The Federal Centre for Health Education (BZgA) as WHO Collaborating Centre
Monika Hünert

Improving Adolescents’ Sexual and Reproductive Health in Europe – The Role of the World Health Organization
Gunta Lazdane

Sex and Young People in Europe: What’s SAFE?
Jeffrey Victor Lazarus, Jerker Liljestrand

Sexual and Reproductive Health Rights of Asylum Seeking and Refugee Women Still Neglected in the European Union
Marleen Bosmans, Kristin Janssens, Marleen Temmerman

Specific Needs of Migrants and Ethnic Minorities in Europe in the Field of HIV Prevention, Care and Support
Georg Bröring

BORDERNET: Integration of HIV/AIDS and STD services at the external borders of the EU
Elfriede Steffan, Tzvetina Arsova-Netzelmann, Kathrin Bever, Irmgard Boeckmann

The BZgA join-in circuit in operation – worldwide!
Regina Krause, Beate Lausberg
FORUM international is devoted to sexual and reproductive health and sex education in the European Community. The broad spectrum, great diversity and the topicality of this subject are evident in equal measure. Since 2002 the BZgA has been a collaborating centre of the WHO and in particular has been supporting the WHO programme of intensive cooperation with the countries of central and eastern Europe. In November 2006 the WHO and the BZgA are jointly staging a large international conference with the theme of ‘Sex education for adolescents in a multicultural Europe’.

This FORUM was designed to tie in with the conference. It describes the urgent problems in a unified Europe and, amongst other things, how the work of the large networks of state and non-state organisations is mutually complementary and increasingly achieve synergy effects.

According to Gunta Lazdane, our contributor from the WHO Regional Office for Europe, ‘It is important to note that over 80% of the people in Europe who are HIV positive are not yet 30 years old.’ She outlines the role of the WHO in improving the sexual and reproductive health of adolescents and refers to the most important documents and initiatives of the WHO policy in this subject area.

It is generally true that sex education which takes the special requirements of adolescents into account is a key element in promoting the sexual and reproductive health of people in Europe, as is also pointed out by Monika Hünert from the Federal Centre for Health Education (BZgA) in her introduction.

Jeffrey Lazarus and Jerker Liljestrand from Lund University in Sweden present the ambitious project SAFE (Sexual Awareness for Europe). Its aim is to produce an overall picture of sexual and reproductive health patterns and trends among European adolescents, as well as developing new activities aimed at reaching this population group and improving health policy in the individual countries.

Marleen Bosmans, Kristin Janssens and Marleen Temmerman, from Gent University in Belgium, report on the situation of female asylum seekers and refugees in the EU and their rights to sexual and reproductive health which have still not been sufficiently implemented.

Georg Bröring’s contribution is the Europe-wide networking project AIDS and Mobility Europe (A&M). He outlines the special requirements of migrants and ethnic minorities in Europe with regard to prevention, treatment and support of people with HIV and shows how, through the exchange of knowledge and information across national borders, A&M promotes and intensifies the prevention of HIV in a large network of state and local facilities.

Elfriede Steffan and her colleagues from Rostock report on the transnational project BORDERNET, which is setting up or strengthening cross-border networks that are active in the areas of HIV/AIDS prevention, investigation and treatment in four pilot regions on the borders of the EU.

Finally, Beate Lausberg and Regina Krause explain the concept of the ‘Mitmach-Parcours’ (Join-in circuit; MMP), an interactive service provided by the BZgA aimed at preventing AIDS in adolescents which has been used successfully for ten years. In that time, in cooperation with the Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation) (GTZ), MMP has been tested in countries throughout the world, including Ethiopia, El Salvador, Mongolia, Mozambique and the Russian Federation, adapting it to the specific conditions in those countries.

As you can see, dear reader, it is a broad subject area that is highlighted in this FORUM, but with impressive examples of far-sighted international cooperation. In an extended Europe, target-group-specific sex education appears to be more important than ever.

Your editorial team
Since 2002 the Federal Centre for Health Education (BZgA) has been a WHO Collaborating Centre in the field of sexual and reproductive health. As such it operates as an advisory and information centre for the WHO and forms a network with other Collaborating Centres for Sexual and Reproductive Health, as well as other governmental and non-governmental organisations at the national and international level.

The BZgA particularly supports the WHO programme of intensive cooperation with the countries of central and eastern Europe in matters of health and promotes closer cooperation with the European Commission. ‘We are glad to be one of the few collaborating centres in this field in Europe’, says Dr. Elisabeth Pott, the director of the Federal Centre. ‘We are particularly proud that our statutory obligation to provide sex education and family planning is being fulfilled at the international level too.’

This legal requirement was devolved to the BZgA on the basis of the Pregnancy and Family Assistance Law (SFHG, Art. 1) in 1992. In implementing the law BZgA develops target-group-specific concepts and corresponding media and measures with the aim of avoiding pregnancy conflicts, as well as providing general sex education. The work is based on the framework concept for sex education developed by the BZgA and agreed with the federal states in which the tasks, aims and target groups (general population, particularly adolescents and young adults, multipliers of information) are listed, as well as the concepts. The BZgA works closely with all the federal states. Cooperation partners include specialist associations and non-governmental organisations (NGOs), with whom the work is carried out in science and practice.

The BZgA uses the following tools:

- **Science/conception/strategy**
  Market overviews, monitoring, quality assurance (studies and data collection, evaluations of selected BZgA media and measures, scientific research to accompany the pilot schemes), development of strategy, networking, advising organisations.

- **Cooperation/further education/training**
  Cooperation with national institutions, NGOs, nationally and internationally recognised experts; development of various models for qualification and professionalisation in sex education.

- **Testing of suitable methods of access to specific target groups**
  Development of curricula for universities, schools and out-of-school activities, as well as for company training; implementation in accordance with gender-specific approaches, paying particular attention to ethnicity, social situation, lifestyle and sexual orientation.

- **Print and audio media**
  Print media as well as audio media for both, personal and mass communication, are developed for the various target groups such as children, adolescents, young adults and adults, parents and families.

The specific working plan of the collaborating centre operates on the basic principle of health promotion and aims to enable people to deal with their sexuality in a responsible manner, by providing information and motivation and teaching them skills. Sexuality is understood as a basic life requirement for human beings, which is a central component of their identity and includes biological, psychosocial and emotional elements.

### Adolescents in a multicultural Europe

Adolescents are at the centre of the first working phase of the cooperation between the WHO and the BZgA. In regional and national strategies to improve sexual and reproductive health adolescents are always an especially important target group. Particularly when increasing globalisation and the process of opening up borders is taken into account, it is a central requirement to inform them of the possibilities for safeguarding their sexual and reproductive health and to provide them with the necessary knowledge.

Sex education which takes the special requirements of adolescents into account thus becomes a key function in the promotion of sexual and reproductive health. Since social
conditions (gender ratios, religion, cultural taboos, etc.) have a considerable effect on people’s reproductive health situation, the individual states must develop improvement strategies and concepts which are tailored to local conditions and take account of the diversity of their population. The specific requirements of the growing numbers of foreign nationals in the population (refugees, migrant workers and immigrants) create particular demands in this respect in many European member states.

To examine the questions arising in this context, in November 2006 the BZgA, in association with the WHO, is staging a conference entitled ‘Sex education for adolescents in a multicultural Europe’.

This major conference will provide specialists in sex education with a forum for the discussion of national strategies and their implementation at state and non-state levels. Participating countries have been asked to fill a questionnaire on the national framework and their respective strategies to implement sex education. The findings have been compiled in a set of country papers and will be disseminated at the conference. Successful pilot schemes are also due to be presented. The forum will serve as an exchange of experience and is aimed at promoting learning processes, forming networks and cooperation in the European region. In terms of content the aim is to collate results from the three main focal points of the conference: multiculturalism, quality management and implementation of the life skills approach in sex education.

We are pleased that with this conference we are able to make a contribution to the implementation of the common aims of the WHO and the BZgA in the field of sexual and reproductive health at the national and international level.

Monika Hünert

Monika Hünert is a fully qualified educationalist. Since 1999 she has been the head of the unit for cooperation and coordination in sex education and family planning, concentrating on committee work, cooperative structures and networking.

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Improving Adolescents’ Sexual and Reproductive Health in Europe – The Role of the World Health Organization

This contribution deals with the policy and strategies of the WHO in the field of sexual and reproductive health, its prerequisites and cooperation with 52 Member States of the European Region. An important joint aim is to inform young people in Europe of all aspects of sexuality and reproduction, to support them in dealing responsibly with sexuality and reproduction and in the development of a healthy lifestyle.

Background situation

In many countries of the WHO European Region and globally, taboos and norms about sexuality pose strong barriers to providing information, reproductive health services and other forms of support that young people need to be healthy. Yet, sexual and reproductive behaviours during adolescence have immediate and long-term consequences. Reproductive and sexual ill health accounts for 20% of the global burden of ill health for women and 14% for men.

During 1996 and 1997, WHO and other United Nations agencies were involved in the selection of 17 common reproductive health indicators to be used for global monitoring. The health behaviours and problems affecting adolescents are unique. Of the factors that contribute to the global burden of disease among young people (as measured by the disability-adjusted life year), sexually transmitted infections (STIs), HIV, unsafe sex, and alcohol and drug use predominate. Many of these factors are inter-related (WHO 1999). The current challenges faced in the field of adolescent sexual and reproductive health consist primarily of STIs, HIV/AIDS, unsafe sex and unwanted pregnancy, and sexual development/risk behaviour.

Multiple studies have shown that, among young people, the average age of first sexual intercourse is between 17.5 and 18 years of age. There is some evidence that the age of initiation may be decreasing. Compared to the age at first intercourse, the percentage of 15 year-olds who had experienced sexual intercourse showed marked country and gender variability. Adolescent pregnancy is a phenomenon that occurs in all countries and at all levels of society. Approximately 15 million adolescents aged 15–19 become pregnant every year throughout the world. From a public health perspective, this entails significant long-term physical, social, psychological and economic consequences for all involved. Girls who become pregnant at the age of 15–19 have twice the risk of dying in childbirth, while girls younger than 15 are five times more likely to die in childbirth compared to women aged 20–35 years.

Significant differences exist between the pregnancy rates in various countries in Europe; from a low of 5.39 pregnancies per 1,000 women aged 15–19 in Switzerland to a high of 64.73 pregnancies per 1,000 in the Russian Federation. Examination of pregnancy outcomes reveals that more adolescents choose to terminate their pregnancy than deliver in Denmark, Estonia, Finland, France, Iceland, the Netherlands, Norway, the Russian Federation, Slovenia and Sweden. Data regarding contraceptive prevalence and STIs in this age group are often missing or unreliable, but it is important to note that more than 80% of people who are HIV-positive in the European Region have not yet turned 30.

‘Universal access to reproductive health services by 2015’ was one of the goals of the International Conference on Population and Development in Cairo in 1994. Most of the countries represented at this United Nations meeting confirmed ‘the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice...’. One of the reproductive rights of every person is the right to information, education and decision-making.

WHO policy documents and initiatives

In 2004, the World Health Assembly approved WHO’s first global strategy on reproductive health: ‘Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets’. Five priority aspects of reproductive and sexual health targeted in the strategy are: improving antenatal, delivery, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating STIs, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health. The document emphasises that ‘meeting the needs and protecting the rights of 1.200 million adolescents worldwide are essential to safeguard the health of this and future generations’ (WHO 2004).

1 www.euro.who.int/countryinformation
Where health services exist, there are many reasons – social, economic and cultural – why people nevertheless do not use them, particularly in relation to reproductive and sexual health. The WHO global strategy states that ‘identifying and overcoming obstacles require working with women, young people, and other community groups to understand better their needs, analyse problems and find acceptable solutions’.

The 2001 WHO European Regional Strategy on Sexual and Reproductive Health (SRH) urges Member States in the WHO European Region to inform and educate adolescents on all aspects of sexuality and reproduction and assist them in developing the life skills needed to deal with these issues in a satisfactory and responsible manner, and to create supportive legislative and regulatory frameworks to review laws and policies to ensure that they facilitate equitable access to SRH education, information and services (WHO 2001).

The European Strategy on Child and Adolescent Health and Development, prepared in collaboration with Member States, was adopted at the 55th Session of the WHO Regional Committee for Europe in 2005 (WHO 2005). It urges countries to ensure that policies, programmes and health systems are in place to work towards the following targets:

- healthy lifestyle development;
- prevention of risky behaviours;
- youth-friendly counselling and health services;
- protection from exploitation and hazardous labour practices;
- prevention of sexual, physical or mental abuse;
- healthy school environments;
- supportive home and community environments;
- control of inappropriate adolescent-centred marketing;
- full immunisation;
- injury prevention and
- relationship and parenthood education.

A large number of European countries are using this set of documents for developing their national strategies and programmes.

When analysing the sexual health of adolescents, one cannot do without the data from the Health Behaviour in School-aged Children (HBSC) study (Corrie et al. 2004). It is a collaborative cross-national research, supported by the WHO Regional Office for Europe, conducted by a multi-disciplinary network of researchers from 41 countries and regions in the WHO European Region and North America, and coordinated by the University of Edinburgh in the United Kingdom. The study seeks new insight into adolescents’ health, health behaviour and lifestyles in the social context. It was started in 1982, and the first cross-national survey was conducted in 1983/1984. Since then, data have been collected every four years by means of a common research protocol, the most recent survey being from 2001/2002, published in 2004.

As well as running the research and monitoring study, the HBSC project also seeks to inform and influence the policies, programmes and practices aimed at young people by health promotion and health education services at both the national and international level.

At its meeting in 2005, the WHO European Regional Advisory Panel on Research and Training in Reproductive Health analysed the available data on reproductive health and agreed on the following priorities for 2006-2007:

- maternal and perinatal mortality and morbidity;
- prevention of unwanted pregnancy and ensuring safe abortion;
- improving sexual and reproductive health and rights of young people, also through the provision of youth-friendly health services, emphasising the needs of vulnerable and underserved groups;
- promoting the role of the health sector in addressing gender-based violence;
- planning of the family in the new Europe.

There are 52 Member States in the WHO European Region, and each of them has at some stage analysed the reproductive health status of the population and agreed on the priorities. The WHO Regional Office for Europe has biennial collaborative agreements with 29 countries, including main areas of work where the country would like to have support from WHO experts. In recent years, several countries (Belarus, Bulgaria, Kazakhstan, Latvia, Turkey and Ukraine) have put improvement of the sexual and reproductive health of adolescents high on the agenda, developing their national policies in this area or building the capacity of family physicians to provide youth-friendly counselling and services. Different types of activities have taken place with the involvement of WHO experts, from evaluation of the present services for adolescents to training of health professionals in methods of contraception for adolescents.

**International partnership**

Most of these activities are carried out in partnership with other international agencies. The United Nations Inter-Agency Group on Young People’s Health, Development and Protection, sub-group on Youth-Friendly Services, held two consultations in Lithuania in 2001 and Bulgaria in 2003. Here, the different governments and other stakeholders from the Baltic states, the Russian Federation and south-eastern Europe agreed that Youth-Friendly Services should be integrated into government services using existing resources (Lazarus 2006). They decided that a multi-stakeholder partnership between government, young people, media, civil society and international institutions should promote this initiative.

Another partnership has resulted in the joint project ‘A European partnership to promote the sexual and reproductive health and rights of youth’ (2005-2007), supported by the European Commission, where the International Planned Parenthood Federation (IPPF) European Network, Lund University (Sweden) and the WHO Regional Office for Europe are together trying to evaluate the present situation and suggest further steps in reaching the goals of international commitments.

Many of the projects and activities going on in the European Region and beyond have been highlighted in the European magazine for sexual and reproductive health, Entre Nous, which has been published by the United Nations Population Fund and the WHO Regional Office for Europe since 1982. While Entre Nous has had special issues to analyse the health and development of adolescents and young people, like ‘Youth Friendly Health Services in Europe’ (No. 58), ‘Does peer education work in Europe?’ (No. 56) and ‘Adolescent SRH – helping young people to protect themselves’ (No. 52), regular issues include articles on this topic from a particular angle, such as violence against women, abortion, etc.
WHO is initiating and supporting research on sexual and reproductive health in 39 countries, some of them in the European Region. Sexual attitudes, risk behaviours and their determinants in young people are being studied in Croatia, Poland and Turkey.

Several WHO Collaborating Centres in Europe work in the field of sexual and reproductive health of young people, having an impact on improving sexuality education (Bundeszentrale für gesundheitliche Aufklärung in Germany), the quality of health services by training health professionals (the Netherlands School of Public Health and the Department of Public Health at the Hacettepe University Medical Faculty in Turkey) or the analysis of sexual and reproductive health of young migrants, refugees and asylum seekers (the International Centre for Reproductive Health at Ghent University) (WHO 2006).

Conclusions

Sexual and reproductive health is a key element of a healthy life. In order to ensure that adolescents in Europe have the ability to achieve good health, society needs to ensure that the required tools are provided. We must provide information and education in a timely and appropriate manner, recognising the importance of peer education, family and friends. We must educate on both the positive and the negative sides of sexual and reproductive health. We need to provide life skills and choices. We need to provide and ensure access to youth-friendly services. Perhaps most importantly, we need to provide a safe and supportive environment, working towards the elimination of poverty, gender inequality, coercion and violence, and ensuring that basic needs are met, such as food and shelter.

It is clear that the goals proposed by the WHO European Regional Strategy on Sexual and Reproductive Health, of reducing unwanted pregnancies, induced abortions and STIs, educating adolescents on reproduction and sexuality and providing access to youth-friendly services, are of utmost priority. Working towards achieving these goals in Europe is a continuous process. Commitment to achieving these goals in Europe ensures a healthy future not only for adolescents, but also for the entire European Region.

Gunta Lazdane
ROLE OF WHO

References


Entre Nous – the European Magazine for Sexual and Reproductive Health. Copenhagen, WHO Regional Office for Europe (http://www.euro.who.int/entrenous)


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Sex and Young People in Europe: What’s SAFE?

The aim of the SAFE project is to create an overall picture of sexual and reproductive health patterns and trends amongst European adolescents and to develop new activities so that this population group is reached and the health policy in the individual countries is improved.

In early 2003, with the tenth anniversary of the International Conference on Population and Development around the corner, Lund University, Sweden, embarked on an ambitious examination of young people’s sexual and reproductive health and rights in the European Union (EU). The arrival of ten new Member States in the EU raised questions as to the differences in health status between countries (see the Figures1 p. 12–14) and their approaches to sexual and reproductive health. To learn from and reach the leading organisations working on these issues at the national level, we teamed up with the International Planned Parenthood Federation (IPPF) European Network and their national member associations. And to help us bring our research to the attention of policymakers, we partnered with the WHO Regional Office for Europe. The resulting three-year tripartite project, which adopted the name SAFE (Sexual Awareness for Europe),2 seeks to provide an overall picture of the region’s sexual and reproductive health patterns and trends among young people, and carry out a series of activities to enable the development of innovative ways to reach this group and improve public policy.

In this article, we report on the research component3 of the SAFE project, looking specifically at sexually transmitted infections (STIs), sexuality education among young Europeans and the approach employed in an initial multilevel analysis of how certain national factors may affect sexual and reproductive health. Little did we know when we began just how scarce current, comparable data were. Not only were most countries unable to provide hard numbers for the prevalence of contraceptive use, for instance, but they could not even estimate it. There was a similar lack of data on STIs, the status and content of sexuality education, and most other sexual and reproductive health indicators, especially for young people, as evidenced in Figure 4, for example, which is not available in age-disaggregated form.

The pursuit of data took us to health ministries, national statistical bodies, Reprostat (Reproductive health indicators in the European Union), Eurostat, non-governmental organisations, and ultimately to the World Health Organization, where we found three invaluable sources: the Health Behaviour in School-Aged Children (HBSC) surveys (Currie et al. 2004), the EuroHIV annual reports (EuroHIV 2005) and the Centralized Information System for Infectious Diseases.4 However, the data they contained were still raw, partly or wholly unanalysed, and often incomplete. Moreover, the age definitions for young people varied.5

The SAFE project

The idea for the SAFE project grew out of the Report on Sexual and Reproductive Health and Rights in Europe (European Parliament 2002a) by Anne Van Lancker (MEP6 Belgium), which was endorsed by the European Parliament on 3 July 2002 (European Parliament 2002b). The Van Lancker report called on EU Member States and accession countries to improve the exchange of information and best practices on the issues of unwanted pregnancies and abortion, adolescent sexual and reproductive health and rights, and sexuality education, and in the development of sexual and reproductive health policies. To respond to this call, the research component of the SAFE project is divided into five main studies, which will be made public during the latter half of 2006 and throughout 2007.

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1 The four Figures present a sample of the types of data collected, which will be presented in the final research report of the SAFE project.
2 Fifteen young people from across Europe agreed on the name at a meeting in March 2005. The SAFE project is funded by the European Union and has Commission of the European Communities Grant Agreement Number 2003319.
3 The two other components of SAFE are the implementation of sexual and reproductive health projects in EU Member States and the dissemination of all the SAFE projects at the WHO meeting of ministry of health officials.
4 Both are available at www.euro.who.int.
5 SAFE follows the United Nations and IPPF in defining young people as being age 10-24, adolescents as being 10-19 and youths as being 15-24.
6 MEP = Member of the European Parliament
1. Multilevel research in Europe
First, SAFE research draws on HBSC survey data (Currie et al. 2004) to provide comparative information on trends in young people’s sexual and reproductive health. Ultimately, 20 countries and subregions from the enlarged EU fit our inclusion criteria. The study goal was to determine which factors have the most impact on contraceptive use among a nation’s young people. We focused on socially vulnerable groups, as defined by specific risk behaviours or lifestyle factors (e.g. coercive behaviour; reported as those who bully others), or young people who drink or smoke regularly, and their sexual and reproductive health status. Contraceptive use was used as a proxy for health status, since there is a high inverse correlation between such use and the prevalence of STIs and unwanted pregnancies. The national variables examined included socioeconomic level, presence of adequate sexuality education and primary religion. In the enlarged EU, this study should contribute to the making of better-informed national health policies for young people and to a more nuanced debate on EU health policy programming.

2. Research in 11 EU and candidate countries
Owing to the limited availability of comparative data, a key component of the project was to conduct detailed national situational analyses and small sub-studies on key aspects of young people’s sexual and reproductive health. Eleven self-selected IPPF member associations participated by preparing country profiles based on a template. Each one studied a key issue that it identified in developing its profile. The idea was that further research on a relevant issue would equip the association to better address it in its daily work. The topics chosen included the age of sexual debut, the low uptake of vulnerable boys in youth-friendly health services, the role of the media as a sexual and reproductive health information source for young people, and how to involve young people in IPPF’s work. The 11 countries involved were Belgium, Bulgaria, Cyprus, Estonia, Germany, Hungary, Latvia, the Netherlands, Poland, Spain and the United Kingdom.

3. User-friendly databases
Searching for studies and data on particular situations or interventions in sexual and reproductive health can be tedious, and success often depends on appropriate training. To make it easier, SAFE is producing five inventories of peer-reviewed articles on STIs, teenage pregnancy, family planning, the use of new technologies in youth outreach, and gender issues) in public-access, user-friendly databases. The ability to find such information quickly should make it easier for programme managers and decision-makers to incorporate the latest scientific evidence in their work. In connection with the implementation of the new WHO global STI strategy, we will also be analysing the STI database to produce a systematic review of interventions used to reduce the spread of STIs among young people in Europe since 1994.

4. Sexuality education reference guide
In September 2005, the European Society of Contraception held a seminar entitled ‘Sexual education: the key issue of reproductive health’. As proponents of comprehensive sexuality education, we were pleased that the society gave the issue such prominence, but we were also concerned that it was being presented as the chief solution to reproductive health problems. As discussed in the next section, many variables need to be factored in when measuring the impact of sexuality education. For example, the link between sexuality education and reproductive health outcomes is quite tenuous, though sexuality education can clearly play an important role in reducing stigmatisation and discrimination and in helping young people understand their bodies and the changes they experience. Ultimately, sexuality education is most effective when it forms an integrated part of life-skills education (IPPF 2006) and when it is addressed in other subjects where appropriate, such as biology, physical education, nutrition and literature. But is this how it is taught in Europe?

In collaboration with external researchers, the SAFE project is developing a European sexuality education reference guide that it will launch in autumn 2006. The aim of the guide is to bring together all the information on the subject systematically and coherently, thus allowing for ready comparisons among countries. It should enable advocates to make well-founded arguments for comprehensive sexuality education in schools, and to refer quickly to what’s happening and what’s working in neighbouring countries. Its preliminary findings indicate that sexuality education is inadequate overall in at least one of every five EU countries while the quality varies greatly within the remaining countries and even within individual schools. In Lithuania, for example, a changing economic and social environment coupled with a strong Catholic Church has resulted in a small but effective opposition to sexuality education in schools (Family Planning and Sexual Health Association of Lithuania 2005). In Denmark, on the other hand, sexuality education has been part of the primary school curriculum for over 30 years, though its quality varies greatly and its structure is under revision.

It is also essential to recognise that teachers are not the only ones providing sexuality education. In Denmark, the national IPPF member association (Sex & Samfund 2005) recently reported that 96% of young people had had sexuality education in school, but only 43% described it as their most important source of information; a higher percentage said peers were the most important source. Far more than half said they never talked about sex issues with their parents. And though young people did want sexuality education in

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7 The HBSC survey asked 15 year-olds four questions about sexual health, such as ‘The last time you had sexual intercourse, what method(s) did you use to prevent pregnancy?’ However, several countries chose to omit these questions.
8 The main results from the SAFE studies will be published in late 2006 as part of a SAFE information day in Brussels, Belgium. Additional results and a description of methodology will appear as a peer-reviewed article in 2007.
9 Four databases (Medline, Embase, CINHAL and PsychInfo) were searched for relevant articles with an extensive search string that included more than 100 terms. For STIs, for example, part of the string read: ‘chlamydi* or trachoma* or b淋enorrhea* or (lymphogranuloma near vener*) or gonorrhea* or gonorrhoea* or gonoccocal* or ophthalmia neonatorum or neonatal conjunctivitis’. The results entered in the STI database include more than 10,000 articles, stratified by country.
10 Rankings were made based on three aspects of sexuality education: whether it is mandatory, the year it began to be mandatory, and the age when children start receiving it. If found to be ‘adequate’, the contents of the education were then reviewed to ensure that they were comprehensive.
school, only 10% of those teaching it felt they were adequately trained. Effective sexuality education could thus be imagined as part of several settings: life-skills education at school, peer education, youth-friendly health services, the health promotion activities of a family doctor or a parent’s qualified advice.

5. Development of policy framework and guidelines
The Van Lancker report recommended that the government of each EU Member State collaborate with civil society organisations in developing a high-quality sexual and reproductive health policy. To provide assistance in developing such a policy for adolescents, SAFE will employ the results of its research in drawing up a policy framework and guidelines. We will conduct a series of consultations with health ministries, young people, EU representatives and IPPF member associations before finalising the guidelines and launching them in 2007.

The European context
While the SAFE project focuses on young people’s sexual and reproductive health and rights, it is clear that they cannot be addressed in isolation. The national and even the international context must also be considered. Ecological models can be especially useful in studying sexuality education and its impact on sexual and reproductive health. According to such models, behaviours are influenced by intrapersonal, social, cultural and physical environment variables. These variables play a critical role in determining population health and how it is distributed, and therefore, some of the most promising structural interventions are directed at elements of this larger context (Berkman, L./Kawachi, I. 2000).

Yet ecological approaches have been slow to influence public health practice in addressing risk behaviours. Researchers and policy-makers often fail to acknowledge the relevance of the environment in which sexuality education or condom promotion programmes are implemented. The prevailing approach has been to help young people cope with risk environments by trying to change their attitudes and behaviours, for instance by promoting sexual abstinence or the use of contraception. This model fails to address adequately how environmental factors may influence attitudes and behaviour or how certain behaviours, e.g. the use of alcohol or other drugs, may in part be responses to environmental conditions.

Looking ahead, we believe the most important step towards improving the sexual and reproductive health of young people in Europe is to address professional and ideological opposition to comprehensive sexuality education and the use of contraception. Across Europe, key stakeholders – such as parents, religious leaders, politicians and the mass media – have a tremendous impact on these issues. However, without up-to-date, accurate information, it will be impossible to know how well we are doing or where we are failing. The SAFE project, with its research and action components, has already identified a number of gaps and suggestions for future directions.

Jeffrey Victor Lazarus, Jerker Liljestrand
### Fig. 1
**15 year-olds in Europe who used contraception during their last sexual intercourse**

<table>
<thead>
<tr>
<th>Country</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium (FL)</td>
<td>64.4</td>
<td>75.6</td>
</tr>
<tr>
<td>Estonia</td>
<td>71.8</td>
<td>84.5</td>
</tr>
<tr>
<td>Germany</td>
<td>75.9</td>
<td>81.0</td>
</tr>
<tr>
<td>Hungary</td>
<td>77.3</td>
<td>84.5</td>
</tr>
<tr>
<td>Latvia</td>
<td>81.3</td>
<td>81.0</td>
</tr>
<tr>
<td>Netherlands</td>
<td>72.5</td>
<td>83.3</td>
</tr>
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<td>Poland</td>
<td>69.6</td>
<td>89.1</td>
</tr>
<tr>
<td>Spain</td>
<td>73.4</td>
<td>89.1</td>
</tr>
<tr>
<td>England</td>
<td>70.8</td>
<td>89.1</td>
</tr>
<tr>
<td>Scotland</td>
<td>63.4</td>
<td>76.2</td>
</tr>
<tr>
<td>Wales</td>
<td>63.6</td>
<td>75.2</td>
</tr>
<tr>
<td>HBSC average</td>
<td>69.6</td>
<td>80.2</td>
</tr>
</tbody>
</table>

Source: Currie et al. 2004

### Fig. 2
**Percentage of reported HIV/AIDS cases in the WHO European Region that are male**

Note: For countries without HIV reporting, the percentages refer to AIDS cases.
Sources: EuroHIV; national reports
Fig. 3

HIV cases reported in the WHO European Region, 1989–2005

HIV diagnoses: 424,670
AIDS diagnoses: 277,974
AIDS deaths: 158,151

HIV diagnoses: 34,393
AIDS diagnoses: 14,869
AIDS deaths: 7,093

HIV diagnoses: 478,200
AIDS diagnoses: 21,323
AIDS deaths: 12,164

Fig. 4

New syphilis cases in Europe per 100,000 population, 1994–2004

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Sexual and Reproductive Health Rights of Asylum Seeking and Refugee Women Still Neglected in the European Union

The authors take as their subject the proposition that female asylum seekers and refugees have a different legal status in the European Union and therefore do not have the same rights to health care. Only a few countries allow female asylum seekers unhindered access to services in the field of sexual and reproductive health.

Recently, the International Centre for Reproductive Health at Ghent University conducted a pilot research project into the sexual and reproductive health (SRH) needs and rights of asylum seeking and refugee women (ASRW) in the European Union (EU). Whereas the European Union has become a major advocate in the defence of women’s SRH rights, this awareness is mainly focused on the situation in developing countries. The research results revealed that the protection and promotion of the SRH rights and needs of asylum seeking and refugee women are still widely neglected and not considered by EU refugee policies.

Growing recognition of SRH needs and rights of refugee women

Worldwide, the women’s movement played a major role in advocating women’s SRH rights. Whereas the focus was initially on mother-and-child health and population growth control, the emphasis gradually shifted to the promotion of SRH as ‘a complete status of physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes’, as defined at the International Conference on Population and Development (ICPD) in Cairo in 1994 (United Nations 1994, Art. 7.2). The ICPD Programme of Action also stated that people should have a ‘satisfying and safe sex life’ and access to safe, effective, affordable and acceptable SRH services. The conference also drew attention to the SRH needs of migrant and displaced women, who ‘in many parts of the world have limited access to reproductive health care and may face specific serious threats to their reproductive health rights.’ In Cairo, SRH rights were recognised as human rights (United Nations 1994, Art. 7.3). At the Fourth World Conference on Women in Beijing in 1995, SRH rights were moreover recognised as specific human rights of women and as a universal, inalienable, integral and indivisible part of universal rights (United Nations 1995).

Although international conference documents are not binding, they nevertheless reflect an important international consensus, achieved as a result of continuous advocacy, negotiations and discussions with and among States. This explains why treaty monitoring bodies refer to them as a standard for evaluating how States are meeting their treaty obligations (Girard/Waldmann 2000). In 1999, the Committee on the Elimination of Discrimination Against Women urged States parties to the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW, 1979) to ensure universal access to a full range of SRH services for all women (United Nations 1999). The Committee highlighted that ‘special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, such as migrant women, refugee and internally displaced women’ (United Nations 1999, Art. 6). Over the years, international agencies with a specific mandate in the protection of refugee and displaced populations, such as the United Nations High Commissioner for Refugees (UNHCR), the United Nations Population Fund (UNFPA) and the World Health Organization (WHO), have developed a series of guidelines, policies and manuals for the protection and promotion of SRH rights of populations in humanitarian settings. Efforts to implement these, however, mainly target situations in developing countries and hardly focus on the situation of asylum seeking and refugee women in the developed world.

Lack of attention for SRH rights of asylum seekers and refugees in the EU

EU refugee policies explicitly distinguish between refugees and asylum seekers. According to the 1951 UN Convention Relating to the Status of Refugees, a refugee is a person ‘who, owing to well-founded fear of persecution for reasons of race, religion, nationality or membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail him/herself of the protection of that country; or who, not having a nationality or being outside the country of his/her former habitual residence, is unable or, owing to such fear, is unwilling to return to it’ (United Nations 1951). Asylum seekers are defined as ‘persons seeking to be admitted into a country as refugees and
Barriers to accessing SRH services

Apart from legal barriers, asylum seeking and refugee women are also confronted with a series of social, cultural and economic barriers hampering their access to SRH services, both at the level of the service providers and at the level of the ASRW themselves. These barriers may be difficult to identify, particularly since asylum seekers and refugees constitute a very diverse population. A study in the United Kingdom pointed out that pregnant women from disadvantaged groups, including asylum seekers, are in a particularly vulnerable position as they are highly unlikely to receive pregnancy-related services (Gwyneth/Driye 2003). This is mainly due to the fact that they have no relatives or friends to support them, or simply that language barriers impede them from accessing the health system (House of Commons Health Committee 2003). Language and other communication problems also hamper access to information about how the health system in the hosting countries operates (Ascoli/Van Halsema/Keysers 2001). A study among pregnant refugee women in the Netherlands found that they had little understanding of the Dutch delivery policy (home birth or hospital birth) and the role of doctors, nurses and midwives in the provision of postnatal care services. Refugee women used to go for antenatal care for the first time when their pregnancy was already at an advanced stage (sometimes they were already eight months pregnant) and most probably many refugee women did not attend any professional maternal health service at all, neither before, during nor after delivery (Ascoli/Van Halsema/Keysers 2001, 372-393).

Women may also refrain from attending maternal health services if they cannot be attended by female health staff. A Sudanese Muslim woman in Austria explained her uneasiness as follows: ‘Once, I went to the radiologist for an examination. He asked me to take off my blouse. I was shocked. How could I take off my blouse in the presence of a strange man? For me, it was not logical - but for him, it was normal.’ A Sudanese woman in the UK talked about the problem of having a pap smear and why it is difficult for women with her cultural background to simply open their legs for a gynaecological examination (Mesthenesos/Gaunt/Ioannadi 1999).

Personal attitudes and lack of intercultural skills of the health staff also determine the extent to which refugee women make use of available SRH services. Somali refugee women in the UK explained that they did not attend maternal health services because the health staff expressed racist attitudes and did not know how to deal with pregnancy and labour in patients who had been genitaly mutilated (Bulman/McCourt 2002).

Community-based services proved to be a good practice for reaching asylum seeking and refugee women who had difficulties accessing the maternal health system. Experience in the UK with midwives who attended a limited number of women in their community on an individual basis proved to be very effective. The midwives followed the mothers throughout their pregnancy, delivery and in the postnatal period. This approach enabled them to create a bond with the mothers and guarantee continuity of care (Thorp 2003). Continuity of care has been identified as an important determining factor in the quality of maternal health care. Particularly asylum seeking women often (have to) change their place of residence as a result of asylum seekers dispersal policies. Dispersal can happen quite unexpectedly or at short notice and may interrupt the maternity care they were receiving. It may moreover increase emotional distress and social isolation of the asylum seeking mothers as the
social support system they relied upon is disrupted (McLeish/Cutler/Stancer 2002).

Communication problems also affect family planning services for asylum seeking and refugee women. There are indications that lack of access to information about family planning leads to higher rates of unwanted pregnancies and abortion among ASRW, who often have limited knowledge about modern contraceptives (Mouthaan/de Neef/Rademakers 1998). The use of family planning methods is also determined by the availability of modern contraceptives to ASRW and the possibilities for obtaining them. In Belgium, for example, women need a prescription from a medical doctor for oral contraceptives, the purchase of which was not always affordable due to financial constraints the women had to cope with (Vissers 2004).

Asylum seekers and refugees often face situations that put them at risk of sexually transmitted infections (STIs), including HIV/AIDS. A study in the Netherlands found that a prolonged stay at the asylum reception centres, and feelings of loneliness and depression, lead asylum seekers to several and often short sexual relations (Jak 2003). Poverty, powerlessness, social instability, human rights violations and sexual violence are all factors that contribute to the rapid spread of STIs/HIV/AIDS among refugee populations. Taboos on sexuality, stigmatisation, lack of information about testing and treatment possibilities and fear of their asylum request being rejected in case they are found HIV-positive, are all factors that hamper the effectiveness of STIs/HIV/AIDS prevention programmes among asylum seeking and refugee women (European Project AIDS & Mobility 2000).

**Conclusion**

Although the European Union has profiled itself as one of the major advocates of SRH rights worldwide, this interest is mainly reflected in its international policies and remains largely unattended within the EU, particularly where asylum seeking and refugee populations are concerned. Particularly in the case of asylum seekers, whose right to health, and more specifically to SRH, is restricted to care for pregnant mothers and emergency care, the lack of universal access to the full range of SRH services may seriously affect their overall SRH status throughout their life cycle. Moreover, the SRH of asylum seeking and refugee women is closely related to SRH provisions made for migrant populations as such. Their use of existing services is largely affected by the same factors and barriers as in the case of other migrants. However, asylum seeking and refugee women are much more vulnerable in their SRH because of their insecure legal status and the situations of distress and isolation they often have to cope with. More advocacy and research into the SRH needs and rights of ASRW, and of migrant women in general, in the EU is needed in order to support the development – and implementation – of policies and programmes that guarantee full access, availability, affordability and sustainability of comprehensive SRH services for all.

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Specific Needs of Migrants and Ethnic Minorities in Europe in the Field of HIV Prevention, Care and Support

The Europe-wide networking project AIDS & Mobility Europe (A&M) enables the exchange of knowledge and information on the subject of migration, population mobility and HIV in Europe. Activities in the areas of prevention, treatment and support can be improved and their effectiveness can be increased by the direct cross-border transfer of know-how.

Introduction

Migration and HIV/AIDS is an issue that is relevant in all European Member States. Epidemiological data in various European countries show that migrants and young people from a multi-ethnic background are at particular risk of HIV infection (Hamers et al. 2004) and that they are disadvantaged regarding access to services (A&M Country Reports 2003, A&M Trend Reports 2006). The marginalisation of (some) migrant groups stresses the need for approaches towards better participation, empowerment and community involvement.

Migration is related to mobility into and between European countries; border regions – particularly in the East of the European Union – are of particular importance. Population mobility and HIV is an issue par excellence to be addressed at the European level, as developments in the field of migration in one country can directly affect the situation in another country.

At the European level, the issue of migration and HIV is addressed by the European networking project AIDS & Mobility Europe (A&M). The information in this article is based primarily on the work of A&M and its partners.

The article will address two major subjects – firstly, the rationale and activities of AIDS & Mobility Europe, and secondly, the major challenges for health workers addressing the issue of migration and population mobility in relation to HIV/AIDS.

AIDS & Mobility Europe

AIDS & Mobility Europe (A&M) is a Europe-wide networking project, established in 1991, on the issue of migration/population mobility and HIV. The reason for setting up the project was the fact that many migrant populations in Europe were not satisfactorily addressed with HIV information. Appropriate prevention materials that take care of the different linguistic, cultural and religious backgrounds were hardly available, and the project was set up to exchange the knowledge, skills and information available, and to stimulate new initiatives in the field of HIV prevention for migrants.

Over the years, A&M has expanded to all European Member States, and it has also added new issues to its agenda, notably in the area of access to treatment, care and support. A&M is based at the Netherlands Institute for Health Promotion and Disease Prevention (NIGZ) and is primarily funded by the European Commission (DG SANCO).

The main aim of A&M is to reduce the HIV vulnerability of migrant and mobile populations in Europe, with a specific focus on young migrants, through the development, exchange and promotion of appropriate policies and interventions.

After starting with a few European countries only, A&M now has a structure of National Focal Points (NFPs) in all 25 European Member States and in Norway, and it cooperates with other actors in the field, such as related European networks. The tasks of the NFPs are to network at the national level and strive to function as an interface between the national and the European level. For instance, they compile country reports to highlight important issues in their respective countries, and they refer people and organisations of their national networks to activities that take place at the European level. On the other hand, the task of the A&M staff is to report back to the European Commission and to facilitate exchange between the participating countries.

In addition to the structured NFP network, A&M has access to a wider network of more than 1,300 contacts in Europe, from community-based to governmental organisations.

An important role of A&M is in the field of monitoring and trend watch. Network meetings, notably the annual NFP Meetings and the European Migrants Meeting, enable access to information and emerging trends in relation to migration and HIV in Europe. In addition, national meetings are organised by NFPs to investigate the situation in the different European countries. Trend reports help identify necessary policies and interventions; they can provide important information to respond to changing situations in Europe.

The NFP for Germany is Deutsche AIDS-Hilfe e.V. – contact S. Klumb, silke.klumb@dah.aidshilfe.de
The results of the project and its activities are disseminated through A&M communication channels, in particular the A&M website and newsletter.

In its current working plan (2004–2006), five major issues are addressed through working groups with delegates from different European countries. The first working group addresses epidemiological developments in migrants and ethnic minorities; it looks in particular at the different ways in which media report on the HIV epidemic in migrant populations. The second working group looks into the situation in the new European Member States with respect to HIV and migration; members of this working group stressed the fact that there is only very limited knowledge about the issue of migration and HIV in the new Member States and decided to compile country reports, which describe the main geographical and epidemiological information, and governmental and non-governmental responses in the field.

The third working group focuses on young migrants living with HIV and ways to address their situation, taking all relevant actors – school, families, etc. – into account. In the fourth working group, the participants look into the issue of HIV and people with an uncertain residence status; this working group is developing a brochure to attract attention. Due to the international collaboration, paediatricians may be aware of important developments and are interested in the situation of migrant children with HIV in their countries. 

Another significant role of the A&M network lies in the field of information exchange between European countries and between the ‘old’ and the ‘new’ Member States. A comparable transfer of expertise may be realised now from the ‘old’ European countries to those countries that joined the European Union in 2004, and European networks may play an important, facilitating role.

European networks are able to identify appropriate organisations or individuals, who may be capable of supporting colleagues who work in NGOs in another country.

The relevance of this exchange of knowledge and skills became particularly evident in the mid-Nineties of the last century, when countries in Southern Europe experienced a considerable and rapid increase in immigration, and where they could take advantage of the expertise that already existed in Northern European countries with a longer history of immigration, such as Belgium, the United Kingdom and the Netherlands. A comparable transfer of expertise may be realised now from the ‘old’ European countries to those countries that joined the European Union in 2004, and European networks may play an important, facilitating role.

**Raising awareness**

Another significant role of the A&M network lies in the field of raising awareness. Due to the international collaboration and contacts with experts in different fields, European networks may be aware of important developments and are
able to draw attention to the issue of migration and HIV in general and/or to specific issues or populations in particular. Specifically, this can mean that migrant associations are encouraged to put the issue of HIV/AIDS on their agenda, or that AIDS organisations are reminded to integrate work with migrants and ethnic minorities in an appropriate way.

Based on the collaboration with various actors at the national and European level, European networks can also increase awareness at the policy-making level, thereby supporting the needs of NGOs. Country reports or reports on specific migrant issues can be brought to the attention of policymakers. One example is the communication of the European Commission on access to health for migrants, which is to a great extent based on the work of AIDS & Mobility Europe.3

Solidarity and fight against discrimination
Finally, the A&M network has the capacity to support NGOs in their fight against discrimination and stigmatisation and to increase solidarity. The involvement in international collaboration can give network members backing for their work. Reports produced together with European partners may have additional value. Good practice that is documented in one country, can help organisations in another country to strengthen their position. Especially where marginalised groups are concerned, such as certain migrant populations, participation in European networks can create a sense of solidarity, between organisations and colleagues in the field of migration, but also between the affected migrant communities. In addition, networks can make (political) statements, for instance through policy papers, but also through the support of organisations that are dedicated to the empowerment of marginalised populations.

Limitations and obstacles of A&M
Considering the wide scope and the multi-faceted nature of the issue of migration and HIV, the activities (and the budget) of AIDS & Mobility Europe are somewhat limited. There is such a great diversity of populations involved, and so many areas – legal, social, political – are touched, that the respective working plans of the project cannot cover them all. In addition, with the expansion of the European Union, there are now so many countries involved that the implementation of concrete projects at the national level is beyond the capacities of the project. Here, the National Focal Points play an important role in taking care of the implementation of such activities. A&M can just support this with advice, either from A&M staff or through the support of experts from other countries.

Challenges in the field of migration and HIV/AIDS
In its project period 2003-2006, AIDS & Mobility Europe and its network partners have gathered important information and data, and formulated conclusions and recommendations, based on the working groups and the European Migrants Meeting. In particular, the following needs were expressed:

• More community involvement is needed, in particular regarding the involvement of youth and migrants living with HIV.
• More communication about living with HIV in migrant communities is needed.

• Efforts to empower communities and organisations through capacity and skills-building opportunities need to be strengthened.
• In the field of policy development, community-based and non-governmental organisations need to have a stronger voice.
• Health practitioners and policy-makers need to be supported with evidence and good practices for making the right choice in the development of interventions and policies.
• Monitoring of the implementation of the project output and of follow-up actions – both by the European Commission and by national partners – is crucial for the success of the project.

Important areas to be addressed are the insufficient availability and accessibility of HIV prevention, care and support facilities that are appropriate for migrant and ethnic minority communities. In particular, access to treatment and care for undocumented migrants is a problem that is not solved in the European Union. In-depth knowledge about the most vulnerable mobile populations is missing, particularly in the new European Member States. Here, more efforts need to be made to investigate the situation – also, and particularly, regarding transit migration. In the field of epidemiology, data collection is very different in the various European Member States, which gives an incomplete and/or inaccurate picture of the situation. Finally, a rights-based approach to appropriate measures to ensure the right to health for all is needed, both at the European and the national level.

One of the major challenges for the development and implementation of HIV prevention and care interventions for migrants in Europe is to create a new momentum of solidarity, in which all groups and populations have the best possible access to services. The political climate in Europe and restricted health budgets are not very favourable for achieving this aim. However, it needs to be stressed that achieving good access is not only in favour of the populations involved, but will improve public health altogether. Many actors in the field of HIV/AIDS – such as AIDS & Mobility Europe – are willing to make their contribution, but efforts are doomed to fail if they are not accompanied by appropriate (national and European) laws and regulations in the fields of health and social policies, and by sufficient financial and political support.

For more information, please check the A&M website at www.aidsmobility.org or contact the A&M staff at aidsmobility@nigz.nl.

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BORDERNET: Integration of HIV/AIDS and STD services at the external borders of the EU

Within the BORDERNET pilot scheme, cross-border networks active in the areas of HIV/AIDS prevention, investigation and treatment are being set up or strengthened in four regions at the EU’s external borders. The authors report on the aims and initial successes of BORDERNET.

The transnational project BORDERNET aims to promote and develop cross-border services for the prevention, investigation and treatment of HIV/AIDS and other sexually transmitted diseases (STDs) in specified pilot regions. This project, which has been promoted by the EU (Department of Health and Consumer Protection) for three years, has developed against the background of the enlargement of the EU to the east, the alarming spread of HIV, especially in eastern Europe, and the particular conditions in border regions, all of which are described briefly below.

Background

There are great differences between the old and new member states of the European Union in terms of culture, economy and health policies. For example, the difference in prosperity between Germany and Poland is one of the greatest in the world between two neighbouring countries. The health care structures are also very different. This also applies to the field of STDs, including AIDS. While anonymous AIDS tests are offered by the public health services free of charge in all current and future EU countries, in numerous countries investigations for many STDs incur a cost and cannot be carried out anonymously. While, thanks to the efforts of the WHO, UNAIDS and the EU, comparable statistics on HIV and AIDS are kept at least at a national level, in most countries there are no reliable data on many other STDs. Both the risk of infection and the health consequences of STDs are systematically underestimated by the general population in many European countries.

Additionally, border areas of countries are particularly affected due to their proximity to the border. Unusually attractive markets and services lure many people over the borders. Migrant workers sometimes move daily from one side of the border to the other. Particularly along the Polish/German border and the Czech/German border there are now well established prostitution areas which put excessive strain on the regional health facilities on both sides of the border. Border regions are therefore rightly designated as special regions.
Development of the pilot scheme

The accession of central European countries to the European Union in April 2004 opened up new possibilities for cross-border cooperation at a regional, national and European level. Against this background, in the autumn of 2003 a working group of German and Polish experts headed by the German Federal State of Brandenburg commissioned SPI Forschung gGmbH to develop a pilot scheme to improve the prevention of HIV/AIDS and STDs in these regions while being responsive to the particular characteristics of the regions around the old and new external borders of the EU. The BORDERNET pilot scheme is being jointly sponsored for a period of three years (2005 to 2008), by the EU (Department of Health and Consumer Protection), the German Federal Ministry of Health, the Federal States of Brandenburg and Mecklenburg-Western Pomerania, the Wojewodschafta Zachodniepomorskie, the University of Zielona Gora (Lubuskie) and other institutions in Austria, Slovakia, Italy and Slovenia.

Aims and purpose of the pilot scheme

Four pilot regions3 connect comparable levels with each other on either side of the border, for example federal states (Germany) with Wojewodschafts (Poland). The working stages of the projects are then transferred in a step-by-step process to other, so-called ‘tandem regions’ at the newly established external borders of the EU.

The function of BORDERNET is to set up and strengthen cross-border, regionally defined networks in the fields of HIV/AIDS and STD prevention, investigation and treatment. In this way the services offered should improve and should be comparable in terms of their standards and structures. The pilot scheme is limited to regions, but is otherwise broadly based, that is it contains scheme-wide data collection, coordination and exchange, as well as the development of common (prevention) services and standards, as well as intervention in certain, precisely defined areas. A uniform documentation structure will be produced using jointly developed documentation instruments.

In order to give consideration to the special characteristics of the individual pilot regions, in addition to measures that are to be carried out jointly in all the regions, the possibility of carrying out specific projects on a purely regional basis was also provided.

Projects in the context of BORDERNET:

- Formation and maintenance of cross-border regional networks for adapting and improving the prevention, investigation and treatment of HIV/AIDS and STDs
- Development of comparable data collection for certain significant STDs (e.g. syphilis, gonorrhoea, chlamydia and HIV/AIDS) on the basis of sentinel data collection already carried out in Germany by the Robert-Koch Institute (RKI)5
- Surveying selected target groups who are considered particularly vulnerable6 (e.g. mobile populations who cross the border, drug users, prostitutes and their clients) in relation to their knowledge (HIV/AIDS and STDs), preventative behaviour and access to health services
- Further development of preventative services in general and for special target groups
- Improvement and standardisation of investigations (HIV and STDs)
- Improvement and standardisation of advice on HIV/AIDS and STDs in accordance with the VCT (Voluntary Counselling and Testing)7 methods

The functions in the pilot regions are based on the particular needs identified and established by the binational regional steering committee set up at each location. As many as possible of the important players locally should be included in this process (see example ‘Youth film days’).

Project situation

Half the time allocated to the BORDERNET project has already passed. Many basic structures have been created, but so many individual measures have to be set up that we cannot even begin to talk about the end of the ‘establishing phase’. In fact, some of the projects only started this year, and it is part of the BORDERNET concept that new part-projects are always brought into being before completion. This ‘Research in action’ process contains the short-term feedback of results into practice, with the intention of making a contribution to the gradual improvement of measures and services. At the end of February 2006 an initial interim report was presented. This can also be viewed and downloaded from the BORDERNET website (www.bordernet-spi.de).

Cross-border networking

More than 130 institutions in the four pilot regions have so far taken part in BORDERNET activities, including NGOs and governmental organisations, projects, health authorities and health centres, registered doctors, hospitals and people responsible for health policy and administrations. It is expected that further institutions and projects will take part (see example ‘Extended Networks’).

Extending the regional services

In two regions, additional HIV/AIDS and STD testing facilities were set up as there was an urgent requirement there. This applies to Frankfurt/Oder where an examination facility for STDs (including HIV) was created in cooperation with the local health authority and a registered doctor. In Zielona Gora and Stettin the clinic and the availability of free and anonymous HIV tests were extended. BORDERNET also allows for the provision of STD services to uninsured persons. This applies particularly to migrants involved in prostitution.

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2 Roughly equivalent to a province or federal state
3 Two pilot regions in Germany/Poland, one pilot region in Austria/ Slovakian Republic and one in Italy/Slovenia.
4 measuring point sampling
5 The Robert-Koch Institute in Berlin is, amongst other things, the national epidemiology centre
6 meaning: at risk, in danger (Ed.)
7 further information, for example on the ‘Family Health International’ website <www.fhi.org>
Extended Networks

Even before the BORDERNET project, in pilot region 1, particularly in Mecklenburg-Western Pomerania, there had been structures for collaboration with health-promoting institutions as a result of the MAT state-wide prevention activity since 1991. These institutions include Rostock University Hospitals, the four AIDS self-help groups, the ‘Abendrot’ (sunset) project, the health authorities and the state health and social services authority. This functioning network was extended further by BORDERNET. In carrying out sentinel data collection MAT, for example, made new contacts with registered doctors such as gynaecologists and dermatologists, as well as hospital personnel.

With targeted research and written surveys, new partners were obtained and existing contacts were used/extended in the preventative field in Mecklenburg-Western Pomerania. Thus, in the first year of BORDERNET, a firm basis was created for future projects, including some in the cross-border area.

Partners from state institutions and NGOs were also obtained for the network in the neighbouring region of Zachodniopomorskie, for example the hospital for infection diseases at Stettin, the association for the prevention of HIV/AIDS and other sexually transmitted diseases ‘TADA’, the voluntary association for the support of people living with HIV and AIDS ‘DADU’, the information and diagnostics centre for AIDS in Stettin and Koszalin, the sanitation and epidemiology ward at Stettin and Swinemünde and the advisory centre for addiction prophylaxis and treatment ‘Monar’.

As this project is concerned with cross-border models for prevention, investigation and treatment, both partner regions have familiarised themselves with the various structures. Setting up the working relationship between each other was often problematical, particularly as communication proved to be difficult because of the lack of a common language. Moreover, cross-border cooperation has to be learnt, which means that a basis of trust must first be established, followed by the development of mutual understanding. After a year and a half of running the project this hurdle has now largely been overcome; relationships are being strengthened and joint projects can be carried out.

Youth film days

The mobile education team on sexuality and AIDS (MAT), which is charged with regional coordination, suggested to the BZgA that youth film days (JFT), that had been successful in Mecklenburg-Western Pomerania in 2005 should be staged again in the border region with their Polish partners. The BZgA supported this suggestion and reacted very quickly. It arranged for Sinus-Büro für Kommunikation to carry out a cross-border workshop in May of this year. It was closely integrated with the BORDERNET project and directly encouraged German-Polish cooperation partners from municipal and private supporters to get involved. The workshop presented local services around the JFT, adapted to the special requirements in the border regions, and the regional development of the concept was supported with specialist expertise.

The aim is to stage the film days under the coordination of MAT in four towns near the border – Stettin, Wölgast, Greifswald and Swinemünde – between November 2006 and June 2007. The often very different structures and networks in the individual regions should be used and tested for this. The Polish-German collaboration has a central role to play here. Experiences within this project should in turn be used as a model for other cross-border activities.
Conference and workshop

In pilot region 1 a conference was held in Swinemünde under the auspices of BORDERNET in May 2006. Polish and German partners jointly devised the programme. The key areas of the two-day conference included medical and epidemiological aspects of HIV/AIDS and STDs, advice and support for people infected with HIV and activities of NGOs and their prevention work. In the preventative area it became clear that the messages regarding protection from HIV/AIDS and STDs in Poland are not imparted in conjunction with sex education as there are definite cultural and religious barriers here. For example, sexuality is discussed very little or not at all in schools and in public, although condoms are mentioned as protective in the context of STDs. So the methodological approaches in the two countries also differ in terms of communicating information on health promoting behaviour.

This first conference under the auspices of BORDERNET was an important meeting to facilitate the exchange between experts from the fields of HIV/AIDS and STDs. During the conference there were many opportunities for discussion and strengthening contacts. This meant that cooperation was improved and future innovative projects could be considered. Another joint conference is planned for spring 2007, this time in Mecklenburg-Western Pomerania, with the main emphasis being investigation and treatment of STDs.

In the educational and social area a cross-border workshop for multipliers from various institutions such as schools, health authorities, hospitals and NGOs will take place for the first time. This workshop on the subject of sex education for young people will provide an opportunity to discuss various preventative and sex educational approaches, to benefit from each other’s experience and to set up a joint, flexible pool of methods for the prevention of STDs.

Data collection

More than 70 partners (registered doctors, health centres, health authorities) have so far taken part in the sentinel study, and others are likely to be added. The aim of this study is to set up cross-border networks for STD and HIV investigations. Information about the distribution of STDs in particular is to be acquired and the risks ascertained, as there are large gaps in knowledge in all the regions concerned. But it is the epidemiological distribution of STDs which can provide important pointers to risk behaviour and is seen as a marker for estimating the proliferation of HIV. The Robert-Koch Institute has been carrying out such a sentinel study in Germany for four years.

To explore the risk behaviours in the pilot regions so-called KAB study concepts have been developed. KAB stands for ‘Knowledge, Attitudes and Behaviour’. Taking already completed studies into account, the target groups were selected in line with current regional requirements, with cross-border mobility playing a significant role in all of the surveys. It was assumed that young adults (aged 18 to 25) are at the greatest risk in all pilot groups, so this target group is being surveyed in all the regions. MSM (men who have sex with men) are being surveyed in two regions in which up to now there has been little or no knowledge about high-risk behaviour and mobility. Migrants involved in prostitution and people with HIV are also included in the target groups for the survey.

Final remarks

On the basis of our many years’ experience we were aware that setting up cross-border cooperation at a tangible practical level could be a very worthwhile, but also very onerous task. Barriers in terms of attitudes and organisational structures often presented greater obstacles than the language barriers. But the many initiatives which are already active in the border region are a productive basis enabling BORDERNET to build on the structures and to promote and strengthen the cooperation processes already started.

Elfriede Steffan, Tzvetina Arsova-Netzelmann, Kathrin Bever, Irmgard Boeckmann,
Elfriede Steffan is a fully qualified sociologist. The results of her work in the fields of health and women’s research have been published in numerous reports, books and specialist journals. She is the deputy executive director of SPI Forschung gGmbH and a member of the National AIDS Advisory Council for the Federal Republic of Germany.

Tzvetina Arsova-Netzelmann is a fully qualified sociologist and has worked for ten years in Bulgaria as researcher, project coordinator and evaluator in the field of health promotion, AIDS prevention and sex education for specially disadvantaged groups (Romanies, prostitutes). At SPI Forschung gGmbH she has been involved in various research and intervention projects concentrating on ‘cross-border cooperation’ since 2002.

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www.mat-rostock.de
The BZgA join-in circuit in operation – worldwide!

The BZgA ‘Mitmach-Parcours’ (join-in circuit) for preventing AIDS in adolescents is now used in many countries around the world. This contribution describes the concept of the interactive circuit and outlines the experience of various users abroad.

The project

AIDS prevention and sex education in Germany are amongst the original aims of the Federal Centre for Health Education (Bundeszentrale für gesundheitliche Aufklärung, BZgA) in Cologne. In addition to other focal points of health care, the BZgA has methodically developed many varied target-group-specific and interactive information services in the nationwide AIDS prevention campaign. One of these services is the ‘Join-in circuit about AIDS, love and sexuality’. The BZgA has been using it successfully throughout Germany for more than ten years.

HIV infections and the AIDS disease are increasingly putting a brake on development in many countries and are therefore hindering the work of the Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation) (GTZ) in Eschborn. Therefore, in 2001, GTZ approached the BZgA with regard to cooperation in AIDS prevention. What was needed were tested and quality assured media and instruments which GTZ could adapt for the worldwide battle against AIDS. The discussion quickly came to concentrate on the BZgA join-in circuit. It became the central project of the collaboration on which the two powerful organisations joined forces. The BZgA and GTZ jointly examined whether the BZgA join-in circuit could be adapted for other countries and used just as successfully as in Germany.

The contents and stations of the BZgA join-in circuit about AIDS, love and sexuality

The join-in circuit alternates between seriousness and fun, communication and action. Using role play, puzzles, pantomime, discussions and questions, the participants are motivated to play their part wholeheartedly. Groups of about ten people at a time pass through five stations, at each of which they are motivated by moderators to action and discussion. At each station the youngsters can collect points for committed participation. At the end a ‘winning group’ is announced, but all the groups are recognised and receive small mementos of the occasion.

‘Means of HIV transmission’ station

Using comic drawings from human day-to-day life and love life the participants learn about the situations in which HIV can and cannot be transmitted. Using a dice which has red, yellow and green sides, they give their assessments for the particular situations (high risk of infection = red, low risk = yellow, no risk = green). The participants then gather information about infection routes with their moderator and can adjust their assessment to the new information. Uncertainties about the risk of transmission of AIDS are revealed at this station and can be cleared up in discussions with one another and with the moderators.

‘Love, sexuality and protection against HIV’ station

At a ‘Wheel of Fortune’ the participants deal with means of protection appropriate to the situation and get involved in discussing subjects which are often still taboo. When should they broach the subject of contraception and protection? How do they explain to a partner that this protection is important to them? What precautions should they take if they live or work with someone with HIV infection?

‘Contraception’ station

Adolescents take turns in drawing various contraceptives out of a container and then explaining to the group what they know, for example, about a diaphragm, the pill or a condom. This leads to a discussion about methods of contraception, how they are used and what they protect against. Then certain statements must be attached to the contraceptive, for example: ‘non-prescription barrier for self-application’, ‘must be taken regularly’, ‘protects against HIV, unwanted pregnancy and sexually transmitted diseases’. Thus the advantages and disadvantages of the individual methods of contraception can be weighed up and made visible.

‘Body language’ station

The participants use pantomime to demonstrate various terms such as ‘pounding heart’, ‘love in the car’, ‘use of a condom’, ‘homosexuality’, etc. which then must be guessed by the group. Most adolescents particularly like this station and it enables a playful and easy approach to taboo subjects. In addition the girls and boys practice expressing themselves
with their bodies and gain a better understanding or non-verbal communication.

‘Living with HIV’ station
Here the participants imagine the day-to-day life of a fictitious person who is confronted directly or indirectly with HIV/AIDS, for example he or she may just have had a positive result from his/her HIV test. What is he/she going through? What does he/she do now? The participants become aware of how HIV infection encroaches upon the life of the person affected, but also their milieu. Who does the person tell about the infection? How do relatives, friends and colleagues react? How would the participants themselves react if they had contact with or were a friend of the person concerned? This station stimulates a very personal debate about the various aspects of HIV infection. One’s own attitudes, preconceptions or uncertainties become clear and can be broken down by the group discussion. The intellectual process sensitises participants to the possible problems of people infected with HIV and can make it easier for participants to show solidarity with them.

Local cooperation partners
The BZgA join-in circuit is always carried out in cooperation with the local public health or youth training institutions. In doing so the BZgA aims to promote sustainable strengthening of local prevention structures, to provide specialised staff with motivation for practicing their own work through ‘learning by doing’ and not least to motivate them to develop comparable prevention services locally.

The BZgA join-in circuit goes out into the world
Amongst other things, quality assurance considerations for the BZgA join-in circuit indicate that the concept of the German circuit fundamentally appears to be well suited to other countries. The main factors having an effect are the participant-centred moderation methodology, which is always responsive to the particular group, and the fact that the contents and presentations in the BZgA join-in circuit reflect the actual world in which the target groups live. But this also means that, for other living conditions and in other cultures, the join-in circuit cannot simply be taken over in the German version. It has to be adapted to the conditions typical of each country so that the quality criteria are also fulfilled under the new conditions. There must therefore be an adapted national join-in circuit for each country. In order to develop and try out adaptations for particular countries, in 2003 the BZgA and GTZ created the pilot scheme ‘Transfer of the BZgA join-in circuit for development collaboration’. It was intended to answer the following questions:

1. How can the BZgA join-in circuit concept be used successfully in other countries?
2. What recommendations for adaptations to specific countries can be made on the basis of the German experience of the project?
3. What quality standards are essential in adapting the concept to ensure that the relevant ‘country circuits’ can be used for the medium to long term and that they are sustainable?

GTZ projects from the following countries took part in the pilot transfer:
1. Ethiopia
2. El Salvador
3. Mongolia
4. Mozambique
5. The Russian Federation

The transfer projects should be established in the individual countries within the existing GTZ projects or programmes.

The adaptation seminars
GTZ commissioned the BZgA to carry out three seminars during the period from January 2003 to May 2004 in order to facilitate the transfer process. The first two seminars were attended by eleven representatives from the countries and six GTZ employees from headquarters. In the third and last seminar there were six representatives from the pilot scheme countries and GTZ headquarters sent four representatives. In the first seminar the BZgA join-in circuit was first presented in detail: the concept, strategy, aims, stations, organisation and quality criteria for staff communication and moderation. On this basis, the participants in the seminar planned how the adaptation should proceed for each country and what should be taken into account. This included particular features for specific countries, for example taboos regarding sexuality and AIDS, attitudes regarding the relationship of men and women or restrictions by church or religion, etc. Consideration was also given to national and regional cooperation partners and what is required for quality assurance. The themes were:
• Initial situation in country
• Aims of AIDS prevention with a national join-in circuit
• Motivation of decision makers.

In the second and third seminars the participants then reported on the progress of the adaptation process in their countries and what experiences they were having there. The next stages were planned on this basis. The many and very varied experiences in the countries offered great learning potential to all the participants. The experiences very quickly showed that standardised adaptations offered little prospect of success and that the transfer of the BZgA join-in circuit must be adjusted very individually to the conditions in the countries concerned.

The most important results
Since 2004 there have been independent ‘country join-in circuits’ based on the BZgA concept in each of the five countries mentioned above — and also in nine further countries, that is in Ukraine, Latvia, Lithuania, Uzbekistan, Kyrgyzstan, Kazakhstan, Zambia, Ecuador and Zimbabwe. The adaptation processes varied a great deal in the different countries. Insofar as they are available to the BZgA, the results are pleasing and present very promising prospects:
• Young people from the most varied cultures took part in the country circuits with a great sense of fun and enthusiasm. The methodology of the join-in circuit always led to the youngsters contributing enthusiastically and speaking relatively openly about their attitudes, wishes and emotions,
including in the context of sexuality, although in all countries there is a taboo about communication regarding sexuality to a greater or lesser extent.

- Participation in the circuit was successful: The participants’ knowledge increased. The intention to protect oneself also increased and attitudes to people with HIV and AIDS improved considerably.
- For most of the moderators the participant-centred and dialogue-oriented moderation was unfamiliar and initially difficult to learn, which led to uncertainties. However, after a little practice, the moderators appreciated this method of communication because they achieved very good results with it. Many of them considered the new moderation techniques as an enrichment of their other activities.

**Service package ‘The join-in circuit in operation – worldwide!’**

To enable as many countries as possible to use the BZgA join-in circuit concept and benefit from the experience, the BZgA and GTZ have documented this pilot scheme in detail and adapted it based on practice. The jointly developed service package consists of a handbook which combines the contents of the join-in circuit, the quality standards and the experiences of the adaptation process based on practice. The handbook also provides a practical introduction for anyone planning a country-specific or regional adaptation. An associated film illustrates the German BZgA join-in circuit and its ‘country variants’ in Ethiopia, El Salvador, Mongolia, Mozambique and the Russian Federation. A brochure gives information about the most important key data in the pilot scheme. With this service the BZgA and GTZ aim to motivate other countries to develop and use ‘their’ join-in circuit. The handbook, which is available in German and English, can be ordered, together with the film DVD and the short brochure, from the contact addresses given below.

Regina Krause, Beate Lausberg

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1 Other join-in circuits are planned in Congo and Bangladesh.
Infotheque

BROCHURES

Media overview

The brochure ‘Medien und Materialien’ (Media and materials), produced by the ‘Sex Education and Family Planning’ department of the BZgA, is now available in its 21st edition (issue 07/2006). As usual it contains all the publications which can be supplied, together with the most important information in terms of content, illustrations, details of dimensions and scope. As before, in addition to the print media, audiovisual media and all of the BZgA’s Internet contributions to the subject area are listed.

Address for orders:
BZgA
51101 Köln
order@bzga.de
Fax (0221) 89 92 257
Order no. 13 010 000

Über Sexualität reden. Zwischen Einschulung und Pubertät
(Talking about sexuality. Between starting school and puberty)

A new BZgA guidebook on the sexual development of primary school-aged children (56 DIN A5 pages) encourages and supports parents in actively seeking to talk to their children about sexuality and their impending puberty.

It is at the primary school stage that children are still very open to their parents, while it is well known that later other information sources and contacts become more important. During this phase parents can make a special contribution to their children’s sex education.

The brochure initially provides basic information on sexuality, sex education and communicating about sexuality. Then the sexual development of boys and girls of primary school age is presented. The brochure shows the contribution which parents can make to children developing a positive attitude to their bodies and their sexuality. This includes explanations in language which children can understand, appropriately ways of dealing with the child’s shame, support with personal hygiene and much more.

Another chapter deals with preventing sexual violence under the title ‘Vorbeugen ohne Panikmache’ (Prevention without scare stories)

Address for orders:
BZgA
51101 Köln
order@bzga.de
Fax (0221) 89 92 257
Order no. 13 660 300

Über Sexualität reden. Die Zeit der Pubertät
(Talking about sexuality. At puberty)

The new guidebook (80 DIN A5 pages) in the same format is aimed at parents who are already confronted with their child’s puberty. The first two chapters on sexuality, sex education and communicating about sexuality are identical to those in the aforementioned brochure. Other subjects covered are the phases of puberty, education about the body for girls and boys, including necessary health care, the start of sexual life, sexual orientation, contraception, protection against sexually transmitted diseases and protection against sexual violence.

Address for orders:
BZgA
51101 Köln
order@bzga.de
Fax (0221) 89 92 257
Order no. 13 660 400

Rund um Schwangerschaft und Geburt
(All about pregnancy and giving birth)

With expert support from the Deutsche Gesellschaft für Psychosomatische Frauenheilkunde und Geburthilfe (DGPFG e.V.) (German Society for Psychosomatic Obstetrics and Gynaecology) BZgA has produced a comprehensive brochure (96 DIN A4 pages) on the subject ‘Schwangerschaft und Geburt’ (Pregnancy and birth) for the target group of parents.

In the first, particularly detailed chapter the individual months of pregnancy are described: In each case, at first, as if from the baby’s perspective (‘baby telegram’), then pregnant women tell how they experience this time. Each month also offers a key point relating to physical and mental changes.

Chapter 2 deals with antenatal care and questions of prenatal diagnostics. Chapters 3 and 4 cover pregnancy and life planning, the couple relationship and sexuality.

Amongst other things, chapter 5 goes into laws which are relevant in this context, chapter 6 deals with the birth itself and finally chapter 7 provides a pregnancy health lexicon with many important key words and pointers to additional brochures, books, contact addresses and advisory centres.

Address for orders:
BZgA
51101 Köln
order@BZgA.de
Fax (0221) 89 92 257
Order no. 13 500 000

Ich bin dabei! Vater werden
(I want to be part of it! Becoming a father)

This brochure for expectant fathers (19.5 x 19.5 cm, 32 pages) addresses men’s concerns in this far from ordinary phase of life: the sometimes
ambivalent feelings about becoming a father, the various phases of pregnancy and sexuality during this time, the man’s role in preparing for the birth, attending the antenatal examinations, the delivery, the first period living as a family and paternity leave. There are references at the end to numerous other materials and books on the subject of ‘Becoming a father’.

Address for orders:
BZgA
51101 Köln
order@bzga.de
Fax (0221) 89 92 257
Order no. 13 510 000

**STUDIES**

Schwangerschaftserleben und Pränataldiagnostik
(Experiencing pregnancy and prenatal diagnostics)

The BZgA has carried out a representative survey of pregnant women on the subject of ‘pränatal diagnostics’ (PND), the results of which were published in June 2006 in the series ‘Forschung und Praxis der Sexualaufklärung und Familienplanung’ (Research and practice of sex education and family planning).

During the course of her pregnancy almost every woman now comes into contact with PND services. The research report deals above all with the important question of whether the women’s standard of knowledge is consistent with the speedy establishment and spread of these services.

The experience of pregnancy, the utilisation of the various PND procedures, the level of information provided to women and their attitudes to it, as well as their assessment of the medical advice and treatment provided in PND, are the subjects which were asked about and analysed in detail.

The report, which is also easy to understand for people without specialist medical knowledge, has numerous graphs and tables; it comprises 62 pages (DIN A4) and can be ordered free of charge.

Address for orders:
BZgA
51101 Köln
order@bzga.de
Fax (0221) 89 92 257
Order no. 13 510 000

men’s lives

The English version of the basis report on the ‘männer leben’ (men’s lives) study is now available free of charge (74 DIN A4 pages). It contains the most important results of a quantitative survey of approximately 1,500 men between the ages of 25 and 54 who gave information regarding their attitudes to ‘family planning’.

Address for orders:
BZgA
51101 Köln
order@BZgA.de
Fax (0221) 89 92 257
Order no. 133 180 70

The Desire for Children and Starting a Family in Male and Female University and College Graduates

This study on the desire for children and starting a family in female and male university and college graduates (68 DIN A4 pages), a representative survey of middle aged men and women (500 of each), is now also available in English.

Address for orders:
BZgA
51101 Köln
order@BZgA.de
Fax (0221) 89 92 257
Order no. 133 191 70

**EVALUATIONS**

Sichergehn. Verhütung für sie und ihn
(Making sure. Contraception for him and her)

In the ‘Evaluations’ series the BZgA provides a series of publications in which the acceptance and effect of various media in the field of sex education, contraception and family planning are examined on the basis of quality assurance measures.

The brochure ‘Sichergehn. Verhütung für sie und ihn’ (Making sure. Contraception for him and her) deals with the established methods of contraception and their advantages and disadvantages. The main questions posed by the evaluation (10 DIN A4 pages) were: Can the brochure effectively support a decision in favour of a specific method of contraception? How do gynaecologists/disseminators assess the contents?

Address for orders:
BZgA
51101 Köln
order@bzga.de
Fax (0221) 89 92 257
Order no. 13 290 004

On Tour! L’amour?
(Love on tour?)

Another 10-page publication is the evaluation of a travel pack for adolescents which contains information on love, sexuality and contraception and is distributed to young people travelling in groups during the summer holidays. The main questions here were, for example, how well the travel pack is accepted and whether the young people find it useful and talk about it.

Address for orders:
BZgA
51101 Köln
order@bzga.de
Fax (0221) 89 92 257
Order no. 13 290 005

Wie geht’s – wie steht’s?
Wissenswertes für Jungen und Männer
(How are you, everything looking up? What boys and men should know)

The brochure deals with the biological/medical aspects of male sexuality. The evaluation (14 DIN A4 pages) examines the questions of how well it applies to the target group and what contribution it makes to understanding physical processes and changes in the sexual field.

Address for orders:
BZgA
51101 Köln
order@bzga.de
Fax (0221) 89 92 257
Order no. 13 290 002

Pränataldiagnostik – Beratung, Methoden und Hilfen
(Prenatal diagnostics – advice, methods and aids)

The leaflet on prenatal diagnostics is intended to provide pregnant women with an overview of the meaning and the methods used. The evaluation (10 DIN A4 pages) asks whether
pregnant women find the information used in deciding for or against a particular method supportive, whether gynaecologists consider the leaflet to be appropriate and whether they would have it on display in their practice.

**Address for orders:**
BZgA
51101 Köln
order@bzga.de
Fax (0221) 89 92 257
Order no. 13 290 001

**Liebe. Ein Film über Jugendliche und ihre große Liebe**
*(Love. A film about adolescents and their great love)*

This is the evaluation of a documentary film in which adolescents tell their own personal love stories: about resistance from parents, abandonment and jealousy. The investigation asked: Does the film encourage adolescents to deal with questions of love and sexuality? Are the subjects addressed considered as important?

**Address for orders:**
BZgA
51101 Köln
order@bzga.de
Fax (0221) 89 92 257
Order no. 13 290 006

**WEBSITES**

**Information channel for children’s health**

The BZgA children’s health department provides a website dealing with the healthy development of children. Information for various target groups is processed on various channels (parents and adult carers, multipliers, children and adolescents).

First a selection of subjects for parents with children up to six years of age was set up. During the course of this year additional subject areas are being integrated, so the ‘Für Eltern’ *(For parents)* channel will have a full schedule by the beginning of 2007. As well as detailed information, for each subject there are additional links, frequently asked questions, everyday tips and various other background information. On the ‘Rat + Hilfe’ *(Advice and help)* channel parents can find out who they can put questions to about the development and health of their child and for everyday advice on families and education.

**Contact:**
www.kindergesundheit-info.de

**TRAINING**

**Additional training in sex education**

The Institute for Sex Education (ISP) in Dortmund is again offering in-service further training lasting one year in 2007. It is aimed at people with full-time or unsalaried employment in education, mentoring, counselling or care work who wish to gain a qualification for dealing with sexuality on a day-to-day basis in their institutions.

The further training comprises eight three or four-day seminars and starts in Dortmund in March 2007.

**Contact:**
info@isp-dortmund.de
www.isp-dortmund.de
Telefon (0231) 14 44 22

**CONFERENCES**

**Glück, Alltag und Verwirrung – Einführung in die interkulturelle Mädchenarbeit**
*(Luck, everyday life and confusion – introduction to intercultural work with girls)*

A specialist conference on 16 November 2006 in Münster will deal with the facets of intercultural work with girls. It offers the opportunity of considering one’s own experience in intercultural work with girls, developing targets, discovering resources and gaining motivations for practical work. The conference is a cooperative event with the city of Münster *(Women’s advice centre and Volkshochschule (VHS) [adult education centre]), AG Mädchen and the Landesarbeitsgemeinschaft Mädchenarbeit in NRW e.V. *(North Rhine-Westphalia state study group on working with girls)*.

**Information:**
Frauenbüro der Stadt Münster
Andrea Reckfort
Telefon (0251) 4921703
reckfort@stadt-muenster.de
Registration: VHS Münster
Telefon (0251) 492-4321
infotreff@stadt-muenster.de
Reports

3  The Federal Centre for Health Education (BZgA) as WHO Collaborating Centre
   Monika Hünert

5  Improving Adolescents’ Sexual and Reproductive Health in Europe – The Role of the World Health Organization
   Gunta Lazdane

9  Sex and Young People in Europe: What’s SAFE?
   Jeffrey Victor Lazarus, Jerker Liljestrand

16 Sexual and Reproductive Health Rights of Asylum Seeking and Refugee Women Still Neglected in the European Union
   Marleen Bosmans, Kristin Janssens, Marleen Temmerman

20 Specific Needs of Migrants and Ethnic Minorities in Europe in the Field of HIV Prevention, Care and Support
   Georg Bröring

24 BORDERNET: Integration of HIV/AIDS and STD services at the external borders of the EU
   Elfriede Steffan, Tzvetina Arsova-Netzelmann, Kathrin Bever, Irmgard Boeckmann

29 The BZgA join-in circuit in operation – worldwide!
   Regina Krause, Beate Lausberg

Infotheque

32 Brochures, studies, evaluations, internet, conferences, training