadbeat dads" or "feckless fathers" that ignore their parenting responsibilities and how this negatively affects the children's emotional, psychological and financial well-being. Men and fathers have, of course, also been discussed in connection with domestic violence and other destructive behaviours that negatively affect their own, as well as, family health.

However, another branch of fatherhood research has challenged the deficit perspective on men's parenting and instead focused on positive aspects of fatherhood that might contribute to better health outcomes. The significance of fathers on children's and adolescents' development and well-being are some examples of topics in this research area.

Discussions about various policies and legislation to support fathers in becoming more involved in caring for their children are also tightly connected to this perspective. More specifically, what do we know about the relationship between fatherhood and health? How can an increasing involvement by fathers in SRH contribute to better health and well being for themselves, as well as, their partners and children? Is there any "evidence" in existing literature to support the idea that men should be more involved during the delivery, ante- and postnatal care? In what ways are men supported as fathers? These are some of the questions in focus in a newly produced literature review, "Fatherhood and Health outcomes. The case of Europe" (1). The report has been a collaborative project between the department of Gender, Women and Health in Geneva and the WHO Regional Office for Europe in Copenhagen.

Positive health outcomes for the man, woman and child

A general conclusion of the literature review is that involvement in fatherhood can provide both increased well-being and other positive health effects for men. For example, studies have found that men who acknowledge their new position as forthcoming fathers and who experience emotional support during their partner's pregnancy demonstrate better physical and psychological health. They also report fewer problems in their relationship with their partner after the birth. Research has also shown that men can be a source of important psychological and emotional support to women during pregnancy and delivery. This in turn can reduce pain, panic and exhaustion for women. Some studies report that men's presence during labour shortens the event and reduces the need for epidural (2). Additionally it has been shown that men's involvement in mother and child health programmes can reduce mother and child mortality in relation to pregnancy and labour by being prepared for obstetric emergencies. However, not all results point in the same direction. Some studies instead empha-

size that even if fathers support in birth can help mothers to have more positive experiences of childbirth, it's hard to find a direct relationship between fathers' support and length of labour, use of pain relieving drugs or obstetric interventions in birth.

Supporting men as fathers

Despite these many positive signs of increased well-being, research conducted with fathers indicates that they experience and receive less support in parenting than mothers, and that mother and child health services have considerable difficulties accessing men and involving fathers. The negative result of this may be that men feel marginalized and seek less information and advice on questions relating to reproductive health (RH), or take part in parent training globally. Nevertheless, this can also partly be seen as a continuation of traditional patterns of division between men and women, where men take greater responsibility for work and support rather than childcare and housework.

In order to adequately promote the involvement of men a variety of new strategies are required – from symbolic changes where, for example, mother and child health services change their name to parent care services, to using new paths of communication which enables access to men during their impending paternity. Today's parent training, which is often based on the participation of parents in open discussion groups, is considered disadvantageous to men as women are more comfortable when talking about pregnancy, birth and parenting in these forums. On the other hand, attempts to pursue parent training for men over the Internet has proven to be more successful, as indeed have approaches which provide more individual support.

However, as the research review also shows, it is clear that the support from the mother and child health care services is not the only factor that influences men's parenting. The construction of fatherhood is also unconditionally connected to other larger structural and cultural



factors. Support for men's increased involvement in parenthood and RH is also dependent on multi-faceted support from the welfare state and employers. We know, for example, from Scandinavian research that generous paternity leave, well developed and subsidized child care services, or family friendly work environments can positively affect men as fathers

Societal inequalities and the support to men as fathers

Fathers are, however, not a homogenous group. All men do not have the same prerequisites or needs as parents. It is therefore important that a range of different types of parent training are offered. Currently, fathers from the academic middle classes seem to access, make best use of and benefit most from the support given by mother and child health services. Vulnerable groups of parents and fathers require special attention and more direct support. Immigrant families are, for example, one such vulnerable group whom experience considerably poorer health than others. Several studies have shown that women born abroad run a higher risk of giving birth to babies of restricted growth and experience greater risk of perinatal death (3). The reason for the immigrants' worse health situation is related to the social determinants of health; poorer socioeconomic status and health-endangering work. High rates of unemployment, dependency on social welfare, and language problems may also contribute to an experience among many immigrant men of losing vital and important aspects of their parenthood. Given that the literature shows that an increased involvement by men in parenthood and RH can have positive health effects on the men themselves, their partner and children, it is therefore important to target vulnerable groups, such as immigrant men, by offering solid support in parenthood.

Health problems in relation to low social and economic status are not only limited to immigrant families. Native families in similarly vulnerable situations are also affected. For example, research

shows that children in the lower and more disadvantaged reaches of society have poorer health and have a higher risk of being affected by physical illness and emotional difficulties than children who are more socially advantaged. The risk of infant death is also three times higher than normal if the child is from a socially disadvantaged group (4).

The same situation applies for teenage parents. Statistics from the National Health Service in England show that the infant mortality rate for babies born to mothers under the age of 18 is more than double the average in many western countries, and there is an increased risk of maternal mortality. The research relating to this group of parents has also shown that an increase in support to men can lead to better health outcomes for fathers, as well as, for other members of the family. For example, a number of studies have shown that support of the partner, whether from the biological father or from a current partner, may be correlated to improvement of the mother's psychological well-being, as well as, better developmental outcomes for the baby (5). Despite this, many studies show that the young fathers are frequently neglected as potential resources to their children, and also as clients with their own unmet needs.

Finding new ways for parental support

In conclusion, even if many fathers want to be involved with their children and evidence exists that this can positively influence health outcomes for men, their partner's and children, very little or no help at all is specifically offered to the majority of men during parenting. Maternity and child welfare services are much more focused on the mother and child's health and, therefore, often exclude men and their needs as parents. Support is better accessed by the middle classes or by parents with a better standard of living, while contact with groups indicating poorer health is weaker and limited. This implies that increasing efforts in reaching these men are required, including new

methods of distributing or restructuring messages and skills in order for them to address both parents. Perhaps information and advice can take place through alternative paths of communication, such as the Internet and thus provide possibilities for increased resources to groups that are more difficult to reach. Additionally, a multisectorial approach that recognizes and supports the benefits of involving men in RH, including fatherhood, is essential. For men to be able to experience positive RH outcomes and enjoy the benefits of fathering, well designed policies and programmes are required. However, in Europe, this type of support differs significantly between countries and continues to fall short in the delivery of equal access to support men during parenthood.

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GENDER-BASED VIOLENCE AGAINST REFUGEES, ASYLUM MIGRANTS IN EUROPE

Gender-based violence (GBV) theoretically seen

Cairo, 1994, International Conference on Population and Development, the objectives are clear; 179 governments acknowledge that all couples and individuals have the right to attain the highest standards of sexual and reproductive health (SRH) and make decisions concerning their sexual health free of discrimination, coercion and violence. These governments endorse that countries should take full preventive, protective and rehabilitative measures to eliminate all forms of exploitation, abuse and violence against women and adolescents, paying special attention to protecting the rights, safety and needs of those in potentially exploitable situations. Documented and undocumented migrant women, refugee women and refugee children are specified as such.

European Union (EU) Member States ratify this action plan. One year later, during the Fourth World Conference on Women in Beijing, the definition of GBV is expanded. It now comprises any act of physical, sexual and psychological violence in the family, community, or perpetrated or condoned by the State that results, or is likely to result in, physical, sexual or psychological harm or suffering, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life or in situations of armed conflict (1). Specific groups of women are recognized to be particularly vulnerable to GBV; the elderly and the displaced; indigenous, refugee and migrants communities; women living in impoverished rural or remote areas, or in detention.

EU Member States endorse this action plan, as well as, many other international agreements that recognize gender as a determinant of health and GBV as a major public health issue, a violation of human rights, and as a crime against humanity. As goals are set to end GBV, the EU intensifies its efforts to evolve into a coherent political territory. Along with this development, new European asylum and neighbourhood policies are formu-

lated (2). The impact of these policies on the protection and health of asylum seekers, refugees and undocumented migrants within the EU territory and on the borders remains to be seen.

GBV in practice

GBV can be of physical, psychological, socio-economic, socio-cultural or sexual nature. In addition to important negative effects on the well-being and the participation in society of the survivor, GBV may have significant consequences on the survivors' sexual, reproductive, physical and psychological health. Increasing empirical evidence suggests that health and health related behaviour is determined by the interplay of a complex set of contextual stressors, health promoters and genetic endowment (3). Stressors include social, cultural, economic and physical environmental factors, such as poverty, discrimination, inadequate housing, socially disintegrated communities, material deprivation, income inequality, oppression and unemployment, lack of social support and lack of education.

These are all ill-health factors which immigrants, asylum seekers, refugees and undocumented migrants in Europe face on a daily basis. These are also factors whose counterparts are recognized as basic economic, social, cultural, civil and political human rights. Realization of these rights is challenging when the possibility to do so is completely intertwined with the legal status one does or does not have. Refugees have obtained an official residence permit. This assures access to health care services and entitles them to realize most rights notwithstanding the financial, cultural, physical and psychological barriers they might encounter when trying to do so. Asylum seekers are still in the insecure process of achieving such a status, or having it denied. This has significant implications for their access to health care and for the fulfilment of the above-mentioned rights. Recent research indicated that European coherence on this matter is lacking. The access of asylum seekers to SRH care, for example,

differs across EU Member States. In some countries, an asylum seeking woman is only entitled to emergency care, in others, exceptions will be permitted when she is pregnant, and in still other countries, full access is provided (4). Restricted access for asylum seekers applies to decent housing, employment and societal participation as well. Being an undocumented migrant multiplies the risk of being exposed to ill-health.

The International Centre for Reproductive Health (ICRH) at the University of Ghent is currently conducting a community-based participatory research project to prevent GBV against minorities in Europe. With EC Daphne funding, this research project is steered by Belgian (ICRH, Zijl, NVR), Dutch (Movisie, Pharos) and British (TandemCom) research bodies and organizations active in the field of GBV, women's rights or health of refugees. It is conducted in partnership with a community advisory board. Thirteen female and eight male refugees, or asylum seekers, with origins from Afghanistan, the Islamic Republic of Iran, Iraq, Somalia, the former USSR or Roma or Kurdish communities were trained as community researchers. They have already conducted 250 in-depth interviews with their peers in Belgium and the Netherlands. They are now collaborating on analysis of the results and the development of prevention tools and strategies.

Research results will be presented at a European Seminar in Ghent, February 14-15, 2008. Preliminary results indicate several important determinants in prevention and protection of their health. The respondents' general profile is one of highly-educated women and men in their reproductive age, who have little or no close relatives accompanying them, and who are struggling with the enforced set-back in their possibility to participate actively in society. They generally relate sexual health firstly to overall physical and mental well-being, secondly to a respectful approach to sexual relationships and sexuality, thirdly to a safe and satisfying sexual life and finally to family planning



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and fertility. They are convinced that one is responsible for one's own sexual health. Regarding GBV, the preliminary results are very clear. An overwhelming majority of the respondents revealed they were familiar with several types of GBV: physical assault, abuse, confinement, structural discrimination, sexual harassment, rape, sexual exploitation, honour killing and forced marriages.

Most cases are not reported, due to lack of knowledge of their rights and the legal system, and fear of negative consequences for their asylum procedure or integration in society. Perpetrators are aware of this mechanism and take advantage of it.

Prevention

From a socio-ecological perspective on prevention of GBV, health status and health behaviour are viewed as affecting and being affected by multiple levels of influence, including individual, interpersonal, organizational, community and public policy. The central premise of this model is that none of its levels should function in isolation from the others. Thus, effective prevention programmes can best be achieved by stimulating synergy among the several levels that comprise the model (5).

When respondents were questioned about perceived risk and preventive factors in GBV, their answers and suggestions covered individual, interpersonal, organizational, community and public levels equally. Asylum procedure and legal status related to the phases in asylum procedure, were shown to be the crosscutting factors across all levels, as well as, a lever for positive change. These results confirm the premise that "although biological sex combined with gender contributes to differential health exposures for women and men, social determinants play a crucial role in determining their vulnerability at individual, community, programme and policy levels" (6).

Conclusion

In Europe, young female and male refugees, asylum seekers and undocumented migrants are extremely vulnerable to several types of GBV. Given that all human rights are considered interdependent and indivisible, and that international agreements on the eradication of GBV are ratified, governments should be prompted to realize that they are still accountable for progressively correcting conditions that may impede the realization of the right to health and other related rights. These structural changes on public policy level should accompany real comprehensive and participatory approaches to multi-disciplinary and multi-stakeholder interventions, creating an empowering synergy between the individual, interpersonal, organizational, community and public policy level. Given that in Europe, the right to health and a life without violence is primarily an intangible theory for many refugees, asylum seekers and undocumented migrants, while GBV is a common practice, research and action are a case of emergency.

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YOUNG WOMEN, GENDER EQUALITY AND SEXUAL WELLBEING

– why culture should be taken seriously

The human rights basis for sexual and reproductive health has contributed to placing gender and sexuality as critical to attaining optimum health and wellbeing. By adding culture to this focus on gender and sexuality this helps us to assess the wide range of cultural underpinnings which shape the lives of young women and girls in Europe. Although the discourse on gender has continued to be equated to women’s issues, it is still important to recognize that women and girls bear the greatest burden of sexual and reproductive ill health. Indeed, by introducing the culture dimension, this raises issues around gender discrimination and inequalities, risks and vulnerability, and the power of individuals to control or exercise their sexual rights.

This article will focus the lens on two gender based discriminatory practices that have been high on the policy agenda in the United Kingdom in particular and in Europe in general. Female genital mutilation (FGM) and forced marriages are both considered to be migrant population concerns which have emerged over the past two decades. While this article will not dwell on the history of these practices within Europe, it will highlight what the key concerns are, progress being made within the policy arena, and some of the remaining challenges in relation to promoting gender equality and sexual wellbeing for affected and at risk young women.

The culture dimension of sexuality-FGM and forced marriages

Sexuality is a central part of humanity and is influenced by multiple factors, including culture. Ideas about what a ‘real’ woman or man should be are rife in all cultures, affect perceptions of what the opposite sex wants or needs, but also form the basis for gender discriminatory practices such as FGM and forced marriages. Gender-based systems often create silences between men and women about sexual desire and practices. Further, what is considered to be pleasurable is influenced by people’s sense of self ‘as a woman’ or ‘as a man’. Gender norms on sexuality assign differential license, possibilities, powers and limitations for men and women in relation to sexual matters (1).

FGM is defined by the World Health Organization as the “partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons”. FGM continues to be valued for a range of reasons, including, conferring gender identity, virginity, aesthetics, rite of passage and enhancing male sexual pleasure. The pressure for practicing communities to continue FGM in Europe remains the same today, because of the entrenched nature of gender norms. Prevailing European notions of sexuality may also cause added anxieties for women. Women may feel alienated and thus bear in silence the psychological effects of FGM. A woman who had undergone FGM expressed her sexual anxieties and fear following her marriage as follows: “your self esteem goes down as you feel you cannot do sex properly...”(2).

Current estimates indicate that globally 100 million to 140 million girls and women have been subjected to FGM. Annually a further 3 million girls (mostly below 15 years) undergo this practice (3). Within Europe, the lack of reliable data compromises policy efforts to tackle this human rights violation. In the UK a forthcoming study that estimates the prevalence of FGM shows that almost 33,000 girls under the age of 15 are potentially at risk of FGM in England and Wales. Despite the limitations of these estimates the results “suggest that the numbers of women living in England and Wales with FGM



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are substantial and increasing. Action is therefore needed to provide appropriate care to girls and women concerned and to prevent FGM being passed on to the younger generation” (4).

Forced marriage is another critical gender equality concern that over the past 10 years appeared on the policy agenda in the UK. This practice is recognized within the UK as a form of domestic violence and child abuse which has grave health and psychological consequences. The evidence available shows that this affects hundreds of girls and young women, some even as young as 13 years of age. The practice involves either being forced into marriages within the UK or sent abroad. It is indicated that the majority of this practice affects families from South Asia, East Asia, the Middle East, Europe and Africa (5).

Forced marriage is defined as marriage conducted without the full consent of both parties and often includes an element of duress. Where a forced marriage involves those below 18 years, this should be categorized as a form of child marriage (6). Forced marriage of any kind is an abuse of human rights and hampers sexual wellbeing. Again many families continue to justify this practice on the grounds of culture, tradition, and often face increased pressure from family gate keepers.

Can policy and legislation be the best option for tackling culture?

Invariably, large parts of the health and social consequences of FGM and forced marriage are tackled by statutory bodies including government, health, legal and social services. Many Diaspora led organizations are increasingly providing more of the social and psychological support services. While policy and legal provisions provide an enabling environment for addressing many of these cultural violations of sexual and reproductive rights, policy makers also see this strategy as the safe option for tackling culture and tradition. In the UK a revised FGM

Law was passed in 2003, which addressed loop holes in the Prohibition of Female Circumcision Act 1985. However, many activists see the law as insufficient to end the practice of FGM. This is because in many cases the decision-making tend to ignore the wishes of parents. Therefore the law “takes a very ‘white Eurocentric’ perspective on family decision-making processes and parental responsibility”(2). To date there has not been any successful prosecutions on FGM in the UK. Does this indicate evidence of lack of community support for the law?

In comparison, the UK government approach to forced marriages seems to have better efforts to adopt a more structured and coordinated approach. The Forced Marriage Unit, a joint Foreign and Commonwealth Office and Home Office unit, is the Government’s core unit for tackling forced marriages. This unit has a mandate to undertake case work, develop government policy, coordinate outreach projects to increase awareness and to work in partnerships with community and voluntary groups (5). The publication “*Dealing with cases of forced marriage: practice guidance for health professionals*,” is an example of a model policy framework developed by this unit to support better government efforts to help detect those at risk and to give protection and care to those affected.

Within Europe, the increasing evidence of culture based practices comes to us through media reporting of the mortality of ‘honour killings’, and in some cases, sensational reporting of ‘victims of FGM’, which tend to further marginalize communities. In order to seriously tackle these growing human rights violations to health and wellbeing, there is need for an European-wide coordinated strategy to sustain policy efforts based on a common framework. More importantly, sustained government support and effective partnership with community-based organizations is needed to mobilize communities, in particular young people, to break the cycle of entrenched cultural practices. Invariably, policy and legal efforts may ap-

pear to be sufficient to solve the problem for governments; however, it is important to heed to lessons that show the merits of multiple strategies which put people and communities at the centre as necessary agents of change.

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YOUNG PEOPLE'S VIEWS ON GENDER AND SEXUAL AND REPRODUCTIVE HEALTH

“The factors that determine health and ill health are not the same for women and men. Gender interacts with biological differences and social factors. Women and men play different roles in different social contexts. These roles are valued differently, and those associated with men usually more highly. This affects the degree to which women and men have access to, and control over, the resources and the decision making to protect their health. This results in inequitable patterns of health risk, use of health services and health outcomes” (1).



This part of the Madrid Statement highlights the importance of gender equity to both sexes. How young people fit into this process is an essential and important component of achieving this goal.

Vulnerability of both sexes

Gender roles learned early in life are different for both sexes and throughout cultures; these roles can result in inequity and inequality amongst both boys and girls. This influences all parts of young people's lives, including sexual and reproductive health (SRH) issues. Girls could be forced to have sex and boys may not be able to express their deepest feelings of love. Mixed messages about gender, roles and identities, from media, families and peers, make it difficult for young people to make or access informed choices/information about their SRH. These gender stereotypes and mixed messages not only make boys and girls vulnerable to poor SRH, but also serve as obstacles to young people's enjoyment of their sexuality.

While in the past, both gender and SRH has been associated primarily with women and women's issues, men are now recognized as being equally important. The existing patterns of gender inequity

such as men's predominant control of economic assets, political power, cultural authority, and armed forces, mean that some specific groups of men control most of the resources required to implement equitable health access, risks and outcomes for women (2). Research also suggests that patterns of viewing women as sexual objects, as performance-oriented and using coercion to obtain sex often begins in adolescence and continues to adulthood (3). Therefore, male involvement in SRH initiatives and working with youth as early as possible is necessary to achieve gender equity in SRH issues for both girls and boys.

Importance of education

As mentioned previously, mixed messages to youth about gender and SRH can encourage both positive and negative attitudes. Thus, young people are in need of a supportive environment that will provide gender sensitive education. Such education helps adolescents understand the concept of gender and how it influences themselves and their SRH. Unfortunately, while education is a starting point for promoting gender equity in SRH for young people, many coun-

tries still have issues implementing such activities. For example, both The former Yugoslav Republic of Macedonia and the Republic of Moldova, offer no sexuality education and the NGO sector remains the only source for SRH information for young people. It is also important to recognize that girls and boys have different needs and thus require different kinds of information. During 2006 research conducted by ASTRA youth network in 10 eastern European and central Asian countries highlighted topics which young people felt they needed more information about (Table 1) (4). Interestingly, when questioned, boys felt their knowledge and information on SRHR was adequate, yet the research demonstrated that boys were more often lacking correct information when compared to girls.

Relevant workshops and lessons learned

During 2007, the Family Planning Association of the Republic of Moldova conducted several SRH workshops, which included a gender focus, with different target groups. These experiences demonstrated very well the importance of working with young people from an early



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Topic	Boys (%)	Girls (%)
Anatomy/physiology of reproductive system	24.4	23.3
Conception	23.4	25.3
Infertility	29.8	33.2
Methods of contraception	30.2	37.5
STI	38.5	43.1
Principles on constructive communication	13.2	17.4
Alcohol and narcotics	23.4	17.4
Smoking	14.6	9.5
Breast cancer	22.4	43.1
Genital cancer	32.7	43.1
Domestic violence	15.1	22.1
Sexual abuse	19.5	31.6
None	17.0	9.5

Table 1. SRH topics young people feel they need more information on.

age, and the difficulty in working with older youth who may have structured their gender roles and identities on myths and stereotypes present in society.

The Republic of Moldova National Army workshop discovered many stereotypes related to gender and SRH. Many men considered contraception the female’s responsibility, believed women only wanted to marry rich men and felt women should practice abstinence and be faithful. Conversely a man was only considered a real man if he was promiscuous and had multiple sexual relationships.

Women also believe in and promote such stereotypes. A workshop conducted with UNFPA Republic of Moldova in the Rusca prison found many women had a discriminative opinion about men and relationships. Some women noted that all men were liars. Many women believed that a women’s sole purpose was to have a family, and that a wife should always obey her husband, especially with regards to contraceptive use or reproductive choice.

In both workshops, education about SRH and gender was presented and myths and stereotypes were discussed. While the importance of equal rights and access to SRH services were stressed, change

in opinion was challenging and often minimal.

On the other hand, our information, education and communication campaign about gender and SRH, performed in summer camps for youth, provided a great opportunity for flow of new ideas and opinions. This was one of the easiest groups to talk with about gender and other SRH issues. It was very pleasant to see that young people were able to move beyond the traditional myths, stereotypes and in certain cases, gender roles.

Conclusion

Our experiences addressing gender and SRH of young people point to the importance of comprehensive, early SRH education. Such an education enables young people to be aware and understand their and other’s gender roles and identities, to support each other and to have healthy lifestyles. By providing the necessary skills and information, young people will be able to begin caring for their SRH and use the benefits from health services. This in turn will result in the maturation of a young generation that is more gender equitable.

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REPUBLIC OF MOLDOVA INTEGRATED MODEL

Violence against women is reported to be endemic in the Republic of Moldova. About one-third of all women in their thirties have experienced violence since age 15, with rural women being somewhat more likely to report having ever experienced violence than urban women. The marital violence (violence perpetrated by partners in a marital union) is widespread: almost one-third (32%) of ever-married women report suffering emotional, physical, or sexual violence by their current or most recent husband (1).

At the same time official data are limited. Official statistics are collected by the Ministry of Internal Affairs, and includes only murders and cases of serious physical injuries, while the majority of domestic violence cases (psychological, economic and sexual) usually remain unregistered. Nevertheless, during recent years there has been a growing awareness in the Republic of Moldova of both domestic violence and its significance as one component of a wider problem of gender-based violence (GBV). A number of legislative initiatives have taken place, and steps were taken in the Republic of Moldova to develop and promote gender equality policies, incorporating a gender dimension into strategic papers and actions. In one of the previous issues of *Entre Nous* we described the Ministry of Health (MoH) of the Republic of Moldova's efforts in integration of domestic violence issues into maternity care (2). The present paper is a description of Moldova's model of integration of the domestic violence and sexual abuse issues into the wider context of the National Reproductive Health Strategy and reproductive health (RH) services.

Background

The social and economic crisis affecting the Republic of Moldova after independence from the former Soviet Union has had an unfavorable impact on the RH of the population; a high level of unplanned pregnancies and abortions, increased incidence of sexually transmitted infections (including HIV/AIDS) and a high level of maternal and infant mortality and morbidity. To address the problem, diverse measures have been undertaken by the government: 47 family planning offices were established in every district and municipality by the MoH in 1994; the law "Regarding reproductive health protection and family planning" was adopted by the Parliament of the Republic of Moldova on the 24th of May, 2000, and the National Programme for Family Planning and Reproductive Health protection (1999 - 2003) was implemented and evaluated. Although the evaluation in

September 2003 showed improvements, such as a reduction in the rate of abortion and an increased usage of modern contraceptives, it has been acknowledged that so far efforts were mainly focused on family planning, while other aspects of RH were overlooked. For instance, little systematic efforts have been made to address, among other priorities, GBV.

Thus, the MoH intended to develop a long term National Reproductive Health Strategy that would bring continuity to the accomplished National Programme for Family Planning and Reproductive Health protection (1999-2003). It would increase the availability and use of RH services through their integration into primary health care (PHC) services, by making the latter able to cope with wider aspects of RH apart from traditional family planning.

Intervention

In February 23 2004, in order to develop the National Reproductive Health Strategy, the National Working Group was established by the MoH. The initial situation analysis, including the analysis of international and European contexts, identified domestic violence and sexual abuse as one out of eleven priorities of the Strategy. The in-depth situation analysis showed the need for an integrated model of family planning into the broader context of RH services, including integration of the latter into PHC services, with an effective referral mechanism to specialized care. To reduce domestic violence and sexual abuse, specific objectives were considered important: the development of partnership between state structures and civil society; increased access through involvement of the family planning services in counseling victims of domestic violence and sexual abuse; and creation of specialized consulting centers for victims, with equal access for women and men. To achieve this, the Strategy underlines the need to strengthen PHC providers' knowledge and skills in recognition, counseling and referral of victims of domestic violence and sexual abuse, and increase the population's awareness



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about the problem and existing services. Among proposed actions the Strategy suggests training providers from family planning offices on the above mentioned issues, development of management of domestic violence guideline for PHC providers, and integration of GBV into the pre- and post-graduate training curriculum for health care providers.

After several rounds of WHO external and internal peer reviews, the National Reproductive Health Strategy was launched, and on 26 August 2005 approved by the government of the Republic of Moldova (3).

Implementation and WHO support

As part of the implementation of the National Reproductive Health Strategy, the MoH recently reviewed the role of the family planning offices all over the country. Family planning offices were reorganized into RH offices in October 2006. According to this reorganization, the job description of the personnel of the RH offices was expanded, making them in charge of all 11 areas included in the National Reproductive Health Strategy: family planning; making pregnancy safer; adolescents and youths; reproductive tract infections; safe abortion; infertility; domestic violence and sexual abuse; human being trafficking; cervical and breast cancer; sexual health of elderly; and male sexual and reproductive health. Under the new regulation of the MoH, the tasks performed by providers from RH offices in the area of domestic violence and sexual abuse include:

- Information, Education and Communication activities on prevention domestic violence and sexual abuse, and counselling;
- Referral of victims of domestic violence to relevant community services;
- Implementation of specific programmes targeted to victims of domestic violence and sexual abuse.

Being previously trained primarily in family planning and contraception, and some of them in abortion issues, providers needed additional training to

be able to cope with new responsibilities (which would include new issues like violence, trafficking etc.), among which addressing domestic violence is particularly challenging. There is a culture of silence surrounding GBV, which makes collection of data on this sensitive topic particularly difficult. Even women who want to speak about their experiences of domestic violence may find it difficult because of feelings of shame or fear. The need to establish an intimate rapport with the woman who comes to seek RH advice, to ensure confidentiality and complete privacy during the visit, is important for the success of the entire intervention.

Given these concerns related to the management of victims of domestic violence, it was well understood by the MoH that qualified personnel only should face this task. To develop a training package for an 11 day course, including 11 modules (one per each area of the Strategy), the MoH requested support from the WHO Regional Office for Europe. Currently the first draft of the domestic violence module has been finalized and submitted for WHO review. A basis for the module was the training package from the WHO Training of Trainers course that we described in our previous paper (2). The module incorporates as handout material the protocol that seeks to assist staff in the appropriate identification and management of domestic violence. It is important to mention that the aim of the training is not to make providers from RH offices experts in all 11 fields of the Strategy, but rather to make them able to identify problems and to establish effective referral/networking with existing relevant services.

Steps forward

To date advanced drafts of 6 out of 11 modules from the training package are ready. It is planned that by the end of the year providers from 47 RH offices will be trained in 4 of these modules: domestic violence, male sexual and reproductive health, cervical and breast cancer, and health of elderly. By the end of 2008 all providers from RH offices will be trained

with the full package. Still, there is a long way forward to monitor their performances in detecting, counselling and referring victims of domestic violence, as well as, their contribution to building evidences for planning further interventions.

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GENDER ISSUES IN SEXUAL AND REPRODUCTIVE HEALTH: TAJIKISTAN CASE STUDY

Historical patterns of development in Tajikistan, along with all central Asia, show that women have generally been under-valued and neglected in the development process. While some progress has been made in gender inequity during the Soviet time, there still remains immense scope for greater use of the skills of women (1, 2).

Independency and the resulting period of transition have resulted in many social changes. Extreme poverty, unemployment and limited access to basic needs affected all society, but especially children and women. Meanwhile prejudiced gender conceptions prevented women from being recognized as equal partners with men, fully participating in political decision-making and achieving equal employment and economic opportunities.

The recent Gender Policy Assessment Project in Tajikistan identified two major concerns in health policy and services: gender inequalities and access to reproductive health (RH) services (3). The aim of this study was to identify progress and challenges in gender mainstreaming with emphasis on gender imbalances in sexual and reproductive health.

Data collection and analysis

The study was conducted in 2005-2006. All health and gender related policy documents and reports produced since 1992 were reviewed. Gender sensitive social and health indicators were included in a questionnaire developed with Tajik Research Institute of Obstetrics, Gynecology and Pediatrics and local NGO Gender and Development. Interviews (250) in urban and rural areas covered diverse population groups; health managers; health care providers; male and female community leaders and health care recipients. Participation in the interview was voluntary. All responses to the interviewers' questions were kept confidential and anonymous.

Common beliefs related to gender and SRH

Gender inequalities in Tajikistan have traditional, cultural, historical, religious and family trends. Traditionally, gender

inequality was embedded in the patrilineal and patriarchal culture that valued men more than women. This contributed to women's low socio-economic position, which in turn impacted their health status (4). Most men believed that contraception was women's business (66%) and that vasectomy would reduce men's vitality and lead to infertility (78%). Some women also held this belief (28%). Despite contraception being women's responsibility, the husband and male members of the family made decisions regarding access and use of RH services (86%). Decisions about fertility were also often made by men (58%). In families which had not achieved a son by the last permitted birth, it was often the husband and the male members of the family who insisted on having another try (48%).

Boys were considered more valuable than girls; they were given higher priorities in terms of schooling and health care. In some families, when children became ill, parents would take only boys to see the doctor. Some girl infants were left in the hospital by their migrant mothers a few days after birth, and unwanted girl infants were disposed in the field in suburban areas.

A "culture of silence" was a key factor contributing to a low level of reproductive health care seeking and a high prevalence of STIs. Most women felt STIs were an ailment they should tolerate. They reported that it was embarrassing for them to talk about such issues as it was not acceptable to their culture (36%).

Access to and quality of SRH services

Most respondents reported that the lack of female doctors was the reason for not seeking care. Female clients did not feel comfortable with male doctors

for RH problems (56%). Local community leaders and managers of the health workforce at country and district levels were mostly men (88%). The focus group interviews indicated that health managers and community leaders did not view women's participation in decision-making as important. This factor might have contributed to a lack of gender-sensitive attitudes in health providers (male and female alike) towards women who ventured to seek services. Lack of skills and educational attainment was cited as one of the impeding factors for women to become doctors, or to be able to advance to managerial positions.

Most district level clinics were able to perform IUD insertion and abortion. However, contraception service was often of poor quality and provided under unhygienic conditions. Family planning service providers and program managers were unfamiliar with relevant medical and health regulations, standards and surgical routines and sterilization procedures established by the Ministry of Health. At district level, women who underwent IUD insertion were not examined for possible STIs prior to the insertion (48%). Clients were not informed about alternative contraception methods or potential risks associated with using a particular method (42%).

In Khatlon province there was no regular transport between villages and district centers. When a woman needed gynaecologic or obstetrical care they walked 6-7 hours to a rural or town clinic. Interestingly, previous studies in some regions of Tajikistan have reported an association between women's status and reproductive health seeking behaviours. A study conducted in Khatlon province found that women's position within the family was positively associated with the likelihood



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that a woman received prenatal examinations, stopped heavy physical work before birth, and gave birth under aseptic conditions (5).

Gender and STI/HIV/AIDS risk

Since 1992 a rapid increase in commercial sex in Dushanbe-city and greater Tajikistan has occurred. Poverty and inferior social position forced many young women into this market. While commercial sex workers are at a high risk for STIs and HIV/AIDS no reproductive health service targets this group. Most sex workers reported that condom use was decided by male clients. Only few sex workers could negotiate with their clients about condom use (6%).

Women were also unable to protect themselves from unsafe sex within marriage. According to the local custom, wives must obey their husbands under all circumstances, including sex. Wives of migrant men who returned to their villages with HIV/AIDS were rejected by their communities.

Young women are also at risk. The emphasis on “innocence” prevents young women from seeking information about sexual health and contraception. With the revival of traditional gender ideology since the economic changes, girls are socialized to be submissive to men. Sexually active young women are discouraged from discussing sex openly with their own partners.

Interviews with health professionals and reviews of the annual screening data confirmed a high prevalence of STIs. (52%). Incorrect diagnosis, inappropriate or over treatment and IUD insertion were a likely cause of the high rate of STIs. This practice was also due to the fact that the grassroots level health workers lacked adequate knowledge of STIs, counseling skills and adequate facilities for conducting proper diagnosis. As a result many women were treated for conditions that they did not have (32%).

Policy and recommendations

Tajikistan’s policy changes and their health consequences in the last decade

suggest that there may be specific structural factors associated with the health system that impact on the access to health services and thus the health status of the population. One concern accompanying gender issues in health care is lack of integration of family medicine, RH and HIV services. While gender issues were highlighted at the National Reproductive Health Strategy by 2014, National Law on Gender Equity (2005) and the National Development Strategy adopted in 2007, existing policies and health care services still have a vertical approach and create barriers to access to quality services, confidentiality and gender equity.

The Gender Policy Assessment Project found the following recommendations may help overcome these barriers:

- 1) The Government of Tajikistan should monitor implementation of gender policy and strategy papers into social and health care practices;
- 2) Integration of SRH services including STI/HIV/AIDS into family medicine services may improve access to vulnerable groups and decrease gender inequalities and cultural barriers;
- 3) The Ministry of Health is advised to increase number of female health care providers through basic and postgraduate education, with gender appropriate guidelines and clinical protocols developed;
- 4) Information awareness and training of health care providers on gender and RH issues;
- 5) Community based interventions focused on improving the role of girls and women in families and communities at all levels;
- 6) Stigma discrimination, prevention of violence in families and communities, including work places, should be highlighted at all levels.

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HEALTH AND HEALTH CARE IN PORTUGAL: DOES GENDER MATTER?

Concern for gender inequalities in health and health care is relatively recent. The key study by Nathanson (1) is generally deemed as the first research on this topic, which provided evidence on women's worse health and higher health care use. The political recognition of gender inequalities in health and health care dates from the Platform for Action, the document adopted by the Fourth World Conference on Women of the United Nations, which took place in Beijing in 1995. This document highlights the health inequalities between men and women, mainly attributing them to the gender inequalities in society. It also emphasizes the inequalities in access to services, and in the way men and women are treated by health care systems as major causes for gender inequalities in health (2).

In March 2007 we finished a report entitled "*Health and health care in Portugal: does gender matter?*" commissioned by the Portuguese Ministry of Health. In this paper we summarize the main results and conclusions regarding the Portuguese situation.

Gender inequality and gender inequity in health

The first part of our work addressed gender inequality in health. In order to understand the differences in treatment between men and women, it was important to explore the differences in health condition. The common thought is that "women live longer, but have worse health condition" (3). Women's longer life expectancy is not questioned and the fact is largely documented. By contrast, the "worse health condition" issue is more intricate. Are some illnesses more prevalent among women? Do men and women die of the same causes? Are men and women's health affected by the same determinants? Are symptoms identical for men and women; do they present themselves in the same way? Should men and women be treated in the same way, with similar procedures, with the same intensity? Answering these questions allows us to identify both sexes needs and then direct the responses of the health care system to those needs.

The second part of our research addressed the issue of gender inequity in health care. We focused on potential discrimination or bias in treatment; do men and women benefit from equal treatment when facing equal needs? The focal point is therefore more on fairness

and justice, where the difficulties stem from distinguishing, when observing differences in treatment, what is due to different needs and what is unjustified on clinical grounds, and then addressing the problems of discrimination.

We took the definition of Whitehead (4) that the health differences that are "unnecessary, avoidable and thus unfair" represent situations of inequity in health. Contrary to differences due to biology, the ones related to gender appear as avoidable and unfair; they result from women's (or men's) social position, the role that is attributed to them, or the discrimination in everyday life, beyond the potential inequity in health care use. These aspects refer to circumstances that are generally out of people's control, a situation deemed as the crucial test for injustice (4).

The situation in Portugal

Women's life expectancy in Portugal is higher than men's. In 2000, women lived 80 years in average, while the same value for men was 73.2 years. Despite higher life expectancy, it does not mean women live in better health. Comparing Portugal to the EU-15 in 2003, we observe men's advantage in terms of healthy years of life (5). This corresponds to the general statement that "women live longer but in worse health".

To document the statement "women have worse health", we examined data from the 1998-1999 Portuguese National Health Interview Survey (NHIS) under a gender perspective. Our results were similar to the ones obtained in several countries. Women are, on average, in

worse health status than men, have a higher use of health care services, report a higher number of disability days, and are more likely to suffer from long-standing illness. Diseases like hypertension and diabetes are more prevalent among women.

Our findings also indicate that women are more frequent users of health care services regardless of their socio-economic status. Thus, the impact of gender on health is not a simple consequence of the gender gap in society. In Portugal, women have a lower socio-economic status than men. As underprivileged people have a worse health status, we might think that women's excess of ill-health derives from their lower socio-economic status. This is not the case; gender differences are observed between men and women with similar income, education and health insurance status.

Previous studies on equity in health care delivery in Portugal provided strong evidence on pro-rich inequity in specialist visits. In our study we have been able to show that the same result holds when men and women are taken separately.

The gender gap in health status is lower among poorer people. Women's health status is systematically worse than men's; yet, as men's health status deteriorates more when income decreases, the gender gap is reduced among the worse-off. This finding shows that differences between men and women's health status are not homogenous across income groups.

We also explored the gender bias in cardio-vascular treatments using data for all in-patient discharges at NHS Portuguese hospitals from 2000-2004 (192,058



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discharges). Notable differences are observed between men and women in the use of high-technology diagnostic procedures (catheterization) and revascularization. When compared to men, women are 28% less likely to be diagnosed by catheterization and 30% less likely to be treated by revascularization. The same results hold when we used adjusted odd-ratios. Three other results also deserve emphasis. First, gender differences are higher among patients suffering from cardiac heart disease before any acute episode. One explanation for this is that once cardiac heart disease is clinically manifest there is less room for differing interpretations among physicians. Second, gender differences were essentially unchanged between 2000 and 2004, except for revascularization among acute myocardial infarction patients, where gender discrepancies worsened. This does not confirm the common expectation that physician's bias would disappear due to increased knowledge about chronic heart disease in women and with the larger diffusion of techniques. Third, differences in treatment are somehow reflected in differences in inpatient mortality. Even if women experience significantly higher inpatient mortality, the difference becomes non-significant among patients treated by revascularization.

We also addressed the issue of waiting times for surgery. Data from the Portuguese system for the management of waiting lists SIGIC ("Sistema Integrado de Gestão de Inscritos para Cirurgias") was used. This system prioritizes surgical admissions along clinical need, place on the list (first come, first served) and having undergone all pre-surgery required tests, and was aimed at tackling inequity in waiting times. We estimated whether gender affects the length of waiting time for elective surgery for non-life-threatening diseases at Portuguese NHS hospitals. We found that gender was significantly associated to waiting times for certain interventions. Women waited 5% longer for ophthalmology, 13% longer for ear, nose and throat and 9% longer for varicose veins surgeries. Men waited significantly longer for carpal tunnel release and hip replacement surgeries. No association be-

tween gender and waiting time was found for knee replacement and arthroscopy.

Conclusions

The situation in Portugal is identical to the one found in countries where similar studies have been carried out (USA, Canada and UK, for instance). This research provides the necessary evidence to inform policy-making. With these results the Portuguese Ministry of Health is better equipped to tackle the gender gap in health and health care. The following steps for action can be proposed.

• **First**, the current situation and recent trends in gender inequality in health should be assessed. There should be a systematic measure of gender issues for several types of diseases and treatments. We were restricted to the use of readily available databases, due to time constraints. Other data should be explored, as the "sex" variable is usually available. We should be able to evaluate gender differences in the use of pharmaceuticals, in particular for cardio-vascular diseases, and psychiatric care (for which gender inequalities have been documented in the United States). Treatment for diseases that represent main causes of death among women should also be assessed, such as stroke and cancer. Women's health status should be systematically evaluated, with a special focus on women-specific diseases, like breast and cervical cancer, on diseases that are more prevalent among women, like mental diseases, and on violence against women and maternal health.

• **Second**, when gender inequalities have been observed in access to treatment, their causes should be evaluated. This is the case for cardio-vascular diseases. Indeed, the main question is still unsolved: is there a gender bias in treatment, or is gender inequality the result of "biological" differences in health and attitudes towards health? This research would require detailed investigation of this topic, through interviews to patients and physicians, as attitudes appear to be the crucial factor. Understanding the management of waiting lists, referral to elective surgery and in-patient admissions should also be one of our research objectives.

• **The third** step consists of an inventory

of possible policies and interventions to reduce gender inequalities in health, and an estimation of their potential impact. Taking the case of treatments for cardiovascular disease, a strategy should be developed to make physicians more aware of the gender gap, seeking to eliminate assumptions such as "myocardial infarction is a male disease". The increase in lung cancer and respiratory diseases among women, while they remain stable among men, should encourage us to think about how to implement health prevention and promotion strategies that are more oriented to women. The search for strategies for action should be "evidence-based"; foreign experiences of gender-oriented policies should be reviewed and evaluated in order to identify the ones that ensure better results.

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THE IMPACT OF GENDER ON SEXUAL AND REPRODUCTIVE HEALTH IN THE FORMER YUGOSLAV

Sexual and reproductive health (SRH) is gender related and highly contingent upon the level of gender equality in one country. The different sexual and gender roles between women and men contribute to different reproductive health outcomes. The former Yugoslav Republic of Macedonia, a pre-accession country to the European Union (EU), under the previous socialist system has achieved great progress in gender equality, including in the area of sexual and reproductive rights. The country's gender development index scores 0.791, which compared to the national human development index of 0.796, shows that there are minimal gender-related disparities (1).

Positive legal and institutional changes of the past fifty years have improved access and quality of SRH services tremendously. However, the process of attainment of many reproductive and sexual rights has not been paralleled with fundamental changes in gender roles and the position of women in the family and society. Traditional division of labour at home has been maintained, despite enormous progress of women in the area of education and employment. Women's traditional role is particularly prevalent in rural areas and among women of Albanian and Roma ethnic origin. The influence of family in issues such as marriage is still considerable. Early marriage is still present among girls from rural areas and of ethnic minorities, and is mostly arranged by the families. Lack of educational and employment prospects, as well as prohibition of sex before marriage, are other reasons why young girls marry earlier, as is unwanted pregnancy. According to a qualitative KAP survey conducted in 2005, the majority of women respondents are unable to negotiate safer sexual life, family planning, and to decide when and whom to marry. Women report that due to persistence of traditional gender roles, communication between husbands and wives about family planning is minimal and that decisions about methods of protection are made by the men (2).

The burden of gender inequality and of the persistence of the traditional gender roles on the reproductive health (RH) of women has been exacerbated during the transition period. Underlying reasons for

this are significant decreases in availability of, access to and quality of services and of knowledge and information about SRH. The deterioration of the conditions of public health facilities, the privatization of the primary health system and the reforms in the health insurance system have had detrimental effects on the availability and the quality of RH services. Likewise, the general impoverishment of citizens and their shrinking budgets have had a taxing effect on women's capacity to afford access to appropriate RH services. The new 1998 Law on Healthcare does not provide any new provisions on the specific protection of women's health, and to date, the country has not developed a comprehensive national strategy on RH.

Major issues of concern

The most pervasive negative effect of gender inequality, underpinning both structural and cultural conditions, on the RH and rights of women is felt in the areas of STIs, prevention of unwanted pregnancy and abortion. STIs constitute an important RH problem although official data shows very low prevalence. However, this is due to under reporting and self-treatment, rather than to comprehensive prevention efforts. According to the medical staff in charge of the diagnosis of Chlamydia, genital herpes and other STIs the number of cases is increasing very rapidly, especially among the younger population (3). The weak national surveillance system, the lack of specific data on prevalence of STIs and the lack of adequate state policies to address the issue, are some of the major

weaknesses of the current health system that affect women disproportionately more than men. The burden of prevention and of treatment of STIs falls on women. Men, in many instances and due to their traditional roles, refuse to recognize STIs as their problem. Recurrent infections are blamed on women and women are responsible for coping with them.

The issue of prevention of unwanted pregnancy and access to safe abortion are other aspects where gender roles and inequality play important roles. Abortion is still the most common way of fertility control in The former Yugoslav Republic of Macedonia. The quality of abortion services is poor and the country has not adopted a model of comprehensive abortion care. Official statistics reveal that over the last decade, the number of registered abortions in the country has continuously decreased, yet it remains much above the average in the EU. In 2001, the total number of induced abortions per 1000 live births was 315.55, while this ratio for women younger than 20 years of age was 188.01 (4). However, it is widely believed that the drop in the official abortion rates does not correspond to the factual situation, but reflects a current registration system that is inadequate. Many women, due to prejudice and social pressure, resort to abortion in private clinics and thus remain unregistered. The fact that the use of traditional methods of termination of pregnancy persist, and are used by women in rural areas mainly, should also not be overlooked. These women also remain unregistered. Data on



post-abortion counselling and access and use of family planning services is absent, however it is believed that such services are either not provided by gynaecologists or are unavailable.

Family planning services in the country are reported as insufficient and inadequate and have resulted in reduced numbers of registered contraceptives prescribed. This has been attributed mainly to the increased costs of medical check-up resulting from the reforms of the health system. According to the latest Multiple Indicator Cluster Survey conducted during 2005-2006, contraception prevalence is 14%, out of which condoms represent 5%, contraceptive pill 3% and diaphragm 1%. The survey also shows that 34% of women report unmet need for family planning, as compared to 29% that considered available services adequate (5). The low level of contraception prevalence is also due to the difficulties obtaining contraceptive pills without prescription and by their unaffordable prices (6).

Available data suggests that lack of attention to prevention through education and health promotion services appears to be another crucial weakness of the RH system in the country. A critical lack of client oriented health information means that women have little access to information crucial to their health and to the health of their families. Lack of knowledge and awareness about their reproductive and sexual rights contributes towards maintenance of the subordinated position of women in the family.

Interventions and collaborations

The deteriorating family planning services have affected negatively the right of women to manage their own fertility and RH. In order to address these negative trends in the RH and rights of women in the country, and in an absence of a comprehensive national strategy for promotion of SRH, UNFPA has initiated support to the government in its efforts to ensure the universal access to RH of its population. Specific objectives of this collaborative effort include:

- a) improving prevention of unwanted pregnancy through increased use of modern contraceptives and access to information, knowledge and family planning services;
- b) ensuring conditions for safe abortion (improving standards, accountability and post-abortion care and counselling);
- c) prevention of STIs, particularly Chlamydia, through early detection and awareness-raising.

Achievement of progress in the areas identified above will require different interventions, including those aimed at:

- a) improvement of data collection system and of knowledge on trends, determinants and policy/intervention needs;
- b) improvement of prevention work through educational and awareness raising activities targeting both the general population and the medical health workers;
- c) improvement of standards and the quality of family planning and RH services;
- d) overcoming barriers to the use of modern contraceptives related to issues of accessibility, affordability and social/cultural gender-based constraints.

The first phase of this project has been initiated. All relevant national stakeholders are conducting a strategic assessment of the status of family planning, abortion and contraception use. Policy recommendations that will serve as a basis for development of a pilot programme to address the gaps, problems and needs identified by the assessment will be developed. The pilot programme will be implemented in a second stage and will eventually be mainstreamed throughout the country in the upcoming years. By doing so, UNFPA and relevant national partners hope to improve the RH and rights of women, decrease the negative impact of gender inequality on women and help change social and cultural norms based on traditional gender roles.

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THE DANISH ACTION PLAN FOR COMBATING TRAFFICKING IN HUMAN BEINGS 2007 – 2010

On 1 March 2007, the Danish Government launched its second action plan on trafficking. The first action plan from 2002 focused on trafficking in women for sexual exploitation only and was supplemented with an annex on trafficking in children in 2005. The second action plan covers trafficking in all human beings. The expanded scope of the action plan is positive, not only from a formal human rights perspective, but because trafficking of both children and men for slave like work conditions has already been experienced, and may even be increasing, in Denmark.

An additional strength of this second action plan is that the Minister of Development is a partner, which allows the Ministry of Foreign Affairs and its supported “Neighbourhood Programme” partners in relation to trafficking in Moldova, Ukraine, Belarus, Bulgaria and Romania to be linked with the national action plan. Similarly, the Nordic/Baltic Cooperation, European Union and Organization for Security and Co-operation in Europe and North Atlantic Treaty Organisation activities in the field are included in the action plan to meet the strategic goal of expanding and strengthening international governmental organization (GO) and non governmental organization (NGO) networks cooperating against trafficking.

Lessons learnt

As in the first action plan, prevention of trafficking, protection of and support to victims of trafficking and prosecution of traffickers and profiteers are essential elements of the second action plan. This requires coordination among the many varied players working together to combat trafficking. However, experiences in Denmark, like other countries, have demonstrated that cooperation among the many actors in the field can be difficult and time consuming. An evaluation of the implementation of the first action plan showed that while cooperation between police and the social NGOs has generally been good, the cooperation between NGOs could be improved.

The evaluation recommended that the social work to identify and support

victims should be better coordinated and that the quality of support for victims should be ensured. It also recommended a more formalized cooperation between the social and health sector is implemented (through guidelines) in order to meet the victims’ immediate health needs better. Treatment of victims staying in a safe house during the reflection period (length of time that allows victims to recover, usually 30 days for citizens outside EU countries) has been offered by the health services, as have tests and treatment of STIs and abortions. However, this is often practiced on an individual case basis only. Thus, monitoring and evaluation are required to ensure these services are standardized and applicable to all. The evaluation also highlighted that very few women have accepted the offer of being received by an NGO in their native country, which leaves them vulnerable to become re-trafficked upon return. In future, victims who will co-operate with police on assisted repatriation to their country of origin may have a longer term of departure, up to 100 days, in order to organize a safe return.

New organization of work and new initiatives

In order to achieve a holistic approach to victim assistance, the second action plan establishes a new structure for co-operation. Some initiatives are directed towards all groups of trafficked persons and some are directed specifically toward trafficked women and children. Overall, the action plan introduces new initiatives to better identify victims of trafficking, as well as opportunities to

recognize possible sources of identification. Examples of these new initiatives include, in addition to the existing hotline and outreach work to foreign women in prostitution, new drop in centres in major cities and common interdisciplinary methods of identification (such as cooperation between police and social organizations or health institutions) of women trafficked for sexual exploitation, who remain the major group of trafficked persons. In addition, police and other relevant professional groups will receive recurring education in trafficking issues, including identification of victims. Finally, establishment of local groups of police, social and health services, relevant NGOs and social outreach workers to foreign women in prostitution will be a new initiative aimed at strengthening the co-operation and support for victims and local awareness on the issue of trafficking. The groups will also serve to ensure the anchoring of government support efforts through multidisciplinary cooperation at the local level where victims are met.

New national Centre on Trafficking in Human Beings

With the expanded mandate, the Inter-ministerial Working Group on Trafficking in Women continues to be responsible for the coordination of the government’s strategy in the field of trafficking. However, a new institution, the Centre on Trafficking in Human Beings, based in the National Board of Services under the Ministry of Social Affairs, is also being established. It should be functional by the end of 2007.



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The Centre will serve as the coordinating body for the social assistance, protection and support for victims of trafficking. Its activities will be many. In relation to trafficking in women it will coordinate the local social efforts and facilitate the operational co-operation between the involved actors. The Centre will also be responsible for outreach work, running the hotline and drop in centres, and for setting standards for the protection and assistance to victims in safe houses. In relation to trafficking in human beings the Centre will serve as a centre for data collection and research, as well as an institution for documentation and monitoring. It will also act to set standards and issue guidelines for identification and protection of trafficking victims. The Centre will also be responsible for com-

munication of knowledge among all relevant local and central social actors and for training of professionals. Finally the Centre will also cooperate with Foreign authorities on programme development on prepared return of victims of trafficking, including cooperating with authorities and NGOs in the countries of origin.

Conclusion

Though not principally human rights based, the new Danish action plan meets many of the recommendations on best practices of the Expert Group of Trafficking in Human Beings of the European Union. The new action plan and the new Centre on Trafficking in Human Beings allow a great strengthening of the Danish efforts against trafficking in human beings within the existing legal framework.

Together they enable Denmark to continue its strong commitment within the European and international cooperation in the field of trafficking.

The action plan may be found on the website of the Department of Gender Equality of the Danish Ministry of Social Affairs: http://ligeuk.itide.dk/files/PDF/Handel/Menneskehandel_4K.pdf

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“Violence will not pass by itself”–

TEEN DATING VIOLENCE IN THE REPUBLIC OF CROATIA

Until recently, the problem of teen dating violence in the Republic of Croatia has not been the focus of social research initiatives, nor education and prevention activities. Only in 2004, did the Centre for Education, Counselling and Research (CESI) conduct an action research which showed that 60% of adolescents have experienced some kind of relationship violence and that 43% of young people acted violently in their relationships. Research results were used in the development of an education and prevention programme for youth, as well as in awareness raising campaigns implemented during the last three years. Besides the developed programme, CESI also created and published a manual for educators entitled *'Better Safe than Sorry: Prevention of Violence in Adolescent Relationships'*, and trained around 60 secondary school teachers for the implementation of this programme.

In 2007, CESI conducted more comprehensive research with the goal of exploring prevalence rates, forms, reasons, consequences, as well as the risk factors for teen dating violence. The aim of this research was to improve the understanding of the needs and problems young people face in the context of dating violence, and to provide creation and implementation of quality and effective school-based education and prevention programmes.

Research results

1014 students, aged 16-19, from 42 secondary schools in the Republic of Croatia participated in the research. Most of the surveyed young people (87%) already had some dating experience, and many of them (79%) consider teen dating violence to be a serious problem. For some respondents, the knowledge about partnership violence is a part of their everyday interactions and social networks: around a third of youth (28%) socialize within peer groups, which include friends in a violent relationship, and every fifth young person is first-hand familiar with someone who is involved in a violent relationship.

More than two thirds of adolescents (70%) reported experiencing some form of violent behaviour from their partner, and a little less than half of adolescents

(43%) stated that they were at least once violent towards their partner. Generally, the results show that the prevalence of teen dating violence varies according to the forms of violent behaviours. The observed patterns indicate that the most common forms of dating violence are those by which young people try to dominate and control their partners; excessive jealousy, possessive and controlling behaviour, accusations and emotional blackmails. Sexual violence and physical aggression are present to a lesser extent.

Partner's excessive jealous behaviour is the experience which characterized the relationships of more than half of respondents (58%). In addition, a quarter of young people have experienced violent behaviours motivated by jealousy, which are instrumental for establishing and maintaining control and dominance in a relationship. Research indicated that a considerable proportion of adolescents do not recognize these behaviours as violent. For some youth this is also true for sexual and physical forms of dating violence. A lack of awareness and ignorance towards violent behaviours, as well as the belief that some forms of violence are a “normal” part of every relationship, could lead to young people's tolerance of risky and violent relationships and could mean that they cannot find enough reasons to end this kind of relationship.

While jealousy was recognized by most of adolescents (57%) as the main reason for the perpetration of dating violence, at the same time, a large number of respondents (61%) consider jealousy to be a way of showing love and not a form of dominance and control in a relationship. Besides jealousy, young people were often violent to their partner because of the fear of breaking up (29%), and violent behaviours were also motivated by the partner's “provocation” (27%), as well as, by communication problems (21%).

Identified risk factors related to victimization, but also to perpetration of emotional/psychological forms of teen dating violence include: low self-respect; frequent alcohol consumption; witnessing/experiencing family violence; acceptance of traditional gender stereotypes; permissive attitudes towards the use of violence; communication problems in relationships; and influence of peers and media. It is also worth mentioning that about half of adolescents (53%) reported being both the victim and the perpetrator of dating violence.

In relation to the sex/gender dimension of the problem, a significantly larger proportion of girls tend to be both the victims and perpetrators of emotional/psychological forms of dating violence, while a greater proportion of boys tend to



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be perpetrators of sexual violence towards their partner. In addition, more boys tend to approve of traditional and sexist attitudes about gender roles, as well as attitudes which justify the use of violence in particular situations. Boys also tend to be more ignorant about recognizing certain behaviours as violent.

While both boys and girls experience dating violence, feelings and reactions stated by respondents as the consequences of partner's violent behaviour clearly show that teen dating violence is not a gender neutral problem. For girls, the consequences are considerably more negative and more serious. For them, experienced violence results more in the feelings of hurt, sadness, insecurity, fear, shame, guilt and uneasiness. Boys, on the other hand, reported that after the violent episode in a relationship they were more indifferent and unconcerned, and that they found the violent situation to be funny.

Fear, shame, lack of awareness, distrust and the lack of relevant information and resources are the main reasons why adolescents try to solve the problem of dating violence by themselves. The same reasons are why adolescents rely on their own capacities and skills to eventually end the violent relationship, and most often do not decide to report violence to adults, nor seek help and advice outside a peer group. Considering the reactions to a hypothetical situation of a physical dating violence, the answers given by respondents show that extremely low numbers of adolescents would decide to contact relevant persons and institutions/organizations to report violence and ask for help and support.

Education and prevention

Around three quarters of the surveyed students (78%) reported that there are no programmes or activities related to the prevention of teen dating violence in their schools. Research results point to the following needs for education and prevention programmes: raising awareness about and recognition of emotional/

psychological forms of violence including warning signs for a violent relationship; change of attitudes about violence and gender stereotypes; understanding of the dynamics of power and control in adolescents' relationship; development and strengthening of self-respect and self-confidence, communication skills and problem solving skills as the aspects of healthy and non-violent relationships; raising awareness and promotion of sex/gender equality and the right to live without violence as a basic human right; raising awareness about the influence of peers and media; additional education for relevant social actors; anonymity, confidence and expertise; encouraging counselling and support for dating violence victims; informing about mechanisms and resources for reporting dating violence; as well as psychological-social work with perpetrators of teen dating violence.

In response to the recognized needs, CESI, in partnership with Open Media Group, is conducting a national awareness raising campaign for prevention of gender based violence (GBV) entitled "Silence is not golden" and financially supported by European Commission, Ministry of Science, Education and Sport of the Republic of Croatia and CARE International. The campaign runs from December 2006 to August 2008, and targets primarily secondary school students, but also their teachers, policy makers and general public. The campaign aims to raise awareness about the need to eliminate gender stereotypes and other causes of GBV among young people, to develop young people's responsibility as future acting and decision-making members of society on the issue of gender equality, and to promote values of gender equality in attitudes and behaviours of young people.

The media part of the campaign aims to raise awareness of youth and general public about the types of GBV. TV clips and print materials (billboards, city lights and newspaper ads) are used to address

three topics – domestic violence, teen dating violence/date rape and trafficking of women and girls. To begin, each topic is presented separately with a clear and strong message. The campaign ends with these three topics combined together to portray all these forms of violence as different types of GBV. All the campaign's activities are presented at www.cesi.hr and www.sezamweb.net.

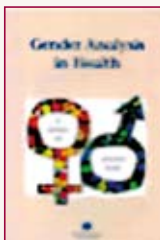
Besides the media campaign, in autumn 2007, around 60 secondary school teachers will participate in capacity building training in order to improve their knowledge and skills needed for working with young people on the issues of GBV. This includes training on a particular technique/form of expression (film, theatre, journalism, and comics) that will be used in work with young people. After the trainings teachers will introduce the topic of GBV to students, who will start working on a particular GBV issue using creative techniques, i.e. theatre play, short film, comics or reportage. Each school/group will produce one piece of work dealing with the issue of GBV. Finalized projects will be presented at the Final Campaign Event in June 2008, put on CD ROM along with other project outputs and distributed both locally and regionally.

Likewise, CESI, through various activities, continues to advocate and lobby for the inclusion of gender perspectives in violence prevention programmes for youth, as well as for the inclusion of comprehensive and systematic sexuality education in school curriculae.

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SELECTED RESOURCES ON GENDER AND SEXUAL AND REPRODUCTIVE HEALTH



Gender analysis in health: a review of selected tools, WHO, 2002.

Published by the Department of Gender and Women's Health, WHO, in Geneva, this publication provides a critical review of tools available for gender analysis and their application to health, focusing on tools which allow recognition of gender inequality and inequity. Tools examined include: social determinants of health, health seeking behaviour, quality of care, health promotion, impact of health financing, policy and participation and consultation.

Available in English at: www.who.int/gender/documents



Integrating gender into HIV/AIDS programmes, A Review Paper WHO, 2003.

This document reviews the impact gender has on the HIV/AIDS pandemic and proposes a framework for considering the issues related to integrating gender into action at programme and policy level. Different categories of interventions (do no harm, gender sensitive, gender transformative and empowerment) are discussed and examples from successful programmes are presented.

Available in English at: www.who.int/gender/documents



Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions, WHO, 2007.

This recent review analysed data from 59 studies of interventions in sexual and reproductive health with men and boys, drawing attention to a group that is often neglected in SRH. Effectiveness of programmes to encourage male participation in reaching gender equity and equality in health were assessed by overall effectiveness and gender approach of the programme.

Available in English at: www.who.int/gender/documents/newpublications/en/index.html



'En-gendering' the Millennium Development Goals (MDGs) on Health, WHO, 2003.

Recognizing the importance of gender in achieving all MDGs, this document identifies areas where gender considerations may affect the work towards the goals, including those directly and indirectly related to SRH. Attention is called to the need for sex disaggregated data and the development of indicators that address gender dimensions.

Available in English at: www.who.int/gender/documents



Transforming health systems: gender and rights in reproductive health. A training curriculum for health programme workers, WHO, 2005.

This manual serves as a training resource for all those involved in reproductive health (health professionals, planners and policy makers) to ensure that reproductive health services are rights based and gender sensitive. Divided into 6 modules the manual starts with the social construction of gender and finishes by linking gender and health, addressing concepts and tools for gender analysis, gender based inequalities and gender mainstreaming along the way. An essential resource for those wishing to gain the skills and tools to operationalize gender and SRH programmes.

Available in English, Chinese, Spanish and Russian at: www.who.int/reproductive-health/gender/index.html

Gender and rights in reproductive and maternal health: manual for a learning workshop, WHO, 2007.

A new publication from WHO, this manual is meant for use in a 6 day workshop that focuses on gender and rights in reproductive and maternal health. The need to increase awareness of gender equality, with participation of both men and women, is emphasized.

Available in English at: www.who.int/reproductive-health/gender/index.html



Women, Ageing and Health: A Framework for Action. Focus on Gender, UNFPA, 2007

This document focuses on the health status of women from midlife onwards, focusing on gender and how inclusion of gender and ageing perspectives are required in programmes, practices and policies to improve health and well being.

Available in English at: www.unfpa.org/publications



State of World Population 2006. A Passage to Hope: Women and International Migration, UNFPA, 2006.

This report examines the scope of female migration, addressing the challenges and risk women face as migrants, particularly pertaining to human rights violations, trafficking, GBV, RH issues and STI and HIV/AIDS. It draws attention to the need for gender equality and recognition of basic human rights in policy framework for migrants.

Available in English, French, Spanish, Russian and Arabic at: www.unfpa.org/publications



Gender Responsive Budgeting and Women's Reproductive Rights: A Resource Pack, UNFPA, 2006.

This document acts as a resource for the provision of knowledge to help facilitate the integration of gender responsive approaches into RH programmes, including how to address gender inequity and inequality from national policy frameworks.

Available in English, French and Spanish at: www.unfpa.org/publications



Research Issues in Sexual and Reproductive Health for Low and Middle Income Countries, Global Forum for Health Research and WHO, 2007.

This document presents a framework to highlight the needs, gaps and priorities for research in sexual and reproductive health. Poverty, equity and gender are presented as crosscutting themes that impact significantly on sexual and reproductive health.

Available in English at: www.who.int/reproductive-health/publications/research



Change, Choice and Power: Young Women, Livelihoods and HIV Prevention, IPPF, UNFPA and Young Positives, 2007.

This document addresses the vulnerability of young girls and adolescents to HIV infection, focusing on the issues of poverty and gender inequality.

Useful websites

- WHO Department of Gender, Women and Health: www.who.int/gender
- WHO Department of Reproductive Health and Research: www.who.int/reproductive-health
- International Society for Men's Health and Gender: www.ismh.org
- EngenderHealth: www.engenderhealth.org
- European Institute of Women's Health: www.eurohealth.ie
- Gender and Health Equity Network: www.ids.ac.uk/ghen
- United Nations Development Fund for Women: www.unifem.org
- United Nations Division for Advancement of Women: www.un.org/womenwatch/daw
- Womenwatch: www.un.org/womenwatch

Upcoming events

Bridge the gender gap. The Northern European Regional Congress of the Medical Women's International Association. Sept. 3-6, 2008 Malmö, Sweden. www.malmokongressbyra.se

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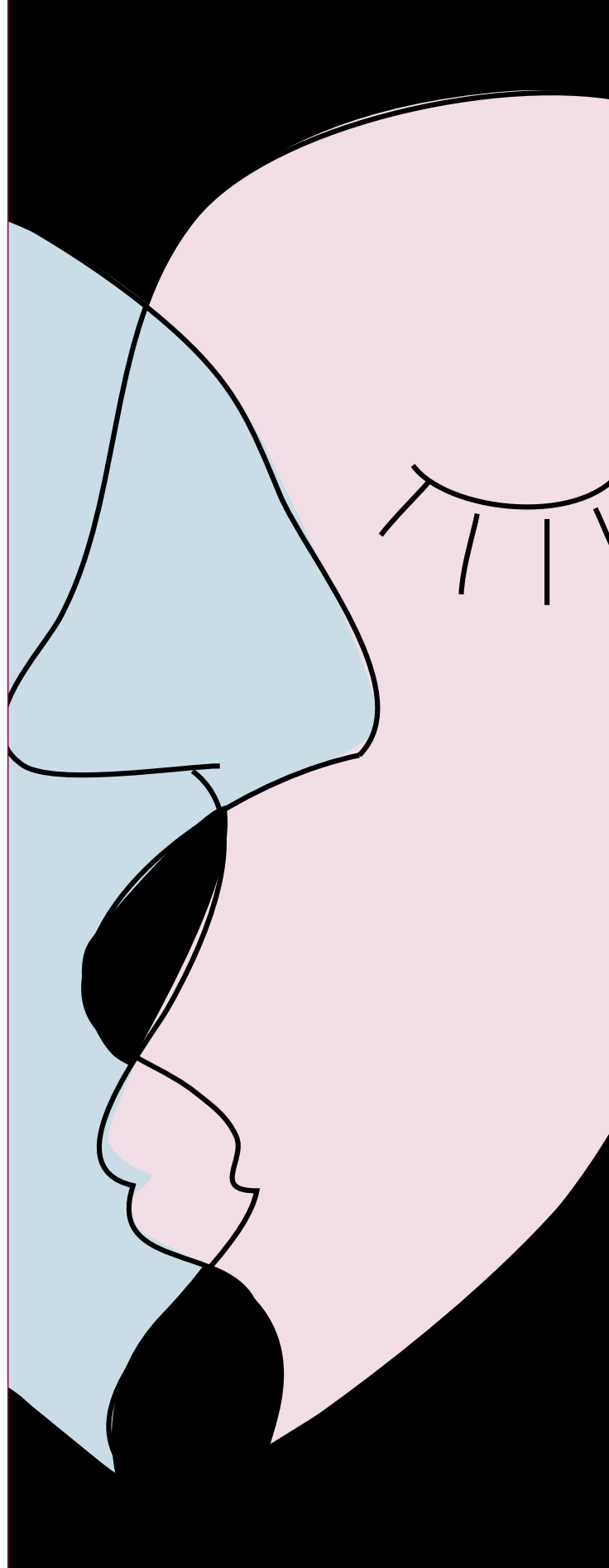
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