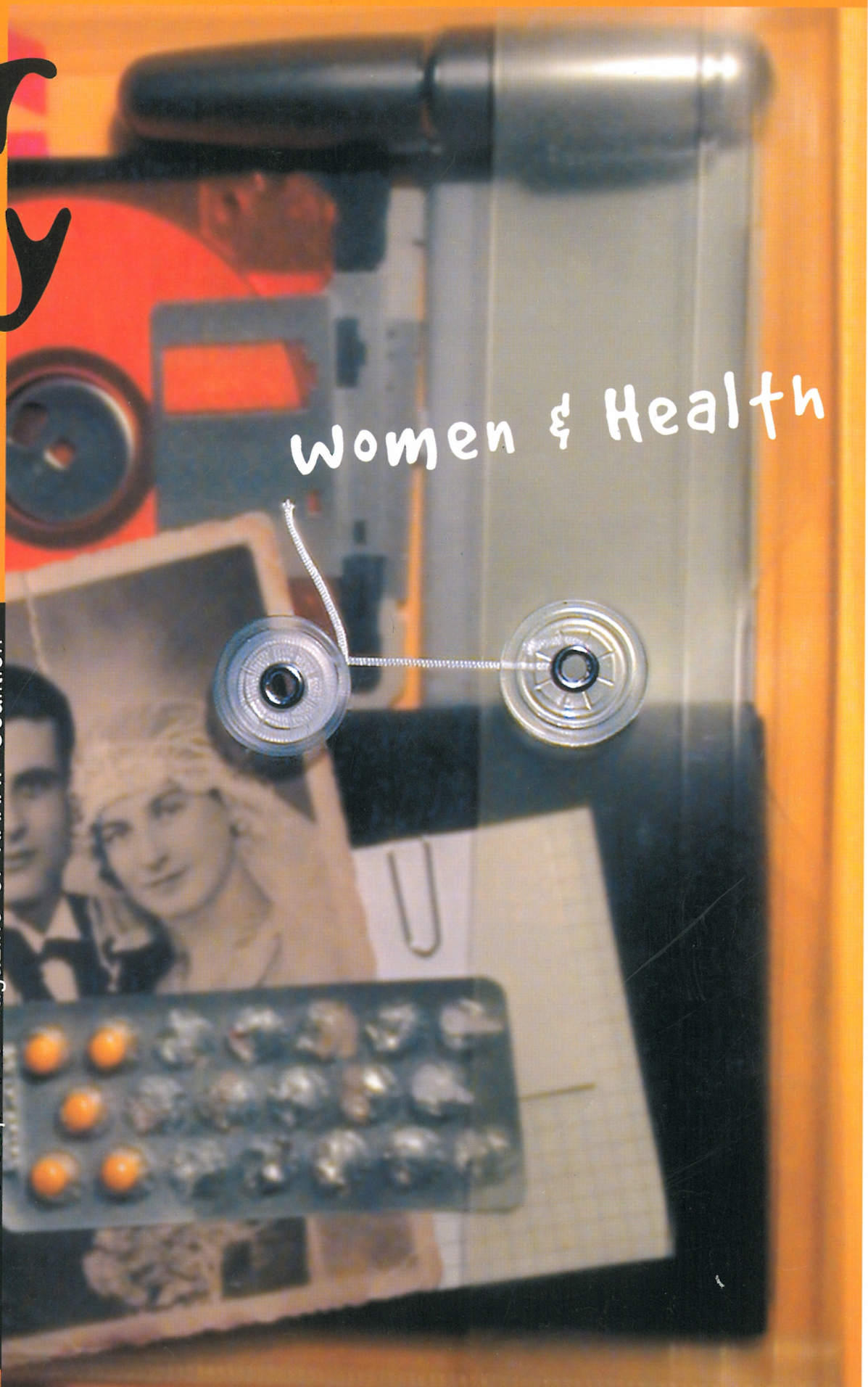
fair play

4/2001



Women & Health

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Gender & Development Magazine of KARAT Coalition

EMPOWERING WOMEN IN CHANGING SOCIETIES

Editorial

After the political systems in Eastern Europe reformed themselves in the eighties of the last century – under pressure from the street in Poland, out of the Nomenklatura elites' own power considerations in Russia and Bulgaria –, one of the first areas in which international institutions like the International Monetary Fund IMF and the World Bank demanded privatization and replacement of the old systems was the health sector. Similar pressures come to bear on public health systems in such Western European countries as Germany or the United Kingdom under the neoliberal *pensée unique* (a term that has entered the French everyday language over the past ten years and may be best translated as *"alternativeless" ideology*). The result however is much harder to bear for people living under the ruined economies of Eastern European countries.

In Bulgaria, like in other countries, economic problems accentuated by the international pressure on health-sector budgets have given a head start to private medical care by creating shortages of consumables and medication in public hospitals, and by keeping the wages of physicians in the public service intolerably low. The result is a dual health system in which people can choose between affordable but at times completely inadequate or even life-endangering care in the public sector and the enhanced services of private physicians and clinics that for many remain financially out of reach. Especially single mothers and elderly people on just a minimum pension (42 German marks a month in Bulgaria) will think twice before seeking the help of a doctor. As adequate health care becomes an expensive luxury, the economic discrimination of women finds its continuation in their reduced access to health services.

At the same time, the conservative backlash observed especially in Catholic countries like Poland or Croatia reduces access to abortion while closing the way to modern contraceptives and information about them. The case of Poland is discussed in detail by **Wanda Nowicka** in our **Hot Spot** article, *The Status of Abortion in Poland* (p. 4).

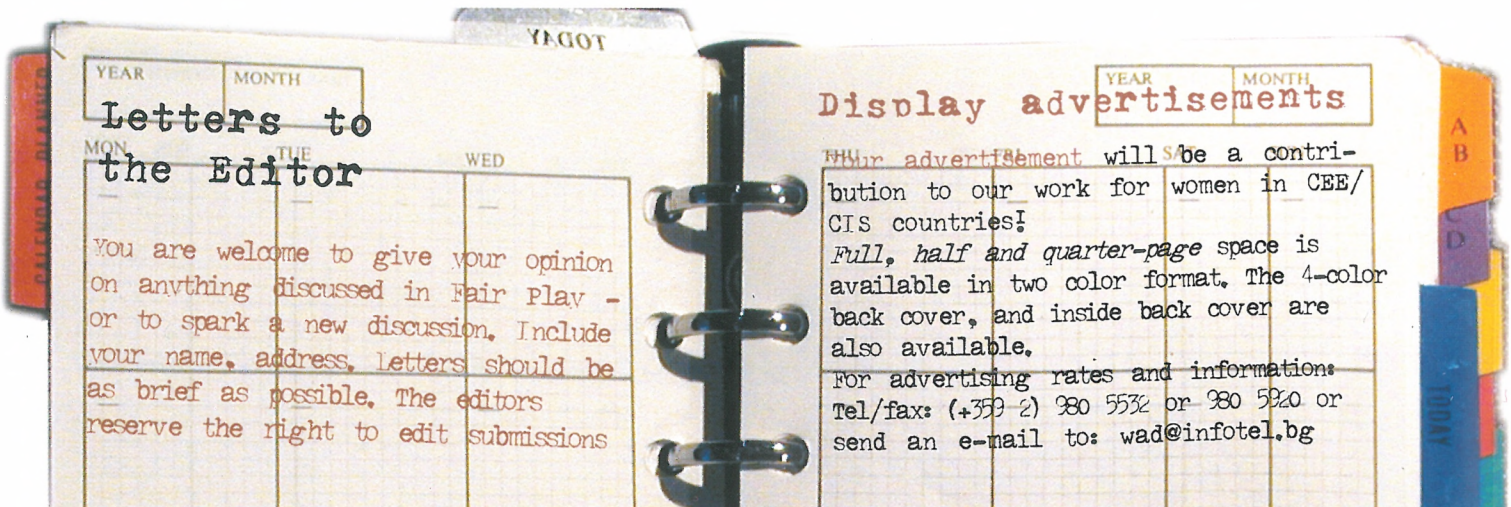
An old debate within the feminist movements, the patriarchal hierarchies between physicians and midwives that date back to the scientific revolution of the 16th and 17th centuries when midwives were persecuted as "witches" to install the new order of modern medicine, is taken up by Petra Hejnova in her double interview with **Ivana Königsmarkova**, Chairwoman of the Czech Association of Midwives, and Zdenek Hajek, Associate Professor of Obstetrics and Gynecology (p. 7).

Another evergreen of feminist critique are demographic policies and the control exercised over women through such policies. In her interview with **Inga Grebesheva** of the Russian Family Planning Association, **Nadezhda Azhgikhina** takes a critical look at the new "Conception for Demographic Policy" of the Russian government. (p. 10)

On the background of her work with women affected by violence, in *Stress and Mental Health* **Rossanka Venelinova** chooses a more theoretical approach to criticize mechanistic views on medicine and outline, using stress theory as a starting point, ways to discuss medical and psychological questions in relation to each other. (p. 14)

In their article *How We Speak about Bio-technologies*, **Stephan Geene** and **Renate Lorenz** provide a careful and in-depth analysis of the *discourses of health, illness and pretended cures* with which the bio-tech industry, with the support of media and parts of the art world, attempt to legitimize an entire field of new and profitable bio-technologies while concealing just how poor the chances are that genetic methods will deliver what they promise. They speak of the double-bind situation in which the mere availability of pre-natal diagnostics puts future parents and especially mothers. The example of compulsory pre-natal diagnostics in the Ukraine in the context of Chernobyl illustrates how the promises of the bio-tech industry are overlaid with perspectives of state control and demographic policies based on economic considerations rather than on ensuring the well-being of women or their families. (p. 24)

Alain Kessi
Editor-in-chief



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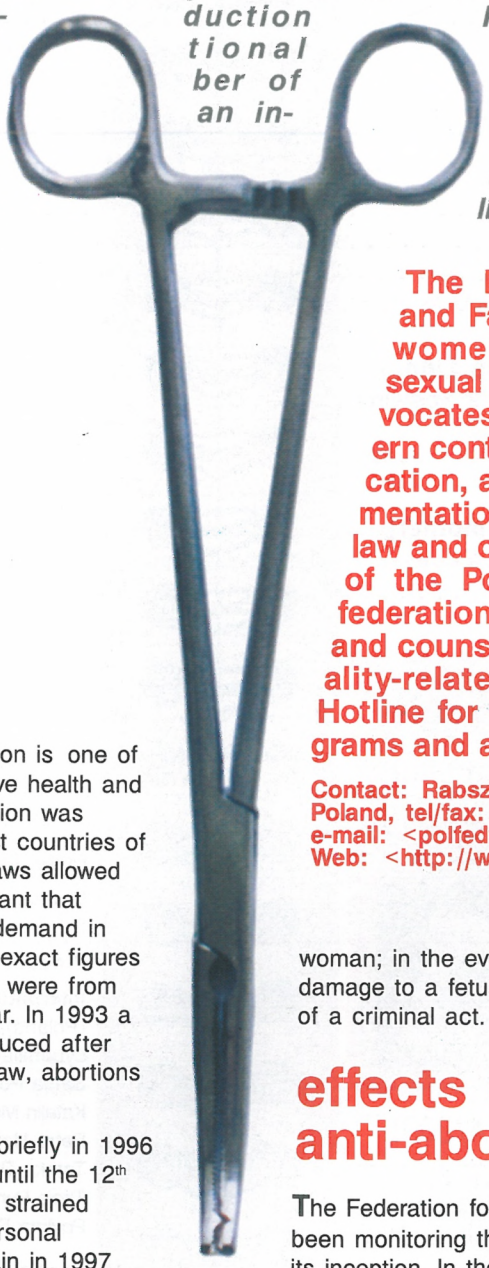
Wanda Nowicka is a classicist by training, but has specialized in reproductive health and rights for several years. Since 1990 she has been active in the nascent NGO movement in Poland and is a co-founder and member of several NGOs, including the Association for Ideologically-Free State Neutrum; the Federation for Women and Family Planning; the Polish Committee of NGOs for Beijing 95; and the National Information Center on Women's Organizations and Initiatives. Internationally, she is a co-founder of the Karat Coalition and of ASTRA – CEE Women's Network for Reproductive Health and Rights.

She has run the federation since its creation, first as president and now as executive director. The federation conducts advocacy, lobbying and monitoring activities for reproductive health and rights.

In 1994 Nowicka was the Polish laureate of the "Women of Europe Award". Since 1996 she has been a member of the Gender Advisory Panel of the WHO's Development and Research Training in Human Reproduction Program, and she is a member of the UNFPA's international group of women NGO Advisory Committee. Wanda Nowicka is also a member of an international HERA (Health, Empowerment, Rights, Accountability) – ICPD and FWCW. active in follow-up activities on an elected member of the local government called Little Parliament of the Mazovia Region. Since 1998 she has acted as



The Federation for Women and Family Planning acts for women's reproductive and sexual health and rights. It advocates legal abortion, modern contraception and sex education, and monitors the implementation of the anti-abortion law and other restrictive policies of the Polish government. The federation provides information and counseling services on sexuality-related issues through its Hotline for Women, open day programs and a series of publications.

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THE STATUS OF ABORTION IN POLAND

by

WANDA NOWICKA

Access to safe and legal abortion is one of the most important reproductive health and rights issues in Poland. Abortion was legalized in Poland in 1956 as in most countries of Central and Eastern Europe. These laws allowed abortion on social grounds, which meant that abortion was available practically on demand in Poland for almost 40 years. Although exact figures do not exist, it is estimated that there were from 180,000 to 300,000 abortions per year. In 1993 a restrictive anti-abortion law was introduced after four years of hot debate. Under this law, abortions on social grounds were outlawed.

The anti-abortion law was liberalized briefly in 1996 (enforced in 1997) to allow abortion until the 12th week of pregnancy if "a woman is in strained conditions of living or in a difficult personal situation". The law was restricted again in 1997 (enforced in 1998) by the Parliament in response to a Constitutional Tribunal ruling that abortion on social grounds was unconstitutional.

According to this law, which is currently in force, abortion is legal only under the following conditions: if the pregnancy constitutes a threat to the life or health of a woman; in the event of severe and irreversible damage to a fetus, or if the pregnancy is the result of a criminal act.

effects of the anti-abortion law

The Federation for Women and Family Planning has been monitoring the implementation of the law since its inception. In the 2000 report on the effects of the anti-abortion law the main findings are:

1. *The anti-abortion law did not eliminate and probably did not diminish the phenomenon of abortion. Illegal abortions are still common. The scale can be estimated at 80 000 to 200 000 abortions per year.*

2. *Illegal abortions are conducted by doctors and are very expensive. This phenomenon is known as the* **abortion underground.**

3. *Some women choose to travel abroad to have an abortion. This phenomenon is known as* **abortion tourism.**

4. *Women experience serious barriers to legal abortion. Public hospitals hardly perform abortions at all.*

5. *Knowledge about conditions for lawful termination of pregnancy is highly unsatisfactory, both in society in general, and among medical staff.*

6. *Years of experience of the federation show that the anti-abortion law has resulted in a number of personal dramas and every year causes health and other problems to hundreds of thousands of women in Poland.*

abortion underground

The abortion underground in Poland is very well developed. Accessing a private clinic that will do an illegal termination is much easier in big cities and towns – it just requires finding the relevant press announcement. In the local press it is harder to find such announcements. In small towns and villages, doctors are not anonymous and are afraid of stigmatization in their immediate environment. Although even in small settlements it should be possible to find a physician willing to conduct abortions, women prefer to travel outside their area of residence to make sure that news of the abortion does not reach the local community. Very often, this fear is justified.

The year 2000 brought a disturbing increase police activity in investigating cases of illegal abortion. In January 2000 police entered a private clinic in Lubliniec, after an anonymous phone call saying an illegal abortion was about to be performed there. Women's groups believe this woman's rights to privacy and integrity were violated, especially when she was obliged to go through gynecological examination.

A similar case occurred in Katowice in March 2000. Police entered a clinic by force as a woman was about to have abortion. The raid followed months of observation. As a result, the clinic was closed. The investigation is continuing.

Another case linked to this issue concerns an abandoned newborn baby in Kielce. The prosecution accuse the police of violating the law in the case of a woman who was detained as a suspect and submitted to gynecological examinations. Only after many hours did it become clear that the woman was pregnant and could not possibly be the mother of the abandoned child. What is most staggering in this case is that any woman can become a suspect on the basis of an anonymous tip-off.

abortion tourism

Information gathered by the federation suggests that the phenomenon of traveling to have an abortion is slowly becoming marginalized. Between 1995 and 1997 there were two trials involvling agencies accused of organizing abortion tourism over the eastern and southern border of Poland. The trials effectively scared potential organizers off. For women this meant less choice and also an increase in prices, because terminations are usually more expensive in Poland than they are abroad.

the role of the medical community

The medical community deserves special attention, due to its important role in the implementation of anti-abortion law and prevailing strong attitudes against abortion. Since the early nineties it has been strongly influenced by the Roman Catholic Church. That is certainly one of the reasons why the medical community, consisting of 90 086 physicians, of which a majority of 54,7 per cent (49 245) are female, became involved in anti-abortion policy and campaigns, even before abortion was restricted by state law. There is no noticeable gender difference in attitudes. In 1991, during an Extraordinary National Assembly of Physicians, the Medical Code of Ethics was adopted in spite of a strong opposition. The code adopted a strong anti-abortion position, according to which abortion is ethically acceptable only to save a woman's life and health, or in case of pregnancy that is the result of a criminal act. The Ethical Code caused public hospitals to stop performing abortions even before the law was changed in 1993.

accessibility of lawful abortion in public hospitals

The anti-abortion law is much stricter *de facto* than *de jure.* Women who are entitled to legal abortion are very often denied the intervention. In comparison to the period of 1993-1995 the accessibility of legal abortion in public hospitals has decreased – a trend that has continued to this day.

Numerous healthcare providers were obstructing the access to legal abortion in the nineties. However, it is highly indicative to analyze the attitudes of the medical community in 1997 when abortion on social grounds was re-legalized. As soon as the law was passed by Parliament, many public hospitals in Poland, even those throughout entire regions such as Krakyw, Tarnyw and Katowice voivodeships, issued statements that they would not conduct abortions on social grounds. According to a 1997 report by the Ministry of Health, 209 obstetric/gynecological hospitals out of the entire number of 435 hospitals in Poland did not perform abortions on social grounds. In 12 voivodeships none of the public hospitals would perform abortions. In 14 voivodeships, abortion was performed in all the hospitals. In the remaining 23 voivodeships availability of abortion depended on the particular hospital. On the other hand, in many places where abortion was not available in public hospitals, it was widely provided in private clinics by the same health-care providers, who treat abortions as an important source of additional income. Such situations have been publicized in the Polish media, particularly in the Katowice voivodeship.

Abortions were opposed not only by directors of hospitals or individual gynecologists but also by anesthetists or intermediate-level medical personnel – midwives, nurses, etc. Some doctors willing to perform abortions were unable to because they had no team to assist them. In some cases gynecologists had to be "imported" to a particular hospital. At the Sokolka hospital all the anesthetists refused to assist with an abortion for a woman with medical (heart) problems and social complications (she already had eight children). The director of the hospital dismissed the head of its anesthesiology department. This dismissal led to great protests and criticism from the medical community. In this particular case, an anesthetist from another city was brought in to assist. This case gives an idea of the range of difficulties experienced by women seeking abortions in Poland.

When the restrictive law entered into force in 1998 the barriers to legal abortion increased. In 2000 for example, a woman with serious eye problems was denied access to a legal abortion. Forced to give birth to her third child, she lost her eyesight almost completely. In 2001 most hospitals in Warsaw denied abortion to HIV-positive pregnant women. It is not surprising then that according to government data, only 151 abortions were performed in 1999.

conscientious objection

According to the Polish law adopted in the nineties, physicians can refuse to perform an abortion on the grounds of conscientious objection. However, they have to refer women to another physician who will provide them with the services she is entitled to. The conscientious-objection clause does not apply in life-threatening situations. The experience of many women reporting to the federation shows that conscientious objection and the way it is handled in Poland has become a significant barrier to women's access to services they are entitled to. Physicians do not consider access to certain reproductive-health services as a patient's right. Their main concern is to protect *their own* right to deny services they perceive as unconditionally unethical. Moreover, those physicians who do not want to perform abortions or prescribe contraception themselves usually do not refer women to other doctors. They often behave as if their main goal is not to individually object to the service, but to make sure that a woman does not receive the desired service at all. Such behavior is not sanctioned by any legal or professional consequences.

At present no system of referral exists, and there is no institution that would secure women's rights to services or set up such a referral system to guarantee that every woman in need of a legal abortion have access to adequate services. Complaint procedures have not been established; women have nowhere to go to make formal complaints. Quite often in Poland, it also seems that conscientious objection is "practised" by the entire hospital, not just by individual doctors, which is in contradiction to the individuality-based concept of the conscientious-objection clause. If the head of a particular hospital is against abortions, he or she declares on behalf of the entire personnel that abortions are not going to be performed in that hospital. Individual doctors who hold a different opinion will never speak in favor of abortions because they do not want to risk losing their jobs. Doctors participating in the two studies by the federation confirm that such practices are quite common.

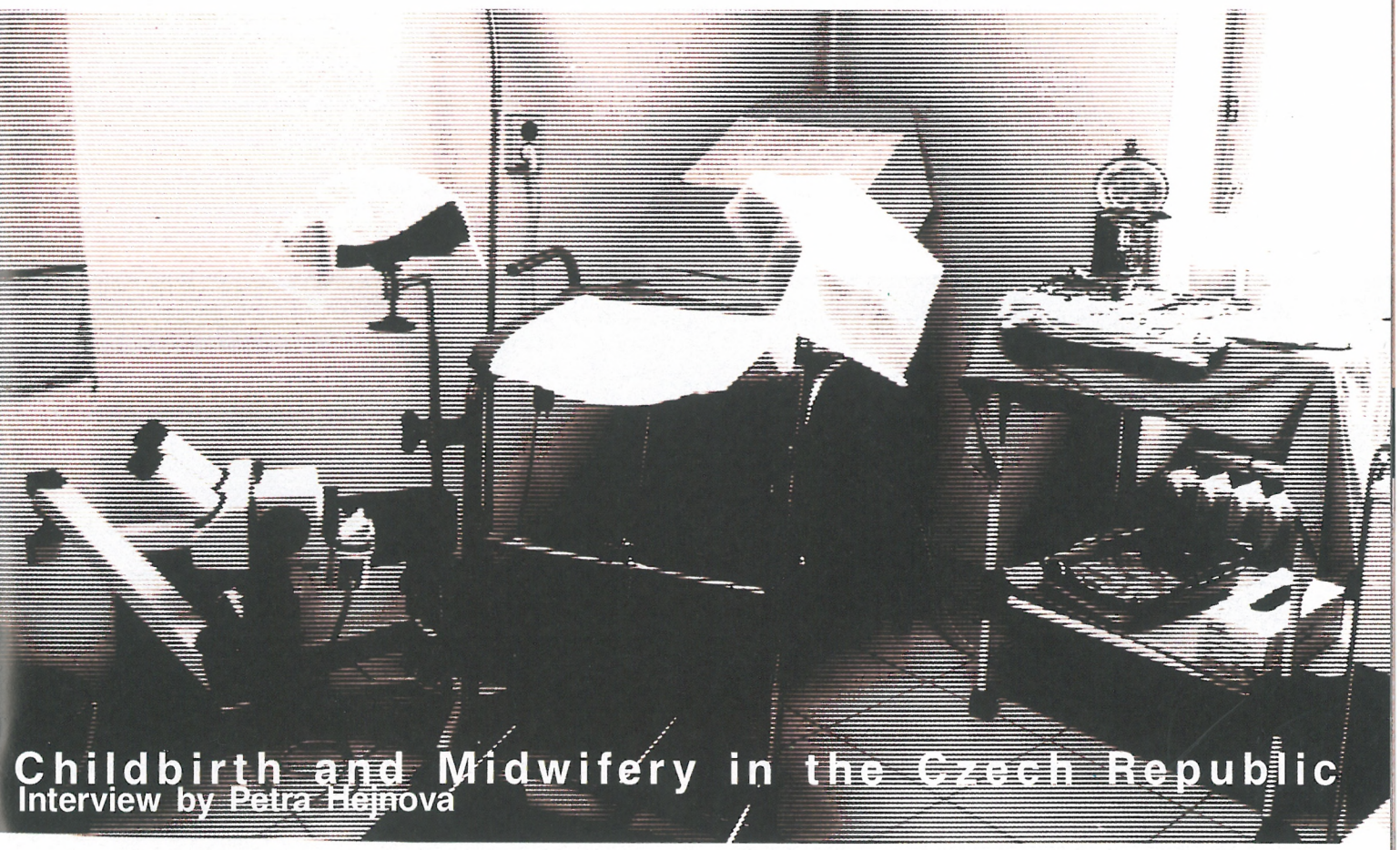
barriers to family planning

Family planning is another area in which doctors often refuse their services. This is particularly questionable against the background of illegal abortions and further limits women's reproductive-health options. Denying contraception and putting women in danger of unwanted pregnancy when abortion is illegal is generally perceived as unethical. In 1999 the public opinion was shocked by the story of a woman who was denied a prescription for a contraceptive pill by a gynecologist in Warsaw. He behaved in offensively and did not refer the woman to another doctor. The woman in question filed a complaint with the Medical Court, which did not find her claim justified. The only violation the doctor was found guilty of and received reprimands for were offensive remarks about other physicians who prescribe modern contraception.

There are other barriers to access to family planning. In 2001 the health institutions responsible for distribution of public funds for health in the Podkarpacie region decided not to refund doctors for contraceptive counseling, a decision in violation of international commitments of the Polish government. Moreover, contraceptive pills are not subsidized by the state, which constitutes a financial barrier to many women, particularly to young women.

conclusion

It seems quite probable that developments in the abortion issue will fluctuate in coming years and will depend largely on the general political situation. In recent history, "right" and "left" parliaments have been elected by turns, which leads to alternating restrictive and liberal abortion regulations, respectively. Pro-choice forces have not yet been able to build a strong pro-choice movement that would defend a woman's right to choose to have an abortion and make that right effective, independent of political circumstances.



Childbirth and Midwifery in the Czech Republic

Interview by Petra Hejnova

The issue of childbirth and midwifery has recently received growing attention in the Czech media. The conditions under which Czech women are forced to give birth are now often questioned. Stereotyped, insensitive behavior of medical staff and lack of freedom for mothers seem to be the most critical accusations levelled at Czech obstetrics.

Petra Hejnova interviewed two experts who may be seen to represent opposite poles of the opinion continuum. Ivana Königsmarkova, an experienced midwife and Chairwoman of the Czech Association of Midwives, is currently working on a project for a first birthing house in the Czech Republic. Associate Professor of Obstetrics and Gynecology Zdenek Hajek is Deputy Chairman of the Department of Obstetrics and Gynecology at the University Hospital of the First Medical Faculty of Charles University in Prague.

P.H. What do you think have been the most important changes in the Czech Republic in the field of childbirth since 1989?

I.K. Some freedom has finally entered the field of childbirth in the Czech Republic. Probably the most notable change is that fathers are now allowed to be present at the birth of their children, which means that women are not left to deal with this alone anymore. Also, in some maternity hospitals, the staff is trying to accommodate the needs of the mothers by providing a variety of equipment with the aim of managing the pain without drugs. Although many say that the quality of health care is a question of money, I think that it really is not. Things could work so much better and be

cheaper if everyone did what they are supposed to. What I mean is that doctors should stop doing the job of a midwife, and midwives should not remain in the position of a mere assistant.

Z.H. The greatest changes are in the equipment of the hospitals. Maternity hospitals today are equipped in a way that was unthinkable ten years ago. The medical care and the electronic devices available today are on the same level as in Western Europe. Of course, as we visited workplaces abroad, we came back and introduced different methods used in other European countries. As a consequence, Czech medicine is generally of good quality. After all, we are among the ten countries in the world with the lowest perinatal [around birth-time; ed.] mortality. This is an achievement of the past ten years, and I think that the results are just fantastic.

P.H. How do you see the Czech situation in comparison with other Western countries?

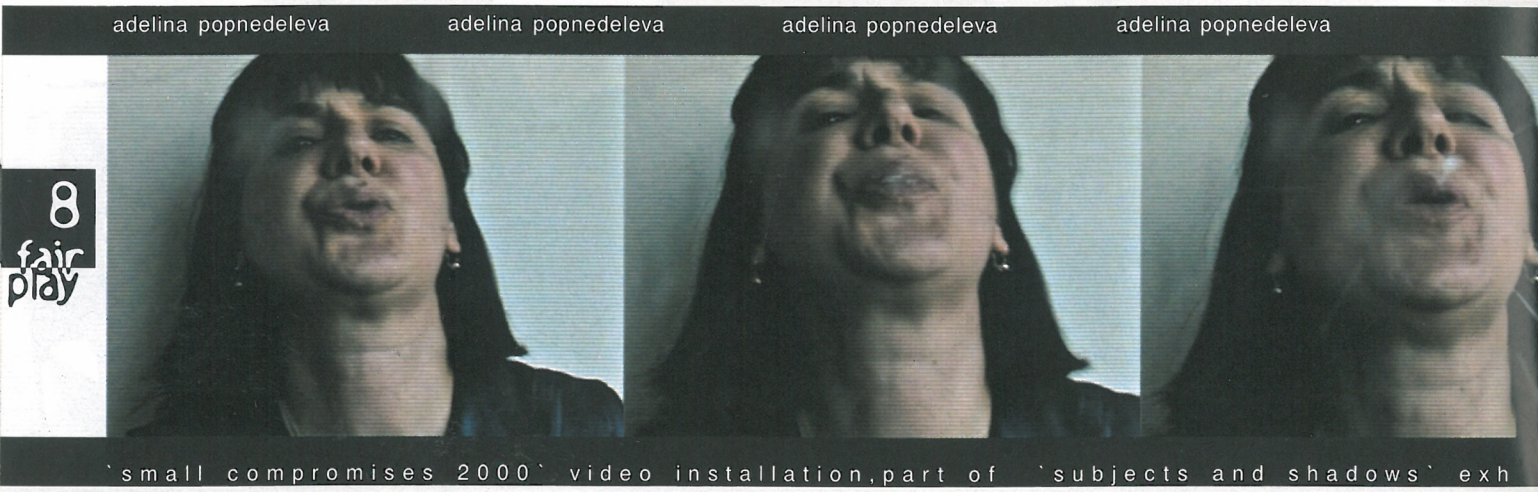
I.K. There are two points of view. The first is about statistics and numbers and from this point of view, we are among the leading countries in the world. Our prenatal statistics are excellent but unfortunately, those who say that there is no space for improvement are hiding behind these great statistics. What is missing in the Czech health care is the human and psychological aspect.

Z.H. As I already mentioned, Czech obstetrics is doing great in comparison with other countries. I do not think there are any new methods that we do not apply here in the Czech Republic. I believe our medicine is of top quality, with corresponding results.

work. After three years of accommodating the needs of many women, the center was closed.

Z.H. We are often criticized for manipulating patients, for telling them what to do. But if the woman states what she does not want – for example shaving in the area where the episiotomy is made – or if she says she does not want any medication, we will meet her wish. But that happens very rarely. What is still a controversy is the claim that we want to speed up childbirth. But what the patients are usually asking me is to do something because they have been lying there for several hours and they are in pain. So I would say that some 90% of the patients trust the doctor they came to see. They know him from their friends, they know how he works, how he behaves, that is why they go to him and let him guide the labor and accept the type of care he suggests is good for them. Of course, we talk beforehand, explain different options, explain what an epidural is about. But it is up to her whether she wants one or not. Sometimes they say they want to fully experience and enjoy the labor, or they ask for an epidural to suppress the pain, and then they really can go through the labor without stress and pain. So I really have a different experience than the alternativists [people supporting alternative or physiological ways of childbirth – P.H.] who keep telling us how many women come to see them wanting to give birth at home without the intervention of a doctor. I have the opposite experience.

Regarding the relationship between the mothers/patients and doctors, much has changed. After all, since 1990, fathers have been present at childbirth. It is normal today, I would say that



`small compromises 2000` video installation, part of `subjects and shadows` exh

P.H. In your opinion, has the role of women – mothers – changed in the context of pregnancy and childbirth? Has there been any shift in the doctor-patient relationship ?

I.K. Well, the situation is finally changing a little. As I said, partners are allowed to be present at the birth of their children, and there is some freedom for women during the phase of the birth process. But otherwise, the woman is still under the thrall of the medical personnel who still manipulate her to where they want her to be.

Institutionally, some three years ago, the so-called Center for Active Childbirth opened as part of the Gynecological-Obstetrical Department of the Faculty Hospital at Bulovka. This center was supposed to provide care in accordance with directives of the EU and the WHO. This means that it took care of women during their pregnancy and the same midwives worked with the women during the childbirth and possibly also after. The center was conceived for women with low-risk pregnancies. The women went there wishing to give birth in a completely natural and physiological way. They could suppress their pain in many ways – by taking a bath, a shower, receiving massages, using a variety of equipment. The environment was intimate, childbirth was a family matter there. The couple could decide on the way the birth would proceed. Unfortunately, time showed that two concepts so different from each other in one workplace did not

50% of the fathers, and sometimes even more, use the opportunity. Also, it is normal to have visitors in the maternity hospital. In this way, childbirth is really becoming a family issue. There are still cases in which the medical personnel does not behave properly, and then the clients have the right to criticize, but that is something we cannot change in one or two days.

P.H. What is the role of midwives in the Czech Republic? How do you see the role of midwives in the future?

I.K. According to an international definition ratified by the International Confederation of Midwives <http://www.intlmidwives.org>, the WHO <http://www.who.int> and the International Federation of Gynecologists and Obstetrics <http://www.figo.org/>, a midwife is an independent provider of primary care, which means that next to physicians, she is the only medical personnel specially trained to provide care during pregnancy, childbirth and during the postpartum period.

However, there is some controversy around the role of Czech midwives. They have really not been given the responsibility they could take. The status of Czech midwives has been significantly influenced by past times when they were viewed as regular nurses. The hierarchy was clear: doctors were the ones to make decisions, and midwives had to listen. At the lower end of the hierarchy was the patient who had to listen to both. Abroad, the situation began to change in the seventies, when these three

groups became partners at childbirth, which is what is slowly happening here now. Also, since the work of midwives is significantly cheaper than the work of doctors, and because our health-care system is not too rich and we want to join the EU structures, I believe that the Czech midwives will play an increasingly important role.

Z.H. There is a major difference between a midwife and a regular nurse, because nowadays, midwives do mostly specialist work. If somebody sees them as cleaning ladies or something like that, he is fooling himself. For example, the monitoring is completely in the hands of the midwife. She examines the patients during the labor and if she wants, she can take over a physiological childbirth. But because we are a perinatal center, there are some 30% of pathological cases. That is something that a doctor must be responsible for, that is why we are a clinic. But midwives can really guide the physiological childbirth, if they have the time, that is. For example, they often assist during surgery, Caesarian sections. This is expert work. We are involving them more and more into other activities because we do not have enough doctors who could take the responsibility. So we prefer experienced midwives, and we let them do specialist work more often. Their significance will grow in the future. But it is important to say that it is the doctor who assumes the responsibility for the childbirth, which is what the Czech Association of Midwives wishes to change. They want to take over the responsibility. But things here are different. I delegate the responsibility, but I would be legally liable if something went wrong.

Z.H. We are rather frightened by those who thoughtlessly want to introduce something without considering whether there are good conditions for it here. They want to copy something that already exists in the Netherlands. This is the mentality of the Czech nation – we keep copying things without being able to say: "Yes, we can use some of it but let's develop it based on the Czech tradition, our obstetrical school". It is something we are having a hard time agreeing on with the people supporting alternative ways of childbirth. I am willing to agree on small steps that may improve the relation to the clients, because on the other hand, we have to admit that we owe them something in this respect. In this way slowly, we might get somewhere, it is just a question of timing. We are in contact with Western Europe, we know very well how they do it elsewhere. For me, Sweden is a good example of obstetrical care, and there, for example, they rejected the idea of giving birth at home. But for example, they have the birth houses, family rooms which people are starting to speak about here in the Czech Republic now. It would be possible to introduce them, but only under certain conditions. It is not possible to say that from tomorrow there will be a birth house in Prague, without caring about the accessibility of medical care in case of emergency.

P.H. Finally, what is your vision of an ideal situation in Czech obstetrics?

I.K. Ideally, every mother would be provided with complete and objective information on the basis of which she herself could choose the type of care to suit her needs. This means that every future mom will know what pregnancy is, what it takes to be pregnant, what kind of complications can occur, how to soothe pain in natural ways and of course, what to do in emergency situations. The same applies to childbirth and the postpartum period. Breastfeeding should be encouraged so that women do not receive wrong information and stop breastfeeding too soon. I hope we will see only healthy mothers and babies.

Z.H. In an ideal case, we would have more time for the clients, more staff, which would allow an individual approach to every patient. For example it would be helpful if during the labor, only one member of the staff communicated with the client, if one doctor could be there from the beginning to the end of the birth. The birth wards would be built as a number of separated rooms. There would be no large groups of students, not more than one or two. And especially, we need to improve the hotel-type services. There is considerable pressure from the public about the way the rooms look. Comfort, rooms for one or no more than two people, equipped with private bathrooms and showers. Lack of finances is one aspect, organization another, but we have a lot to improve in the way of the ethics of the patient-doctor relationship. But that will take some time and it is not only the problem of the health-care sector. It applies to other sectors as well.

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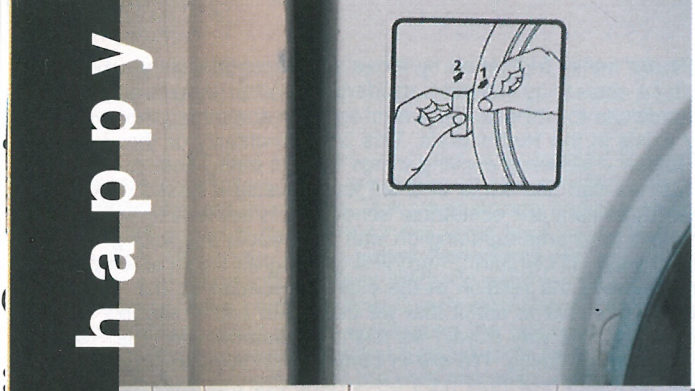
ibition, in ATA center for contemporary art, sofia, bulgaria. curator maria vassileva

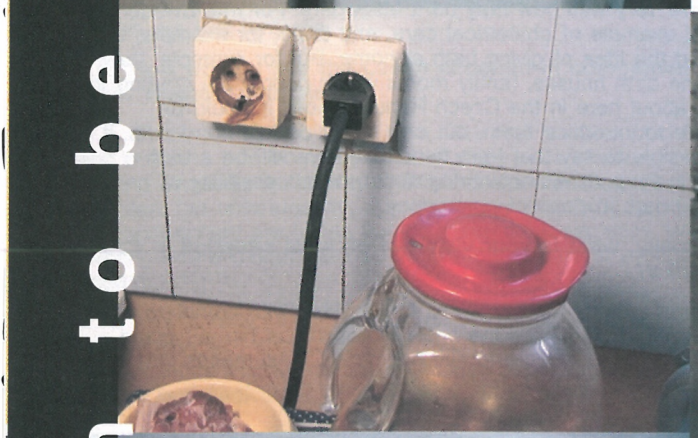
P.H. What is your opinion on alternative or physiological ways of giving birth?

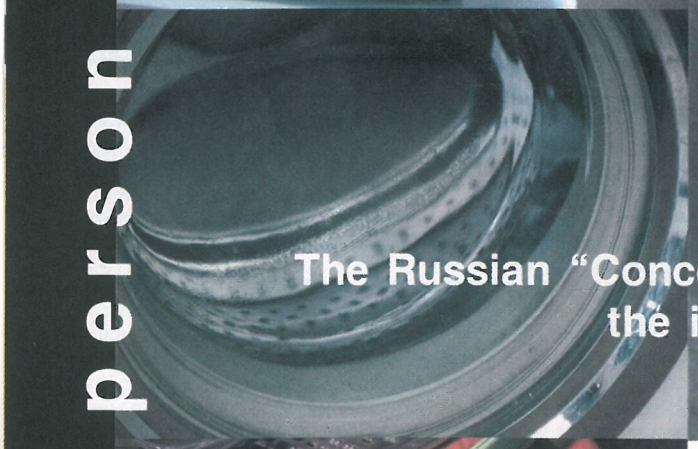
I.K. First of all, I really do not like the word "alternative", since it raises in many an association with some kind of witchcraft. Physiological childbirth, if there are no complications, is not a state of illness. It is just a different physiological state of a woman. Therefore I believe that we do not have to intervene in it, we can just let it happen naturally. It is almost the same as when you have a headache – it is purely up to you whether you want to take some medicine or not. If there are no complications, you do not need a doctor to intervene. It is as if you went to the movies and let an experienced pediatrician baby-sit your child in case something happened to him/her.

What is working well in many developed countries are so-called birth houses or birth centers where it is mainly midwives who provide the necessary care. And of course when I say mainly midwives, I mean that not only midwives are available there – in the event of complications, they closely cooperate with experienced doctors. I believe that such a birth house is something that is missing on our health-care market. Currently, I am working on a project "Birth House", and the legislative and methodological basis for its development are being prepared. I hope that in the near future, perhaps not in the matter of days or weeks but rather of month and years, such an institution will be available to pregnant women in the Czech Republic.

every person is born to be happy







The Russian government recently approved a "Conception" for the demographic policy of the Russian Federation until 2015. Among professional demographers this document has prompted varied reactions. Nadezhda Azhgikhina asked Inga Grebesheva, general director of the "Russian Family Planning Association", for her comments.

The Russian "Conception for Demographic Policy" neglects the interests of Russian women and families

Interview by Nadezhda Azhgikhina

Inga Grebesheva, you have been working in the field of public health and demography for a long time. What are your impressions about the new document?

The fact that the document has appeared is in itself reasonable. On the basis of falling birth rates in Russia the mortality in the population is rising, especially that of the male workforce. High mortality rates among children and mothers continue to be witnessed. Only about 30% of all children are born healthy (and more than 80% of today's

teenagers suffer from chronic illnesses). At the same time, the number of homeless children and social orphans, whose biological parents are still alive, is growing. According to recent statistics there are more than 2,8 million homeless children in Russia. President Vladimir Putin, in an official speech to the Duma, the State Parliament, defined demographic problems as one of the state's top priorities. The main points of the document are well founded – a country as large as Russian must be populated. It is indeed important to replenish the future as part of socio-economic policy, which is intended to increase the prosperity of the population. In essence, the purpose of every fundamental activity of a government is to ensure peace and prosperity for its citizens: men, women and children. Indeed, people are not born to replenish the ranks of the military or labor resources, but to be happy. And families create children not in the interest of the government, but first and foremost in their own interest. The function of the

government is to create conditions in which a family would want to have children. This is why it must respect the interests of the family. First of all, it should ensure that there are jobs, adequate salaries, and normal living conditions, and that individuals show an interest in their own future. So-called "children's welfare" does not solve the problem. In fact, it serves to divert the problem. The government should have reflected on all of these problems when setting up the "Conception" for demographic policy. It should have devoted more attention to the quality of health care and education. Special attention should have been given to the "sexual" health of the youth.

Government policy, quite simply, should be based on the interests of the individual and the family, and then on economic interests, which provide a basis for people's lives, and not the other way around.

The wording of the "Conception" document is vividly reminiscent of Soviet era documents, which prioritized the interests of the state and not the individual.

It is about time we all realized that the interests of the individual are also the interests of the state. If citizens do not feel secure or comfortable, they will not choose to have children, and this is directly damaging to the state's interests. And it is impossible to get people to have children in a situation where they are not receiving salaries, have no roof over their heads, and are unsure of the future. The authors of the document are high-ranking specialists. I am sure that if they had written the document using a scenario of unlimited governmental and financial resources, the "Conception" would have looked quite different. I think that they were given the task of creating a document that could be implemented based on the derisory financial resources available today. This is disappointing to me. The "Conception" does not reflect the critical situation of today's society, and urgent steps are needed to correct that situation. For it is indeed critical! And resources currently available for the population are not being used. The fact is that families are not conceiving children, and talented specialists are leaving the country because they cannot find work in their fields. Graduates of institutes cannot find jobs, and nobody even mentions housing opportunities for young people. Inherently, the cost of private education and health care are a seriously depressing factor for the young.

It is nice to remember the policies of the state during the 1980s, when there were government subsidies for families with newborn children.

Yes, you know, in those years women in maternity wards were giving birth on the floor and in hallways. There was a real "baby boom" – young families were promised apartments. And state subsidies played out their role. The policy was not bad. Unfortunately, today young families are promised a lot, but they are given no concrete support. Special attention must be paid to the sexual health of the young – today 20% of all couples of child-bearing age are not able to conceive. Of course, today's family is our potential, our future depends on it. It should be taken into account that it is more efficient and cost-effective to prevent sexually transmitted diseases – as well as diseases leading to infertility – than it is to cure them. There is no effective system in place to help the prevention of sexually transmitted diseases.

The "Conception" talks about changing the reproductive practices of Russian families so that they have two to three children instead of one. What is your opinion on this?

The reproductive stereotype of the Russian family has always been somewhere between the European model of having few children and the Asian model of having many children. Therefore, the family model with two to three children for Russians is not a new model, but rather a tradition. And many families would have a second child, if this did not automatically plunge

them into poverty. As far as improving the status of families with children, as mentioned in the "Conception", this status is already high, and there is no need to create new television programs and information campaigns to promote it. Instead, it is important to help families survive and live well. As a matter a fact, many countries with low birth rates have long implemented governmental programs to support families with children. In England, for example, parents receive government subsidies that are sufficient to keep a child in daycare or cover the expense of a nanny, so that having children does not create a financial crisis for the family. In Sweden the government takes care of every newborn citizen by providing subsidies and implementing a whole system of measures to support families with children. Children with disabilities receive not only free medical and health care, but also receive free individual housing if they wish to live independently when they come of age. So on the one hand parents care for their newborn children from the day they are born, and on the other, the government supports them on their way through life.

What can be said about the state of women's health today? Have its characteristics changed as a result of reforms carried out in health care?

I cannot say that women's health has improved – rather the opposite. More than half the pregnant women today are anemic, and the level of gynecological diseases has not decreased, including among girls. In this sense, the state of girls' health is worse than in previous generations. Reforms conducted in the sphere of health care are carried out without proper resources. This is not something new. I have worked in the field of maternity and childcare for 40 years, and we have always had to beg for funding. In Soviet times, many talked about how childhood was considered a priority, but financial security for motherhood and childhood was never a priority. Today the situation is much more complicated. Today's so-called free health care in reality calls for women to spend a good deal of money, and it is inaccessible to many.

I recall that a few years ago some good results were achieved in preventing sexually transmitted diseases and abortions, when the government-funded program "Family Planning" was in effect.

Yes, the overall rate of abortions dropped by 30%. The number of girls under 14 years of age needing an abortion decreased. Reproductive health centers did some good work with the younger population; contraceptives and advice were available free of charge to young couples and families. Unfortunately the program's funding was cut. The number of abortions is increasing and is now about 3 million per year. For every birth in the country there are about two abortions.

What is your advice to those who will read and use the new document?

I believe that it could use some changes. Also I think that it will become more realistic and comprehensive. The "Conception" covers a long period of time. It is itself a long-term plan, and corrections are inevitable. I would like to believe that it will become useful and adequate for current needs.

stress and mental health

by Rossanka Venelinova

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Rossanka Venelinova, MD, is a psychiatrist and psychotherapist. She is a graduate of the Medical Academy in Sofia, Bulgaria. She has specialized in brief, solution-oriented psychotherapy, social development, health management and administration.

She has more than 16 years' of experience in the field of mental health, crises and crisis intervention, and women's problems including violence against women. She has been actively involved in the women's movement in Bulgaria since 1996. Dr. Venelinova is a founder of the care and preventive psycho-social programs against violence and the first and unique shelter for battered women in Bulgaria, and co-founder of the Nadja Centre Foundation, whose mission is to help women affected by violence. She has been its executive director since 1998.

Traditionally, disease has been described as a physical condition. Disease exists apart from the observer, and so the social organization of the thoughts of the sick person has no effect on the disease. This view of disease as a physical process, and the corresponding view that we have a mind inside a machine-like body, has made it difficult to develop a behavioral medicine. In a truly behavioral medicine, behavior, including thoughts, feelings and lifestyle, would occupy the same conceptual space as physical bodies. The mind and the body influence each other, and our health and behavior are part of the same process of life.

The mind remains a mysterious, nonphysical presence inside our biological machinery. Discussing and introducing the theory of stress helps clarify the nature of the relationship between the mind and the body. Recent advances in biology and the neurosciences provide a clearer picture of the inherently interactive behavioral character of neurons and neuronal systems. This understanding provides a basis for rethinking the relationship between the physical side of our nature and our mental existence.

Disease is a disorder of a machine which otherwise runs smoothly. The cure is to disrupt the causative agent at the physical level to help the machine repair itself and regain normal function.

Stress is defined as a bodily mental tension resulting from factors that tend to alter the existent equilibrium. For example, severe cold stresses our bodies if we are outside inadequately dressed. The stressor is the factor that challenges the integrity, or health, of the body. A stress response is the compensatory reaction of the body to the disturbance caused by the stressor.

It is also possible to distinguish between physical and psychological stress. I refer to physical stressors as events constituting a direct physical threat to one's well-being. Cold, in the above example, is clearly a physical stressor, as are heat, infection, or toxic substances. In contrast, I also refer to psychological stressors. Such events challenge our well-being not because they are physically threatening but because of how we perceive them. We may find that a major personal disappointment or the sound of footsteps in a dark street in a strange neighborhood are very distressing and may evoke strong physical responses. The disappointment may evoke sadness, a sensation of heaviness in the chest, and feelings of lethargy. The footsteps may result in a sudden fear response accompanied by a racing heartbeat and rapid breathing. It is important to note here that these physiological responses start out with events, psychological stressors that are not physically threatening. The physiological responses and accompanying emotions arise because our disappointments or the footsteps behind us are challenges to our expectations about ourselves and the world, or because they signal the potential for impending physical danger.

If a stressor is a challenge or threat to the normal processes or integrated function of a living being, the response of the organism to this threat is the stress response. We speak of a threat when the environment moves beyond the range of conditions the system or organism is adapted to. So a small change in temperature in the living room is not a stressor. We have compensatory mechanisms to deal with that, and

they are readily effective. On the other hand, being locked out of the house on an evening when the temperature is below freezing might evoke not only severe physiological but also major behavioral adjustments, including the impulse to break into the house by any means necessary.

All biological systems are organized, interacting entities. Their functions are literally a form of systemic behavior. All such systems are able to tolerate a range of environmental conditions, and they must compensate the exposure to increasingly severe environmental conditions by internal changes. At some point, extreme environmental circumstances will result in complete cessation of system-level function – i.e., death. Stress implies a level of challenge that is severe enough to require major readjustment to meet the challenge, or that is prolonged enough to alter system function. The current ideas about stress and its effects are based on the idea that the machinery of the body has to have a way to protect itself when outside conditions change unfavorably. Multiple control systems operate to maintain homeostasis (equilibrium). These homeostatic mechanisms are adaptive and serve to maintain life. However, in severe or prolonged states of stress, they may themselves become damaging.

There are several schemes for classifying stressors. One of them classifies them according to sociological groups. In this scheme, there are stressors for adults – wars, earthquakes, floods, fires, accidents, physical and sexual abuse, death, suicides and suicide attempts, drug abuse, marriage and divorce, reproductive problems, job loss and retirement, climax. And there are stressors for children – child abuse, child neglect, "broken home", beginning learning process, puberty, etc. For women especially there are additional stressors linked to reproductive problems – pregnancy, birth, hormonal disbalance, and climax – as well as the severe and complex stress associated with domestic violence. Another classification of the stressors is in physical and psychological stressors, where psychological stressors are such events as the loss of a loved one, failure to achieve a highly valued goal in life, or a turn for the worse in a significant relationship. These can be acute, traumatic events or long-lasting strains. Such challenges clearly do not pose a threat because they are physically harmful in the way that cold can be, and so we must consider what mechanism allows a piece of bad news to bring about a crushing sense of oppression, perhaps tears and sorrow, a loss of faith in the future, and even illness.

Hans Selye (1936) recognizes that exposure to a stressor can increase a body's ability to cope with that stressor in the future by a process of physiological adaptation. Exercise is an excellent example of increased coping with repeated exposure. Physical training involves doing a set of exercises with increasing intensity over an extended period of time. The increase in ability with training is an example of adaptation to the required effort. Selye also notes that severe and extended exposure to any stressor can ultimately exceed the ability of the system to cope or adapt.

Humans have evolved a complex set of physiological controls to maintain homeostasis. These controls compensate for physical changes in the composition of the external environment. In contrast to physical threats to homeostasis, we can often experience perceived threats and emotional pain associated with psychological distress. Psychological stressors also affect the state of the body by altering the same mechanisms that we evolved to compensate for physical threats.

The immune system is a highly evolved collection of structural defense mechanisms, specialized cells, and chemical messengers. Together, these allow us to survive in a hostile environment containing viruses, bacteria, and other harmful foreign material. The immune system operates in two-way communication with the brain and the endocrine system. Because of this extensive communication, the immune system can influence how we feel and behave. Similarly, our behavior affects the operation of the immune system. Negative emotional states involving feelings of distress are associated with endocrine and autonomic changes that can inhibit immune system function. This results in decreased resistance to new infections. Studies of humans exposed to stressors for brief or prolonged periods of time illustrate an array of specific alterations of immunity reactions and lowered resistance to disease. A few encouraging studies suggest that positive emotional experiences and strong social support networks can enhance immune system function and perhaps improve health.

Many authors (Querido, 1936; Lindemann, 1956; Tyhurst) have written on reactions to stress described as "sharp

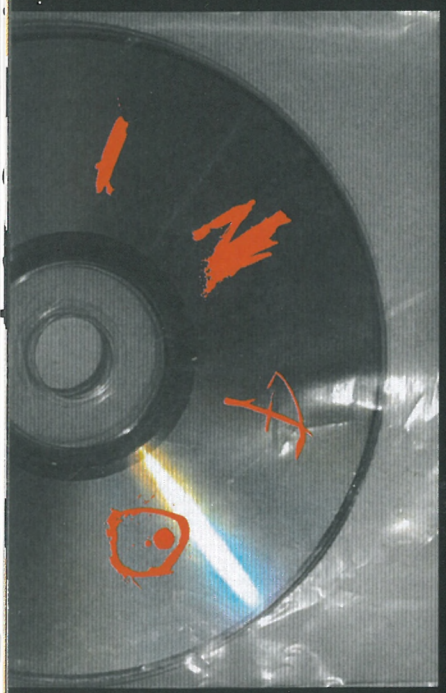
stress reaction", "adaptation disorders", and "Post-traumatic Stress Disorder".

The theme of "prevention" is probably the next major development to appear in the literature. The prompt and skilled intervention at times of crisis and illness might have a constructive and preventive aspect. It should be possible to help individuals and families under stress to avoid overt mental illness and, in learning through experience, to avoid, or at least to cope better with, subsequent problems, illness, and crises.

aborted thinking

aborted thinking

With the very first act of his presidency, George W. Bush managed in one fell swoop to alienate myriad family-planning groups, women's health organizations, physicians and European allies. A memo to the U.S. Agency for International Development revived what is officially known as the Mexico City Policy – or, less formally, the Global Gag Rule. The order states that U.S. AID cannot dispense family-planning money to an organization unless it agrees to neither perform nor promote abortion. Rather than barring funds for abortion itself – the 1973 Helms Amendment already does that – the policy instead curbs health care providers' ability to talk about medical options at organizations that continue to accept aid. For those that do not comply, the policy means a loss of funds for counseling and contraception. The order is likely to seriously impede the work of health organizations around the world and in effect to lead to more abortions, not less.



Source: Marguerite Holloway, *Aborted Thinking*, Scientific American, April 2001. The full text can be found at <http://www.sciam.com/2001/0401issue/0401scicit1.html>

"Until 1998 Poland had a law requiring sex education to be taught in the schools. The legislature recently amended that provision of the law, and amalgamated sex education into part of a "pro-family" curriculum endorsed by the Catholic Church. For any sex education course to be introduced into schools, local school authorities must organize a meeting for all parents where the goals and content of the course are reviewed, and parents must approve."

"Maternity and child care leaves may appear to benefit women. But in the seven East Central European countries profiled in this report, these policies send a more mixed message, especially to private employers who absorb the indirect costs associated with such generous leaves, and may engage in discriminatory employment practices to avoid the costs. In Croatia, private companies hire men over women, or women off of an official contract, to avoid paying such benefits. Similar trends can be found in Poland and Romania where job advertisements specify gender and marital status characteristics. Lithuania's Law on Equal Opportunity makes such advertisements illegal."

The Center for Reproductive Law and Policy (ed.), Women of the World: Laws and Policies Affecting Their Reproductive Lives – East Central Europe, New York (2000) <http://www.crlp.org/pub_bo_wowece.html>.

"Better health is unquestionably the primary goal of a health system. But because health care can be catastrophically costly and the need for it unpredictable, mechanisms for sharing risk and providing financial protection are important. A second goal of health systems is therefore fairness in financial contribution. A third goal – responsiveness to people's expectations in regard to non-health matters – reflects the importance of respecting people's dignity, autonomy and the confidentiality of information."

"Paying for health care can be unfair in two different ways. It can expose families to large ***unexpected*** **expenses, that is, costs that could not be foreseen and have to be paid out of pocket at the moment of utilization of services rather than being covered by some kind of prepayment. Or it can impose *regressive* payments, in which those least able to contribute pay proportionately more than the better-off. The first problem is solved by minimizing the share of out-of-pocket financing of the system, so as to rely as fully as possible on more predictable prepayment that is unrelated to illness or utilization. The second is solved by assuring that each form of prepayment – through taxes of all kinds, social insurance, or voluntary insurance – is progressive or at least neutral with respect to income, being related to capacity to pay rather than to health risk."**

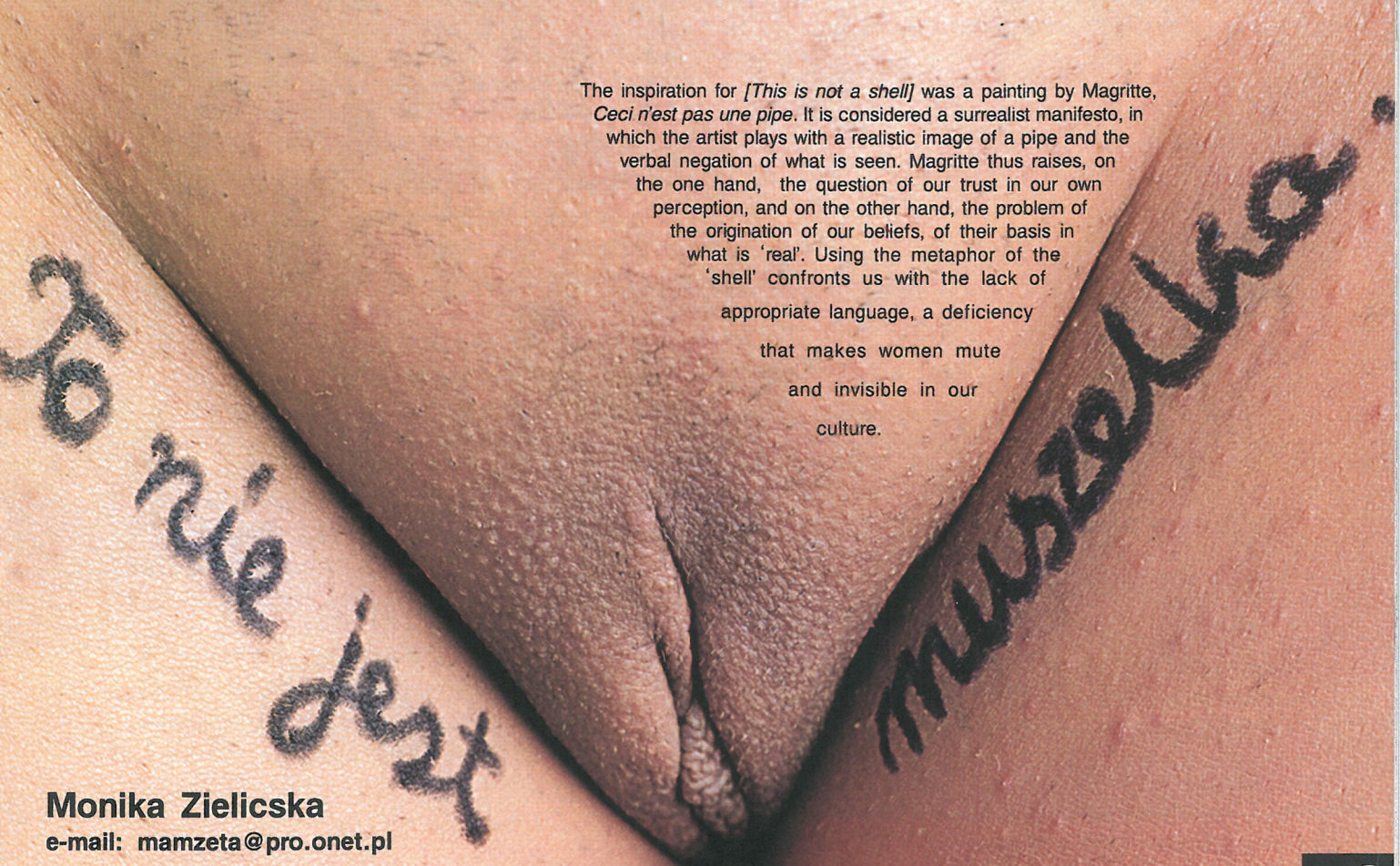
World Health Organization / WHO (ed.), The World Health Report 2000 <http://www.who.int/whr/2000/en/report.htm>

"If a physician is either unable or unwilling to provide a desired medical service for non-medical reasons, he or she should make every effort to achieve appropriate referral."

"The principle of autonomy emphasizes the important role women should play in the decision-making in respect to their health care. Physicians should try to redress women's vulnerability by expressly seeking their choice and respecting their views."

"With regard to reproductive cloning in humans, producing individuals by nuclear transfer cloning because they are genetic copies of identified adults does not respect human identity and individuality. It objectifies human beings, and as well as having unknown physical risks is likely to be psychologically harmful to individuals produced this way. The technique allows people with some predetermined characteristics to be made. This aspect means the technology can be used in an exploitative way (e.g. to produce a matched organ donor)."

The International Federation of Gynecology and Obstetrics / FIGO, Recommendations on ethical issues in obstetrics and gynecology by the FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health (August 2000) <http://www.figo.org/default.asp?id=6001>.



The inspiration for *[This is not a shell]* was a painting by Magritte, *Ceci n'est pas une pipe*. It is considered a surrealist manifesto, in which the artist plays with a realistic image of a pipe and the verbal negation of what is seen. Magritte thus raises, on the one hand, the question of our trust in our own perception, and on the other hand, the problem of the origination of our beliefs, of their basis in what is 'real'. Using the metaphor of the 'shell' confronts us with the lack of appropriate language, a deficiency that makes women mute and invisible in our culture.

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Genealogy/gynealogy [scar after mother] **(1999) as well as *[This is not a shell]* (1999) are both macro photographs designed to be presented on billboards. From November 2000 till January 2001, *genealogy/gynealogy [scar after mother]* was displayed on 400 billboards in Poland's main cities and on thousands of free postcards by the AMS Outdoor Gallery. The presentation of body fragments with handwritten inscriptions in spaces assigned to advertising made it possible to enter a specific discourse.**

A discourse in which, according to Lacan, images and symbols meant for women coincide with women's images and symbols. Frequently, in advertising, the female body is used to enhance the attractiveness of products. Sometimes it sells the stereotypic concept of women as cooking and cleaning servants. Certain meanings are absent, excluded. The symbolic and synthetic presentation in the public (city) space of brisk but tabooed aspects of 'being a woman' opens the possibility for confrontation.
It recalls the problem of the special status of the female body - a cultural *terra incognita*.

The navel – the only natural scar on the human body – reminds us of the fact that we originated united with our mother's body. According to psychoanalytic concepts, this fact appears to endanger our individuality, which has made the mental and cultural separation from the mother a must. Pointing out the fact that each of us bears a scar after our mothers opens the possibility for questioning the banishing of the mother, among others in the social concept of genealogy as a male line of origination.

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The World Association of Community Radio Broadcasters

amarc

The World Association of Community Radio Broadcasters is an international non-governmental organisation for the promotion, support and development of community radio worldwide. The international headquarters were set up in Montreal, Canada, following the founding assembly in 1988. AMARC has consultative status with UNESCO and observer status with the International Telecommunications Union through membership of the Platform for Democratisation of Communication.

The principal activities of AMARC Europe are policy, research and advocacy; training and exchange of personnel; programme exchange and co-productions; solidarity and co-operation between East, Central and Western Europe and with community radio broadcasters in other regions of the world.

AMARC Europe Women's Network

The European branch of the AMARC Women's Network met for the first time in 1994 at the first pan-European AMARC Conference in Ljubljana, Slovenia. It voted to prioritise training courses for women broadcasters from Eastern Europe.

The starting point of the European network was in Eastern Europe, in a seminar for trainers for women radio held in Lviv, Ukraine in October 1995. This was the first step in the direction of acknowledging two of the priorities of AMARC-Europe: the commitment to new and emerging community radios in former Eastern bloc countries, and to women's active involvement in them.

At the Pan-European Meeting in Copenhagen in October 1996, the women's network formulated a plan of action for the development of a strategy for women working in community radio. The plan of action can be summarised in three main points:

1. **Exchange and networking in all its appropriate forms, such as partnerships in projects, twinning of women's radio stations and programs, exchange of information, programs, training, ideas and staff. One of the first steps towards implementing that objective would be employing a women's co-ordinator to support the creation of a good basis for a strong solidarity and exchange network.**

2. **Training for women working in radio, new technologies, communication, journalism and radio management, with particular attention to the training needs of women of ethnic minorities, migrant women and Central and Eastern Europe women broadcasters.**

3. **Representation of the needs, aspirations and concerns of all women in community radio. Make representations and submissions to relevant policy and funding bodies at European level. All these proposed actions placed special emphasis on the needs of women working in community radio in Central and Eastern Europe.**

Representatives

Women members in Europe can choose two representatives in Europe: one representative for the Western countries, and another for the Central and Eastern European countries. Both become members of the regional board as women's representatives. They serve a four-year term in this position and are elected by the women's meeting, although this election has to be ratified by the general regional assembly.

Both are responsible for the developing of the network in their region and maintaining contacts and information between the women members of their countries and the rest of the European and international network.

Our current representatives are Adriane Borger from Radio Flora, Hannover, Germany, for Western Europe and Eva Thun from Civil Radio, Budapest, Hungary, as a representative for the Central and Eastern Europe.

Since July 1998 there has also been a co-ordinator, who is currently Fiona Steinert from Radio Orange in Austria, contracted full-time to work for the women's network, working from the AMARC Europe office in Sheffield, England.

Projects

Three projects have been approved in Western Europe by the European Community to develop different parts of our action plan. They involve several partners in different countries and offer training materials for women in community radio. *Permanent Waves* <http://www.amarc.org/pw> is a transnational project focusing on training on new technologies in communication. In this project AMARC's main role is the dissemination of the materials produced by the partners through the Women's network web site. *Women on Line* <http://www.amarc.org/europe/women/wol> is another transnational project co-ordinated by AMARC. It also aims to help women gain new skills in information technology through the development of training materials. And finally, *Women grab the microphones* <http://www.amarc.org/europe/women/wgm> has included ten different radio stations as partners. This has been a project of exchange, visits and joint production of broadcast material for the stations on the general subject of women's rights.

Recent developments

The Central and Eastern European Office of AMARC Europe is based in Budapest and is in the process of being established as a foundation according to Hungarian law.

The Central and Eastern European office serves as an information resource for and about creating community radio stations in the region. The office works to create a network between community radio stations and those in the process of being established, to connect ideas with projects, projects with people, and people with project supporters.

The role of the regional office is to clearly reflect the concerns of community radios in the region: the independence of all peoples; solidarity with other countries; international cooperation based on equality, reciprocity, and mutual respect; non-discrimination on the basis of race; and respect for the cultural identity of citizens of Central and Eastern Europe.

The Central and Eastern European office of AMARC-Europe is hosted by the Hungarian Federation of Free Radios (SZARAMASZER). Attila Halasz has managed the office since July 1999.

The objectives of the Central and Eastern European office of AMARC Europe are:

to encourage pluralism on the media landscape of Central and Eastern Europe by developing and consolidating community radios;

to develop opportunities for public participation in broadcasting, in particular for the minority communities;

to combat racism and xenophobia by providing news and information about and open a public space for communities & peoples subject to discrimination and human rights abuses;

to empower women and support their strong participation in all aspects of society by promoting the active involvement of women in media and the idea of women's programmes in community radio;

to strengthen links and solidarity between community radio stations through networking and the exchange of people and programmes;

to enable community radios to extend their outreach and public service remit by taking advantage of electronic media developments to broadcast and exchange programmes;

to promote examples of good practice throughout the region through training.

At the Pan European Meeting in October 2000, which was held in Balatonfured, Hungary, the AMARC Europe Women's Network has drafted the following plan of action for the years 2000-2003:

Training: Ensure the availability of existing training materials and produce new ones according to women's needs. Organise and promote training courses for women in all aspects of radio production to empower and encourage more women to participate. Train existing and new women's trainers and promote trainers' networks.

Networking and exchange: Enlarge the network using different strategies such as meetings, conferences, services and exchanges. Development of the Women's Network in Central and Eastern Europe and promotion of national and thematic networks (migrant, lesbian, etc.) and projects, partnerships and exchange of programmes and information.

Representation/promotion: Promote the presence of women in radio production and decision making within the AMARC Europe network. Represent the Women's Network at international level with such institutions as the ITU (International Telecommunication Union), UN, UNESCO, EU and others as well as with funding bodies, policy makers and other organisations.

Campaigning: Co-ordinate and encourage campaigns on women's rights, working closely with women's rights organisations.

Meeting reproductive health and sex education needs

The Bulgarian Family Planning and Sexual Health Association (BFPA) is a non-governmental organization founded in 1992. The BFPA is a member of the International Planned Parenthood Federation (IPPF <http://www.ippf.org/>), the National Anti-AIDS Coalition and the Union of Bulgarian Foundations and Associations (UBFA <http://www.ngo.bg>).

The main goal of the organization is to create conditions for the realization of the rights of Bulgarian citizens to family planning and sexual health, as well as for the promotion and popularization of reproductive-health ideas in Bulgaria. The BFPA's efforts are focused in two main directions – health and education.

One of our key priorities is the prevention of sexual and reproductive health through the services we provide. Our main target group are youngster and women of child-bearing age. Free examinations and counseling are available in the 12 centers of the

association. We established two women-friendly comprehensive centers in Sofia, two in Plovdiv, and one each in Stara Zagora, Haskovo, Burgas, Varna, Rousse, Pleven, Gabrovo and Veliko Tarnovo. The services they provide are focused on the following areas: family planning and contraception, gynecology, venerology, sexology, psychiatry and psychotherapy. Modern oral, intra-uterine and barrier contraceptives, pregnancy tests, chlamydia tests and substitutive therapy for pre-menopausal and menopausal women are available. About 20 000 clients visit our centers annually. The main goal in the work of those centers is not only to offer highly qualified and competent services, but also to respect the rights of the client, underlining the right to confidentiality at every counseling session, as well as providing maximum comfort.

Since 1998 the BFPA has widened its range of services by putting a special accent on minority women in the context of an EU-funded project called: "Reproductive health and contraceptive choices for the marginalized Roma people in Bulgaria." A preliminary needs assessment led to the conclusion that the need for care in this field is enormous. An important part of the project was the opening of three specialized family-planning centers located in the following Roma districts: Faculteta in Sofia, Stolipinovo in Plovdiv and Dolna Mitropolia in the Pleven region. The centers are staffed by ethnically mixed teams (Bulgarian, Roma, Turkish) consisting of three persons (gynecologist, advisory nurse and administrator). At the same time an active sex education campaign is carried out in schools with predominantly Roma students. The campaign is supported by printed materials and videos prepared especially for that target audience.

Over 7 000 people (predominantly women) have visited the centers during the first year of their existence. In the training program, which was the second major aspect of the project, 110 Roma leaders, volunteers, teachers, and local authority representatives learned about family planning, reproductive health and human rights. The effectiveness of all those activities depends on the efforts of our volunteers, who have conducted a great number of meetings and discussions within the community. A door-to-door approach helped many Roma women overcome substantial communication barriers and acknowledge family planning as their fundamental right.

The first project in our second priority area – health and sexual education – started in 1994. The sessions take place in different types of schools – ordinary, technical, schools for children with special needs and for youngsters with criminal records. The main topics are sexuality, puberty, the male and female reproductive systems, safe sex, contraception, and sexually transmitted disease.

In the last three years we put special emphasis on such target groups as blind and deaf children as well as juveniles with criminal records. This project is being implemented in four cities – Sofia, Plovdiv, Varna and Pleven. At every location two ordinary high schools and one school for students with special needs are selected. Teams of six young people prepare educational sessions for their peers. The project also includes a series of training modules. The goal of the training program is to provide young people not only with knowledge about new sexual and reproductive health, but also with communicative skills so that they can present the safe sex message to their peers. An equally important aim of the project is the re-integration into society of young people with special needs. Educational modules are completely based on such interactive training techniques as brainstorming, role games, case studies. As supporting material, we are designing and preparing for the first time in the country an informational brochure in Braille.

Both by providing family planning services and through its activities in health and sex education the Bulgarian Family Planning Association aims to improve the reproductive health status of Bulgarian women and young people as well as to assure them of their right to informed choices in developing themselves as individuals.

Dr. Dessislava Georgieva
BFPA <bfpa@online.bg>

Sexual and reproductive health and rights constitute fundamental human rights, form a vital aspect of the women's empowerment agenda and are key to the achievement of gender equality. However, we are dismayed to see sexual and reproductive health and rights continuously absent from women's empowerment and development policies and programmes in Central and Eastern Europe.

Striving to promote sexual and reproductive health and rights in the region, while simultaneously hoping to bridge the gaps between women's issues, health issues and rights issues, **ASTRA** has been established by organisations of the region which share common concerns and goals. **ASTRA** will strive to increase awareness about these issues and to ensure that the specific reality of women's sexual and reproductive rights and health in Central and Eastern Europe receive the highest attention and are treated with adequate priority on international and regional agendas.

ASTRA believes that women's sexual and reproductive health and rights in Central and Eastern Europe must find a prominent place within the multilateral processes in which our governments are engaged. These include the anticipated accession of many of the countries of the region to the European Union and our participation in the United Nations and the Council of Europe. **The sexual and reproductive health and rights issues of the women of our region must be adequately recognised and addressed.**

ASTRA hopes that the network's activities will strengthen co-operation between its members and supporters, building our capacity to effectively achieve our goals. We are also bringing the attention of the international community to our strengths and skills. In this way we are making a meaningful contribution at international, regional and national levels to promote and protect women's sexual and reproductive health and rights.

Planned activities of the **ASTRA** network include:

- **influencing national, regional and international activities and processes related to reproductive and sexual health and rights and gender equality;**
- **information generation and sharing both within the network and beyond;**
- **co-operation to improve legislation and policy at the national level;**
- **implementation of joint projects at the national, regional and international levels;**
- **capacity-building activities;**
- **establishment of cyberpresence as a source of information and resources on reproductive and sexual health and rights.**

ASTRA
Central and Eastern European Women's Network for Sexual and Reproductive Health and Rights

Some regional highlights from Central and Eastern Europe

The region of Central and Eastern Europe consists of 27 countries with economies in transition with a combined population of 627 million inhabitants from many diverse cultural backgrounds. However, the effects of political and economic transition confer a similar profile to these former communist countries in terms of general trends and reproductive health. Women face many barriers in accessing satisfactory reproductive health services and in exercising their reproductive rights, i.e. the right to free and informed decisions concerning reproduction and sexuality.

The use of modern contraception is low and abortion is widely used as a method of fertility regulation. In some countries restrictions on legal abortion have been introduced or are being considered on the basis of ideology or religion. Sexually transmitted diseases (including HIV) have increased dramatically and infertility is a major concern. The sexual health of young people is at great risk due to limited access to sex education and services. Violence against women has been neither recognised nor satisfactorily addressed.

Reproductive and sexual health and rights are, therefore, issues of critical importance for the countries of this region - crossing borders, political systems and cultural differences. At the same time, women of the region remain underrepresented in political and economic arenas, consistently receive lower wages than men for equal work, shoulder an overwhelmingly large proportion of responsibility for child rearing and domestic work, and suffer from widespread violence. All these trends are interrelated.

ASTRA members:

Family Planning Association of **Albania**
Women's Rights Center of **Armenia**
Women's Independent Democratic Movement of **Belarus**
Bulgarian Gender Research Foundation
B.a.b.e (Be Active, Be Emancipated) of **Croatia**
CESI, Center for Education and Counselling of Woman, **Croatia**
Family Planning and Sexual Health Association of **Lithuania**
Latvia's Association for Family Planning And Sexual Health
Federation for Women and Family Planning, **Poland**
East European Institute of Reproductive Health, **Romania**
AnA: **Romanian** Society for Feminist Analysis
Institute of State and Law, **Russian** Academy of Sciences

To find out more about ASTRA contact:
Wanda Nowicka, Federation for Women and Family Planning
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Mr. Johannes Linn,
Vicepresident
The World Bank
Europe and Central Asia Region

Warsaw, 2 February, 2001

Dear Mr. Johannes Linn,

We are writing to bring your attention to gender inequalities in our region. The rise and feminization of poverty, the deterioration of access and quality of health care, the erosion of social protection, gender and age based discrimination in the labor market, informalization of female labor, the widespread corruption, and gender inequalities in the access to the benefits of transition warrant serious concern.
Therefore, we very much appreciate the initiative of the Bank to organize a workshop on Gender and Labor Markets, and to carry out a dialogue on gender issues with stakeholders in the ECA region. The participants of the dialogue included women's NGOs, senior government officials, women in business and academia, gender experts from the region, the staff of the Bank's headquarters, UN ECE and UNIFEM. The workshop was extremely useful and productive. We have pointed out what the Bank has done well, and what needs to be done better. We have also elaborated the list of 19 specific recommendations to the Bank and 7 suggestions to enhance Inter-Agency Partnerships.
We would like you to provide personal leadership to mainstream gender in the programs and operations of the Department, and to legitimize gender equality as an important policy issue to your partners in governments.
We would also like you to give priority to:
1. ensure that all Country Assistance Strategies, as well as economic and sector work address gender issues,
2. create a mechanism for a systematic national dialogue between the Bank, government agencies, women's NGOs and other stakeholders,
3. create a Regional Gender Consultative Group that will include women's NGOs,
4. provide support for gender analysis of national and local budgets,
5. ensure gender training for Bank staff, including country missions, as well as your partners in government, and create a team of gender experts in the ECA headquarters.

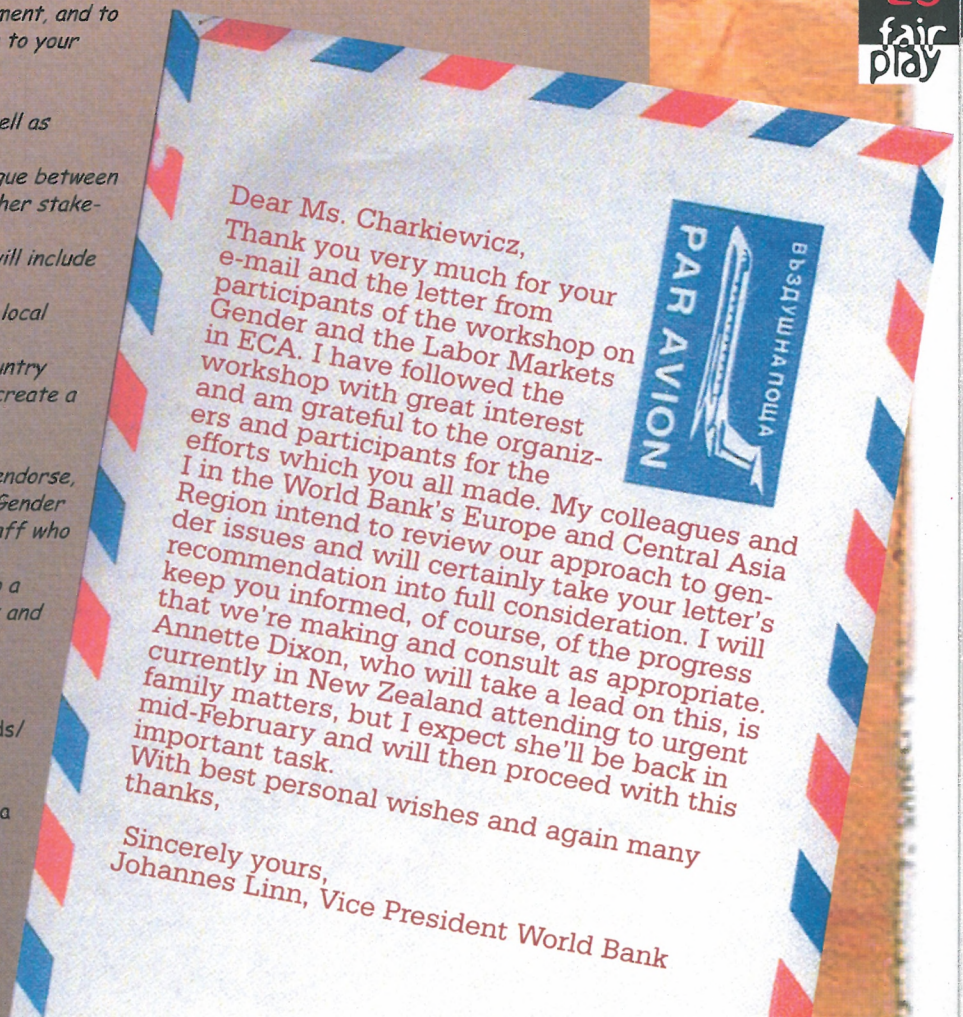
For further specific recommendations, that we fully endorse, we would like to refer you to the OED Review of the Gender Impacts of the Bank's Assistance, and to the Bank staff who took part in the meeting.
We hope this meeting breaks ground and opens way to a sustained and constructive dialogue between the Bank and women of the ECA region.

Sincerely Yours,

Ewa Charkiewicz, Tools for Transition, the Netherlands/ Poland; Patricia Droblyte, Vilnius University, Women Studies Centre, Lithuania; Elena Kotchkina, Women's Resource Centre, Open Society Institute, Russia; Kinga Lohmann, coordinator, Karat Coalition, Poland; Erika Papp, Femina Creativa, Yugoslavia.

With endorsements by email from:

Tamar Abramishwili, International Advisory Centre for the Education of Women, Georgia
Duska Andric-Ruzicic, Women's Association Medica Zenica, Bosnia & Herzegovina
Erin Barclay, director, Network of East-West Women, United States
Daniela Draghici, The Centre for Development and Population Activities, Romania
Valeri Elizarov, Moscow University, Centre for Population Studies, Russia
Simel Esim, PHD, International Centre for Research on Women, USA and Working Group on
Women Home-based Workers, Turkey
Lara Griffith, advisor on gender issues, Office for Democratic Institutions and Human Rights,
Poland
Sayora Hodajeva, deputy mayor of Tashkent, Uzbekistan
Malgorzata Kalinowska-Iszkowska, Positive Inc., Poland
Alicja Kostecka, PSF Women Centre, Poland
Ewa Lisowska, PHD, Warsaw School of Economics and International Forum for Women, Poland
Sonja Lokar, CEE Network for Gender Issues, Slovenia
Anastasia Posadskaya- Vanderbeck, director, Women's Network Program, Open Society
Institute, USA
Alisher Rahmonberdiev, director, Information and Education Centre Manizha, Tajikistan
Aniko Soltesz, SEED, Hungary
Anna Spacekova, Integra Foundation, Slovakia
Malgorzata Tarasiewicz, Network of East-West Women, Poland
Genoveva Tisheva, Gender Research Foundation, Bulgaria



The following are excerpts from an article by Stephan Geene and Renate Lorenz originally published in German as the introductory chapter of geld.beat.synthetik (CopyShop 2), Edition ID-Archiv, 1996, pp. 8-27. The full text in English (and Russian) translation was published in 1999 in the pilot issue of Tusovka <http://www.savanne.ch/tusovka/en/pilot/read-me.html>.

How We Speak about

Discourses of health, illness

by Stephan Geene and Renate Lorenz

read

A

In the course of the thematic evening on Arte [French and German culture- and education-oriented television station; ed.] on the question "Genetic engineering, danger or chance?", two French advocators and two German critics of gene technologies are invited to a round-table discussion. In her relatively long contribution, the sociologist Gerburg Treusch-Dieter criticizes the often-made demand to control the dangers and the chances of gene technologies by means of

Bio-technologies

and pretended cures

(translation from German by Alain Kessi)

me

legislation. According to her, the decisive questions elude legislative approaches. She quotes an example from the United States, where a field of genetically modified corn (Brit. maize) was flooded and the question arose as to whether the modified genes could be transmitted to other organisms through the water. The processes going on in this field are outside the view of the observer, says Gerburg Treusch-Dieter. How could one then demand that a "right" be applied? Overall the "vocabulary of security" used in such legislation shows how besides the point the social/state measures are. It is part of a militaristic language according to which, for example, a prison's "high security wing" is set up; this language cannot be reconciled with the promise of "salvation", of "healing" through gene technologies. Noëlle Lenoir, a member of the French constitution council and advocator of gene technologies, opens her reply with the remark: "I understand what you are saying, from an emotional point of view, but less from the point of view of the argumentation."

B

A scientific television broadcast: music (heart-warming). Voiceover: "Gene technology. After years of research work in the laboratory, the youngest branch of biotechnology has now reached the long-awaited breakthrough to profitability. In California at least. Los Angeles, the Golden West. There are more than 100 gene technology firms there. This is where the most important innovations of the past 50 years have come from. With a microscope and a micro-manipulator, the genetic engineer alters the genes of fertilized egg cells. Parts of a foreign gene are injected into the cell with a glass needle. Planned in advance on the drawing board, purposeful and controlled. With the penetration of the needle a new life has been created, with characteristics hitherto unknown in nature in this form. Man has now really begun to take nature, evolution into his own hands." Further on, the broadcast concentrates on the Californian company AMGEN which is already testing six genetically modified pharmaceutical products. The greatest profit – a turnover of around $ 350 million is expected – is likely to come from the production of a human enzyme ("Epo") by genetically modified bacteria. The company AMGEN uses its information edge – it maintains consultancy contracts with 12 university professors all over the United States. The television program notes that 60 scientists from Harvard University alone represent 33 biotechnology companies.

*

Gene technology is brought into circulation in society by TV programs, feature films, newspaper reports, presentations, exhibitions, advertising, discussions in doctors' offices. Representations like those in the examples above contribute to determining the social and individual relation to the models coming from science and to the promise of applications. Neither gene technologists nor critics of gene technology are immune to these effects.

Today, in general, conflicting worlds of ideas are connected to each other by gene technology: The clean, efficient, glittering images of new technologies from the computer sector reappear in gene technology as "code", "message", "copy" – i.e., the arsenal of disturbance-free + immaterial functioning. But gene technology also refers to another area, of illnesses, pregnancies, birth, dying. While the latter is associated with duration, weariness, fatigue, fear, and bodily resistance, the technology in the consumer sector is associated with speed, precision and indifferent painlessness. The term "gene technology" relates the two fields one to the other. The traditional motive (topos) of "health" fulfills the function of a mediator between the two "worlds of experience": As a commodity, health promises a way out from the socially rather tabooed zone of bodily limitations and a way into the phantasm of a sovereign existence as a consumer.

Each of us on their own goes through the socially predetermined ideological patterns which are embodied in (bio-) technologies: by falling into the trap of the technologically mediated expectations of happiness, ownership and self-experience and through individual skepticism or resistance. The obvious economical interests of the pharmaceutical industry must impose this new type of goods, i.e., must develop new forms of adaptation for the user/patient. To what extent such adaptation can be achieved by building up the attractivity of the technologies, is at this moment being field-tested through the current hype on biotechnologies and communication technologies (Internet, etc.). People are not helplessly exposed to this – be it only because past attempts to allow other forms of attractivity ("jute instead of plastic") are an integral part of the set of social instruments. This finds its prolongation on the level of the resistance against the authoritarian gesture of medicine (and reaches all the way to the wide dissemination of alternative medicine + then turns into the integration of this critical potential into a 'window' of the capitalist choice of goods).

a

The disparaging of the feminist sociologist Gerburg Treusch-Dieter in the TV discussion shows that the debate around gene technology is not about the pros and cons of 'good' arguments. The knowledge on genetics and gene technology is considered to be expert knowledge not accessible to persons outside a constructed community of natural science. While this knowledge is considered to be objective, criticism/resistance is considered subjective (attributions which apply doubly to female critics). There is no way to speak of a balanced coexistence – often demanded in the name of 'pluralism' or 'democracy'. Arbitrary disparaging, intrigues, deals, representations of oneself, gender struggle, career expectations etc. are part of this debate.

In this concrete example, the historical separation between the social sciences and the

natural sciences (the 'two cultures') comes to bear, in which the latter claim their need to refer to the requirement of objective facts, while the former only embody an additional cultural achievement of thinking about ethics and sense. Even if it is widely recognized by science theory that this separation is itself not objective and that mental, psychological and social factors make the scientificity of science possible in the first place (1), in practical terms all non-scientific arguments retain 'emotional value', i.e., are subjective and relative. Gerburg Treusch-Dieter's line of argument in the Arte program, pointing out the contradiction between the security rhetoric of bio-technologies and their metaphors of salvation, has a similar claim to 'objectivity' as, say, a thesis on the program logic of a cell - both introduce into their observations preliminary knowledge and prejudice, both make an implicit judgment on what might be sensible in research. The 'world stands on its head' when, as in the Arte program, the line of argument of Treusch-Dieter receives sympathy, even approval, but this explicitly refers only to its quality as an emotion (the moderator becomes pathetic and thinks he sides with Treusch-Dieter when he expresses how important he thinks emotions are in this debate) and thus denies the seriousness of the argument.

b

The TV program on the AMGEN company however names the economic relations + dependencies between research and applications - the industry finances research at universities and thus makes decisions on potential research projects. The universities pass on information about potential areas for investment to the industry, which in turn sets the trends for research projects. Despite this critique the program contributes to imposing the model of a gene technological intervention - the assumption that specific DNA fragments can be included in cells in such a way as to have a predictable effect on the functioning of the organism. The inclusion of the DNA fragment is represented in a computer graphic and apparently 'observed' through a microscope. It is commonplace even in TV programs critical of gene technologies to use computer graphics without labeling them as simulations. It is thus suggested that the transfer of genetic material can be visualized or controlled in this way. The representation in the program anticipates the 'success' - both economical and technological.The non-functioning of so-called gene therapy (a word creation which already links the gene technological intervention with medicine, with the anticipated 'healing') on the other hand shows that such a simplified model of control cannot be applied to the phenomena observed.

DNAss

Gene technology belongs to the bio-technologies, in the sense that the latter designate all technologies in which one proceeds purposefully on a biological/biochemical level. On the other hand, the term "bio-technology" receives its strong meaning only with the spread of gene technologies.

This central position of gene technology for the new industrial applications of biology/chemistry/bio-technology stems from the fact that gene technology sets to work at the point where organisms are themselves active in producing, namely at the growth stage, i.e., the cell division.

Genetics, the 'science of heredity', is not new; the fact that characteristics are transmitted is obvious from family resemblance. The historical development of genetic research from the experimental 'beginnings' to its apparent breakthrough with the discovery of the double helix has followed a winding path and can be told in different ways.

The plausibility of the double-helix model - i.e., its success in the science community - has lifted cognitive contradictions and unified fragmented approaches. In principle, i.e., on the level of the model, what happens in the cell now seems explainable. Precisely these models of genetic activity which are present nowadays on all levels of communication are a problem in themselves, with their one-dimensional technicality charged with meaning. To repeat them here in the book instantly brings along the whole scenario of a truth of life held in technical termini. The endless metaphorical descriptions of the 'program', the 'building blocks' or the 'alphabet of life' carry, besides the claimed (but never materialized) determinism of the cellular processes, also a reification of what life is supposed to be. While 'life', 'growing up', and 'death', as subjective factors are experienced [by the subjects; ed.] as rather obscure + contradictory, a phantasmagoric substance which - once completely grasped - is meant to embody the solved riddle of life, is now offered to the subjects.

Is the description of cell division accurate or not? - This question is not put correctly: Obviously there is 'something' in the cells that can be described in this way; if this was not the case the experiments could not be made. But - by what criteria are the categories, the drawing of boundary lines, the discarding of that which is considered irrelevant, determined? For the material described here could also be analyzed uring different parameters, according to other criteria, if everything was not

Note 1: Cf., e.g., Thomas S. Kuhn, 1967.

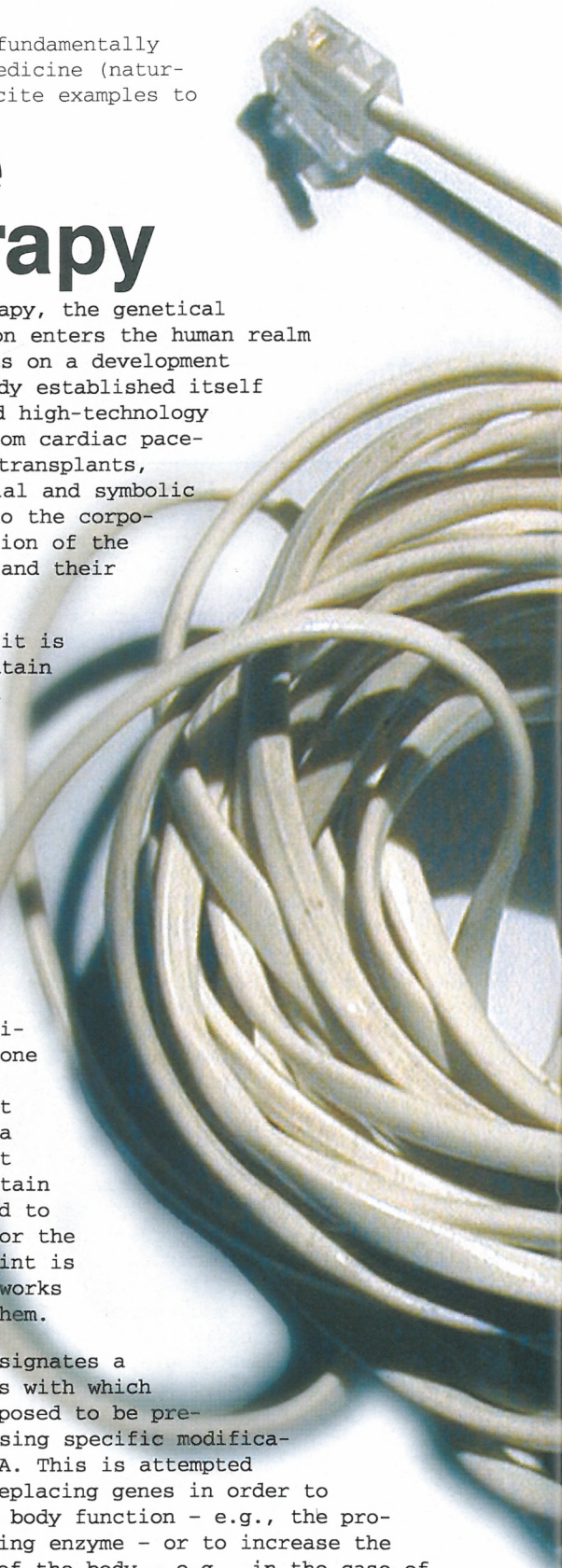
already 'arranged' in the experimental setup (the training and selection of the scientists, the financing, the machines to be used, access to the laboratories, the formulation of research goals, etc.).

Seen from this perspective the technological approach is not fundamentally more correct than for instance an approach based on natural medicine (naturopathy). But neither is it more false. The various 'schools' cite examples to prove the extraordinary conclusiveness of their approach + always also refer to especially glaring examples of the failure of the other 'ideological' approaches. The question which arises as political in this context is in what continuity + with what tendency the 'facts' are selected (e.g., the historical continuity of biologizing and eugenics). On a more concrete level however such models must be judged based on what role they attribute to the subjects. The deterministic picture is especially elaborate in giving the subjects virtually no freedom of movement to interpret their own state + to deduce an action from this interpretation - the subject is faced with a mechanism that can be treated only through a medical complex/system.

The establishment of the double-helix model led to the formulation of the so-called Central Dogma according to which the genome determines body traits and characteristics (the DNA moulds the RNA, the RNA the proteins), but can itself never be influenced in its turn. The hereditary material present in the somatic cells thus determines the processes of life, but is not itself influenced by these processes.

The Central Dogma has been repeatedly challenged and has nevertheless remained to this day the yardstick for the representation. Epigenetic functions influencing the expression of genes, according to the US molecular biologist Richard Strohmann, are thus not taken into account. "Let us assume that 100 genes are involved in an illness (such as high blood pressure or cancer) - this is not an unrealistic number. These genes code 100 proteins, some of which are enzymes, so that we have an epigenetic network of 100 proteins, numerous biochemical reactions and many reaction products. This is a system which evolves from minute to minute under the influence of signals from the body and the environment and feeds back to the DNA through various components, thus controlling the expression and non-expression of genes." (2)

Gene Therapy



With gene therapy, the genetical technologization enters the human realm and thus carries on a development which has already established itself in the so-called high-technology medicine and, from cardiac pacemakers to heart transplants, implies existential and symbolic interventions into the corporeal self-perception of the people concerned and their surroundings.

For gene therapy it is necessary to maintain the Central Dogma for, unlike in laboratory cultures in which it is sufficient that from an arbitrarily large number of cells some turn out to react to the manipulation in the manner envisaged. In the application to humans one must be able to expect the highest specificity; for a patient, it is not enough that a certain percentage respond to the treatment - for the individual the point is that the therapy works successfully on them.

'Gene therapy' designates a variety of methods with which illnesses are supposed to be prevented or cured using specific modifications of human DNA. This is attempted chiefly through replacing genes in order to control a desired body function - e.g., the production of a missing enzyme - or to increase the immune responses of the body - e.g., in the case of cancer. The DNA fragments required are to be introduced into the body cells by means of genetically modified viruses or through physical methods. So far no illness has been demonstrably cured or improved through gene therapy. Richard Strohmann notes that at best 2% of human illnesses make sense as targets for gene therapy,

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Note 2: Richard Strohmann in a discussion with Ludger Weß, *Die Mausefalle - Der Molekularbiologe Richard Strohmann über das erfolglose 'genetische Paradigma' in der Medizin*, WoZ 17. November 1995. (Engl. "The mouse trap - the molecular biologist Richard Strohmann on the unsuccessful 'genetic paradigm' in medical science")

since all the others are due to the complex interaction of many genes and environmental factors. But even 'monogenetic' illnesses, i.e., illnesses provoked by a single gene, can in no way be explained using the simple model of the double helix and the Central Dogma, says Strohmann looking back on his 20-year-long research on muscular dystrophy (a muscle-wasting condition). "Take for instance the BRCA-1 gene, the so-called breast cancer gene: So far over 100 mutations have been found in this gene, and there is no correlation between the mutation event and the symptom; the same applies to mucoviscidosis. This means that even these monogenetic illnesses for which there are linear models - here the gene as the cause, there the illness as the effect - are non-linear. Whether a mutation will give rise to a product which is defect, normal or anything in between, depends on the circumstances, on the genetic context, on the environment and a combination of these factors; and it is practically impossible to predict these elements of modulation and regulation." Here, Strohmann disputes the affirmation made in human genetics that hereditary and environmental factors are additive and can therefore be analytically separated from each other.

The expectations of profit linked to gene therapy are based on the possibility of bringing a row of completely new medication onto the market. Specifically, the patenting of processes of therapy would become possible, which has so far been ruled out. Because the European Patent Convention excludes patenting of therapies only on the human body; the gene therapeutic treatment however is applied to cells temporarily extracted from the body. These economic factors also apply to the whole spectrum of prenatal diagnostics being developed at this moment, i.e., the prediction of illnesses for which no symptoms are apparent (yet). Predictive diagnostics is applied prenatally, i.e., fetuses are tested for certain genes in order to get confirmation that the child will not be born with a so-called hereditary illness, or disabled. Since the tests are available, every pregnant woman is individually forced to make a choice as to whether she wants to make use of them or not. As a woman grows older, or if illnesses conceived of as hereditary have occurred in the family, the medical doctor - but also representations in magazines, TV programs, etc. - will recommend that she make use of the test. The availability of the test creates a coercive situation - omitting to have it loads as much of a burden of responsibility on the woman concerned as the test she actually goes through: the choice is thus between two 'dangers'.

The test creates the possibility for the practice of eugenics also based on economic criteria. In the Ukraine a medical-genetic decree effective as of 1993 requires every pregnant woman to undergo several prenatal examinations. According to WoZ 8/96 [WochenZeitung, a weekly newspaper from Zürich, Switzerland; ed.] the representatives of the authorities in the region of Chernobyl openly mention that fetuses with anomalies would have to be aborted because the state lacks the means to look after disabled people.

That a person with a gene for high blood pressure should not have high blood pressure is an 'exception to the rule' in the logic of gene diagnostics. The exception must by all means be integrated into the rule (by making the rule more specific or by adding a 'yet'; the person does not y e t show signs of high blood pressure + if they die at some point, they died before the illness manifested itself), or the theory is abandoned. At any rate the field to be regulated conforms closely enough with this training of regulation to suggest homogeneity even where the individual experiences just as often testify to the failure of the rule. How often do we hear of wrong diagnoses; how often do people contract a life-threatening illness + the cause + possible treatment remain unknown. Not to speak of the fundamental incapacity of classical medical science in the face of AIDS and most forms of cancer. But it is not for its failure that mainstream medical science and research should be blamed, but rather for covering up its incapacities + standing in the way of seeing the field of illness as more complex.

Machine

The health system, the macrostructure of the pharmaceutical industry + presently the need arising from a capitalist crisis to develop new markets using gene technologies. The fact that bio-technologies are always developed and applied in an existing social context explains why critics cannot make any difference, or so little, in parliamentary committees or so-called 'bio-ethics' committees. Ethical criteria for the application of bio-technologies accept the existing capital structure as the basis of society and pretend that its members are equal. They reproduce the socially effective mechanisms of exclusion instead of attacking them as the triggers and concomitants of a bio-technological ideology of progress. In Switzerland for instance, asylum seekers are denied kidney transplants.

Looking at reproduction technologies we can also clearly see how the development of medicine remains in agreement with the social regulations of normal/abnormal categories, but also of sexuality and gender and does not lead to an increase of self-determination. Since the eighties, the relationship between technologization, expectations of profit, and control has been described by women's/lesbian groups under the keyword of 'demographic control'. Thus beyond the expected profit in-vitro fertilization, fertilization in a test-tube, stands in a social context which reinforces the family model with a legislation allowing IVF only for married + hetero couples. Since IVF does not treat an illness, politicizing it, e.g., through self-help groups, is difficult and possible only if women have already been damaged through the massive hormone treatment or the long-lasting + painful but mostly unsuccessful therapy. A critique of IVF cannot however consist solely in pointing out the dangers + the limited prospects for success. 'Image pollution', or the attempt to circulate different images, inherently accepts the commodified nature of reproduction technology. 'Counter-advertising' can function as counter-information, but also serves the individualization driven by the bio-technological promises.

Since the birth of Dolly the cloned sheep in February 1997, assiduous attempts have been made to emphasise the potential benefits of human cloning techniques which do not result in a cloned baby: replacement body organs; cancer and ageing research; testing new pharmaceuticals, to name a few. Such research would pave the way for the replication of humans and for human genetic engineering.

CornerHouse Briefing 16

If Cloning is the Answer, What was the Question? : Power and Decision-Making in the Geneticisation of Health
by Sarah Sexton

<http://cornerhouse.icaap.org/briefings/16.html>

FairPlay presents the performance "The Real Thing" by Adelina Popnedeleva and Michele Beck

The Real Thing

part of the project "Bulgaria, NY – Bulgarian and American Women Artists Collaborate" at the Elizabeth Foundation for the Arts in New York, 2-28 November 2000.
The two artists developed their collaborative work first over e-mail, having not met yet, and finalized it together in New York. Seven Bulgarian and seven American women artists participated in the project, teaming up by pairs.

Never before have so many and such different societies embarked all at once on changing traditional ways of life. Ten years after the fall of the Iron Curtain it's time to unveil the untold story of transformation, the challenges, the progress and the backlash.

Fair Play tells you what it means to:

- be a fourth-generation working woman with full responsibility for a family
- learn to have a voice of your own at the age of 40
- have excellent professional qualifications and yet be unwanted on the job market
- feed a family on an extremely low income
- fight social degradation and exclusion
- be blamed for not wanting enough children
- be capable of reviving communities and social fabrics destroyed by chauvinism and intolerance
- challenge dominating rules and attitudes

This is the real life story, told through women's eyes. This is the story only FairPlay has.

Share good news with a colleague!

if you know someone who is interested in learning about empowering women in changing societies in Central and Eastern Europe, please fill out the form below and send it to the Editor of the FairPlay magazine:
Women's Alliance for Development, 52 Neofit Rilski Str., 1000 Sofia, Bulgaria; e-mail: wad@infotel.bg, and we will send them a sample copy.

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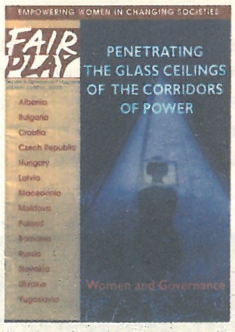

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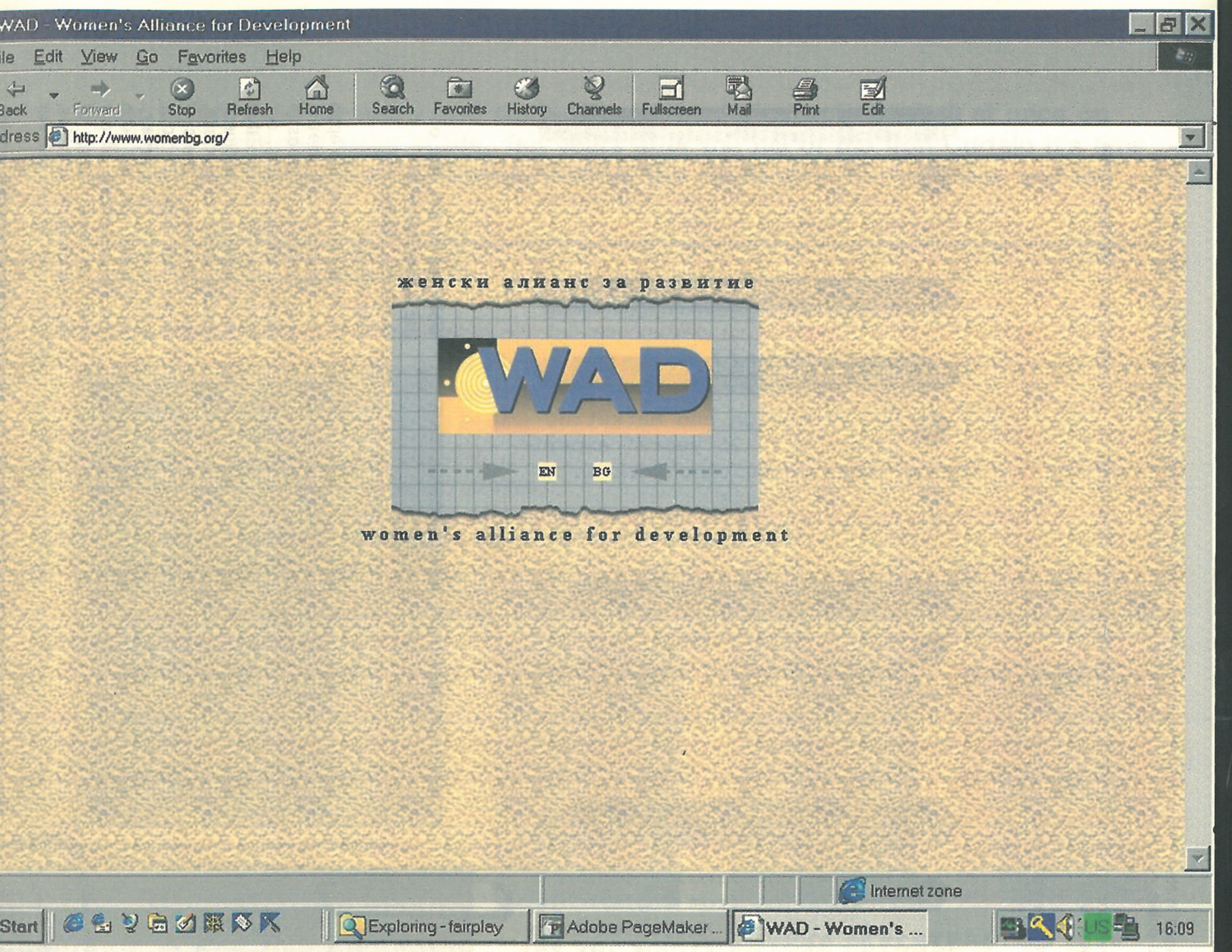

Women's Alliance for Development The Web Site! Women's Alliance for Development The Web Site!
http://www.womenbg.org http://www.womenbg.org http://www.womenbg.org

You will find a wealth of information about the projects, publications and activities of the Women's Alliance for Development, but also on women's organizations in Bulgaria, Eastern Europe and world-wide.

News briefs, announcements of upcoming events, reports on meetings and seminars, contact information and presentation of organizations.

Bulgarian and international networking,
the Karat Coalition,
and of course
FairPlay, your Gender & Development Magazine.

SUBMISSION GUIDELINES

The mission of the FairPlay quarterly is to provide a forum for women in the CEE/CIS countries to exchange ideas and best practices to improve social, economic, political, and legal conditions for women, their children, their families and their countries. It also aims to be a voice that carries and interprets grass-roots women's concerns to national and international policy and decision-makers.

Make your voice heard! Send in your articles and artwork.

What kind of submissions are we looking for?
Interesting, readable, personal articles with compelling headlines and sub-headings which

- illustrate the plight of women living under certain conditions and show how conditions, cultures, laws, and financial situations can affect women's life and the life of her family.
- show how women have overcome certain negative conditions by working individually, in groups, with decision-makers, through NGOs, and benefiting from support from funders or from changes in laws or policies.
- present analytical views of a given topic – analyses of situations, tendencies, trends, policies, and possible solutions to concerns that affect women.

Submissions should express the views and analyses of the author on situations, tendencies, and trends. The use of statistical data is encouraged to strengthen and add credibility to the position/analyses. Please be sure to cite sources for all statistics and materials quoted. Materials providing a regional view are highly appreciated.

Please follow these format guidelines:

- Contributions have to be written in English;
- articles must have a clear logical structure, ideas be clearly explained;
- art work should be accompanied by conceptual text and brief CV (descriptive, not list of exhibitions);
- send in a few sentences about the author;
- attach contact information, including Web sites, e-mail if available.

We strongly encourage writers to contact the editor-in-chief in advance, to ensure that their submission is suitable.
Articles will be edited. FairPlay retains the copyright for original contributions.
Artistic submissions should be either slides or photos. Submissions will be returned after the issue is published.

Coming Issues

- **Violence:** domestic violence, sexual harassment; trafficking in women, armed conflicts, violations of women's Human Rights
- **Diversity:** disabilities, Roma, indigenous women (far North), sexual orientation, polygamy
- **Media:** gender images, advertising, Internet, legislation, ethics, pornography, women media workers, sexist language

You may also submit materials on other topics if you think there is a considerable interest in them.
Send all submissions: by e-mail to <fairplay@womenbg.org> or by post to Women's Alliance for Development, 52 Neofit Rilski, 1000 Sofia, BULGARIA.

It pays to contribute! You

- make sure your country's activities are presented to funders and other supporters abroad,
- ensure your country's activities are elaborated and clarified in a prestigious document suitable for reading by your Members of Parliament and others in a position to make changes in your country
- will receive two free copies of the issue in which your contribution has appeared
- will receive one free classified add in FairPlay.

The **Center for Reproductive Law and Policy** (CRLP) is a non-profit organization based in New York and Washington, DC dedicated to promoting women's reproductive choices. CRLP's domestic and international programs engage in litigation, research, policy analysis and public education in efforts to achieve women's equality in society and ensure that all women have access to appropriate and freely chosen reproductive health services.

The full text of many of our publications can be found at no charge by visiting our web site at <http://www.crlp.org/publications.html>. Specifically, our 194-pages report **"Women of the World: Laws and Policies Affecting Their Reproductive Lives – East Central Europe"** can be found at **www.crlp.org/pub_bo_wowece.html**

Katherine Hall Martinez Deputy Director, International Program Center for Reproductive Law and Policy
120 Wall Street, 14th fl. New York, NY 10005 U.S.A.; tel ++1-917-637 36 18, fax ++1-212-701 87 70, e-mail: <kathy.martinez@crlp.org> Web: <http://www.crlp.org>

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W.A.D. offers leadership and gender training in nine different areas.
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Wad@infotel.bg

Translation

Written and simultaneous translation from English into Bulgarian and Bulgarian into English.
Anelia Vassileva
tel/fax: +359-2-9805532; 9805920
e-mail: nelly_vas@yahoo.com

Exchanges

Employment Opportunities

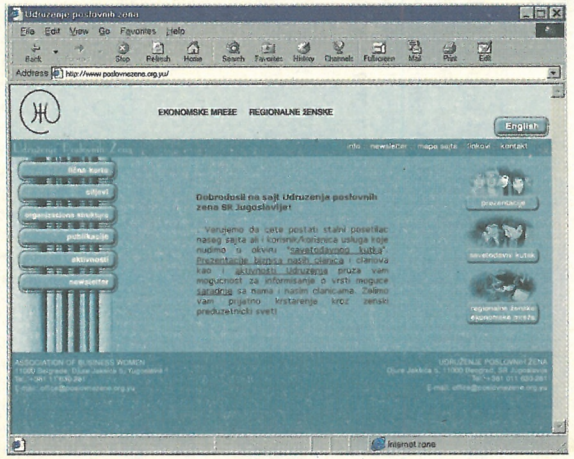
Volunteers Wanted

Intern/volunteer wanted for the Women's Alliance for Development office in Sofia. Interesting work on different projects including the FairPlay magazine.
wad@infotel.bg

Miscellaneous

Regional Craft for Sale

Web Master Services



Welcome to the site of the Association of Business Women of Yugoslavia!

We kindly invite you to open the treasury of ideas, projects and businesses of women entrepreneurs, our members. We believe that you are going to become a regular visitor of our site, but also a user of the services we offer in our **Advisory Corner**. On our site, you will also find **presentations** of our members' businesses, of the Association's activities, as well as information on various possibilities of cooperating with us and with our members. http://www.poslovnezene.org.yu
We wish you pleasant surfing through the women's entrepreneurial world!

Who are you?
A: I am a leader for young Europe.
M: I am a moment of this moment.

Where did you come from?
A: I come from Adelina country.
M: From a place that is present and misplaced.

Why did you come here?
A: I am here because I choose an American original.
M: I came here to try to touch what disappears.

How are you feeling now that you are here?
A: I am feeling like a woman.
M: I am feeling like what is empty and what is open.

What do you think about our country?
A: It's the real thing.
M: It is not – and it is. Beautiful surface, meaning and hallucination.

What do you believe in?
A: I trust only in the true values.
M: I believe in contradiction and pleasure.

What do you want to wish the American People?
A: I wish you to be wild, to be young, to be free forever. To be fresh and beautiful, to be sweet and sexy.
M: I wish for them to discover that there is a word in language called citizen.

What do you think about the future?
M: The future...? To create the future.
A: Enjoy the future!

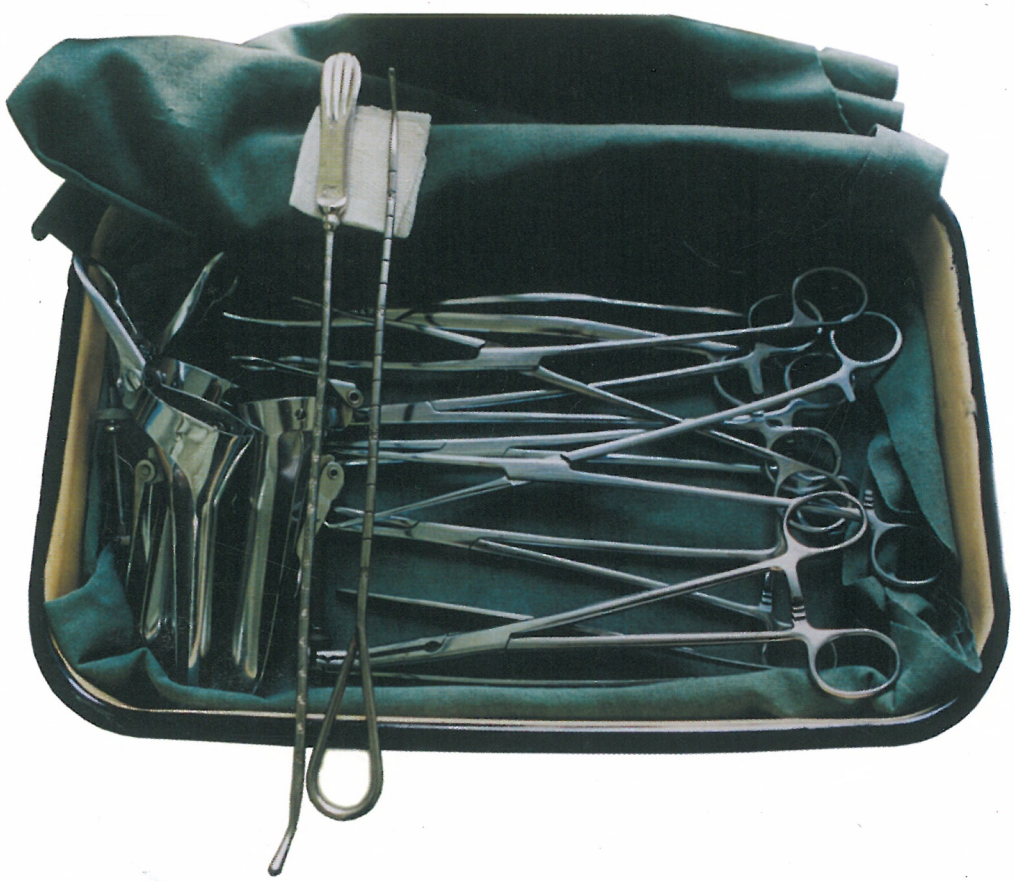
A: Let's make things better!
M: Make everything better.
A: Yes, let's make things better.

Michele Beck was born and lives in New York. She graduated with an MA from Parsons School of Design, New York, in 1996. She works mainly in the United States and in Spain, doing performances and video installations.

Adelina Popnedeleva was born and lives in Sofia. She graduated in textile design from the Art Academy in Sofia in 1988. Her earliest works display the means of expression and methods of woven fabrics, but are invested with social meaning expressing the attitude to the social changes that have occurred after the mid-1980s. She has created objects and installations, working with hand-made paper, wire, color slides, video and sound.

The Real Thing, New York 2000 Michele Beck Adelina Popnedeleva

4/2001



Since 1989, the citizens of all of the seven East Central European countries have experienced reduced access to health care – a loss of an important social right achieved under state socialism. This does not mean that all health care services were up to WHO standards of care, or that free, universal health care was economically sustainable. However, the regional trend towards privatization in health care has had detrimental consequences, such as a decline in overall health indicators, and a looming sense of malaise.

"Women of the World: Laws and Policies Affecting Their Reproductive Lives - East Central Europe", The Center for ReproductiveLaw and Policy (2000)

fair play