



EXPLORING PARTNERSHIPS
IN SEXUAL AND REPRODUCTIVE
HEALTH IN EUROPE



Entre Nous

THE EUROPEAN MAGAZINE FOR SEXUAL AND REPRODUCTIVE HEALTH



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EDITORIAL

- Strengthening strategic partnerships in sexual and reproductive health in Europe

Gunta Lazdane



This issue of *Entre Nous* will be focussing on partnerships, on the ways of how one individual, organization or programme is associated with another in common activities, in reaching common goals in the area of sexual and reproductive health and rights in the WHO European Region and globally.

During the International Conference on Population and Development (ICPD) in Cairo in 1994 more than 180 countries agreed that for further progress and to reach the objectives of the Programme of Action adopted, it is important to promote broad and effective partnerships among governments, NGOs, the private sector and the international community in all aspects of program development, implementation and evaluation. It was emphasized that such partnerships will depend on appropriate systems that enable each organization to contribute according to its distinctive role, responsibility, autonomy and capacity.

The importance of this ICPD goal was confirmed in 2000 by the United Nations Summit in defining the Millennium Development Goals where 189 countries agreed to focus their efforts towards elimination of poverty and sustainable development. The 8th goal "Develop a global partnership for development" includes various levels and forms of global partnerships - partnerships between countries, national and international partners as well as cooperation with pharmaceutical companies and the private sector. Before the five-year review of the Millennium Declaration took place in September 2005, the General Assembly was holding hearings with civil society and the private sector. The hearings represented a significant step forward for civil society, who continuously supported the principles of

the United Nations and of multilateralism. The strengthening of partnership between the United Nations and civil society in the formulation process of the Millennium Declaration was important for retaining the issues related to sexual and reproductive health and rights in the document. This is evident as the member countries of the United Nations confirm their commitment to: "Achieve universal access to reproductive health by 2015, as set out at the International Conference on Population and Development, integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration aimed at reducing maternal mortality, improving maternal health, reducing child mortality, promoting gender equality, combating HIV/AIDS and eradicating poverty".

Having said this, the concept of "partnership" is hard to define in very formal way, however, if we go to the Latin origin of the concept it is strongly related to "partition" from *partire* "to divide" and that may be interpreted as dividing responsibilities, resources and efforts to reach common goals. This echoes what the Executive Director of UNFPA, Thoraya Obaid, said in her speech, which we have the pleasure of sharing with you later in this magazine: "I want to stress that when we speak of partnerships this goes beyond just networking to integrating and co-ordinating the activities of various stakeholders. This will ensure that each group and organisation plays its role and uses its comparative advantage...".

Partnerships are formed to utilise comparative advantages, to learn from each other and to become stronger together. These principles are clearly defined by the international community and we have success stories to share as well as failures to analyse. Everybody agrees that partnerships improve efficiency and effectiveness, however, coordination on the ground at the country level often remains weak, experiencing competition, inconsistent reporting requirements and administrative barriers.

The WHO European Regional Strategy on Sexual and Reproductive Health (2001) has provided strategic guidance to many Member States collaborating in development of policies and deliverance of programmes towards improving the sexual and reproductive health of their population. It has been defined that without intersectoral collaboration, collaboration with private sector and collaboration within the health sector, it would be impossible to reach the goals and objectives of the strategy.

This *Entre Nous* includes several examples from our Member States on how to build successful partnerships that may be of help for others, who are just trying to initiate the process.

How do we reinforce and maintain strategic partnerships? How can currently separate communities such as the HIV/AIDS specialists, women's health advocates, human rights activists and the sexual and reproductive health community join hands? How do we ensure that the broad and comprehensive definition of reproductive health is not split into pieces and maternal health is recognised and dealt with as a very important part of reproductive health, but not as a separate entity? This issue of our magazine will try to answer some of the questions, will introduce our main partners and we hope will be a trigger for further development of partnerships in Europe and beyond.

Gunta Lazdane
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Chief Editor

BREAKING THE BARRIERS

– Partnership to fight HIV/AIDS in Europe and central Asia

It is absolutely clear that HIV/AIDS is not only a public health issue; it is a social and economic issue as well. And it is only through partnerships involving a wide range of stakeholders that we can address the epidemic and its many consequences and save human lives.

In certain parts of Europe there has been considerable progress since the epidemic first began in the mid 1980s. Prevention efforts have been particularly successful in western, central and southern Europe and effective partnerships have contributed to this success.

It is urgent that similar efforts now take place in other parts of the region where the epidemic is rapidly spreading, especially eastern Europe and central Asia. Successful prevention efforts depend on multi-sectoral and inclusive approaches that bring together expertise and resources from government, civil society, public-private partnerships and research workers. It is clear that partnerships need to be broad-based and include a variety of sectors, groups and individuals, including people living with HIV/AIDS.

I want to stress that when we speak of partnerships, this goes beyond just networking to integrating and coordinating the activities of various stakeholders. This will ensure that each group and organisation plays its role and uses its comparative advantage, be it in prevention, sexuality education, behaviour change, harm reduction or caring for affected individuals, to reach the collective goal to halt the HIV/AIDS epidemic.

UNFPA has consistently stressed the importance of partnerships when addressing HIV/AIDS.

It is absolutely clear that HIV/AIDS is not only a public health issue; it is a social and economic issue as well. And it is only through partnerships involving a wide range of stakeholders that we can address the epidemic and its many consequences and save human lives. It is clearly of the utmost importance that there is high-level commitment to the prevention of HIV/AIDS, and a high-level commitment to partnership around HIV/AIDS. There are many challenges to establishing and maintaining effective partnerships for the prevention of HIV/AIDS and for the treatment and care of people living with HIV and AIDS.

I would like to highlight some of the

elements that are important to achieving effective partnerships for HIV/AIDS prevention, treatment and care.

At both the country and regional levels:

- It has to be repeatedly stressed that there needs to be committed leadership at all levels if partnerships are to be effective in slowing the spread and severity of the epidemic. UNFPA has been a long-term supporter of parliamentary involvement in sexual and reproductive health issues, and UNFPA has been able to underline the issue of HIV/AIDS in eastern Europe and central Asia in a highly visible meeting of Parliamentarians. This was the Round table on Sexual and Reproductive Health and Rights in central and east European Countries: The Role of Parliamentarians, held in Poland in July 2002. During this meeting, UNFPA emphasised that political leadership is one of the most essential elements in the strategy to combat HIV/AIDS, and that HIV prevention must be part of the sexual and reproductive health debate. There need to be more occasions where this happens.
- Partnerships have to be wide and include not only parliamentarians and policy makers in ministries in central government, but also those in local government and local community leaders. This has been successful for UNFPA where it has worked with local leaders in several countries, most notably in the central Asian Republics, with regard to advocacy and sensitisation of the importance of coordinated action in response to the epidemic. Commitment has to happen from the top but also from the bottom up!
- While a continuing challenge, it is also important that we strengthen the effectiveness of civil society, particularly local non-governmental orga-



nizations (NGOs) and those serving women and youth, and public-private partnerships. These partnerships are often not easy to establish and maintain, but do have a substantial impact on the coverage of preventive and care activities. Partnerships increase the coverage of prevention and care activities. And it is particularly important to include the most vulnerable – young people, women and young girls, trafficked people, and injecting drug users.

- We need to promote wider stakeholder participation and networking between related organisations and groups to reach the most vulnerable members of society. In the present context, this particularly includes young people in general, but more specifically, those exposed to pressures such as drug taking. In addition, there are other specific groups that are particularly vulnerable to HIV/AIDS in Europe and these include marginalised people, such as those exposed to trafficking and to sex work. NGOs and various groups working with these people, or coalitions of these groups, need to be brought into partnerships with others working to prevent the further spread of the epidemic and to help to provide care for people living with HIV/AIDS. Partnerships need to be strengthened to ensure the specific needs of marginalized and vulnerable groups are met and their rights, and particularly reproductive rights, are not violated.
- UNFPA is working closely with NGOs in several countries in the region, for instance, the Humanitarian Action Foundation in St. Petersburg in the Russian Federation, the NGO Return to Life in Moscow and Gender in Development in Dushanbe, Tajikistan. The European Red Cross/Red Crescent Networks on HIV/AIDS and Tuberculosis and their Harm Reduc-

tion Initiative are good examples of such partnerships. They work with young people in the region and concentrate on a human rights approach and inclusion of people.

- It is absolutely essential that coordinated efforts are made to ensure that young people are involved in education efforts which provide necessary knowledge on sexuality in the context of healthy lifestyles and harm reduction and which promote attitudes and skills to make responsible and healthy choices. This can and should be done through in-school and out-of-school education, using various approaches including peer education. UNFPA has provided—together with other United Nations agencies and other organisations—considerable support to in-school education. In the European region, special focus through peer education has resulted in the Y-Peer Network in South-eastern Europe.
- Given the increase in sexually transmitted infections (STIs) in all countries of the region, it is essential that awareness, early diagnosis, prevention and treatment activities be provided by a range of partners. A focus on STIs as an entry point for HIV reduction is particularly important in Europe, given the worrying increase in STIs. There need to be stronger partnerships between different medical specialists in preventing and managing STIs.
- Partnerships between the public and private sectors can provide critical support for HIV prevention activities. UNFPA has had positive experiences working with private organisations like MTV to disseminate and promulgate messages regarding safer sex among young people through this popular medium. In other situations, private employers have an important role to play in ensuring workers are aware of how HIV infection is spread

and how to prevent infection. UNFPA has made significant contributions to preventive activities through condom programming via the public sector and, in several countries, through partnerships with social marketing programmes, which contain information and educative components.

- Migration and forced migration, including trafficking, are concerns in Europe, which require regional partnerships. There are clearly fundamental issues related to ensuring reproductive rights that are critical concerns with regard to migration and trafficking and regional partnerships are urgently needed to address these critical issues.
- At a regional level, there needs to be improved mechanisms for sharing information about AIDS. To an extent, UNAIDS fulfils this crucial role but it is likely that European Union bodies could and should also play an increasing role in networking and sharing technical expertise on a range of partnership issues. This could certainly cover support for relevant regulatory and legislative issues concerned with sexual and reproductive health and reproductive rights, including those related to HIV/AIDS.

So, it is clear that there remain many challenges for all countries in Europe regarding effective partnerships to combat HIV/AIDS. However we now have many examples of how to establish and maintain these partnerships that are crucial to success.

Let us also hope that existing partnerships in western Europe can be strengthened to meet the emerging challenges of HIV infection among migrant groups and are extended to other parts of the region to prevent the spread of HIV and to maintain the long-term health and quality of life of people living with HIV and AIDS.

The overall challenge is commitment

to coordinated implementation and support for those types of coalitions that have been successful and to replicate similar ones, particularly in the parts of the region where the epidemic is worst and where resources are severely limited. Let us particularly hope that the more affluent parts of the region can form substantial partnerships with less fortunate areas to meet the challenges presented by HIV/AIDS.

There remains much to be accomplished for effective partnerships to combat HIV/AIDS in Europe.

Partnership requires investment—investment in time, investment in resources—however the results fully justify the efforts.

Acknowledgement

This speech by Thoraya Ahmed Obaid, Executive Director, UNFPA, has been adopted from her Concluding Remarks held at the Ministerial Conference "Breaking the Barriers – Partnership to fight HIV/AIDS in Europe and central Asia" on 23 February 2004 in Dublin, Ireland.

Thoraya Obaid
Executive Director, UNFPA



During the Ministerial Conference 'Breaking the Barriers- Partnership to fight HIV/AIDS in Europe and Central Asia' held in Dublin, Ireland in February 2004 the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia was adopted. In this Declaration the following important commitments were made about partnerships:

- Strengthen coordination, cooperation and partnership among the countries of Europe and Central Asia, as well as with their trans-Atlantic and other development partners, to scale up local capacity to fight the epidemic and mitigate its consequences in the most affected countries with the greatest needs, and in countries with a high risk of a major epidemic;
- Involve civil society and faith-based organizations, as well as people living with HIV/AIDS and persons at the highest risk of and most vulnerable to HIV/AIDS infection in the development and implementation of national HIV/AIDS prevention and care strategies and financing plans, including through participation in national partnership forums;
- Work with leaders from the private sector in fighting HIV/AIDS through workplace education programmes, employee non-discrimination policies, provision of treatment, counseling, care, and support services, and through engagement with policy makers on the local, national and regional levels;
- Involve the national and international pharmaceutical industry in a public-private partnership including with relevant international organizations such as the World Health Organization in helping to tackle the epidemic along all points of the drug supply chain – from manufacturing to pricing to distribution;
- Ensure effective coordination between donors, multilateral organizations, civil society and Governments in the effective delivery of assistance to the countries most in need of support in the implementation of their national HIV/AIDS strategies, based on ongoing processes on simplification and harmonization particularly the UNAIDS guiding principles;
- Establish sustainable partnerships with the media, recognizing the critical role that it plays in influencing attitudes and behaviour and in providing HIV/AIDS related information;
- Support stronger regional cooperation and networking among people living with HIV/AIDS and civil society organizations in Europe and Central Asia, and call upon the Joint United Nations Programme on HIV/AIDS in partnership with the European Union, existing civil society networks and other regional partner institutions to assist, facilitate and coordinate such collaboration;

*The complete Declaration can be downloaded from:
http://www.euro.who.int/aids/treatment/20051018_1*

THE WHO/UNFPA STRATEGIC PARTNERSHIP PROGRAMME (SPP)

Using evidence-based guidelines to improve national policies and programmes in sexual and reproductive health

Background

At the 1994 International Conference on Population and Development (ICPD), governments recognized that ensuring universal access to reproductive health care was essential for improving the lives of all people and imperative for development. Although countries have made substantial progress in the implementation of the ICPD Programme of Action, notable gaps and unmet needs still remain. The achievement of the Millennium Development Goals (MDGs), particularly those related to health, strongly depends on accelerating progress on the attainment of sexual and reproductive health. Access to and quality of sexual and reproductive health care services are key determinants. World leaders at the 2005 World Summit committed to: "Achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development and integrating this goal in strategies to attain the internationally-agreed development goals, including those contained in the Millennium Declaration ..." (1).

This echoed the earlier report by the Commission on Macroeconomics and Health (2) which stated: "Investments in reproductive health, including family planning and access to contraceptives, are crucial accompaniments to investments in disease control. The combination of disease control and reproductive health is likely to translate into reduced fertility, greater investments in the health and education of each child and reduced population growth". The European Union stated, in 2004, that "The MDGs cannot be attained without progress in achieving the Cairo goal of universal access to sexual and reproductive health" and "implementation of the ICPD Programme of Action is key to poverty reduction and is fundamental to achieving the MDGs". It called on Member States to provide additional resources towards implementation of the ICPD agenda (3).

In May 2004, 191 Member States adopted the WHO Global Reproductive Health Strategy (4), which, among other things, proposes that necessary actions should be taken to make sexual and reproductive health central to national planning and strategy development processes, including Poverty Reduction Strategy Papers. It is thus widely recognized that sexual and reproductive health is a key component of the policy framework needed to reduce poverty. Investing in

sexual and reproductive health is key to socioeconomic development.

To address the challenge faced by countries in achieving ICPD goals and other international development goals related to sexual and reproductive health, development agencies should foster partnerships that build on their collective strength and comparative advantages. Such partnerships should, in particular, strengthen capacity in countries to improve the quality of sexual and reproductive health care services.

"Any strategy to meet the Millennium Development Goals requires a special effort to build scientific and technological capacities in the poorest countries."

J.D. Sachs and J.W. McArthur, Lancet, 365:347-353, 2005

WHO and UNFPA working in partnership to improve sexual and reproductive health

The Strategic Partnership Programme (SPP) between UNFPA and WHO is a collaboration to improve quality of sexual and reproductive health care through utilization of consensus-driven, evidence-based practice guides developed by WHO and partners, which include UNFPA. The Partnership seeks to promote sexual and reproductive health at national and sub-national levels through support to countries in the introduction, adaptation and

adoption of selected practice guides in family planning, prevention and control of sexually transmitted and reproductive tract infections (STI/RTI), and maternal and newborn health, as illustrated in Figure 1.

The process entails the systematic dissemination of guidelines where, according to the baseline situation analysis, they could be adapted to local contexts or used to update national policy and/or programme guidelines. Following awareness meetings on the guidelines, countries are supported to convene workshops to introduce the guidelines and orient key stakeholders on their content. This is followed by the adaptation, where relevant, and implementation of key interventions or practices recommended in the guidelines to improve service delivery. Where relevant, countries are encouraged to monitor and evaluate the adoption and implementation of the recommended practices. Depending on resources available and in collaboration with partners, the SPP recommends the subsequent scaling up of successful interventions. The activities being implemented within this project bring together key programme areas of WHO and UNFPA, namely those concerned with the compilation of best practices and the translation of the evidence-based interventions into practice to improve sexual and reproductive health services.

Figure 1: The process for systematic introduction of guidelines

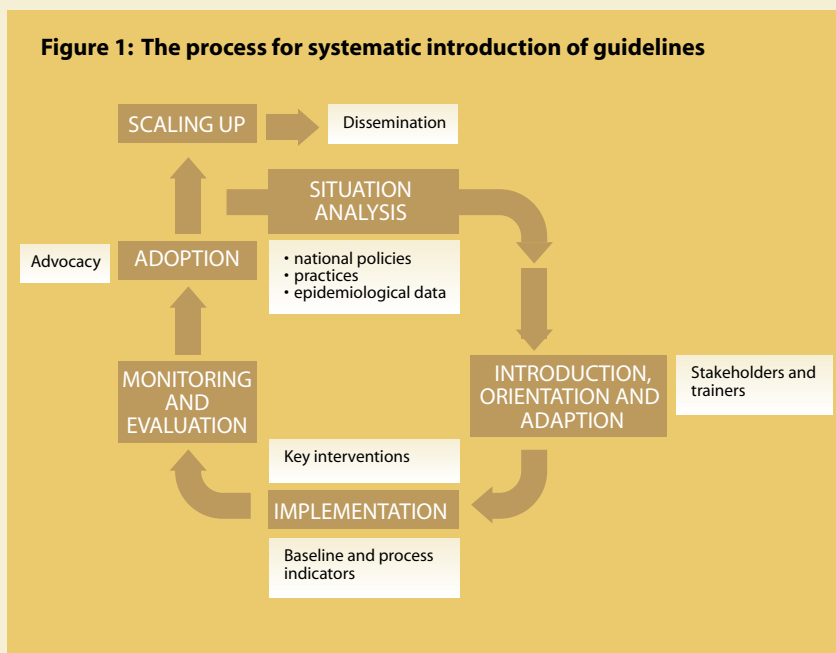


Table 1: Countries receiving intensified support

Africa:	Benin, Cameroon, Kenya*, Nigeria, South Africa, United Republic of Tanzania, Zambia, Zimbabwe
Americas:	Honduras, Paraguay, Peru
Eastern Mediterranean:	Afghanistan, Iraq, Morocco, Pakistan, Sudan
Europe:	Armenia, Kyrgyzstan, Romania*, Tajikistan, Turkmenistan, Uzbekistan
South-East Asia:	Bangladesh, Indonesia, Myanmar, Nepal
South Pacific:	Solomon Islands, Tonga, Vanuatu
Western Pacific:	China, Mongolia, Viet Nam

*Supported for field-testing and assessing utilization of guidelines

How the Strategic Partnership Programme is working in practice

Following agreement on the workplan in October 2003, the SPP has conducted six regional guideline introduction workshops involving 60 countries. The workshops involved nationals selected by the respective Ministries of Health and representatives of WHO and UNFPA Country Offices, Regional Offices and UNFPA Country Technical Services Team (CST) offices. There have also been two SPP global workshops involving staff from WHO Headquarters (HQ) and WHO Regional Offices and UNFPA CSTs. The global workshops were preceded by a meeting in 2003 of CST Directors and WHO/HQ and WHO Regional Office staff which refined the SPP implementation process. Workshops were also conducted involving some SPP-supported countries on Gender and rights in reproductive health, the Reproductive Health Library and evidence-based decision-making, and to create regional networks of expertise in STI/RTI.

A number of guidelines in the areas of family planning, STI/RTI and maternal and newborn health have been translated into Arabic, Chinese, French, Portuguese, Russian and Spanish and other languages as a crucial step in enhancing their utili-

zation to improve sexual and reproductive health through the SPP. Of the 60 countries involved in SPP workshops thus far, 30 are receiving intensified support through approved project proposals. Countries of intensified focus (Table 1), are those countries from which representatives who attended the relevant regional workshops submitted a proposal which was subsequently approved for catalytic financial and technical support within the SPP. Countries of general focus are the remainder who attended the workshops and are encouraged to proceed with use of the guidelines without project-specific support. In the Americas region, Health Ministers from MERCOSUR (Southern Common Market) countries issued a statement reaffirming the need for utilization of SPP-supported evidence-based guidelines to improve sexual and reproductive health.

Summary of key activities of the SPP to date are:

- Provision of financial and technical support towards a systematic process for in-country adaptation, adoption and utilization of guidelines selected for improving sexual and reproductive health and for overall implementation in countries of intensified focus.
- Support for the updating of national guidelines and policies including pre- and in-service curricula, development of job aides, brochures or wall charts to promote and strengthen effective practices as identified or recommended in WHO guidelines.
- Dissemination, in a targeted manner, of technical guidelines in collaboration with UNFPA and WHO country offices.
- Increase of the number of national sexual and reproductive health advocacy products that are based upon WHO guidelines.
- Catalytic up-scaling of practices based on SPP-supported guidelines.



UNFPA/WHO SPP activities in the WHO European Region 2004-2006

- Translation of the guidelines "Medical Eligibility Criteria for Contraceptive Use" (3rd ed.), "Selected Practise Recommendations for Contraceptive Use" (2nd ed.), "Sexually Transmitted and Other Reproductive Tract Infections: a guide for essential practices" into Russian – 2004-2005
- Workshop "Implementation of WHO Family Planning and STI/RTI tools in Central Asian Republics" Issyk-Kul, Kyrgyzstan, 25-29 May, 2004

Outcomes

- Participants were familiarised with and updated on family planning and STI guidelines
- Next steps required to reach the desired situation were outlined and concrete action plans were developed
- Printing of the family planning guidelines – 2005 available on the web: www.euro.who/reproductivehealth
- Adaptation and implementation of the WHO family planning and STI guidelines in Turkmenistan, Armenia, Kyrgyzstan, Tajikistan and Romania
- Printing and dissemination of the updated Making Pregnancy Safer core manuals in Russian - 2005
- UNFPA/WHO SPP sub-regional meeting on SPP activities in Eastern Europe and Central Asia, Yerevan, Armenia, 19-21 April, 2006

Main achievements and lessons learnt

As outlined above, the WHO-UNFPA SPP introduces guidelines through a collaborative process that fosters a harmonized, coherent and synergistic approach to development support. The country progress reports indicate that the stage is being set for a systematic approach to the introduction of recommendations to improve quality in sexual and reproductive health care. This is partly done with the help of some of the 23 partners of the Imple-

menting Best Practices initiative who have supported SPP activities in a number of countries and offer a mechanism for collaboration through field offices of these agencies.

- The workshops represent one step in the continuum of sharing knowledge and promoting community well-being through application of evidence-based practices and interventions. Lessons learnt to date include:
 - The SPP is being instrumental in the uptake of evidence-based guidelines in countries and further collaboration between development partners should be promoted and strengthened.
 - The SPP is accelerating progress to establish links between UNFPA and WHO at headquarters, regional and country levels, thus contributing to the improvement of sexual and reproductive health in countries through collective efforts of UN and other partners.
 - The endorsement of the SPP at the High-level Consultation involving WHO's Director-General and UNFPA's Executive Director (June 2004) followed by jointly signed letters, has served to enhance technical collaboration and mutual reinforcement between the two agencies.
 - The SPP provides a unique opportunity for fostering interagency communication, message harmonization and joint intervention on common goals and objectives. The inclusion of several agencies and the creation of networks of expertise allow for multiple perspectives and the opportunity to develop/enhance partnerships that support country requests.
 - The involvement of all major partners involved in sexual and reproductive health at country level, in particular the governments, should help to scale

up successful interventions to ensure sustainability.

In conclusion, the SPP framework brings together WHO, UNFPA and relevant partners in sexual and reproductive health under the leadership of Ministries of Health to update and revise national guidelines and introduce and adapt normative tools. Progress is being made towards improvement of the quality of sexual and reproductive health care through implementation of evidence-based guidelines developed by WHO and partner agencies.

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PARTNERSHIP DEVELOPMENTS AND STRATEGICAL THINKING OF WHO REGIONAL OFFICE FOR EUROPE

- Partnerships in health in general and in the area of “sexual and reproductive health”

Importance of partnerships

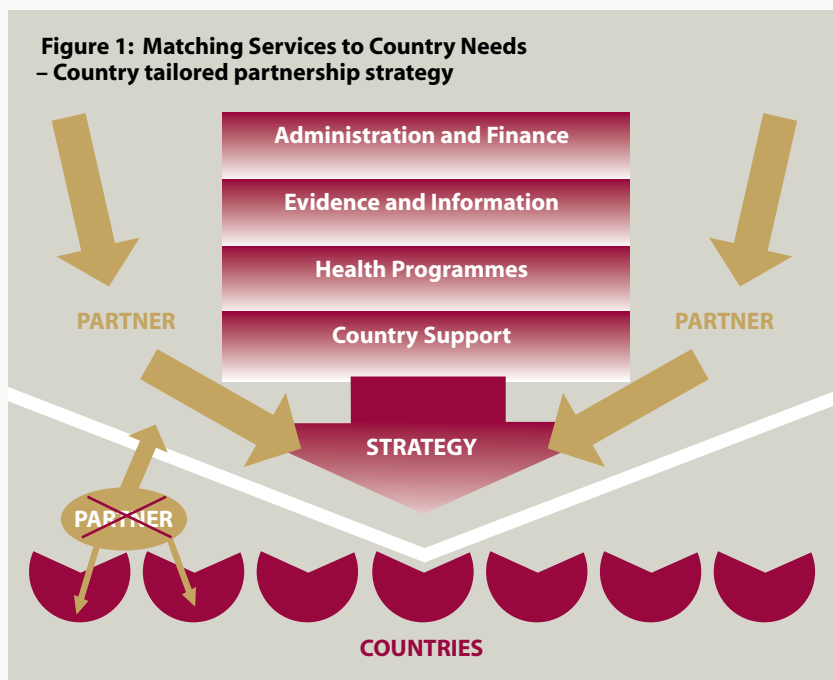
WHO, its Member States and all actors in the health sector are increasingly looking for the most effective and efficient means to deliver services in a growing interdependent world, characterized by limited resources, increased inequity, unmet needs and the mounting complexity and challenges posed by globalization. Partnership development therefore - and obviously not restricted to our area of work “sexual and reproductive health” alone - is valued as essential for WHO’s work and it is a strategic tool to maximise the use of resources in this new and rapidly changing environment.

General definition of partnerships

“Partnerships are commonly defined as voluntary or collaborative relationships between various parties, both State and non State, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities, resources, competencies and benefits.” (1)

By the above definition of the Secretary General of the United Nations about partnerships all possible forms of partnerships are embraced and the most important prerequisites for partnerships highlighted. For WHO as a specialized agency of the United Nations in the health sector partnerships have to: a) be based on common values as for instance described in the “Health for All” vision, i.e. solidarity, equity and participation, b) identify and use comparative advantages of partners and thereby avoid overlapping and c) share common and specific goals in the joint work program. These are just some of the major elements needed in an effective and efficient partnership approach.

A WHO characteristic is the fact that its work is based on multiple (nearly uncountable) different forms of partnerships. They can be either formalized by agreed workplans sometimes covering many years and periodical review and analysis of their benefit to both partners. This is the case of for example the fellowship program, the official WHO collaboration centres (close to 400 in the



European Region), the official networks created in programs like “Health Promoting Schools” and “Healthy Cities” and the NGOs in official relation to WHO. Other times WHO identifies partners on a more ad hoc basis with a less formalized approach, this is especially true for the collaboration with the civil society (which includes NGOs, foundations, interest groups, academia, etc.). This allows both partners to be more flexible and less bureaucratic. Another way to formalize a partnership is to sign of a specific, time-bound Memorandum of Understanding.

WHO Regional Office for Europe's understanding and operationalization of partnerships - Partnerships at country, regional, global level; evidence based partnership development

“The Regional Office will rapidly take initiatives to mobilize the international community, help countries themselves to coordinate the interventions by different organizations, and ensure that these interventions result in progress for the health systems of the countries concerned and, ultimately, in better health for their people (2).”

(The WHO Regional Office for Europe Country Strategy “Matching Services to New Needs 2000”)

In the last few years, WHO has highlighted the importance of country-focused work and the crucial role that partnerships play in that context. At country and at regional level, the Regional Office must react to the efforts and interests of many stakeholders active in health. Strengthening health systems and eventually improving the health of all people is neither exclusive to WHO nor a goal which WHO can achieve in isolation. In terms of country work, the WHO Regional Office for Europe Country Strategy “Matching services to new needs” set the direction by emphasizing an orientation towards countries. Consequently, the Regional Office now continues to support its Member States with consistent approaches and tools tailored to support them in helping themselves, and specifically to help them improve their health systems. Partnerships are one of the key elements of the organization in general and the implementation of the Country Strategy in particular. This approach is illustrated in figure 1. To identify partners and to base partnership building on a evidence based approach WHO carries out stakeholder analysis in each country and in each of its technical areas of work in relation to a specific country and/or region. Ideally, the goal is that once partners are identified,

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joint workplans are developed, the partnership monitored over the implementation phase and evaluated at periodical intervals (very often following a two-year planning cycle of WHO).

It is important to understand that in this whole dynamic and changing process WHO is lead to fulfil specific objectives when engaging in partnerships. These are mainly following five (of which most partnerships fulfil more than one):

- to strengthen WHO's technical and policy leadership in health matters as well as its management capacity through the involvement and coordination of external inputs, to strengthen WHO's political influence and promote the health agenda in political and socioeconomic spheres;
- to increase Member States and WHO's human and financial resources
- to increase the acceptance, dissemination and impact of WHO values, standards, guidelines and recommendations by partner organization and medical associations, through the implementation and application of these tools at regional, national and community level.
- to make best use of respective comparative advantages and thereby to achieve a more efficient and effective division of labour. This will contribute to achieving international targets through measurable programme impact, while avoiding duplication of efforts in a context of limited and "insufficient" resources available to the health sector;
- to build practical agreements with selected partners to provide focused support (through coordinated funding, exchanging information, training, etc) for Member States to reach their national development goals including strengthening of their health systems;

Partnerships in the area of reproductive health

WHO "Reproductive health strategy to accelerate progress towards the attainment of international development goals

and targets", adopted by the 57th World Health Assembly in 2004 emphasizes that "at the global level, WHO will continue to strengthen its partnerships with other organizations in the United Nations system (in particular UNICEF, UNFPA and UNAIDS), the World Bank, associations of health professionals, nongovernmental organizations and other partners in order to ensure collaboration and coordinated actions by the broad range of partners" (3).

The Reproductive Health and Research programme in the WHO Regional Office for Europe has a long standing experience of working together with other key public health programmes including child and adolescent health, HIV/STI, gender mainstreaming, health systems, immunization, nutrition, non-communicable diseases and others. In many countries, like the Central Asian and Caucasian republics, the priority component of the sexual and reproductive health is the Making Pregnancy Safer initiative and improvement of maternal and neonatal health. The efforts to save lives of women and their children are to be doubled and that will be possible only if the efforts of all involved will be united.

There are 19 designated WHO Collaborative Centres working in the area of reproductive health in Europe. Partnership with these research and academic institutions ensures that the goals in research and training are met, that there is joint effort in development and implementation of policies and programmes, guidelines and protocols.

Several best practices of partnerships in the area of reproductive health and research are included in this issue of *Entre Nous*, but besides these there is collaboration with many others for specific projects and activities and one issue of a magazine cannot cover all of them.

The European Regional Advisory Panel (RAP) on research and training in reproductive health, that unites experts with different specialities and backgrounds from different sub-regions of Europe, meets annually. RAP members in presence of the observers, the main part-

ners working in this area in this region (UNFPA, IPPF EN, GTZ, etc.), analyse the achieved results, failures and define the priorities for the future. This is one of the best examples of real partnership.

Partnerships in 2020

The importance of WHO to work in partnerships at country, regional and global level has full support by WHO's leadership and its Member States. The importance has been described in recommendations and declarations as the MDGs, the Paris and Rome declaration (4) (5); WHO Regional Office for Europe's 11 priority processes for 2005-2010 (6) and the Euro Health Futuregroup 2020 just to name a few.

Successes and achievements in the area of sexual and reproductive health are linked closely to the ability of organisations to build effective and efficient partnerships and to monitor and evaluate their performance and impact on a regular basis.

However, we all must be aware not only of potential risks of investment in the damaging partnerships (for WHO for instance tobacco companies and arm related industries as extreme examples) but also to the costs involved in establishing and maintaining partnerships. This is to say that it might be better to have ten partnerships which are well defined, have clear country objectives, which are sustainable and country driven than a 100 ad hoc, unsustainable, partly inefficient so called partnerships.

This is to say that the leadership in WHO supports clearly to expand and strengthen partnerships with the Civil Society, international and national organisations and the private sector on the basis that this is evidence proven and helps achieve our member states goals in a better, more efficient and sustainable way.

Challenges

Public health threats are increasingly recognized as important challenges to health security of people, populations and nations. The MDGs highlight the importance of sexual and reproductive

health. In order to be able to meet these and other public health challenges more effectively we need to strengthen partnerships.

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The magazine *Entre Nous* is itself a product of a longstanding partnership; one which has had its ups and downs but which is still warm and still respected. Like any relationship really. But unlike a quiet couple, our news, advocacy, communication and training tool is much in view and has to survive strong winds blowing hot and cold around it.

As all of us on the Board believe, *Entre Nous* is one of the many beats at the heart of development partnership. And a good case study during this time of reflections on United Nations reform and the relationship with civil society – the magazine's audience list of ministries of health, education, national and United Nations agency documentation centres and select organizations, academic institutions, non-governmental organizations (NGOs), libraries and numerous professional individuals reads like a good governance checklist.

Coming "on board" fifteen years after Waddad Haddad's first issue in 1982 (a newsletter of six typewritten pages sent out occasionally to know family planning activists in Europe) clearly I am not the magazine's institutional memory, nonetheless I know of no more consistently daring and technically sound a publication within the UN family in Europe and Central Asia. We have a reputation for consulting widely and getting input from others who might not otherwise find a voice on what are called (annoyingly for some) the sensitive issues surrounding sexual and reproductive health. And being a polyglot *Entre Nous* is also able to make people think in Bulgarian (ot 2000 godina), English (since 1982), Hungarian (1989-tol), Portuguese (desde 1987), Romanian (on and off de la 1996), Russian (since 1994), Spanish (desde 1986). The French have had to think for themselves since their language version ended tristement in 2000. Two years later *Entre Nous* went online.

By funding and publishing *Entre Nous* UNFPA and WHO are literally putting on paper the commitment made by leaders at the 2005 World Summit to achieving the goal of universal access to reproduc-

tive health by 2015, as set out in the ICPD Programme of Action. Although there is obviously a contract between UNFPA as the moneyed partner, and WHO, it is a relationship based on inspiration and confidence such as we glean from the Executive Director of UNFPA talking to her Board in January 2006 about partnerships:

Many times the most innovative solutions rise from the bottom up. I consistently tell the UN country teams to work together and not to wait for instructions from us at the UNDG at headquarters. I tell them do it, succeed, and then tell us how you did it based on your local knowledge, partnerships and expertise.

The *Entre Nous* team has featured such bottom up solutions, whether in ensuring universal access to sexual and reproductive health for minority and migrant women, or reporting on Bosnia & Herzegovina's struggle to preserve a place for reproductive health programmes in health system reform. The magazine is indeed read around the world, but faces up squarely to the weaknesses, obstacles and challenging still to be faced in the region, for example in improving Maternal, Newborn and Child Health – where the new ad hoc Partnership is just as much needed in Europe as elsewhere.

Entre Nous was created in 1982 by Wadad Haddad, the first WHO Regional Adviser for Family Planning in Europe as a joint UNFPA/WHO project. Luc Van Parijs was the earliest editor, retained on an "as funds available" basis. And even though funds were generally not available (!) he still managed to give the publication its popular scientific dimension by writing articles and commenting on others submitted in the form of papers. It was initially published for seven years as a bi-annual newsletter then as a quarterly magazine since under Daniel Pierotti (Regional Adviser before Assia Brandrup-Luckanow and Gunta Lazdane, each of whom exercised the responsibility of supervision). The editorial team currently consists of Gunta as Editor in Chief, Jacqueline Bryld as Editor and Dominique Gundelach, the long-standing Editorial Assistant (and real institutional memory). Members of the



editorial advisory board have come and gone, some without waking up. Together they represent a broad range of international agencies and backgrounds – we should indeed be grateful for their quiet inspiration and institutional insights as well as the advocacy use they make of the magazine.

Entre Nous is primarily aimed at a central and eastern European audience and is sent free of charge to policy makers, training institutes and health care providers dealing with sexual and reproductive health issues, adolescents and women's health issues. The majority of the distribution is to transition and developing countries in addition to some specific mailing lists of relevant western European and Central and South American institutions. It is also sent worldwide to all UNFPA Representatives, Country Directors and Country Technical Service teams.

Quote about *Entre Nous* from Daniel Pierotti:

"Il y a un os de taille c'est un colosse aux pieds fragiles car il ne s'autofinance pas. It's quite jarring really, a giant with fragile feet because it is not self-financing."

In Bulgaria and Romania as well as in many other countries which help with

the translation and dissemination, there are excellent relationships between WHO, UNFPA and other members of the *Entre Nous* family. The question is of course whether these partnerships (with the Global Fund in Bulgaria, or youth peer educators in Romania) are feeding into the magazine, or whether the magazine feeds the interest for partnership. Whatever, it is really collaboration and a good example of complementarities and scaling up. The return on the Fund's initial investment in 1989 for four years has clearly shown itself as the Division of Arab States, Europe and central Asia has particularly chosen the magazine as one of UNFPA's main communication tools for disseminating information about adolescent and youth issues. Notwithstanding, WHO puts its own money into the publication and is active in the search for authors and ad hoc partners, such as IPPF European Network and the Spanish government – a technique, which allows for thematic issues of common or specific concern as well as ensuring the publication is sustainable.

Past and present members of the Board, past editors and language version coordinators, together we count on a spirit of partnership as we publish a challenging magazine that is produced by many

and accessible to more. It is an intergenerational partnership too, which has been one of the reasons it has remained for a quarter century as an inter-disciplinary training and advocacy tool. The leadership of all *Entre Nous* partners praise the Magazine for its comprehensive and inspiring articles, showing that they value it as a tool of transparency in the promotion of sexual and reproductive health and rights in Europe and central Asia. Commit resources to it.

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No.30-31	Tuning into women, the Beijing conference	No.42	STIs: Stopping the spread of sexually transmitted infections in Europe	No.55:	Health sector reform and reproductive health
No.32	Reproductive health: every step of the way. Women & AIDS, violence against women	No.43-44	Wealth through Health :The linkages between social deprivation and reproductive health	No.56:	Does peer education work in Europe?
No.33	Reproductive health for all in Europe Health care for older women, STD epidemic in Eastern Europe	No.45	The role of men + Special issue: Reproductive health in Armenia, 1999	No.57:	ICPD at ten
No.34/35	Breast and cervical cancer: Will screening programmes protect our daughters?	No.46	Health in emergency situations	No.58:	Youth friendly health services in Europe (Special issue funded by UNFPA)
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		No.52:	Education and adolescents		
		No.53:	HIV/AIDS		
		No.54:	SRH in emergencies		

IPPF'S COLLABORATION WITH WHO

WHO Regional Office for Europe and IPPF European Network: partners in Sexual and Reproductive Health and Rights

In recent years the International Planned Parenthood Federation European Network (IPPF EN) and the WHO Regional Office for Europe have intensified their collaboration specifically on the subject of sexual and reproductive health and rights (SRHR). IPPF EN is the largest SRHR non-governmental organization (NGO) active in this field, covering 40 countries in Europe and central Asia. Through the activities of Member Associations in each of those countries, IPPF EN strives to improve the sexual and reproductive lives of millions of people, with a special focus on young people, the poor and underserved.

To develop their actions, the Member Associations have to establish good relations with their governments, in particular the Ministries of Health and the Ministries of Education. Secondly they need research and guidelines to conduct their work in a way that is scientifically based and which complements on the ground experience the Member Associations have by working directly with the people concerned. It is in those areas that a partnership with WHO Regional Office for Europe is of key importance.

IPPF EN has participated in a large number of WHO activities and meetings where IPPF EN brings practical experience and gains the insight of scientific development. Added to that is the oversight of the situation in Europe and central Asia which is gained through the direct contacts with WHO Regional Office for Europe staff and the relevant Ministries in the countries we work in. The WHO Regional Office for Europe Health for All database is invaluable for the planning and management of IPPF EN's work.

WHO has benefited of IPPF's network where the Member Associations have been very instrumental in promoting and implementing WHO guidelines. In the course of 2005, several workshops have been conducted by the WHO Regional Office for Europe and IPPF EN in relation to the WHO Regional Office for Europe Safe Abortion Guidelines. IPPF EN also participates regularly in Technical Meet-

ings, which provide the opportunity to hear which problems individual governments are facing and what their responses are. This way of working increases our understanding of the constraints governments face but also gives us the opportunity to assist the governments in their endeavours. This is particularly important for the countries of eastern Europe and central Asia, where partnerships between governments and NGOs have not been developed in the same way as in western Europe.

The key to this partnership is that both organizations profit of the knowledge and experience of the other, they share the same subject and they can reinforce their work by using their own networks to improve their programmes to the benefit of the populations in the countries. This partnership definitely creates a stronger voice for SRHR in Europe.

Development of the EU Project

In the course of 2003 IPPF EN started developing a project proposal for funding by the European Commission, Directorate General Health (DG SANCO). Through the grassroots' work of the Member Associations it became clear that even within the European Union, there was not sufficient information on how governments and societies are dealing with the SRHR needs of young people. There is great diversity and disparity between the countries resulting in countries with e.g.

Roles and responsibilities

IPPF EN provides overall co-ordination of the project and is the intermediary for all communication between the project partners and the EC. In addition to the co-ordination role, IPPF EN is responsible for the implementation of a number of project activities such as ensuring that youth are involved in project activities at all levels and is responsible for the documentation of project activities, lessons learned and best practices, and to disseminate this information to European actors.

Lund University takes the lead role for the research component of the project, and provides comparative information on the main patterns and trends in SRHR among young people in the European Union. More specifically, Lund University conducts a multi level analysis of quantitative data from 26 countries and produces seven inventories on research topics, an information database and an annotated bibliography; conduct detailed situational analyses on the SRHR of young people for 11 countries and produce a policy brief on the basis of the full policy framework and guidelines.

WHO Regional Office for Europe provides technical expertise to the project and facilitates exchange of information with health policy-making bodies in Europe. More specifically, the WHO Regional Office for Europe organizes a consultation meeting with 40 representatives of Ministries of Health, counterparts of the Reproductive Health and Research programme on the draft European sexual and reproductive health policy framework and guidelines; promotes the policy framework and guidelines amongst policy makers and other stakeholders and co-ordinates with WHO's focal points in the Ministries of Health to provide the project with qualitative data and official statistics.



low teenage pregnancy and low teenage birth rates and others with very high rates. This is just an example but certainly an indication that countries have different ways to deal with this. IPPF EN wanted to know the reasons behind this and wanted to look for good practices in order to bring this issue under the attention of the Ministries concerned. In addition to this the project would also provide the European Commission with an insight in the practices of the EU Member States and the possibility to stimulate exchange of experience and knowledge.

IPPF EN's thinking was to develop the project around three main axes, which ended up becoming the project objectives:

Research and documentation: to develop a comprehensive European SRH for youth policy framework and practical guidelines for various stakeholders using evidence-based and operations-oriented research that is underpinned by gender, culture and rights issues and that accurately presents the current situation by employing or further developing the latest data and evidence.

Dissemination of information and advocacy: to raise awareness of and advocate for the integration of a European SRH policy framework and practical guidelines both at the level of public policy and public opinion (the media and civil society).

Testing best-practices, Youth for Youth: to improve the adaptation and implementation of modules and methodologies of best practices related to sex education programmes, in formal and informal settings.

Very soon IPPF EN realised that this was a very ambitious plan and that more partners would be needed. In June 2004, IPPF EN invited the WHO Regional Office for Europe and the Lund university, Sweden for a first inception meeting. During that meeting the project goal, objectives, activities and budgets were carefully reviewed and the roles and responsibilities of each partner were clarified.

The project has a range of different activities such as a desk research and multilevel analysis of SRH for youth in 26 countries; surveys and qualitative

sub-studies on selected determinants in 11 countries; research and development of a comprehensive European Reference Guide on sexuality education for youth. Very important is the provision of youth led communication activities, which include the establishment of a regional youth committee and an e-forum for its members. The Regional Youth Committee will also develop the project logo and an interactive web-game. In terms of advocacy there will be workshops on media training and a press conference to launch the first results of the research as well as consultative meetings with the relevant Ministers of the countries participating in the project.

A Memorandum of Understanding was agreed and signed by the three partners, detailing their individual roles and responsibilities.

Forming an effective partnership

It is clear that there not only are the three main partners, IPPF EN, WHO Regional Office for Europe and Lund university but a multitude of partners which have their specific role in the project. These are obviously IPPF EN Member Associations in the project countries, the young people of the Regional Youth Committee, and a number of other institutions/consultants with specific expertise to assist in certain aspects of the project. Furthermore one should not forget the donor, in this case the European Commission, who should also be considered as a partner.

How do you go about such an ambitious plan and how do you nurture and feed a partnership in a project of this size? First of all it needs to be explained that the start of the project was delayed because of administrative problems but finally started off on 1 May 2004 and will run for 42 months up till 31 October 2007. This time-frame gives the opportunity for the partners to build up a relationship which has the potential of being sustainable in the long term.

Another condition for good collaboration is that from the design of the project enough time and budget has been allocated for meetings with the partners. IT

technology does allow a lot of communication but it does not replace the richness of face-to-face meetings. This has thus far been very fruitful and a couple of these meetings are planned throughout 2006, which will enable partners to monitor the project very closely.

An important detail in this partnership is that none of the main partners are direct competitors for funding, which takes away a level of uneasiness and mistrust which can easily be found in other partnerships.

Challenges

Looking a bit more closely at the three main partners one will see that these are three complete different entities with their own structures, cultures, positive and negative sides. IPPF EN is a membership NGO with grassroots activities; Lund university is an academic entity and WHO is an intergovernmental organization. Each of the partners have their own specificities and expectations of the project and this needs to be clarified from the beginning, as not all of these expectations will be achievable, compatible or even desirable. The development of a common vision, a good understanding of where the project needs to lead to and what the specific roles of each of the partners are takes time and continuous monitoring. This is particularly true in this project where the partners have a varying degree of involvement at different stages of the project, which can lead to a loss of ownership. The challenge here is building up trust and open communication and taking all opportunities to meet and discuss the project.

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PARTNERSHIP TO INCREASE WOMEN'S ACCESS TO SAFE ABORTION SERVICES

Addressing the complex problem of unsafe abortion at the global, regional and national levels requires the commitment and participation of a range of groups - multilateral organizations, non-governmental organizations (NGOs), professional associations, community organizations, and others. A particularly valuable collaboration over the past several years has involved WHO and Ipas, working together and with other partners to prevent abortion-related deaths and to improve women's health and ability to exercise their sexual and reproductive rights. While not codified in detailed partnership agreements, our evolving collaboration has been highly productive and suggests some best practices that may be helpful to others.

A key result of our partnership has been the development and introduction of WHO's safe abortion guidance (1), a rare example of "translating" global policy into action at a very practical level. In 1999, the United Nations General Assembly recommended that "health systems should train and equip health-service providers and should take other measures to ensure that [legal] abortion is safe and accessible" (2). Although the literature documenting unsafe abortion and its causes had increased over the years, little authoritative guidance existed for health systems at the time on how to provide safe, legal abortion services. Since virtually every country in the world permits abortion for at least one reason, such guidance is critical to ensure that health services are able and available to offer safe services to the extent allowed by law and that women are able to exercise this legal right in a safe and open manner.

WHO-Headquarters in Geneva sub-contracted with Ipas to compile the best evidence-based literature on the clinical, service delivery and legal aspects of abortion and prepare an initial draft of the guidance. An expert group meeting was subsequently held at WHO to review the accuracy, applicability, and appropriateness of the draft guidance for different settings. Two additional NGOs – the International Women's Health

Coalition (IWHC) and Reproductive Health Alliance Europe (RHAE, no longer in existence) – brought their extensive contacts and experience with abortion and global health to the planning process for this expert group meeting. More than sixty experts participated from all regions of the world, bringing medical and public health expertise as well as legal and policy input to the discussion.

Following this technical consultation, WHO finalized the document based on expert input, verifying that all recommendations were based on the highest level of evidence, and obtaining additional expert review before publishing the document. The guidance was issued in English in 2003, and subsequently has been produced in Spanish, French, Polish, Portuguese, and Russian.

However, the process did not stop there. With the guidance in hand, we set out to disseminate it and effectively prepare people to use the guidance at the country and local levels.

Disseminating the guidance

Key steps in dissemination have been the translation of the guidance into multiple languages and developing tools to support dissemination, such as a presentation package developed by Ipas and Family Care International, customized for three regions and available in multiple languages (3).

The cornerstone of dissemination efforts has been introducing the guidance through workshops, where participants can hear and discuss the guidance and learn about existing tools for implementing it. Because abortion laws, policies and practices vary among and within regions, regional meetings that include teams from several countries have been a good way for participants to learn from the similarities and differences in their various settings, use each other as resource people, and develop country-specific plans and strategies.

In Europe, the WHO Regional Office for Europe, Ipas, and IPPF European Network have each organized meetings for teams of participants from multi-

ple countries. For example, in 2004 the WHO Reproductive Health and Research programme, with active involvement of both Headquarters in Geneva and the Regional Office for Europe in Copenhagen hosted a meeting in Riga, Latvia with representatives from Moldova, Lithuania, Latvia, Russia, and Ukraine that included development of country plans for strategic assessments of reproductive health services including those for abortion. Ipas worked with WHO to implement the meeting, and both groups have supported and participated in follow-up. Additionally, Ipas, WHO and other groups have used the guidance as a central tool in regional policy events and meetings of professional associations.

Country-level partnership

At the country level, WHO, Ipas and colleagues from other organizations have presented on the guidance at numerous meetings and conferences and have introduced complementary tools, such as the presentation package mentioned above, and other technical assistance materials on safe abortion. For example, Ipas, the WHO office in Tirana, and the Ministry of Health of Albania held a one-day workshop "Safe Abortion – a Public Health Challenge for the Albanian Health System" in April 2005. The workshop gathered fifty-eight policymakers, hospital administrators, chiefs of abortion services, abortion providers, representatives of reproductive health and women's NGOs, and other stakeholders. Workshop participants performed a mini-audit of current abortion practice in Albania against the WHO guidance in order to identify the gaps in existing services and make recommendations for improvements. Following this event, the Ministry of Health established a working group with representatives of all relevant institutions to work on new standards and guidelines for abortion care.

How we did it – addressing key challenges

Developing the guidance and disseminating it throughout the world to policymak-

Tracy L. Baird



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Entelu Shehu



ers, healthcare providers, and program managers have been challenging tasks. The style and process in which we implemented this partnership has allowed us to accomplish them. The first draft of the guidance document was developed under contract. For the most part, however, we have worked without the typical documents that characterize a formal partnership, such as memoranda of understanding, sub-contracts, or sub-grants. We have mainly relied on clear and frequent communication and a joint commitment to work well together. Constant communication was necessary and valuable for sharing ideas, strategizing, and keeping the process moving forward, even when each group was busy with other pressing work. In supporting WHO in the design of the expert meeting, for example, the three supporting NGOs (Ipas, IWHC and RHAE) jointly selected tasks each was best suited for and divided the work accordingly.

At the dissemination stage, the interested organizations shared ideas about what each could do based on experience and capacity, with a view to complementing, rather than duplicating, each other's work. While we have not used formal processes to document these decisions, we do track our agreements about, for example, how much money each organization will contribute to an event, or how our logos will be used; much of this documentation has been through email.

A mutual spirit of generosity about resources – financial, human, and otherwise – has characterized our partnership for many regional activities. The Ipas/WHO Regional Office for Europe partnership is a case in point. In one specific example, the WHO Regional Office for Europe translated the guidance into Russian, and Ipas was able to assist in printing and distribution.

The evolving partnership with WHO and other NGOs on the abortion guidance has been instructive in improving our collaborative work and may also be useful to other groups tackling common objectives. Some of our key lessons include the following:

- Each organization has best practices to share and each partner needs to be willing to try new things to see what works in the context of the partnership. For example, some WHO offices and Ipas teams have different styles of structuring and facilitating meetings. Understanding the parameters within which each group is accustomed to work, and combining our styles and skills made the meetings more successful.
- Organizations of different sizes and from different sectors have varying strengths and weaknesses. In partnership, it is important to respect each other's limitations while leveraging each other's strengths. As a large multilateral organization representing and serving governments WHO has broad influence. As an independent NGO, Ipas is very flexible and can react to opportunities very quickly.
- Communicating in advance about expectations cannot happen too early or too often. Even without formal partnership documents, we discussed roles and responsibilities and were clear about our expectations.
- Acknowledging the contributions of each partner cannot be over-emphasized. Our local partners are sensitive to potential competition among technical assistance agencies, and by demonstrating our teamwork they are freer to work effectively with each of us. It is critical to acknowledge the contributions of each partner and the partnership itself.
- Recognition of the varying skills and reach of each organization has allowed us to embrace additional partners. By expanding the partnership to include other international NGOs, like IWHC, IPPE, and Family Care International and local partners in each region and country, we increased the reach and impact of our efforts enormously.

Conclusion

Working in partnership can be challenging. Groups often have limited human

and financial resources to apply to nurturing partnerships and may also be competing for funding. But it is only through strong partnerships that critical issues like prevention of unsafe abortion can be addressed effectively at the global, regional, national and local levels. Through our collaborative efforts, WHO, Ipas, and others have reached people around the world with information and technical assistance, thereby saving women's lives, health and fulfilling their sexual and reproductive rights.

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THE IMPORTANCE OF PARTNERING WITH PARLIAMENTARIANS

To truly understand European support for sexual and reproductive health and rights (SRHR), one should become aware of the massive efforts that have been made at all levels of decision making – pan-European, European Union, regional, national and even sub-national – to create partnerships with and among Parliamentarians.



Recent European leadership on SRHR would not have been possible without a cohort of well-informed Parliamentarians who have progressed from being the targets of education efforts to some of the strongest and most influential advocates, making the right decisions at the right times. For NGOs that support SRHR, Parliamentary advocacy has become a significant, if not major, aspect of their work in Europe. This phenomenon has expanded over the past five years, when less than 10 European SRHR NGOs made this an important aspect of their work; there are now SRHR NGO advocates actively working with Parliamentarians in over 20 European countries.

The role of IEPFPD

The Inter-European Parliamentary Forum on Population and Development (IEPFPD) is the newest regional Parliamentary network concerned with SRHR; it is preceded by sister Parliamentary networks on other continents. The Asian Parliamentary Forum for Population and Development was founded in 1982. The Inter-American Parliamentary Group was founded in 1983 with the support of the International Planned Parenthood Federation Western Hemisphere Regional Office. Finally, the Forum of African and Arab Parliamentarians was created in 1997 with the help

of the United National Family Planning Association. It was not until 1999 that the European forum was created with the help of the International Planned Parenthood Federation European Network.

In the subsequent five years, the IEPFPD expanded its membership from seven to twenty-five all-party Parliamentary groups (APPGs) and built relationships with Parliamentarians and SRHR advocates in an additional nine countries in Europe (Europe is defined as including all the members of the Council of Europe). Altogether, by 2005 IEPFPD had worked in 83% of European countries, with member APPGs in over half the Parliaments in Europe (this excludes the micro-states of Andorra, Monaco, Liechtenstein, San Marino and the Holy See).

The IEPFPD fills a gap in SRHR advocacy in Europe, namely that of offering a pan-European platform for the exchange of information, experiences and ideas among Europe's political decision-makers. This gap became all the more apparent in the late 1990s as decision-making in Europe became more complex. During that time, increasing powers were being transferred from the national to the EU level per the Nice and Amsterdam Treaties and the work on a European Constitution. Twelve countries intensified their negotiations for accession to the EU,

requiring a complete overhaul of their legislation in many areas in order to meet new EU standards. National parliaments were exercising oversight of EU decisions more thoroughly than before. And some countries initiated or intensified a process of devolution from a centralised national parliament towards legislative assemblies (United Kingdom, Spain, Belgium and the Russian Federation are some examples of the trends in some countries towards federalism). Decisions on SRHR, both in international development and in domestic policy, were thus being taken all over Europe, but in different settings and by new actors compared to even a few years prior in many countries.

The importance of Parliamentary advocacy

It was for this reason that many SRHR NGO advocates came to see effective Parliamentary advocacy as crucial to their work. At the same time, Parliamentarians themselves associated working through an APPG as an expression of joining a Europe-wide consensus on SRHR. The existence of an independent organisation whose membership is composed of APPGs and was directed by Parliamentarians (namely, the IEPFPD Executive Committee) liberated many from feeling uncomfortable at being too closely linked



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to any one organisation or approach to an issue (which in a number of countries is a cause of concern for Parliamentarians regardless of the specific issue or organisation in question). In this way the IEPFPD facilitates partnerships between Parliamentarians and NGOs so that they can benefit from each others' expertise and work together for a common goal, but still maintain their independent identities.

The first Parliamentarians to become involved in SRHR advocacy have generally been women from left-leaning parties, such as the Socialists or the Greens. This has been the case in Portugal, Spain, France, the United Kingdom, Belgium, Switzerland, Austria, Sweden, Finland, Norway, Scotland, Poland, Lithuania and Turkey. In countries where (as of 2005) there is no APPG, women Parliamentarians from left-leaning parties have been the ones most active in trying to start one - for example in the Netherlands, Cyprus, Albania and Estonia. As of 2005, 79% of the chairs of the APPGs around Europe were women and 57% of all APPG chairs (both men and women) came from Socialist or Green parties.

The role that these 'founding' Parliamentarians play is of critical importance in generating consensus on SRHR. Once they have participated in an SRHR advocacy activity, they understand that advancing the SRHR agenda requires some level of cross-party consensus so that gains are not reversed with a change in government. They therefore actively reach out to like-minded Parliamentarians from other parties, often other women Parliamentarians, to share their newly acquired understanding of the importance of SRHR and the need to take it up actively in Parliamentary work.

It is perhaps no coincidence that the countries with the highest representation of women in Parliament, namely Sweden, Denmark, Finland, Norway, the Netherlands, Iceland and Germany, are all among the strongest supporters of SRHR and largest donors to the field (1).

The role of Parliamentarians in SRHR
For advocates who work with members

of Parliament, it would be useful to remember a few key characteristics about their needs and motivations. First and foremost, Parliamentarians are a group of people who have made a commitment to a political party (except those who are unaffiliated/'independent') and have expressed a public commitment to certain goals and ideals, which in their opinion will somehow improve society. Second, upon election a Parliamentarian will be called upon to take positions and vote on a whole range of issues ranging from foreign affairs to international trade, health care reform, budgetary or fiscal policies, immigration, agriculture or education. Many Parliamentarians may have expertise in a specific field, but few can claim to be equally expert in all areas. Finally, Parliamentarians are politicians and are therefore ambitious and forward-looking. With the exception of those planning to retire shortly, most Parliamentarians do wish to advance within their political party, within parliament and would like their political party to gain in influence.

Thus we can sum up three important characteristics of Parliamentarians: they are committed to improving society; they are forced generalists; and they are ambitious. Each of these characteristics generates certain needs, which can be met by involvement in SRHR advocacy. For example, because SRHR affects fundamental aspects of health and well-being, NGOs can offer concrete suggestions to Parliamentarians for improving society in a way that touches every human being.

Experience in mobilizing Parliamentary support for SRHR has demonstrated that the parliamentarians themselves benefit from their involvement in advancing SRHR causes. This is true because all Parliamentarians, regardless of their level of experience, will be called upon to make legislative, policy and budgetary decision on a wide range of issues, whether they are equipped to do so or not. In addition, Parliamentarians have an honest desire to make the right decisions and to do well in their own careers.

For these reasons, Parliamentarians welcome expert information that is fact-based

and has the public's best interests at heart. It is in the interest of good policy-making both from the Parliamentarian's and the SRHR advocate's perspective to ensure that information and expertise is available when necessary. Access to information and the opportunity to develop their own expertise lead to more convincing, fact-based argumentation by Parliamentarians. Gradually, these Parliamentarians can become recognized as 'experts' on SRHR and related issues (such as women's rights, international development and HIV/AIDS). This in turn improves the quality of the debate and leads to a higher profile and greater prestige for the issues and the member of Parliament.

Conclusion

NGOs can also help generate media visibility for a Parliamentarian's involvement in SRHR (such as participation in a field visit, international conference, United Nations meeting, and so on). This in turn can result in greater knowledge of and recognition for the issue, the activity, the Parliamentarian, the APPG, and the importance of Parliamentary leadership.

The experience of the IEPFPD shows that the partnership between NGO advocates and Parliamentarians can be mutually beneficial; but more importantly, it proves that Parliamentary advocacy is an essential tool for creating a broad base of support among European decision-makers for protecting and promoting SRHR.

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THE REPRODUCTIVE HEALTH SUPPLIES COALITION: A HIGH-LEVEL PARTNERSHIP

Working to eliminate reproductive health supply shortages

Getachew Bakele of Marie Stopes International/Ethiopia recently recounted a story of a young Ethiopian woman who, after the birth of several children, began using the depo-provera injectable contraceptive. However, a stock-out of depo-provera in the region of Ethiopia where she lived left her with an unwanted pregnancy. She resorted to unsafe abortion and died as a result, leaving behind three young children.

History of the reproductive health supply shortfalls

As demand continues to outstrip supply, bare clinic shelves — where contraceptives and condoms are usually found — threaten to stall progress towards critical development objectives. There is a growing demand for reproductive health services. This is a result of the success of family planning efforts in recent decades, compounded by a surge in the number of women and men of reproductive age as the largest ever generation of youth entering adulthood, and the growing HIV/AIDS pandemic. The need for contraceptives, condoms and other reproductive health supplies will only continue to increase. Shortages of critical reproductive health supplies — including condoms for HIV/AIDS prevention — undermine progress towards achieving the reproductive health goals set in Cairo and the poverty reduction targets set by Millennium Development Goals (MDGs). Without supplies, no program can be successful. If shortages persist, the toll of maternal and infant deaths, unintended pregnancies, unsafe abortions and deaths

from HIV/AIDS will be great indeed.

While bilateral and multilateral donors have supported both the purchase of supplies and the improvement of logistics management for over two decades in an attempt to reduce the number and frequency of supply stock-outs, persistent shortfalls of contraceptives and other reproductive health supplies have continued to plague health delivery sites. Unfortunately, evidence points to even greater shortfalls in the future. The number of organizations and institutions working on individual aspects of the issue are many. Until now, these groups have been fragmented and have not united in a singular quest to address the multiple aspects of the causes.

A focus on global coordination: A new partnership

In the past several years awareness of the supply crisis has grown and organizations, institutions, governments and foundations are responding to calls to action. The solution to the crisis in reproductive health supplies will require action on many front — improving logistics management, better market segmentation to encourage the growth of the private commercial sector, increasing donor inputs, fostering country ownership and capacity building, improved coordination of aid and an attention to the influence new funding mechanisms such as poverty reduction approaches are having on the supply of contraceptives. The Reproductive Health Supplies Coalition is a new partnership of high level reproductive health stakeholders who have formed a coalition and work collaboratively on joint problem solving to address the crisis in reproductive health supplies.

Building on the momentum of the United Nations Population Funds (UNFPA's) 2001 "Global Call to Action,"⁽¹⁾ a global stakeholder meeting on the supply crisis was organized by the Supply Initiative (then called the Interim Working Group on Reproductive Health Commodities) in Istanbul, Turkey in 2001⁽²⁾. One of the four strategic objectives arising out of this key meeting was for

"coordinated collective action by, among, and between implementing and funding partners. Specifically, participants called for: *A revitalized donor coordination council... supported with human and financial resources to ensure that the principal funders of supplies are working together, sharing information, and helping to solve this looming crisis (3)*".

Following the Istanbul meeting, a group of high-level stakeholders began to meet regularly at UNFPA and formed a new partnership to discuss collaborative consensus actions. Facilitated by the Supply Initiative and chaired by the World Bank, The Reproductive Health Supplies Coalition now meets twice yearly and counts as its members UNFPA, United States Agency for International Development (USAID), The World Bank, The Foreign Affairs Ministry of the Netherlands, The United Kingdom Department for International Development, the European Commission, KfW/Germany, World Health Organization, developing country representatives, and groups representing social marketing, civil society and technical interests.

The Coalition recognizes that the availability of reproductive health supplies is an issue not only of resources but also of their efficient and effective use. The primary objectives of the coalition are to:

- Facilitate timely sharing of organizational priorities and perspectives relative to RH supplies.
- Identify and address key issues that can be most effectively advanced through the collaborative efforts of the Coalition (as a whole or in smaller groups) where the organizations involved have and will provide the necessary financial and human resources; and
- Respond to and act on specific issues where organizations will commit to the necessary financial, technical, and/or human resources to solve them.

Over the past year, the profile of European participants in the reproductive health supplies field has grown. Two European countries, Germany and the Netherlands, will assume joint chairmanship of the



Reproductive Health Supplies Coalition in April 2006.

The European role in solving the supply crisis: Setting sights at the country level

European donors along with USAID, the World Bank and UNFPA are the primary funders of donated reproductive health supplies. While USAID and UNFPA have invested heavily in supply delivery systems, logistics management and technical assistance, European donors have taken a leadership role in working directly with country governments to build capacity. Europe has also taken the lead in recent years in filling critical funding gaps. For example, in 2004, under the Dutch Presidency of the European Union (EU), more than \$75 million was raised to help UNFPA meet urgent contraceptive needs. This money, coming from the EU's 25 member states and the European Commission through a special contribution, is helping to fill the gap in contraceptive and condom supplies as identified by UNFPA in 2005.

Due to the reorientation of European development assistance through mechanisms offering greater country ownership such as direct budget support, sector-wide approaches (SWAPs) and country strategies, European donors have an increasingly important role in ensuring sustainable supply systems. By encouraging country ownership and assisting countries in shaping supportive supply policies, European donors play a critical role in moving towards a solution to the supply crisis. Via consultative processes with southern countries, European donors can help countries prioritize budget allocations and ensure that supplies are accounted for in health sector strategies. The integration of supplies into new financing mechanisms is a great challenge and has thus far been met with mixed success. European donors have a great opportunity to ensure these mechanisms create a supportive environment for supplies.

What can the European community do?

1. Encourage country governments to place greater emphasis on reproductive health in SWAPs, poverty reduction strategy papers and in other new development financing mechanisms. Assist country governments to make the links between reproductive health supplies, poverty reduction and the other MDGs clear and encourage the inclusion of appropriate indicators (such as contraceptive prevalence rate and level of supply provision).
2. Encourage countries to include reproductive health supplies on national essential drug lists through the adoption of the new Interagency List of Essential Reproductive health medicines.
3. During the transition between project funding to sector approaches, support is crucial to build capacity. Success for supply provision in new development assistant approaches is dependent on a country's capacity to prioritize supplies and manage supply procurement and logistics systems.
4. Encourage the inclusion of budget line items for supplies, including an allowance for capacity building. Budgets should take note of all funding sources, including in kind donations, to ensure that countries can plan for the cost of supplies if a donor withdraws support.
5. European donors should increase their own financial commitments to reproductive health supplies in order to help alleviate the gap between unmet need and supply. They should also encourage similar commitments to reproductive health from developing country governments.
6. European donors should track spending on contraceptives and participate in existing mechanisms that are working to improve information sharing, collaboration and coordination such as the RHInterchange (a web-based system that consolidates procurement and shipping data) and the RH Supplies Coalition.

7. Encourage active civil society participation, including local and international NGOs, in the health sector and increase civil societies' role in the poverty reduction processes. Support NGOs in their country-level efforts to raise awareness of reproductive health supplies among country governments.

While the crisis in reproductive health supplies remains a major threat to the health and well being of men and women in many countries of the world, including the WHO European Region, progress achieved thus far through the Reproductive Health Supplies Coalition members and through the emerging leadership of Europe on this issue, sets the tone for real action and hope.

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EXPLORING THE PARTNERSHIP BETWEEN SEXUAL AND HIV/AIDS

The recognition that the sexual and reproductive health and rights (SRHR) and HIV/AIDS community have to join hands in order to respond effectively to both these issues is growing fast. However, big challenges remain in ensuring that the theoretical understanding of these linkages is translated into changes in the way we work. *Entre Nous* interviewed Jerker Liljestrand, who has worked extensively as a researcher, programme manager and consultant for the past 25 years on prevention of sexually transmitted infections and HIV/AIDS and recently led the development of the manual 'Synergising HIV/AIDS and Sexual and Reproductive Health and Rights – A Manual for NGOs'

How would you describe the current partnership between SRHR and HIV/AIDS theoretically as well as in practice, in Europe in particular?

JL: Europe is big and particularly in the former Soviet Union we suffer from the compartmentalization around STIs and HIV/AIDS and the lack of flexibility in finding new approaches. We need to hook up with action-oriented groups that are there to a much higher extent than in many other parts of the world. We also need to be opportunistic and use outlets or services for people who come there because of their sexual life or their need for contraception or antenatal care. There is a compartmentalization between that and the HIV/AIDS services by history in the former Soviet Union and that is quite a challenge to overcome. Then generally if we look globally, we were more into the sexual aspects of HIV/AIDS in the late 1980'ies and the early 1990'ies and then the focus has moved to mainstreaming AIDS in development operations in the 1990'ies. However, also here in Europe, the biomedical aspects of the HIV/AIDS epidemic have recently become such a big and challenging task to manage. Particularly the medications to people who are already HIV infected is challenging as they are typically taken care of by the infectious disease departments. For this reason there is somehow a division between the HIV/AIDS people, the nurses, and doctors, and those working in the field of sexual and reproductive health in for example family planning, family practice and antenatal care - those who don't

deal that much with HIV infected people. Once the diagnosis is set the person is taken care of by the infectious disease department, highly specialized to be able to manage these antiretrovirals.

And then there are linkages – when we want to work in a primary preventive fashion against HIV/AIDS in parts of Europe, we know that we must try to combat chlamydia, we know that we must combat gonorrhoea and syphilis. We know that we must discuss dual protection. We know that our primary preventive work needs to become stronger and stronger on the sexual side. But again the mere fact that we are different medical disciplines in the health sector such as the reproductive health people on the one hand and the infectious disease people on the other hand. The fact that these people don't normally meet that much means that there is a particular challenge.

What role do you see health sector reform and the strengthening of the health systems play in terms of promoting the partnership between SRHR and HIV/AIDS?

JL: The health sector reform issues in Eastern Europe, with the shift from highly specialized care to primary care, meaning from the gynaecologist to the family doctor, seems to be leading to less awareness of sexual and reproductive health issues. The confidentiality issues, the need for GPs to be trained to discuss sexuality, because this is something that requires training, as it is not easy to do, are challenges. And then the confidentiality issues

of the system – how are the records kept, what does the regulation or law tell you to do when it comes to information of parents etc.

I think that in many of the former Soviet States plus Poland the shift in the health sector reform still is at an early stage. Health sector reform is a continuous process over many years, and when you are in the early stages of moving from the highly specialized Soviet Union system over to a GP system, it takes quite a while for even fundamental public health issues to be safeguarded, lets say immunization or cervical cancer screening. These are easily lost in this transition because you have to contain your cost in health care, you need to bring down the cost, you need to retrain specialists into GPs and so on. Then the little bit difficult issues, such as lets say broader preventative programmes, even in the non-controversial ones like immunization, we have seen signs of decline. And then there are the more controversial ones and the pretentious ones with religious values like sexuality, which face even more difficulty. I am fairly sure that they will be salvaged along the road, but right now I see, we are at a fairly early stage of the health sector reform. Further to this, health system strengthening efforts are to some extent made less effective due to the health sector reform than may have been necessary, as the health sector reform is so concerned with curative care that the preventative aspects are forgotten.

There is sufficient evidence to establish a



clear resonance for why to address HIV/AIDS in partnership with sexual and reproductive health rights. However, do you feel that there are areas in terms of research that deserve more focus and that would help reduce the gap between theory and practice?

JL: I see myself more as a public health activist in reproductive health than a researcher even though I have meddled in both. In my view, if an issue is very charged, very loaded and contentious I think that is an issue that requires research, so that we can become more practical and leave our values behind. For example, if we have a very high frequency of men who have sex with men or people who buy sex, and this is something which is very contentious or religious or politically used, then we need to bring it to the forefront by exploring it. For example in cities where kids who live on the street have a lot of HIV and are exploited it is important to bring this to the forefront, so that everybody can see that laws and regulations and religious beliefs are not protecting these young people but are also contributing to the spread of HIV in the mere existence of kids living in the streets. Or for example clandestine unsafe abortions or adolescent pregnancy or repeated abortions among women that are not in the official statistics because the abortions are being carried out by various practitioners. I think that exploring this kind of issue is formative research – action oriented research – you want the research because you want to influence the national policy setting. I believe in that – and to pursue that I think that right now, what we are facing in notably the Eastern part of the WHO region, is a situation where both HIV professionals and the SRHR professionals need to go out of their way to meet and serve better the groups that contribute to the spread of HIV. Here I am speaking of men who have sex with men, commercial sex workers and intravenous drug users – groups of people that in the now 25 years of history of AIDS, as we know it, are classically being stigmatized, hidden and neglected and ignored, punished and

incarcerated. They are not the first people you think of and meet, and they are not the first people you serve. But they are the first we need to serve now – by the AIDS programmes and the SRHR programmes. Both programmes need to take steps to serve these people better for humanitarian and human rights reasons but also for epidemiological reasons – that is how I see it. It requires an effort on both sides – different kinds of efforts.

To be more concrete – if we go with your suggestion, where would the two areas meet in responding to the issues with injecting drug users, female sex workers or men who have sex with men, are we mainly talking about service delivery?

JL: Service delivery and information. I think to a varying extent in all these three groups there is a component of information and advocacy that does not need to happen through the health sector. I think it should largely happen outside the health sector; apart from within the health services. If we for example look at the needs in a jail in Russia, you need to have advocacy but you also need to have condoms, testing and treatment for STIs. To be credible you also need to be able to offer ARVs, and if prisoners are not among the ones who will get the ARVs first, but the ones who will contribute to spreading HIV - not voluntarily – this is victim blaming! The other example – people who are intravenous drug users - who are taking care of their contraceptive needs? Can they go somewhere and get a one-stop-shop? Where they might get a sandwich, exchange their syringes and get condoms. Is there something like that for them? Here clearly the HIV/AIDS programme and the SRH programme could collaborate - some of this is happening, but the question is, is it happening fast enough? Are we putting enough effort into this, while it is still an overlapping area where we actually can help control the pandemic.

What are the main challenges in reaching the vision of a stronger partnership between SRHR and HIV/AIDS?

JL: Pragmatism, flexibility, action groups, the NGO blow torch and the interest groups – the good NGO is often more dynamic, flexible, can do things that the government is slow to do - so let 1000 flowers bloom, listen to your NGOs and see what they are doing. All the 25 years of the pandemic the NGOs have led the way, the disadvantage being that they don't roll out countrywide programmes. They come from an interest group, they serve an interest group but when they do good work listen to them, support them, support them with funds, help train them, help make them accountable, have monitoring and evaluation, help them do evidence based work, but listen to them. We need that pragmatism and flexibility to change the way we are doing business.

Lastly, how do you see the future, as you have been watching this situation evolve over the last 25 years?

JL: In parts of Eastern Europe it takes longer because the structures inherited from the Soviet system are in place and the way we think in squares and boxes – there are a lot of good people, but we need to support more flexible ways of working. It is not always that you can wait for the Ministry of Health to do things. You need to make it happen in the city or in the province where you are working. All signs indicate that we have to expect a significant rise of HIV in the Eastern part of the European region and we need to intensify efforts.

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LINKAGES BETWEEN SEXUAL AND REPRODUCTIVE HEALTH AND OVERWEIGHT

Obesity: a life cycle epidemic

Obesity has reached epidemic proportions, affecting preferentially women. Between 10% and 35% of women in Europe have a Body Mass Index (BMI) greater than 30 kg/m², with the highest proportion in the Russian Federation and southern Europe. Even more worrisome is the prevalence of overweight that affects up to three quarters of the adult population in some countries of the region, and is also associated with increased morbidity. Obesity absorbs from 2% to 8% of overall health budgets and represents a major economic challenge and a handicap to social and economic development through the loss of productivity and income, also in view of the fact that the socially deprived groups are more affected.

Obesity is a life cycle problem that is now shifting to earlier age. Already at 7-9 years between 10% and 30% of the European children are obese, and many studies indicate that both prevalence and incidence are rapidly increasing. To give an example, in an Icelandic cohort study the prevalence of obesity at age 6 was 4.3% in 1994, while it was 1.1% in 1988 (1). Those obese children would then be likely to become obese adolescents and adults. Half of the overweight Icelandic 6-year-olds were still overweight after puberty. As a result, over the last decade, there has been an alarming increase of Type 2 diabetes mellitus in youth.

An intergenerational cycle of obesity

The number of women who start pregnancy with overweight and obesity is increasing. Obese mothers are much more likely to have obese children, especially if they have gestational diabetes or a pre-pregnancy metabolic syndrome, indicated by high serum insulin, high LDL-cholesterol, low HDL-cholesterol and high gestational weight gain.

The number of children with high birth weight (birth weight > 4500 g or above the 95 percentile of the z-score for standardized birth weight) is also increasing. A larger birth weight is linked to an increasing risk of obesity later in childhood. In the Icelandic cohorts born in 1988 and 1994 the children that weighed above the 85th percentile at birth were more likely than the other children to be overweight at the age of 6 years, 9 years, and 15 years.

This closes the circle, determining a problematic intergenerational cycle of obesity, that will take major public health efforts to break.

On the other hand, reduced fetal nutrient supply in early gestation, as a result of maternal malnutrition or reduced placental transfer of nutrients, have the potential to substantially increase the risk of the offspring to become obese in later life.

Several investigators have reported a relationship between maternal obesity and low rates of initiation and duration of breast-feeding. Poor infant feeding behavior and reduced hormonal responses in the early postpartum period result in delayed lactogenesis and early cessation of breast-feeding among overweight/obese women.

This is potentially another mechanism that transmits obesity to the next generation. Breastfeeding is in fact a protective factor in the later development of obesity. A systematic review of published studies investigating the association between infant feeding and a measure of obesity or adiposity in later life, considering data from 355 301 subjects, concluded that mean BMI is slightly lower among breastfed subjects. Another study assessing the association of breast-feeding duration with adolescent obesity within sibling sets indicated that siblings who were breast-fed longer than their family mean had breast-feeding duration 3.7 months longer than their shorter-duration siblings and that the adjusted odds ratio for overweight among siblings with

longer breast-feeding duration, compared with shorter duration, was 0.92, and the protective effect was not confounded by socio-cultural factors.

Overweight and reproductive health

Overweight and obesity in early adulthood appears to increase the risk of menstrual problems, subfertility and hypertension in pregnancy. Overweight adolescents have earlier sexual maturity and in the 1958 British birth cohort study early menarcheal age was associated with higher risks of menstrual problems by 16 years. Obese women at 23 years were less likely to conceive within 12 months of unprotected intercourse (2).

Pregnancies in obese women have increased rates of pregnancy-associated hypertension, gestational diabetes, large babies, Cesarean section and perinatal mortality and morbidity. A 15-year, population-based cohort study using the Nova Scotia Atlee Perinatal Database (3) indicated that moderately obese women had an increased risk of pregnancy-induced hypertension, antepartum venous thromboembolism, labor induction, cesarean delivery, and wound infection. The risk increased in severely obese women. Fetal and neonatal complications may include congenital malformations, high birth weight, and shoulder dystocia. The literature suggests that women with a BMI ≥ 30 have approximately double the risk of having a child with a neural tube defect compared to normal-weight women, and the increased risk associated



with higher maternal body weight does not appear to be modified by folic acid supplementation. In the 54,505 pregnant women who were examined in the Danish National Birth Cohort prepregnancy obesity was associated with an increasing excess risk of fetal death with advancing gestation, possibly related to placental dysfunction.

Pregnancy is also a critical period for women's health. Excess pregnancy weight gain and failure to lose weight rapidly after that are associated of obesity in midlife. In a cohort of 484 women followed for 15 years baseline BMI, weight gain during pregnancy, weight loss by 6 months postpartum, were all related to current BMI and weight gain at follow-up (4). Women who breastfed beyond 12 weeks and participated in postpartum aerobic exercise had lower BMI and weight gain 15 years later.

Overweight and sexual health

Overweight and obesity also pose problems for sexual health. In a US based study college students with high BMI, negative body image and inability to control their weight were more likely to engage in high-risk sexual behaviors, such as having a casual sexual partner, being intoxicated at intercourse, using no or unreliable contraception. Failure to use contraceptives was also significantly associated with obesity in the USA Behavioral Risk Factor Surveillance System in 2000 (5), possibly in relation to the unjustified fear that uptake and continuation of hormonal contraceptives might be conducive to weight gain. For all methods of hormonal contraception, weight above 70 kg is associated with increased failure rates.

Conclusions and implications for health care

Overweight and obesity are affecting a large proportion of the European population, with an increasingly earlier appearance and a transmission from one generation to the next. This apparently uncontrollable epidemic requires actions throughout the life cycle, but the earlier

times of life are absolutely crucial.

First, there are issues related to women's sexual and reproductive health. The health care professionals should be aware of the increased risk of incorrect behaviours and should advise about the correct use of contraception. In view of the higher frequency of menstrual abnormalities, diet and exercise should be advised to teen-agers. The management of anovulation should involve diet and exercise prior to the standard approaches of ovulation induction.

Second, there are issues related to women's own health: the providers of women's health care should assess the presence of metabolic syndrome; in every pregnant woman presenting with obesity, hypertension or dyslipidaemia, better post-partum follow-up and treatment will be required. Guidance and assistance should be given to undertake a program of weight loss before pregnancy (6).

Third, in the presence of pregnancy, attention should be posed in total weight gain and in diet and lifestyle behaviours during pregnancy.

Fourth, after delivery strong encouragement should be given to breastfeed exclusively at least until 6 month of the child's age and to then continue breastfeeding at least until the first year of life.

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INTERNATIONAL COLLABORATION IN EFFORTS TO IMPROVE HEALTH IN UKRAINE

At the start of the new century the quality of medical services in Ukraine had taken a hit from the economic and social upheaval of that time. The impact on women's health was especially severe. Despite some measures taken by the Ministry of Health of Ukraine, the health of pregnant women was not improving, the number of fatal complications was still quite elevated and maternal mortality remained high when compared with the countries of western Europe. The situation was further complicated by the negative influence of the high abortion rate and low rate of contraception use in most areas on the health of women, especially young women.

Maternal and neonatal health in Ukraine

Two-thirds of Ukrainian women of reproductive age use contraception but less than one half (38% of all women married or in union) reported using a modern method. When pregnant typically Ukrainian women deliver alone without partners or family members to support them. They are discouraged from ambulating during labor. Although most newborns are breastfed initially, exclusive breastfeeding is not the norm. Separation of babies from their mothers after birth delays the initiation of and reduces breastfeeding. Separation also decreases the opportunity for maternal-child bonding, and in some low-resource settings, may contribute to hypothermia of neonates. According to the 1999 Ukrainian Reproductive Health Survey, a third of Ukrainian women received inadequate prenatal care and ten percent received no prenatal care. In addition Ukraine is facing the fastest growing HIV epidemic in the world and the highest prevalence of HIV infection among pregnant women in the European region.

Recognizing the need for working in partnership

Facing all the above challenges the Ukrainian Government started to give considerable emphasis to the development of appropriate services for pregnant woman and newborns. From the very beginning it was clear that any positive change can be achieved only through close collaboration and involvement of all partners in health who are present in the country.

The challenge of improving maternal and neonatal health and meeting the Millennium Development Goals was addressed not only through close collaboration between Government and various external and internal bilateral and international organizations, but also through intensified coordination and synergy work of different partners.

In 2002 the United States Agency for International Development (USAID) contracted John Snow, Inc. (JSI) to implement the Maternal and Infant Health Project (MIHP). This project was designed to improve women's reproductive and infant health services and increase public awareness of healthy behaviors and the reproductive health conditions of women in Ukraine. With its partner, the Academy for Educational Development (AED), and in close collaboration with the Ministry of Health (MOH), MIHP has promoted best practices known to decrease maternal and neonatal morbidity and mortality and a more client-focused approach to services. Working initially in eight big regions (oblasts) of Ukraine (Donetsk, Lutsk, Lviv, Crimean Republic, Kirovohrad, Zhytomyr, Poltava and Kyiv) the project focused on the following areas of work:

- Development of standards of care and clinical guidelines/protocols for maternal and infant health services and practices;
- Revision of reproductive health curricula at the Institute of Higher Medical Education;
- Reinforcement of skills and services of family medicine practitioners in

reproductive and child health so that they are the first-line contact for timely diagnosis and referral;

- Introduction of new evidence based standards/protocols for complicated maternal and infant cases at pilot outpatient clinics and hospitals;
- Promotion of evidence-based best practices for delivery services, management of complicated pregnancies, and neo-natal resuscitation and basic neonatology services, and
- Promotion of public awareness of healthy lifestyles promoting improved maternal and infant health.

Since its start MIHP was concerned about the quality of assistance, which was provided to the MoH and to individual mothers and children. In order to ensure this high quality and coherence of all technical recommendations to internationally accepted standards, the project decided to establish close collaboration with the Making Pregnancy Safer (MPS) initiative in the WHO Regional Office for Europe. This collaboration which started with the use of recommended WHO/MPS materials for maternal and child health and use of services of WHO/MPS international consultants, gradually developed in real partnership as strong features of both sides were equally represented in joint activities.

The latest and still ongoing example of such successful partnership is the revision of a new training package for health care providers on effective perinatal care. Both partners decided that existing materials on Promotion of Effective Perinatal Care



(PEPC) which were developed in the mid 1990's by the WHO Regional Office for Europe, and updated by MPS in 2002, today do not fully respond and meet the changing needs of the countries of Eastern and Central Europe. In addition to this the material did not fully describe the training methods used by international facilitators, in order to make training dissemination easier. Therefore it was decided to undertake a complete revision of the package, using the expertise of major partners in maternal and infant health in the region.

The MIH project Ukraine jointly with sister projects in other European countries like Russia, Georgia and experts from different European countries agreed to take the leading role in this big undertaking.

The new training package, which is being developed is now close to entering the testing phase, and is built around a full cycle of effective evidence-based antenatal, perinatal, postpartum and infant care. It builds on a good solid scientific base ensured by the research supported by the WHO Regional Office for Europe and Collaborating Centers, but also by using operational expertise of the project, which was gained during several years of project implementation in Ukraine.

Improving partnerships in 2006

During 2006 all partners involved will continue their close collaboration and coordination, testing and then implementing this new training package for Effective Perinatal Care in project pilot sites and health facilities. There are also future plans to use newly developed collaborative materials during the revision of maternal and infant health curricula at the Institute of Higher Medical Education and as a part of post diploma training of existing health staff to introduce and reinforce evidence-based practices especially at the first level health facilities.

The above describes only one aspect of successful collaboration and coordination in the area of maternal and infant health, but the MIHP Ukraine continue active joint work with many other partners, which also include United Nations Children's Fund (UNICEF), POLICY project, Swiss Cooperation and local NGOs. All these partners were traditionally involved in the health sector and therefore working closely with them is logical and an essential part of ongoing efforts to support Ukrainian health infrastructure. At the same time MIHP continues its search for new innovative ways to strengthen partnerships for maternal and infant health. The latest example of such new collabora-

tion is a recently signed agreement with the private oil company THK-BP and the project. TNK-BP has agreed to contribute up to \$1.2 million, to facilitate the roll-out of the MIHP project in one big region (Lugansk) and to help to demonstrate the necessity and benefit of implementing evidence-based perinatal technologies to improve maternal and child health. It is expected that the result of such collaboration will improve the capacity of selected Lugansk oblast maternities for provision of effective maternal and child services. One of the new approaches, which will be used through this collaboration, is the organization of nation-wide mass media campaigns to promote the new public health concept and vision of maternal and child health, as well as making the evidence-based and family-oriented principles of quality perinatal care clear to the general public.

For more information regarding the project please visit: <http://www.mihp.com.ua/>

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- The Partnership for Maternal, Newborn & Child Health was launched in September 2005, representing an unprecedented collaboration of the world's leading maternal, newborn and child health advocates.
- The Partnership's **vision** is to intensify action, globally and nationally, to reduce maternal, newborn and child mortality and morbidity through universal coverage of essential care. To achieve this, The Partnership is taking an integrated approach to maternal, newborn and child health, ensuring a "continuum of care" from pregnancy through childhood, and recognizing that maternal, newborn and child health are inseparable and inter-dependent.

- The Partnership's **goal** is to support the achievement of Millennium Development Goals 4 & 5, reducing maternal, newborn and child mortality through:
 - Strengthening and accelerating coordinated action at global, national, sub-national and community levels;
 - Promoting rapid scaling up of proven cost-effective interventions;
 - Advocating for increased resources.

For more information about the 'The Partnership for Maternal, Newborn & Child Health' please visit <http://www.pmnch.org/>.

COLLABORATION EXPERIENCE OF THE HEALTHY FAMILY DUCTIVE HEALTH IN THE REPUBLIC OF UZBEKISTAN

It is impossible to solve the problem of reproductive health only with the efforts of healthcare providers. The solution to the problems in this field can only be found by using a complex approach that involves inclusion of target groups of the population, community, state organizations and NGOs.

The Healthy Family Project is a five-year program that is working in four countries to improve maternal, child and reproductive health (MCH/RH) of the population of southern Uzbekistan, Tajikistan, Kyrgyzstan and Turkmenistan. In the Republic of Uzbekistan the program is working in Kashkadarya and Surkhandarya regions. Until September 2007, the program will serve more than one and a half million people. The Consortium, which is comprised of seven members and headed by Project HOPE, is responsible for the implementation of the project. The United States Agency for International Development (USAID) is rendering financial support to the project. Taking into account the importance of reproductive health, the project is working on several areas in this field, i.e. changing the healthcare policy, training the healthcare providers and raising the awareness among the population.

Partnership in healthcare policy

The project is working with the Uzbekistan National Core Group, which includes representatives of various ministries and agencies that are involved in maternal and child health, to develop its capacity to effectively analyze and present the data critical to the promotion of MCH/RH best practices. The project and the Ministry of Health (MoH) together with other ministries and agencies of the Republic of Uzbekistan has prepared “The report on identification of the situation on contraceptive security in the Republic of Uzbekistan”, which was approved by the Cabinet of Ministers. The project held discussions with stakeholders (UNFPA, PSI, MoH, private sector) regarding the Contraceptive Security Briefing document (CSBD) (1), which describes the current reproductive health situation and contraceptive security in the Republic

of Uzbekistan. The Healthy Family Core Group members facilitated the Contraceptive Security workshop in Tashkent in February, 2005 and the work accomplished during this workshop serves as the base for work which is undertaken related to the Republic of Uzbekistan’s combined Reproductive Health/Contraceptive Security Strategic Plan.

The project facilitated an expanded Core Group meeting on Strategic Planning on reproductive health and contraceptive security in the Republic of Uzbekistan with the participation of the MoH, Ministry of Social Affairs and Trade, Ministry of Finance, Ministry of Public Education, Ministry of Justice, Republican Reproductive Health Center (RRHC), international organizations (UNFPA, ADB, USAID), local NGO’s (Women’s Committee of Uzbekistan and ZdravPlus) and the private sector (Schering AG, Gedeon Richter). The participants discussed a number of issues concerning the strategy and started the work on a National Reproductive Health Strategy (2006–2015) and Action Plan (2006-2010). Special attention was paid to “The report on identification of the situation on contraceptive security in the Republic of Uzbekistan”, statistical data on reproductive health and reports on the state program for community reproductive health. Prior to holding the meeting, members of the Core Group prepared a draft of the National Reproductive Health Strategy and Action Plan, which reflected what various ministries and agencies should do in order to improve reproductive health in the community. Thus representatives of the MoH and the RRHC made inputs related to the public healthcare services, representatives of the Ministry of Education highlighted issues related to the introduction of reproductive health into the educational curricula, and representatives of the Ministry of Justice verified, whether proposed actions were in compliance with existing legislation. One of the main factors that made it possible to combine the efforts of various ministries and agencies was the leading role of the MoH, and the close supervision by the Cabinet of Ministers.

The main advantage of the developed National Reproductive Health Strategy and Action Plan is that these documents were developed with the active participation of all key stakeholders and are based on a real situation analysis and financial capabilities of the country. The National Reproductive Health Strategy and Action Plan for the Republic of Uzbekistan were finalized by the Core Group based on regular meetings and with the participation of the MoH Financial-Planning Department in August 2005. The MoH asked reproductive health and research experts in the WHO Regional Office for Europe to review the final draft of the strategy and action plan. International organizations involved in RH/MCH issues also provided the Core Group and MoH with necessary funding information.

Partnership in service delivery

The project pays special attention to the training of healthcare workers that provide reproductive health services to the community. For the training, the standard program and training materials of WHO were adapted by other projects and approved by the MoH. In order to support the sustainability of the RH/STI program, the Healthy Family Project together with the RRHC has prepared a team of local trainers.

The specialists of the project together with the RRHC have developed instruments and a methodology for monitoring the RH/STI program. These instruments for monitoring trained providers are used by other projects in the country. The monitoring facilitates the effective implementation of the project and the findings are discussed with healthcare providers, trainers, and heads of the healthcare facilities.

Intersectoral partnership: work for and with communities

Increasing the level of awareness of the population is another important component of the program. The specialists of the project have developed a RH/STI campaign program and work plan. The four-month campaign on RH/STI was initiated in pilot areas in September, 2004. Before the start of the campaign, the

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project specialists had identified key information, target groups and main events of the campaign. Jointly with the RRHC, the project specialists developed a manual and program for training the volunteers on RH/STI. More than 200 volunteers, activists of Makhallas, women's councils, schoolteachers, religious leaders, Red Cross and Uzbekistan Red Crescent society volunteers, were trained on this program. These volunteers were used by the project for dissemination of key messages on reproductive health among the population. An assessment of the volunteers' work showed that they were successful. Special attention was paid to the establishment of a link between volunteers and primary healthcare workers. In those regions where this link is strong volunteers and healthcare workers are continuing to cooperate without project support. Together with the partners, the project has developed booklets on reproductive health and sexually transmitted infections for women, men and adolescents. In collaboration with partners, the project has organized educational events in neighborhoods, schools, and other crowded sites. Such educational sessions were organized with the support of local authorities, in places where mothers received their cash benefits, at different meetings, gatherings. Volunteers did educational sessions at schools, markets and in the field. Time has showed that not all of the activities conducted by volunteers are sustainable however, the volunteers' work was most sustainable in areas, where there was a link between volunteers and healthcare workers, and where local authorities supported volunteers. In such Makhallas volunteers continue their work without support of the project.

Five local NGOs in pilot regions of the project received grants to work with population and healthcare providers in

the field of reproductive health. NGOs were also actively involved in the reproductive health campaign conducted by the project. After the end of the campaign the work among the population was continued. Further awareness raising of the population was continued with the assistance of volunteers and social mobilization specialists of the project. This was mainly done through educational sessions and discussions. The project together with the Red Cross and Red Crescent Society has developed a follow-up and incentives system for the work of volunteers. Volunteer training was widely supported by the local authorities, because it represented a ready resource for working with the population and later on without the support of the project. In mahallas where authorities continued to support volunteers or in those places where communication with healthcare providers was set up, the work of the volunteers among the population is still ongoing.

Lessons learnt and challenges

It is impossible to solve the problem of reproductive health only with the efforts of healthcare providers. Understanding the need in protecting reproductive health must be formed at all levels and reflected in specific actions depending on capabilities and scopes of responsibility. Laws and national plans of actions have to be adopted at a political level. Healthcare providers must be able and have all necessary means to render quality services. The population must realize the importance of their reproductive health and under specific support must form new skills. One of the main lessons learned was to change the government policy and its focus to long-term and systematic implementation of new principles of protecting reproductive health based on WHO recommendations. Changing

government policy will provide sustainability to the implemented program of the project although adoption of a new policy does not guarantee its implementation. It is necessary to implement events on training healthcare providers already working in the healthcare system and students of Institutes and colleges. The receiver of services on reproductive health is not of any less importance. Informing the target group, forming new skills among them, is not simple, but rather it requires long and hard work. It is necessary to have cooperation on all levels i.e. between various organizations and agencies, governmental and non-governmental organizations. In matters of cooperation, formations of various organizations for the sake of one purpose requires flexibility, searching for various approaches and most importantly patience

In conclusion, our experience shows that the main condition for the successful implementation of programs in the healthcare system lies in the close collaboration with all concerned partners.

More detailed information on the activities of the Project can be obtained from the website of the Project: <http://www.healthfam.uz>

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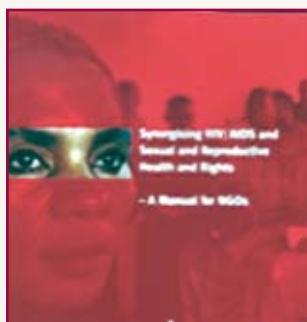
The following organizations have partnered up with the project in conducting the events on RH/STI:

- Neighborhood committees (communities) Mahalla – is a structure that was formed a long time ago and nowadays is supported by the government. One of its objectives is to care about the health of the population living in the territory of Mahallas. Mahalla leaders have helped to organize educational sessions, and invite local people to events. Some of the Mahalla workers have expressed a desire to become volunteers
- Healthcare facilities
- Local authorities
- Public education establishments
- Branches of the Health Institute
- Religious leaders. People living in village areas traditionally visit mosques for prayers or come to religious leaders for advice on various issues. Religious leaders, who were informed and trained by the project informed population on the key information during Friday prayers or during individual conversations
- Regional RH centers
- Red Cross and Red Crescent society
- NGOs
- Mass media

“Partnerships for health: Collaboration within the United Nations system and with other intergovernmental and nongovernmental organizations”; EUR/RC54Inf.Doc.3 Information Paper for the 54th session of the Regional Committee, WHO, Copenhagen.

This paper reviews the collaborative activities of the WHO Regional Office for Europe with emphasis on traditional strategic partners such as the European Union and its institutions, the Council of Europe, the World Bank and other United Nations organizations. It highlights the major developments in maintaining and establishing partnerships at regional and country levels.

<http://www.euro.who.int/document/rc54/einfdoc03.pdf>



Synergising HIV/AIDS and Sexual and Reproductive Health and Rights - A Manual for NGOs Published by Aidsnet and WHO/Europe, Sept. 2005

Available online at www.aidsnet.dk

The 28 short chapters of this manual for NGOs illustrate how work on HIV/AIDS, sexual and reproductive health and rights, and other public health issues can be integrated. It emphasises important societal aspects and the most important health system factors. The manual is meant to be a practical tool for NGOs and therefore provides “entry points” for NGOs as well as annotated resources. The manual includes a CD-ROM, which contains the manual in a PDF format and design files, which enable any organisation to adapt and reprint the manual according to their needs. Finally, the CD-ROM contains a host of additional relevant full-text resources for all the main topics covered in the manual.

Macura M. and Beets, G. (eds): “Dynamics of fertility and partnership in Europe insights and lessons”, Volume 1 and 2, UN, New York, Geneva, 2002

This report is a product of the Fertility and Family Survey (FFS) project, which was conducted between 1988 and 1999 by the Population Activities Unit (PAU) of the United Nations Economic Commission for Europe (UNECE), with financial support from the United Nations Populations Fund (UNFPA). Through contributions from various authors it discusses issues such as low fertility and its underpinnings, fertility and partnership developments in eastern and western Europe and other interesting issues. More information on the origin and history of the FFS project, its achievements and limitations can be found on the website www.unece.org.

Important upcoming events



9th Congress of the European Society of Contraception: “Improving Life Quality Through Contraception and Reproductive Health Care”

3-6 May 2006, Istanbul, Turkey. For more information about the registration fees and the program for the Congress please visit

<http://www.contraception-esc.com/istanbul.htm>



8th Congress of the European Federation of Sexology,

June 4 – 8, 2006, Prague Congress Centre, Czech Republic. For more information regarding registration and programme of the Congress please visit

<http://www.efs2006.cz>.



XVI International AIDS Conference,

13 – 18 August 2006, Toronto, Canada. The Conference theme “Time to Deliver” - will focus AIDS 2006 on the promises and progress made to scale-up HIV/AIDS treatment, care and prevention. For more information about the conference please visit

<http://www.aids2006.org>.



The 14th European Conference on Public Health will take place in Montreux in Switzerland from 16-18 November 2006.

The main theme of the conference is 'Politics, Policies and/or the Public's Health' and includes topics such as adolescent health, health promotion, chronic disease epidemiology and prevention, general practice, substance abuse, quality of health care and public health training. For more information please visit http://www.eupha.org/html/menu3_2.html

Interesting web-sites



ASTRA

is a central and eastern European Women's Network for sexual and reproductive health and rights, which was established in 1999 by organizations of the region who share common concerns and goals in the area of reproductive health and rights to strengthen women's voice and to bridge the gaps between gender, health and human rights issues. ASTRA provides a collective voice to advocate for policies and programs that recognize women's and young people's health needs and human rights. The network is utilized to share information and strategies, building the capacity of women's organizations, and linking the central and eastern European women's movement to wider global processes on women's health and rights. For more information please visit: <http://www.astra.org.pl/>



The Gender Task Force

(GTF) is a south-east European regional initiative which was formed as the Stability Pact Gender Task Force (SPGTF) in October 1999. The SPGTF operates under the auspices and with in-kind support of the Organization for Security and Cooperation in Europe (OSCE). The GTF consists of governmental and non-governmental focal points from each south-eastern European country and territory, an Advisory Board composed of representatives of international organizations and regional NGO's with a gender equality mandate and representatives of donor country gender experts. GTF National Focal Points cooperate in bringing together national actors working on gender equality for the formulation of joint regional and national priorities, collection and dissemination of information, and national implementation of GTF Regional Programs. For more information please visit: <http://www.gtf.hr/aboutus/index.php>



Voices of Youth

is a web-site which aims to connect young people from around the world is dedicated to making sure young people from all countries can learn more, say more and do more about the world they live in. Two sub-topics of the website focus on HIV and AIDS and commercial sexual exploitation. For more information please visit: http://www.unicef.org/voy/about/about_255.html

Entre Nous

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