

EWHNET
European Women's Health Network



Women`s Health Network:

**State of Affairs, Concepts, Approaches, Organizations
in the Health Movement**

**Country report
Germany**

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Part I

1. Introduction

Similar to other West-European countries, the women's health movement came up at the beginning of the seventies. Two events were important for the development:

- The campaign for legal abortion, which united a large number of women
- Some Californian women visited Berlin, introducing the method of self-examination

In between diverse approaches, organizations and institutions have been developed. A big part of them is working autonomously or rather getting financed by their own at a large degree. Main topics are clearly recognizable at the field of health care, health education and counselling. Questions on women's health also extended to associations (adult education centres and charitable institutions) and governmental institutions. Especially the women's representatives at a communal level are concerned with topics in the field of women's health. Also, these questions are increasingly accepted at the level of politics, but the relevant ministry itself doesn't offer its own main topic on women's health. Instead of this the federal ministry for families, women, seniors and youth as well as other public and political actors (as e.g. the federal head office for health education and lately the German city association (Deutsche Städtetag) are dealing with the issues of women's health as a cross-sectional task. The medical system itself is just about getting influenced. Now and then the educational system starts to include some perspectives on women's health. Also (singularly treatment, rehabilitation and psychiatric institutions took over women centered approaches.

Although the German health care system shows high standards when compared, there are a couple of areas, which women would like to criticise and get changed. The following topics are discussed: professional competence, conflicts about methods, that are more adequate, differences between women. The first topic is about different models of treatment and support, e.g. gynaecological problems, pre- and perinatal company, psychotherapy and reproductive technologies. Further discusses topics are unnecessary operations, violence against women, menopause and hormonal substitution, mammography-screening, suppressing women's voices in research. The discussion about the meaning of differences among women is related to different aspects of discrimination, to different disorders, different ethnic groups as well as different sexual orientations.

The following survey doesn't claim to show all developments, aspects and topics. But it might offer a survey on some topics and organizations. Single thematical aspects, that show more depth are meant to offer you a choice. Each constituent may be read independently from others. The single parts are based on the following questions:

- What was the reason for arousing displeasure and conflict?
- Which structural problems became clear?
- Which different solutions could be identified?
- Which organizations focus on the issues?

The former project-leader of EWHNET Dr.Vera Lasch and her collaborator Brigitte Hantsch (The Institute of Women in Society) are responsible for the selection of the contributions, the introductory frame and the characteristics of the health systems. A revision of the report and supplementing with the texts concerning violence against women and health as well as concerning the women's health research in Germany was undertaken by the recent project-leader Ute Sonntag and her colleague Katja Eichler (Landesvereinigung für Gesundheit Niedersachsen). The contributions have been written by experts in the field of women's health.

2. Aspects of the women's health movement

In Germany, when the talk turns to the women's health movement, it mostly refers to the development in Western Germany. This doesn't implicate that in Eastern Germany women's health was no issue of concern. Here however, it was an integral element of a "socio-political model" of governmental life welfare. The state felt responsible for guaranteeing social conditions supporting women's health. This included especially legal arrangements of compatibility of professional and family life (legal protection of expectant and nursing mothers, maintenance of industrial health and safety standards, day-care, excuses in the case of illness), care for health through examinations at business and securance of the financial frame, so that illness and its effects wouldn't put too much stress on women. Family support, living, recreation and taking part in culture were also included. In this governmental frame abortion as a way of family-planning was integrated. There was no public discussion about women-specific desires and problems. Some special problems like violence within families and the medicalisation of depressions got tabooed. The reunification dissolved the structures of the governmental health system. Health became a matter of supplier and demander based on one's own initiative. On the one hand issues that were tabooed up to then now were considered, as e.g. the installation of a women's emergency call, houses just for women and care in the field of psychiatry in the community, as well as women-friendly initiatives and women's health centers. On the other hand socio-political structures for an existence insurance for women have ceased, as well as the only chair of social gynaecology, which was run by a woman.

In Western Germany the women's health movement started with three topics:

The fight against the criminalisation of abortion, the changes in the patterns of birthing in clinics and the criticism of getting expropriated by the medical system. In the field of health these three topics reflected the women's movement's fight for self-determination which has lead to a general sensibilization in regard to male dominated structures of power. Debating women's health means debating women's roles in society. It should end up getting politicised in order to raise consciousness about suppression. The critical view on the medical perspective of women's bodys and treatment of women resulted in a desire to set an own perspective and tacit female knowledge (the knowledge of midwives, natural healing) against this pejorative view. Women in self-organized groups began to examine themselves. They discussed femininity. Early the demand for women's health centers came up. The first was founded at the end of the 70s in Berlin, more were to come. The criticism on the medical system was concentrated on some areas of conflict:

- reductive organ-medicine versus holistic approaches
- hierarchical versus egalitarian structures
- pathologising versus high regard
- medicalisation versus natural healing

According to the lack of public knowledge of female bodily functions, of female lifestyle and problems, important aims of the women's health centers (and not just of those) were (and are) *passing on knowledge* (in the field of gynaecology and biomedicine, in natural healing, in alternative and preventive health care) and the *guidance for self-help* as well as *supporting powers of self-healing*.

In the 80s violence against women was discussed increasingly, ending up in building decentralised institutions for shelter and help. Moreover already existing therapeutical approaches were debated critically. Women specific concepts of therapy and institutions of counselling (e.g. for eating disorders, drug counselling and therapy as well as some help for people with Aids) came up as well as methods and institutions of feminist therapy. Concepts and offers for health care were developed and extended. In the field of science, questions about

gender differences that were raised in the field of gender studies are also related to issues of women's health.

At the end of the 80s and the beginning of the 90s nationwide and interdisciplinarily working national organizations and networks were installed, as well as approaches of a better cooperation and coordination at the local level (but not as a "healthy community" project with a women specific main emphasis as in Glasgow). And the women's perspectives was debated carefully in the professional associations of medical doctors.

The women's health movement extended rather fast from the main emphasis on reproductive health to further areas. It is difficult to reduce the recent situation of the women's health movement on a common denominator. "Autonomy" versus "integration" describes one area of conflict. To a large extent the women's health movement in Western Germany follows the principle of autonomy. Independency of "heteronomous power" and financing as well as strengthening the independency of advice seeking persons of institutions as a principle of help for self-help are ambivalent in their results. They protect from absorption and activate the search for independent solutions, but are also related to the danger of isolation. This tendency well describes parts of the German women's health movement. It is necessary that the addressees want to get better self-organised and self-responsible. In this regard an alternation of generations shows up. A part of the women demand some individual and specialized help, that doesn't correspond with the group-oriented structure of many offers. Consum-oriented offers as e.g. fitness compete with occupying with oneself through a self-examination. Young women start from the achievements of the women's movement, without taking any notice of it's aims and contents.

On the other hand the development shows, that integration (e.g. by communal and federal promotion of women's consultation) and change within the groups and initiatives does occur. The following in -depths contributions will show that this development is not in all cases unproblematic.

Also within the health system new problems have emerged. This is e.g. true for the legal changes in advice services concerned with abortion and also for the consequences of the health reform law by e.g. expanding extra pays and limiting expenses in the field of health promotion.

3. In-depth contributions

3.1 The rise of gynaecology and the pathologisation of womanhood under special consideration of female transition stages: puberty, pregnancy and menopause

Eva Schindele

3.1.1 The rise of a profession

In the past 30 years gynaecology has gone through an impetuous development. In the former West German States the number of registered gynaecologists doubled from 3870 surgeries in 1976 to 7811 in 1997.

At the same time gynaecologists have become women's family doctors. Nevertheless, most of the women who consult a gynaecologist are not ill, but, at most, uncertain about their womanhood.

Gynaecology in the last decades managed to seize power over healthy women and to influence radically their self-perception (cp. Schindele 1993/95)¹. Several factors have pushed ahead the rise of this profession in Germany.

3.1.2 The boom of hormones

The success of gynaecology is closely linked to the pharmaceutical industry, especially with the boom in producing synthetic hormones:

- hormonal contraception (birth control pill) which have become more and more accepted as the standard contraceptive since the 1970s
- hormones, taken to regulate the cycle and to stimulate ovulation for in-vitro-fertilisation (since the middle of the eighties).
- substitution of hormones during menopause (since the beginning of the eighties)

Hormones are available on prescription only and require regular examinations by a gynaecologist. This makes women dependent on experts. Gynaecologists have become consultants concerning sexuality and partnership problems. Not only have gynaecologists as organ doctors hardly any knowledge about psychological or psycho-sexual questions, but also the questions of contraception or partnership conflicts become a typical woman's problem and women are thus supposed to be responsible for their solution.

3.1.3 Risk factor: being female

Women have been made dependent on gynaecology above all by introducing the term "risk factor" into this field. Who is not intimidated by the great number of risks women are allegedly exposed solely because of their sex? At the same time risks are not more than sheer calculations of probabilities for an incident that could happen or not. Gynaecology offers to overcome these statistical risks by steady controls of the individual woman, but quite often without any scientific studies proving that the one medical treatment or the other really makes sense.

¹ Schindele, Eva: Pfsch an der Frau. Krankmachende Normen. Überflüssige Operationen. Lukrative Geschäfte. Aktualisierte Ausgabe: Frankfurt /M.: Fischer Taschenbuch Verlag GmbH, 1996

The idea of prevention has been propagated by gynaecology more and more in the last decade. It includes a very limited idea of prevention: the early detection of symptoms in order to be able (it is at least hoped) to treat them better in this phase. Prevention means then to check constantly the female body and to look for pathological complications. Simultaneously, it is often difficult to draw a line between pathology and something which is "still normal". Therefore a lot of deviations are suspected in advance as pathological, in order to keep them under control.

There is an implicit threat to women at the center of this propaganda: they will fall ill, if they do not follow the doctor's advice, if they do not have a mammography, early diagnosis check-ups or if they do not go to pregnancy care and do not take hormones. This term - risk - conveys from the very beginning a fear of illness (or, in case of pregnancy, the fear of an ill/disabled child) instead of promoting the joy of living and joy in one's own body.

Female life transitions

Women do live in month and life cycles. Puberty, pregnancy and menopause are transitional periods which are not only accompanied by physical changes, but which also include an emotional-mental and social component. Especially in these transitional periods women feel insecure and seek support and advice from their gynaecologists.

Puberty

Already young girls learn quite early that seeing the gynaecologist is a part of growing up and becoming an adult. Girls describe their first experiences with the gynaecologist partly as an initiation rite, as an introduction into a kind of culture which defines and checks their femininity with the help of male and female specialists. They learn that their normality has to be confirmed regularly by experts. Not only are their sexual organs placed at disposal, but also their self-images as women, including different roles they will fulfil in our society e.g. as wives, lovers or mothers.

Such experiences shape girls' self-understanding and self-estimation. With entrance into their physical fertile phase of womanhood, a visit to gynaecologist is benevolently recommended to girls as a "service" for the body. Female sexual organs are described as a ticking time bomb which could allegedly threaten woman's integrity what can be prevented by gynaecologist.

That is why girls are early informed about their sexuality being needed to be controlled and especially their sexual organs. They receive little motivation to listen to their own physical impulses or to trust them. Their body (and their sexuality) become the business of experts. In this way the foundation for a dependent patient is being laid, for a patient who is going to see the gynaecologist for the rest of her life in order to receive confirmation she is healthy and 'all right'.

Pregnancy

Pregnancy and child birth in Germany are by now less social events than medical projects² Being pregnant has been re-interpreted as a risky state, which should be permanently controlled by the gynaecologist. The possibility of projecting the picture of an unborn baby onto a monitor has changed the view and the opinion of pregnancy. A powerful female body became a naked embryo and medicine felt the call to protect it (sometimes even from its own mother). Thus, nowadays, medicine is less interested in the relationship between a pregnant woman and a baby in her womb, but rather in optimal 'pregnancy product'. Pregnancy care has become a check-up of pregnant women and their foetus. The number of medical examinations

² Schindele, E.: Schwangerschaft. Zwischen guter Hoffnung und medizinischem Risiko. Hamburg: Rasch und Röhrig, 1995

is five times as high as 15 years ago and the number of caesarean sections and of women which are being classified as risky cases has risen drastically (1996: 17,8%).

Menopause

Gynaecology has appropriated especially this stage of female life in recent years. Women have been confronted with new terms such as 'hormone substitution' and 'osteoporosis', terms which per se are connected with a terrible vision of old age. Women have been told by experts that menopause is a process leading to illness and that oestrogen substitution is one of women's basic rights³. There is a threat behind this demand for the right to hormone substitution: if you don't go along you will die sooner or later from osteoporosis or a heart infarct.

Gynaecology does not show much respect for elderly women. Their wombs are described as being "rotten", "decomposed", "heavily cartilaginous" or as "redundant". In this way a message is given to women that their sexual organs and they themselves are not very valuable anymore. According to some experts' estimation, until some years ago wombs were regularly removed before or during menopause, and about 80% of them without any reasonable medical indication. As a consequence, every second woman over 50 in Germany has her womb removed. (Ehret-Wagner, 1994)⁴ By now, because of the massive critique expressed by many engaged female gynaecologists, the number of hysterectomies has declined. Still, as recent developments show, the total amount of gynaecological operations has not decreased. Particularly 'quick' endoscopies are often applied, as well as laproscopic extirpations of cysts, which disturb anyone but the gynaecologist. Because of false positive "results" by mammography the extirpation of breast tissue has increased as well.

3.1.4 Women's expectations of gynaecology

Without women's willingness to co-operate, gynaecology would never have invaded sexual intimacy to such an extent. Women expect support and security from gynaecology when they feel irritated by their physical states. This occurs especially during transition periods. In cases of clashes between expectations of society and conditions of one's own body, women long for medical support. This, for example, applies to the menopause: e.g. one of hormones producers propagates hormone substitution with the slogan: "No time for change"

Gynaecologists are regarded as cultural agents which not only help to produce children, but also which give the guarantee of creating healthy children, an image reinforced by their own propaganda.

3.1.5 On the agenda - placing the women's health movement

The Women's Health Movement criticizes pathologisation of femininity. In the 1970s and 1980s many women's health centers were established in order to enable women to have non-medical access to their own bodies, for example with the help of self-examinations.

In the last 15 years the Women's Health Movement has developed more and more into self-help movement. Practical help and support in self-help are its main foci. Quite often its advisers and counsellors are fully occupied with reducing the negative effects of the standard medical system.

³ Quoted in: „Balanceakt der Hormone“ in Focus 7/93

⁴ Ehret-Wagner, Barbara; Stratenwerth, Irene; Richter, Karin (eds): Gebärmutter – Das überflüssige Organ? Sinn und Unsinn von Unterleibsoperationen. Reinbek/Hamburg: Rowohlt Taschenbuch Verlag GmbH, 1994

Initiatives directed at structural changes within the established medical systems have been neglected in recent years. Some groups did express their opinion on health-political questions, such as pregnancy care or prenatal diagnosis, but only in a very modest and basic way. Women are seldom lobbyists for women's health and only few laywomen dare to enter the terrain of public-political discourse. And yet some critique expressed by the Women's Health Movement has been brought into some institutions, for instance into Pro Familia, an organization which by its prevention and advisory activities aims at strengthening women's health competency. Moreover, there are so-called 'round-tables' at a communal level, in which professional women from the health care field and from self-help groups discuss the latest problems of health politics and try - at a communal level - to change political decision-making processes in favour of women-friendly medicine. The Forum for Women's Health in Bremen founded in 1995 is one example for it.

Can gynaecology be changed by women patients or would this role expect too much of them? After all, the majority of women doesn't question gynaecology and its image before having made bad experiences with it. Others start brooding after having fallen seriously ill.

Are women doctors able to change gynaecology? In recent years more and more female gynaecologists started to question their own roles (e.g. the Deutscher Ärztinnenbund). Nevertheless, nowadays, there are still less female (2434) gynaecological practitioners than the male ones (5377). Female doctors have studied and learnt a kind of gynaecology, which has been shaped by men. Moreover, female gynaecologists are afraid of losing their patients if they start to encourage women's self-perception instead of promoting women's dependence on gynaecologists' judgements. Furthermore, doctors earn their money by treating the ill not the healthy. That is why, female gynaecologists feel themselves forced to imprint the mark "pathological" on women.

All this means that another kind of gynaecology has to be found. Structural changes have to be achieved, not only within the subject gynaecology and obstetrics but within the health care system itself as well. In 1994 the organization Arbeitskreis Frauengesundheit in Medizin, Psychotherapie und Gesellschaft e.V. was founded. Under its roof professionals as well as women from self-help groups have joined together. Through interdisciplinary co-operation they try to achieve structural changes in women's health care.

3.2 Pregnancy care and obstetrics between standardisation and reform

Catrin Halves

3.2.1 Introduction

The discussion of norms in obstetrics and pregnancy care is shaped by conflicting opinions, such as controversies and competition between midwives and physicians, the desire for a perfect child and the attraction of the idea of security through prenatal diagnostics, the new "motherhood" and feminist social criticism.

All debates in the health sector in the Federal Republic are conducted against the background of a care system financed by health insurance and the State. The majority of the population is insured in the statutory public health insurance system. In this way, health insurance companies have a substantial influence on developments in the health sector, for example standardised pregnancy care. It is the patient's choice to decide whom they are going to consult as a physician or specialist. Pregnancy care is primarily exercised by certified specialists in gynaecology and obstetrics. Midwives work as freelancers or employees and bill their services to the health insurance company in question. They can conduct normal births by themselves

and conduct pregnancy care and care of women in childbirth. However, pregnancy care guidelines have been determined without the involvement of midwives' associations⁵ and are therefore completely oriented towards the physician's model of care.

3.2.2 Critique of hospital births

Due to dissatisfaction with hospital birth which was forcibly promoted since the 40s in Western Germany, about 25 years ago interest groups first came to be formed which took critical issue with the running of clinics, with medical technology and with the psycho-social care of pregnant women. At the beginning of the 1970s, the issues involved were "natural childbirth," opposition to separating newly born babies from their mothers (rooming-in) and a reevaluation of breast-feeding as an important psycho-social aspect of the mother-child relationship. Substantial areas of discussions are currently prenatal diagnostics, genetic counselling, hospital deliveries, artificial feeding of infants and psycho-social attendance during pregnancy.

3.2.3 Objections to prenatal diagnostics

The network against selection⁶ by means of prenatal diagnostics, individuals and institutions from the fields of pregnancy care, obstetrics, women's health work and handicapped work have joined together to demand more conscious handling of prenatal diagnostics and to curtail its use. A central critique directed at the objectives of a pregnancy care which is not primarily concerned with the health of mother and child but with an active search for possible disabilities for which there is no therapy. Furthermore, a critical view is taken of inadequate information about tests which have been conducted and about examinations, in particular their consequences for further diagnostics and the far-reaching decision to interrupt pregnancy. By means of competent counselling, the women concerned and their partners should recognise the problematical nature of prenatal diagnostics and not see it as a routine measure in pregnancy care. The most vehement critics consider pregnancy care examinations including their basis, motherhood guidelines, as selective and thus as immoral.⁷

3.2.4 The heuristic model of pregnant women at risk

Since the introduction of the motherhood passport, the criteria for pregnancy care have increased. The parameters of mother and child are examined, which has become particularly feasible with the introduction of ultrasonic diagnostics and new laboratory tests. In the new care programme, three ultrasonic examinations are prescribed, in actual fact during pregnancy on average up to seven examinations are carried out. Highly controversial is the second ultrasonic examination in the 19th-22nd week of pregnancy which serves to recognise deformities. Similar criticism applies to amniocentesis (amniotic fluid examination) in the 15th-17th week which is in particular offered to "risk-pregnancies."

The heuristic model of the pregnant woman at risk is of particular significance in care. Thus, for instance, every pregnant woman over 35 is automatically considered a pregnancy risk although most hereditary and non-hereditary children's diseases are independent of the mother's age. Statistically speaking, chromosome deviations, particularly trisomy 21, occurs

⁵ Bund Deutscher Hebammen (Association of German Midwives) and Bund freiberuflicher Hebammen Deutschland (Association of German Freelance Midwives)

⁶ Netzwerk gegen Selektion und Pränataldiagnostik (Network against selection and prenatal diagnostics), c/o Bundesverband für Körper und Mehrfachbehinderte (Federal Association of Physically Handicapped and Multi-handicapped), Brehmstr. 5-7, 40239 Düsseldorf

⁷ Karin Giese, "Sittenwidrige Schwangerenvorsorge," 23 Dr. med. Mabuse, no 112

more frequently with advancing age at birth. Nonetheless, the "age risk" does not suddenly increase markedly beyond the mother's 35th birthday.⁸

Pregnancy care and prenatal diagnostics impart, seen critically, a presumption of security. At the same time it is suggested that if the pregnant woman will only go regularly for care, the child will automatically be healthy. Monitoring pregnancy, which is a natural process, leads to pathologising healthy women.⁹

This process is only enhanced further by health insurance payments. All services connected with pregnancy care are included in a payment number, the service is only considered to have been rendered if all examination parameters have been taken. Women are not allowed to choose specific services. At the same time, the physician's side is obligated for legal reasons to engage in total care. Last December, the Federal Constitutional Court decided that doctors are liable for treatment errors if they result in an unwanted, e.g. handicapped, child being born. In such jurisprudence the child is considered "damage". This way of looking at things requires fresh ethical debates on the goals and perspectives of modern medicine.¹⁰

Pregnancy monitoring continues up through the time of birth in hospital. 97 % of all births in the Federal Republic occur in hospital. Only in larger cities there is a possibility of choosing between home delivery, delivery in an obstetrics institution or delivery in the surgery of a physician or a midwife.

3.2.5 Clinical routine and marketing strategies

In general there is a trend to ambulant delivery in hospital. Facilitated by the interest of health insurance companies in cheaper models, the hospitals are interested in a maximally short stay of their women patients.

At the same time, many women welcome this model because it promises more security to mother and child at birth while making it possible for them to leave hospital a few hours after birth. In exchange they accept the disadvantages of hospital delivery such as being cared for by an anonymous midwife, restrictions on birthing positions (normally the lithotomy position), being confronted with hospital routines and the use of medical techniques.

Decline in the birth rate additionally exacerbated hospitals' competitive pressure on each other and thus ultimately helped innovations like habitable delivery rooms with wide beds, bathtubs and to some extent birthing chairs to become accepted in a more birth-friendly hospital. Thus ultimately, marketing strategies of hospital administrations have entailed reversing the technicalisation of the birth process. In varying degrees, it is possible for women to make their own decisions and have a relative say in the matter. The rejection of controversial routine measures such as eye drops and vitamin K no longer constitutes a problem in many hospitals. Nevertheless, one routine has been maintained which every woman accepts when she enters hospital. This includes examinations, including by physicians not just midwives, purgative measures, shaving, taking of a CTG¹¹ etc. While more recently a greater degree of movement has been accepted for the woman in the initial phase, the actual delivery position is determined by the delivery bed. In addition, the possibility of invasive obstetric measures like caesarean section or administration of oxytocic agents entails increased risk of their use.

⁸ H Benthaus, M Griep, H Wegener, *Vorgeburtliche Diagnosen: Der Traum vom perfektem Kind*, Darmstadt, 1997

⁹ Eva Schindele, *Schwangerschaft zwischen guter Hoffnung und medizinischem Risiko*, Hamburg, 1995

¹⁰ Oliver Tolmein, "Der Mensch ist dem Menschen ein Gegenstand," *23 Mabuse*, no 112

¹¹ Cardiotocogram (infant heartbeat and labour pain recorder)

3.2.6 Alternatives to delivery in hospital

The alternatives to hospital delivery consist of delivery in a doctor's surgery, new types of delivery venues like larger midwife's surgeries or birthing houses and home births. The first birthing house was founded in Berlin in 1982. Since the beginning of the 1990s, birthing houses have sprung up in all major cities, managed by freelance midwives. The purpose of this institution is to provide the woman giving birth with more rights of decision making and to take her wishes and needs more seriously. The use of medical techniques does not occur except for CTG examinations. Only in the case of deviant course of the birth process are physicians brought in or transfer to hospital is considered.

The essential advantage of this concept lies in the continuous care of the pregnant woman by a midwife during pregnancy, birth and childbed. This concept of a holistic approach was co-developed by Gesellschaft für Geburtsvorbereitung e.V (GFG)¹². GFG has three essential focal points in its work: 1. Changing conditions for obstetrics in Germany to the point where women may give birth actively and independently and so that transition to family life occurs in a positive environment; 2. Interdisciplinary cooperation with all professional groups; 3. Offering and establishing new forms of birth preparation in Germany.¹³

It is not widely known that midwives can take over pregnancy care independently of physicians. The presence of a midwife during birth is legally mandated for the hospital sector and therefore mandatory. Physician's care is, on the contrary, not prescribed for normal births but is customary. For ten days after delivery, every woman lying-in has the right to assistance from a midwife. The relationship of trust resulting from continuous care makes confrontation with the newly found role of mother easier as well as confrontation with crisis situations during birth such as handicap or even still birth.

The midwife is able to support essentially health-promoting processes with her experience such as promoting successful nursing.

3.2.7 Breast-feeding

In the 1950s and 1960s breast-feeding was considered unhealthy and old-fashioned. Due to mothers' enhanced consciousness of health and of themselves brought about by the women's movement, breast-feeding became more popular again. At the beginning of the 1980s, about 7% of all mothers in the Federal Republic nursed their child for more than four months, by the 1990s it had become more than 30 %. The nursing groups which developed in the Federal Republic developed out of the self-help movement and have been in existence for about 25 years. Important interlocutors have been local self-help groups which are generally associated with the Arbeitsgemeinschaft freier Stillgruppen Bundesverband e.V. or La Leche Liga Deutschland e.V.¹⁴ By now, nursing with mother's milk is considered healthy, particularly in view of its immunological content (immunoglobulin A), its vitamins as well as its particularly usable fats. However, one of the most important aspects is the intimacy and closeness of mother and child during nursing.

The disadvantages of nursing are intimately connected with the social conditions of being a mother. Nursing requires close mother-child bonding, but does not allow for any other reference persons with equal rights. Entry into gainful employment is made more difficult by

¹² Gesellschaft für Geburtsvorbereitung e.V., (Society for Birth Preparation), Postfach 220106, D-40608 Düsseldorf

¹³ Ines Albrecht-Engel: "Brauchen Frauen Anleitung und Übung zum Gebären?" in seminar documentation from the seminar "Unter anderen Umständen" Mutterwerden in dieser Gesellschaft, September 1996

¹⁴ Hannah Lothrop, Das Stillbuch, Kösel, Munich, 1996

this. Under the provisions of the Motherhood Protection Act, the gainfully employed nursing mother may take off one hour from work every day for nursing purposes. Where and how she keeps her child during the remainder of the working day is not regulated. In addition, the working mother has to cope with the prejudice of mothers who have their child looked after by others. The ideals of the "good mother" and of the gainfully employed woman can still not be recon and place. However, nursing in public is still not unrestrictedly possible.

Mother's milk came into disrepute because of the hazardous materials which it contained, particularly chlorinated hydrocarbons which are contained in insecticides and fertilisers. Nevertheless, the benefit of nursing for the child's psycho-social development is prioritised over the possible risk to health. Yet ideas have been voiced about making screening available everywhere for diox ciled with each other in Germany's western provinces.¹⁵

Nursing instead of bottle-feeding saves time, money and work since it can be done independent of time in mother's milk, something which is, however, not feasible due to the high laboratory costs. In any case, critical initiatives recommend testing mother's milk. In this matter, new norms could evolve.

3.2.8 Midwives' research

The attempt is being made to address these issues in the largely recent field of midwifery research. Since 1989 there has been a discussion of midwifery research in the Federal Republic triggered by a workshop of the international midwives' association in Tübingen. Since then, there have been regular research workshops once a year. Their content is: 1. Introduction to scientific work for midwives (midwifery is not a subject of studies but an apprenticeship occupation at hospitals); 2. Presentation of research work; 3. Exchange of experience. Important subjects have been, in particular, evaluating one's own work in the context of quality control, particularly in obstetrics. There are research programmes on obstetrics and midwifery at the universities of Bremen, Hanover and Osnabrück.¹⁶

Literature:

Angelika Ensel; Silke Mittelstädt:

Pränataldiagnostik und Hebammenarbeit: ethische Fragen und Konfliktfelder in der Betreuung von Schwangeren, Gebärenden, Wöchnerinnen; Unterrichtsmaterialien für die Ausbildung von Hebammen und Angehörigen medizinischer Fachberufe.

Düsseldorf: Verl. Selbstbestimmtes Leben, 1999

Monika Zoega:

Bestandsaufnahme der qualitativen und äußeren Rahmen der Hebammen-Ausbildung im Auftrag der Hebammengemeinschaft.

Hannover: Linden-Druck Verl.-Ges., 1997

Eva Schindele:

Schwangerschaft: zwischen guter Hoffnung und medizinischem Risiko.

Hamburg: Rasch und Röhring, 1995

Eva Schindele:

Gläserne Gebärmutter: vorgeburtliche Diagnostik: Fluch oder Segen.

Frankfurt am Main: Fischer, 1992

Hausgeburten, Praxisgeburten, Geburtshäuser, Geburtshäuser, Entbindungsheime:

Dokumentation der 2. Deutschen Arbeitstagung Haus und Praxisgeburten. Hrsg.: Rupert Linder; Sabine Klarcku.A.. Frankfurt am Main: Mabuse-Verl., 1996

¹⁵ Eva Dörpinghaus: Stillen, Jede kann es, keine muss es, Kunstmann, Munich, 1990

¹⁶ Prof. Schücking, Beate, Arbeitsgruppe Gesundheitswissenschaften, Gesundheits- und Krankheitslehre

3.3 Menopause

Cornelia Burgert, Christina Sachse, Regina Stolzenberg

3.3.1 How menopause is seen in our society

Menopause, like other female bodily processes, used to be a taboo in our society. For a long time it was not mentioned publicly. This has obviously changed over the last ten years. Two main reasons explain this change: firstly, nowadays women have a different, more open-minded attitude toward their own body; secondly, medical science has "discovered" the necessity to treat the symptoms women experience during this lifespan.

The public discussion focuses, on the one hand on menopause as a hormonal deficiency disease, which should be treated with hormones and, on the other, on a changed image of women, which demands that women should be efficient and attractive during their second lifespan. Against this background, the choice of taking hormones has become a problematic decision for each woman, which considerably influences and marks her own experience of this lifespan. Today symptoms of menopause, in the past considered and treated as a natural condition or seen in the context of social conditions, are attributed by women themselves to an oestrogen deficiency: in a recent study, 90% of menopausal women mentioned oestrogen deficiency as the cause of their health disturbances (Schultz-Zehden 1997). In contrast, only 4% of middle-aged men considered their extremely similar symptoms as hormone conditioned. In fact, men interpreted their symptoms as a manifestation of familial and occupational stress (Degenhardt 1992).

It should be noted that actually only one third of all menopausal women complain about intense symptoms, which need to be treated; another third reports minor changes, requiring no treatment, and the last third is symptom-free.

The most frequently mentioned symptoms are: hot flushes, insomnia, cardiovascular trouble, changes of mood and depression.

As a consequence of the official information campaign many women are also afraid of osteoporosis or cardiac infarction as a potential disease.

3.3.2 Social background

Cross-cultural studies suggest that the cultural and social background plays an important role in the experience of menopause. It is generally reported that menopausal complaints are almost unknown in cultures where menopause is accompanied by a rise in social status.

For a long time we characterised the psycho-social situation of menopause as "Empty-Nest-Syndrome", which manifested itself primarily in depression. Today this applies only to a limited number of women, in particular to those who are strongly focused on family life. Studies indicate that nowadays women feel partly more stressed by children who do not want to leave home.

All in all, a profound social change marks the situation of women today. Nowadays more women are working than in the past, although the majority of women is employed in lower qualified or part-time jobs (Statistisches Bundesamt 1994). At the same time, hardly anything has changed in the sexual division of labour in society. That is why women following and unifying different roles are burdened more and more. Additionally, the standards within various spheres of life, considered as women's domain have risen: e.g. the management of the

household, childcare, diet, and expectations of physical appearance. Since the menopause can be considered as a transitional period toward old age, during which the situation of elderly women is often marked by a decline in social contacts and in social security, the debate on menopause becomes even more important. This entire social background is reflected in women's subjective perception of this period. The complaints they mention most frequently are:

- a decline in functional capacity, which hinders realization of occupational and/or familial requirements, although the requirements themselves are not questioned.
- changes of mood, generally characterised as petulance or nagging (by women themselves or by their social surrounding), which make it difficult to perform the expected function of maintaining social balance and harmony.
- the loss of attractiveness to men, which may actually be in contradiction to one's own positive self-perception as an ageing woman (Schultz-Zehden 1997).
- a fear of osteoporosis, which may be also interpreted as a projection of generalized anxieties regarding the life in old age on this illness.

At the same time women mention these phenomena as the main reason to take hormones.

So far, there are hardly any studies in Germany analysing the impact of these changed social factors on the experience of menopause.. There is certainly a definite need for research. Possible questioned problems could be: How do lifestyle and occupational activities influence the experience of menopause? Does the sexual orientation effect the course of this change?

3.3.3 The medical approach to menopause

Since in Western societies menopause is defined as hormonal deficiency with a potential disease character, its symptoms are exclusively dealt with by gynaecology. Consequently, the treatment is, entirely limited to replacement of allegedly 'lost' endogenous hormones by the dose of artificially produced preparations. Thus, not only women with menopausal complaints who seek medical aid but many middle-aged women without any symptoms are advised by their gynaecologists to take hormones as well. The necessity to prevent osteoporosis and cardiac infarction is used also as a reason for such a treatment.

This is a problematic situation in so far as the international controversy concerning the taking of hormones as well as other critical scientific positions are hardly noticed by the German medical professionals and not passed on to their female patients. Women receive insufficient information on risks, potential side effects and long-term effects of the hormonal treatment, such as the increased rate of breast cancer or frequency of thrombosis.

Besides the fact that in today's practice the effects of hormone replacement therapy is mistakenly portrayed in a biased positive way, many women report that gynaecologists have pressurised them into taking hormones. This practice, then, neglects the unique situation of the individual woman as well as her individual risks and preferences.

Medical professionals often get only one-sided feedback on the efficacy of the treatment they recommended - an obvious shortcoming of the organizational structure of our health service system because many women prefer to change their physician when they suffer side effects rather than reporting back to the doctor prescribing.

The health service system should, therefore, leave it to women themselves to decide - following comprehensive information - for or against the taking of hormones.

Women should insist on adequate advice on personal benefits and risks of this kind of therapy as well as on detailed information on different medications, including adverse and positive effects and instructions regarding their use.

3.3.4 The problematic nature of osteoporosis prophylaxis

Up to 30% of all women may be effected by what is commonly known as postmenopausal osteoporosis. However, since all women experience the menopause, the hormonal change can only be one factor of the genesis of this disease. Hormonal products for osteoporosis prophylaxis only provide protection as long as they are taken. However, the increasing risk of breast cancer when taking hormones on a long-term basis (40 - 50% increase after five years consumption) argues against a long-term use of hormones. Opponents to hormone therapy for all women as osteoporosis prophylaxis dissuade from this therapy since it basically gives healthy women a potent medicament that is itself a risk to health. There are other successful and healthy methods to prevent the disease, e.g., a well balanced, low-phosphate and high-calcium diet as well as sufficient, selective exercises (Love 1997).

3.3.5 Alternatives and other methods of treatment

Understanding menopause as a natural and important process during a woman's life and knowledge about the physical process itself can help women to reduce potential anxieties and increase their acceptance of possible menopausal discomfort. Access to information as well as the possibility to exchange ideas and experiences with other involved women has also proved to be helpful.

If therapy is required, it is absolutely necessary for a successful treatment to identify the cause of the symptoms, which is often little related to hormonal change but generally rather to the decline of the regenerative power of an ageing body or to the malfunction of other organs.

Furthermore, it is important to educate women on the various forms of therapy available today as well as on their benefits and risks, so that they can decide individually on the appropriate way to deal with their own menopause.

It would be helpful to keep in mind that there are already several possibilities to meet the cause, such as:

- General invigoration of the body through:
 - Exercises to improve the blood circulation of the abdominal organs, to prevent osteoporosis, to support detoxification, to stimulate the spirits.
 - Diet, to support liver function, since many complaints are caused by its impairment.
 - In addition, specifically during this phase of life the diet should ensure a sufficient supply of vitamins and minerals, which provide - as biocatalyst - an important metabolic function.
- Self-help to support the process of hormonal change in general:
 - Phytoestrogens in food products
 - Phytoestrogens or other hormone-like substances in vegetal products (e.g. Remifemin, Mastodynol, Agnolyt)
 - Homeopathic complex-agents (e.g. Klimactoplant Cefakliman)
- Self-help to alleviate specific symptoms:
 - to reduce hot flushes, for instance: sage capsules, cold water cure on the forearm, etc
 - If these means of support and self help do not lead to an improvement, it is advisable to consult an experienced naturopath who has specialised in this area.
- Naturopathic treatment:

Phytotherapy, homeopathy and acupuncture have proved successful, and may be assisted by other therapeutically methods such as balneo-therapy, respiratory therapy etc.

For comprehensive information on the issues mentioned above refer to "Menopause - a guide to self help". Further literature and organizations are listed below.

3.3.6 Organizations dealing with the subject of menopause

In Germany, different organizations work on the subject of 'menopause', covering various aspects as well as several points of view. Many possibilities have occurred during the last ten to fifteen years, simply to break the age-old taboo menopause but also as a reaction to the trends in gynaecology mentioned above.

The various possibilities available to women today provide them with the chance to acquire information on the natural life cycle, the process of ageing, and related questions, interests, anxieties etc., as well as offering them the possibility to share and exchange experiences with each other.

Apart from individual women, who as an alternative medical practitioner, like naturopathic practitioner, physiotherapist, (body) therapist, yoga instructor etc. can support menopausal women, the following organizations and independent institutions should be mentioned:

Sekis; Selbsthilfe- Kontakt und Informationsstelle in Berlin, Albrecht Achilles Str. 65, 10709 Berlin, Tel 030/8926602

Nakos, Nationale Kontakt- und Informationsstelle, dieselbe Adresse, Tel. 030/8914019
Angebote in Volkshochschulen

Lachesis e.V., Verband der Heilpraktikerinnen, Rilkestr. 40, 53225 Bonn, Tel. 0228/42 00 27
Dachverband der Frauengesundheitszentren (gibt Auskunft über die Adressen von Frauengesundheitszentren in 18 Städten der Bundesrepublik) Geschäftsstelle Goetheallee 9, 37073 Göttingen, Tel: 0551/ 4870, Fax: 0551/ 5217

The following women's health centers or projects are working on menopause:

Berlin

FFGZ, Bamberger Str. 51, 10777 Berlin, Tel. 030/213 15 17, Fax 214 19 27; E-mail: ffgzberlin@snafu.de, Homepage: www.ffgz.de. Beratung, Vorträge, große Bibliothek und Materialsammlung, Broschüre

Akarsu e.V., Oranienstr. 25, 10999 Berlin, Tel. 030/6147031 (Migrantinnenprojekt zu Gesundheit)

Raupe und Schmetterling, Frauen in der Lebensmitte e.V., Pariser Str. 3, 10719 Berlin, Tel. 030/8837313

FFGZ Stuttgart; Kerner Str. 31, 70182 Stuttgart, Tel. 0711/29 63 56; Beratung, Veranstaltung, Informationsmaterial

FGZ Hamburg, Elmenhorststr. 4, 22767 Hamburg, Tel. 040/4395389, Beratung, Veranstaltung, Kooperation mit VHS Altona, Osteoporosetraining, Vermittlung von Referentinnen

FGZ Regensburg, Untere Bachgasse 12-14, 93047 Regensburg, Tel. 0941/81644, Selbsthilfegruppe, Veranstaltungsreihen

außerdem: "**Netzwerk älterer Frauen**", sind über KISS (Kontakt und Informationsstelle in Regensburg unter 0941/52822 zu kontakten).

FGZ München, Nymphenburger Str. 38, 80335 München, Tel. 089/129 11 95, Fax 129 84 18; Informations- und Gesprächsabende, Homöopathie und Luna-Yoga
außerdem: **Pro Familia**, Türkenstr. 103, München, Tel. 089/ 39 90 79

FGZ Nürnberg, Fürther Str.154, 90429 Nürnberg Tel. 0911/328262, Gruppen, Einzelberatungen, Veranstaltungen

FGZ Lübeck, Steinrader Weg 1, 23558 Lübeck, Tel. 0451/ 4082850. Beratung, Veranstaltungen, Selbsthilfegruppe

außerdem: In **Schleswig-Holstein** machen auch die Frauenbüros dazu Angebote

FFGZ Köln, Roonstr.92, 50674 Köln, Tel. 0221/234047 , Literatur, Infomaterial, Kurzberatung, Veranstaltung

Außerdem: **Frauen lernen Leben** 0221/9541661, die Vorträge anbieten

FGZ Heidelberg, Alte Eppelheimer Str.38, 69115 Heidelberg, Tel. 06221/21317, Veranstaltung, Selbsthilfegruppe

In Heidelberg ansonsten: **Pro Familia**: Selbsthilfegruppe und Vorträge (eher schulmedizinisch orientiert)

FGZ Göttingen, Goetheallee 9, 37073 Göttingen, Tel. 0551/ 484530 , Beratung, Vorträge

FGZ Bremen; Elsflethstr.29, 28219 Bremen, Tel.0421/3809747

Außerdem: **VHS**, Schwachhauser Heerstr. 67, 28211 Bremen; **Pro Familia**, Holler Allee 24, 28209 Bremen.

FGZ Tiamat in Erfurt, Schlösserstr.24, 99084 Erfurth, Tel. 0361/5621777, Beratungen, Veranstaltungen, Bibliothek

Initiative Frauengesundheitszentrum e.V., Nymphenburgerstr. 38/Rgb., 80335 München, Tel. 089/1291195, Fax 1298418, Information, Psychische Komponenten, Homöopathie, Luna-Yoga; Weitere Anbieterin: **Pro Familia**

Frankfurt:

FFGZ, Kasseler Str. 1a, 60486 Frankfurt, Tel. 069/ 70 12 18 Beratung, Vorträge

außerdem: **Evangelische Familienbildung**, Darmstädter Landstr. 81, 60598 Frankfurt, Tel. 069/ 610308, F. Piepho, G. Voigt, **Evangelisches Pfarramt für Frauenarbeit**, Stalburgstr. 38, 60318 Frankfurt, Tel. 069/550985; **Landessportbund Hessen, FrauenAusschuss und Bildungswerk**, Otto Fleck Schneise 4, 60528 Frankfurt, Tel.069/6789 220/115, I. Brezy, U.Steck; **Pro Familia** Frankfurt, Auf der Körnerwiese 5, 60322 Frankfurt, Tel. 599286;

Internationales Familienzentrum Bockenheim, Adalbertstr. 10 A, 60486, Tel. 703084, B. Katz; **Katholisches Frauenreferat**, Eschenheimer Anlage 21, 60322, Te. 1501 162, E. Gurberlet, K. Müller-Hesse; **Sozialzentrum Marbachweg des Frankfurter Verbandes für Alten- und Behindertenhilfe**, Dörpfeldstr. 6, 60435, Tel. 5480080, H. Bradt; **Verein zur beruflichen Förderung von Frauen**, Kasseler Str. 1 A, 60486, Tel. 705555; **VHS Frankfurt/ Amt für Volksbildung**, Hochstr. 49, 60313, Tel. 212 37661; **Psychosoziale Ambulanz der Universitätsklinik**, Theodor Stern Kai 7, 60596 , Tel. 6301 6308; **Selbsthilfe-Kontaktstelle Frankfurt**, Jahnstr.49, 60318, Tel. 559444; **Frauengesundheitszentrum Neuhofstraße**, Neuhofstr. 32,60318, Tel. 501700; **Informationszentrum Wechseljahre (IzW)**, Bolongarost. 82, 65929, Tel.31405338.

Arbeitskreis Frauengesundheit in Medizin, Psychotherapie und Gesellschaft AKF e.V., Claudia Czerwinski, Geschäftsstelle: Verdener Str. 20, 28205 Bremen, Tel: 0421/ 4349340

Institut Wildwuchs, Angelika Koppe, Im Grohenstück 3 A, 65396 Walluf, Tel. 06123/72604, Selbstheilungsarbeit nach der Methode Wildwuchs speziell auch für Wechseljahre

Deutsche Menopausengesellschaft e.V., Universitätsfrauenklinik Münster, Albert Schweitzer Str.33, 48129 Münster, Tel. 0251/8348204 (schulmedizinisch!!!)

Kuratorium Knochengesundheit e.V., Leipziger Str. 6, 74889 Sinsheim, Tel. 07261/92170 (schulmedizinisch!!!)

Bundesselbsthilfeverband für Osteoporose, Kirchfeldstr. 149 Berlin, 40215 Düsseldorf, Tel. 0211/319165

Deutsches Zentrum für Altersfragen e.V., Manfred von Richthofen Str. 2, 12101 Berlin, Tel. 030/7866071

Pro Familia (Bundesgeschäftsstelle), Frau Thonke, Stresemannallee 3, 60596 Frankfurt, Tel. 069/639002. Einzelne Pro Familia Beratungsstellen bieten Beratung dazu an, ist aber unserer Einschätzung nach eher schulmedizinisch orientiert, da sie von Ärztinnen angeboten wird.

In this context also should be mentioned: Frauen- bzw. Gleichstellungsbeauftragte, Gesundheitsämter, Nachbarschaftsheime, Kirchengemeinden, Evangelische Familienbildungsstätten und Volkshochschulen, which offer several and different lectures and events for women in the middle of the life course.

Literature:

Czerwinski, Claudia: Gesund und gelassen durch die Wechseljahre. Niedernhausen/Ts. 1998

Degenhardt, Annette: Wechseljahre des Mannes: gibt es sie? In: Fischer, S. u.a. (Hrsg.): Wechseljahre für Fortgeschrittene. Frankfurt/M 1992

Feministisches Frauen Gesundheits Zentrum Berlin: Wechseljahre - Aufbruch in eine neue Lebensphase. Komplet überarbeitete Neuauflage. Berlin 1999

Love, Susan, Lindsey, Karen: Das Hormonbuch. Was Frauen wissen sollten. Frankfurt/M 1997

Nissim, Rina: Wechseljahre - Wechselzeit. Berlin 1995/1999

Schultz-Zehden, Beate: Körpererleben im Klimakterium. München/Wien 1997

Statistisches Bundesamt (Hg): Datenreport 1994. Zahlen und Fakten für die Bundesrepublik Deutschland. Bundeszentrale für politische Bildung. Schriftenreihe Bd. 325. Bonn 1994

STIFTUNG WARENTEST: Annette Bopp: Wechseljahre, Berlin 1997

Schultz-Zehden, Beate: Frauengesundheit in und nach den Wechseljahren. Die1000-Frauen-Studie. Marburg 1998

3.4 Breast Cancer

Ute Wülfing

3.4.1 The problem

Incidence:

Despite the fact that exclusively women are affected by it, breast cancer is the most common organ cancer in general. From a statistical point of view, one out of ten women in Germany is expected to develop a breast tumour during her life. While the risk has roughly doubled over the past twenty years, there has been no successful breakthrough in providing a curative method. It is possible that the shift within the age pyramid, with its high proportion of women, will lead to a nominal increase in the incidence of breast cancer in the near future. Another significant factor is the initial peak in the disease between the age of 45 and 55 years: Through the lower age of the disease's onset more women feel threatened. Apart from this, nowadays, women are more active in shaping their lives - including their inner life - and they want to face up to their crises rather than ignore them.

Diagnostics:

The reasons for the outbreak of breast cancer are not known, that is why, prevention is impossible. The only reliable method to avoid breast cancer is to have both breasts amputated. Some women who recognised themselves to be at particularly high risk have already taken this course. Amputations have therefore already been conducted at several German hospitals (e.g. in Munich) (Amputation or removal of healthy organs to prevent the disease is still carried out occasionally in the case of the tonsils and appendix, and frequently in the case of the uterus).

The term prevention still emerges; this raises hope of protection from the disease, but this hope cannot be satisfied at present. The most important factor for the course of the disease is its early detection, as it is a matter of dealing the disease before the dissemination of cancer cells. But what is the best form of early detection? Mammography is the method of choice from a medical point of view, but it is not suitable for women of each age. Among women's circles, self-examination is the method of choice. A completely new problem arose with the discovery and mapping of the first two of a series of genes that apparently contain a hereditary predisposition to breast cancer. A defect of BRCA1 and BRCA2, as these genes are called, can lead to the development of such a hereditary predisposition. A blood test has been developed, and women who have a higher incidence of risk factors for breast cancer or ovarian cancer in their families can make use of this diagnostic aid. In Germany, there are already several centers that conduct this genetic test. Although only 5-10% of all breast cancer cases have appeared in women with a hereditary predisposition and there are women with a hereditary predisposition who do not develop breast cancer, still a genetic test offers certainty. Since there is no prevention, the genetic test raises ethical questions. After all, what is the point of genetic diagnosis if there is no therapeutic measure available to counteract specifically a possible disease's outbreak.

Therapy:

Breast cancer also occupies a key position in the area of medical care: Only a fraction of the surgical measures is medically necessary since breast cancer is not a local, but a systemic disease. The dissemination of the cancer cells and thus the danger of metastasis is decisive for the prognosis. Removal of the tumour is therefore sufficient, and removal of the breast is not necessary in most cases. Nevertheless, it is striking how often doctors use their scope for action to present amputation as the 'safest' solution. Numerous women have reported that such patient information consultations end with the indication of the possibilities for breast reconstruction. Even today, in 1998, first of all, the style of the hospital and not the size, location and histology of the tumour decides whether the patient wakes up with or without a breast after surgery. In a study on over 8,000 cases, Lazovich investigated the changes in therapeutic strategies in stage I and II of breast cancer between 1983 and 1989. Breast-maintaining therapy with subsequent radiation therapy is the recommended standard therapy for both stages. In fact, only 33.7 % of women underwent breast-maintaining therapy. Within the period studied, it can be seen that there was a slight short-term increase in the number of breast-maintaining operations in 1985 - due to a study on this subject. However, this change did not settle. Incidentally, the first study, that pointed to the fact that amputation does not necessarily improve the chances of healing, was carried out in 1948. Patients who decide to have their breasts 'reconstructed' must make detailed inquiries if they want to obtain a satisfying result. There are various possibilities of reconstructing the amputated breast. Silicon is widely used in Germany, about 250,000 women currently carry silicon in their breasts, 80% of them because of cancer surgery.

Symbolism:

For women, the symbolism of the breast is twofold. It is an organ which women can experience with both, the motherly and the erotic aspect of their femininity. The special symbolism of this organ can have three effects. Firstly, there is danger that a taboo surrounding the organ will inhibit the woman in confronting her disease and in obtaining support. Many women stay silent because they fear that they will no longer be considered a 'complete' woman if their disease becomes known. Secondly, there is evidence that, from a medical point of view, the necessary decisions are sometimes made irrationally on the basis of the importance of the breast. Thirdly, the symbolism makes it difficult for the woman to come to terms with the diagnosis of cancer and the operation. A part of the therapeutic decisions and the process of coming to terms with the consequences of the disease are thus closely connected with conflicts

regarding sexual roles. The societal interpretation of the breast for female identity causes special problems for some women. They have few prospects for redefining their femininity in their social environment.

3.4.2 Historical development

Self-help:

Mildred Scheel was the first person who raised public awareness on the matter of cancer at the beginning of the 1970s. As a doctor and a wife of a federal president, she founded the Deutsche Krebshilfe (German Cancer Aid), which was followed by the foundation of the Dr. Mildred Scheel Stiftung für Krebsforschung (Dr. Mildred Scheel Foundation for Cancer Research) in 1976. Even after Mildred Scheel's death of cancer, both institutions continue to be very successful and are able to provide considerable funds. For example, the Deutsche Krebshilfe supports the self-help movement. A disproportionately large number of breast cancer patients are to be found in the self-help groups and in the association 'Frauenselbsthilfe nach Krebs' [Women's self-help after cancer] which is represented throughout Germany. For thousands of women, these groups are helpful as a first point of contact, as a forum for exchanging experiences among fellow-sufferers. Nevertheless, in the area of self-help it must be noted that neither the relation to the medical profession is reviewed critically nor the individual losses in life's quality can be related to dealings with breast cancer in the social environment.

Medical system:

For the time being, a change in surgical techniques can be observed within the medical system. The radical amputation with removal of the large and small breast muscles is no longer performed. The total operation has now taken its place, in which the breast is amputated, without removing the muscles. The next step was taken in 1987, when a relevant textbook (Noltenius) recommended that tumorectomy should be considered in tumours up to 4 cm in diameter. 80% of women could thus undergo breast-maintaining surgery, although this percentage was never achieved. In 1985, Ingrid Olbricht's book on the symbolism of the breast was published. As a doctor, she reported on psychosomatic consequences of cosmetic breast operations and thus stimulated discussion. At its 23rd scientific congress in 1993, the German Association of Women Doctors cautiously raised the subject of the risks of silicon implants and mentioned the questionable nature of 'reconstruction' after breast amputation. Outside the medical sphere, the medical system has reacted with the establishment of tumour centers and cancer counselling centers. Similarly to the hospitals' social services, they deal with socio-legal questions. They also provide consultation and offer courses and information on related subjects and alternative methods. In addition to these institutions, which are integrated into the medical system, initiatives and associations with critical counselling approaches have become established.

Women's movement:

The women's movement in Germany which regards biomedicine critically, is an isolated movement that arose from the reception of the American breast cancer movement. It has limited contact to women affected by breast cancer, especially to the older generation of them and to the decision makers within the medical system as well. Nevertheless, this movement can become politically effective if the initial co-operation and networking activities are successful.

3.4.3 What must be changed?

In Germany, there are around 43,000 new cases of breast cancer every year, with a 5-year survival rate of 70%. Consequently, there are hundreds of thousands of women affected by breast cancer who are living with the consequences of the disease without making a public issue of it. They remain invisible with their special needs. Visible however is the list of risks which make insecure and which indicate biographical decisions as disease's causes. This must be changed.

The available information carries indirect messages and accusations about women affected by breast cancer and fills with fear not only women. This is particularly alarming in the sphere of the psychological interpretational pattern. An example: The model of the cancer personality, published at the beginning of the 1980's, is an integral part of everyday knowledge and it is a burden for the concerned. A reception of the American breast cancer movement which questioned the role of environmental toxins and radiation exposure has only partially taken place in Germany. In German lists of risks emerge, for example, the term 'unmarried'. This may be easy to ascertain, but it is just as informative and revealing as the connection between shoe size and intelligence. Too little is known about the true causes of breast cancer. Research is primarily carried out within commercially attractive areas like chemotherapy and genetic analysis. On the other hand, epidemiology leads a shadowy existence; there is no unified cancer register in Germany, data protection laws are claimed to be an obstacle.

What must become better? The gynaecological departments which are in line with the latest scientific research and which are capable of dealing sensitively with their patients must not be an insider tip any long. The women's health movement must exert influence on education and further training in order to reduce existing shortcomings in this area. Additionally, we need psychosocial support that always takes into account the gender question, as well as critical public exposure. Lists of risks that spread feelings of guilt must be exposed as ridiculous and research on causes of breast cancer and a cancer register are urgently needed.

3.4.4 Which organizations take this subject up?

Within the medical system, in addition to the tumour centers (see above), there is the Krebsinformationsdienst (Cancer Information Service) and the Gesellschaft für Biologische Krebsabwehr (Society for Biological Cancer Prevention) Offers of psychotherapy for women affected by breast cancer are directly available in the rehabilitation centers, there are also some hospitals focused on breast cancer. This may mean a good possibility of change for the concerned, but it can encourage the psychologization of disease's origins and course.

In acute clinics, patients' groups, partly with psychotherapists employed permanently on the wards for gynaecological oncology, are a new approach. In the acute phase, it is mostly a matter of medical questions and of coping strategies. This initial psychosocial care is decisive in coming to terms with the disease and must be urgently expanded.

Instead of cutting off all health courses of the statutory health insurances, cancer courses are still maintained. These groups fall under the self-help movement.

Outside of the medical system, a broad spectrum of health courses is offered. They do not address explicitly women affected by breast cancer, but often provide a suitable forum for the concerned. Here should be highlighted the Feministische Frauengesundheitszentren (FFGZ) [Feminist Women's Health Centres] represented in most larger towns and cities. The autonomous, church and communal education services on the spot have also joined contide

into the field of health especially since the health insurance funds were forced to withdraw their wide range of courses.

The Arbeitskreis Frauengesundheit (AKF; see address list) is working towards qualified courses on the subject of Women and Health in the field of education, and directly intervenes in training with their publication of a women's gynaecology textbook. Among other numerous activities, the annual AKF congress was dedicated to the subject of the breast in 1999.

The new organizations Wir Alle (All of Us) (Cologne), MUT (Courage) (Münster) and Brustkrebsinitiative (Breast Cancer Initiative) (Berlin) are all working exclusively on the subject of breast cancer and want to follow their American models 'One in Nine' and 'Breast Cancer Action'. In a close co-operation between the affected and non-affected, public relations work has taken as its task to oppose actively the taboo surrounding breast cancer. Information and counselling is being offered for breast cancer sufferers and their context and the deficiencies in research and care are being identified and challenged.

3.4.5 Structural characteristics

The German social security system gives primary importance to the medical diagnosis. In principle, a cost/benefit analysis of the therapeutic measures to the patient does not ensue. Patients, therefore, often have to protect themselves against excessive therapy. However, this requires a high degree of awareness and an immense capacity to be assertive, quite difficult for many women faced with a diagnosis of cancer. At the same time, there is no basis for financing non-medical programmes.

The cost-saving measures in the healthcare system can also have positive effects: Competing hospitals must come into line with patients' wishes, so must competing practices. In this phase, it will be particularly effective to join forces with women affected by breast cancer in order to demand an approach that satisfies their needs.

Literature:

Becker, Hans:

Psychoonkologie. Krebserkrankungen aus psychosomatisch-psychoanalytischer Sicht unter besonderer Berücksichtigung des Mammakarzinoms. Berlin: Springer 1986.

Bunte:

Notlösung Silikon. Interview mit Dr. Bettina Pfeleiderer (Chemikerin). 10.2.98

Johne-Manthey, Brigitt, Thurke, Monika:

Bewältigungsstrategien bei Brustkrebs. Ergebnisse einer Längsschnittstudie. Heidelberg: Asanger 1990.

Lazovich, D.A. et al.:

Underutilization of Breast-Conserving Surgery and Radiation Therapy Among Women with Stage I or II Breast Cancer. *Jama* 266, 1991. S. 3433-3438.

Noltenius, Harald:

Tumor-Handbuch. Pathologie und Klinik der menschlichen Tumoren. Band 3. München: Urban & Schwarzenberg. 1987. S. 927-949.

Olbricht, Ingrid:

Die Brust. Organ und Symbol weiblicher Identität. Reinbek bei Hamburg: Rowohlt 1989.

Schmidt, Roscha:

Brustprothesen und chirurgischer Brustaufbau nach Brustamputation. *CLIO* 25, 1992. S. 12-15.

Spiegel, David et al.:

Effect of Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer. The Lancet 14, 1989. S. 888-891.

3.5 Critical points in operative gynaecology

Christiane Niehues¹⁷

3.5.1 Gynaecology as a "surgical" subject

Gynaecology as a subject developed from surgery, and attitudes - tending to concentrate on craftsmanship and technique - are accordingly coloured by surgical thinking (if your operative technique is good, everything will turn out fine).

The present-day training of gynaecologists is substantially shaped by hospital surgical activity, and this subsequently also influences their behaviour as practising doctors.

The main problem in operative gynaecology is determining the indications for this or that operation. When is an operation necessary, when is it optional, when are there good prospects for non-operative treatment?

Conservative methods, such as physiotherapy for a prolapsed bladder and incontinence, for example, are somewhat underrated in Germany: they are certainly not employed to the maximum before it is decided that an operation is required. The prolapse operation is often carried out without a sufficiently strict insistence on the indications being present. If the condition is a weak or irritated bladder, or a combination of these conditions, it is hardly surprising if the symptoms actually deteriorate after the operation.

Chronic gynaecological illnesses such as endometriosis and chronic lower-abdominal pain are too rarely treated by a combination of methods, requiring an interdisciplinary approach involving psychologists and other therapists. There are no specifically gynaecological facilities in pain-management centers catering for the special needs of gynaecological patients.

3.5.2 Quality assurance in operative gynaecology

Information regarding quality assurance was also gathered in the field of operative gynaecology.

One of the factors investigated was the extent to which operations on the ovaries are carried out without the appropriate indications being established. In a strikingly large number of cases (31.3% on average) simple functional cysts were found: these often occur during the cycle as a result of normal physical processes, only to disappear spontaneously later.

*"In this example follicular and lutein cysts constitute physiological processes which often look like tumours of the adnexa in sonography, but which generally spontaneously subside. Without exposure to major risk, therefore, the patient can be treated with drugs while developments are awaited. The use of such a procedure can reduce the rate of operations in which follicular or lutein cysts are found to below 5%."*¹⁸

¹⁷ Dr. Christine Niehues is a gynaecologist in the Gynaecological Rehabilitation Department of the Burggraben Clinics, Bad Salzuflen

¹⁸ Quality assurance in operative gynaecology, ed.: Federal Ministry of Health, Dr. med. Max Geraedts, volume 98 of the series of papers of the Federal Ministry of Health, Nomos Publishing, Baden-Baden, 1998, p.45

Here the authors themselves call for an important improvement in quality.

*"In future it will be the task of the German Society of Gynaecology and Obstetrics to provide clinics with external support by supplying them with consensus guidelines regarding the establishment of indications."*¹⁹

3.5.3 The problem area of operative technique

In Germany there is as yet no body with the power to monitor the success of various operative procedures in clinics and to ensure that the most successful are adopted as normal practice. Operations for incontinence are an example in the gynaecological field. Various different procedures are still being used, despite the fact that certain techniques exhibit a relapse rate of more than 50%.

Other organ-preserving procedures involving the raising of the cervix of the bladder and, under certain circumstances, no interference with the uterus have not yet achieved general acceptance, even though among specialists they are internationally acknowledged to have produced good results.

3.5.4 System-related conflicts of interests

The system whereby doctors with their own practices also perform operations and are responsible for a number of hospital beds produces a conflict between the interests of the patient and the directly pecuniary interests of the doctor. The more operations the doctor recommends, the more beds are occupied in his or her department.

In other hospital departments, too, the pressure has been increasing to carry out more and more operations more and more quickly - and in the competition for ever-shorter hospital stays the departments which survive are those which quickly carve out markets for themselves and adapt to new trends.

To this day it remains the case that recognition as a specialist gynaecologist is conditional on the performance of a minimum number of operations: hysterectomies, curettages, operations on the Fallopian tubes, ovaries, breasts etc. This can lead to patients being advised to undergo more extensive surgery, for example to have a hysterectomy following a curettage.

This catalogue of operations will not continue to exist in this form in the long term: specialist training is also being discussed among gynaecologists and by the specialist associations. Changes are planned which will mean that although doctors who wish to practise as gynaecologists will continue to take part in operations, there will not be as many of them as there are now and they will not actually carry them out themselves. Instead other fields of gynaecology will take a more prominent part in training: endocrinology, prenatal diagnosis, reproductive medicine etc.

3.5.5 The value put on female organs and psychosomatic connections

The general view of the uterus continues to be that it is a more or less useless organ once its owner no longer wishes to have children. Both under pressure from better-informed patients and with an eye to possible legal proceedings where the indications are not entirely unambiguous, the number of operations in which organs are preserved has increased in

¹⁹ *ibid.*

proportion to those in which they are removed. Whether this indicates a genuine change of heart on the part of the doctors who actually carry out the operations is not entirely clear. The number of hysterectomies, which in 1991 was estimated at 146,000, has fallen by a quarter - although the number of gynaecological operations overall has substantially risen.

Generally speaking operative consequences - post-operative functional disorders of the bladder and bowel, pain, vegetative symptoms and sexual dysfunction - tend to be underestimated, and there is insufficient knowledge of how to approach delayed convalescence following gynaecological operations and their particular psychosocial associations.

The psychosomatic aspects of gynaecological illnesses - menstrual disorders, for example, or recurring abdominal inflammation - are certainly theoretically acknowledged, but sufficient account is not always taken of them in everyday practice. The invoicing system applying to established practitioners limits the activity in this field of even well-trained gynaecologists competent in psychosomatics.

The abyss between in-patient and out-patient treatment, between psychosomatics and organ medicine, makes overall observation difficult. The increasing tendency towards specialisation ultimately means that only this and that "partial" truth is perceived and treated.

3.5.6 Rehabilitation and aftercare

In-patient gynaecological rehabilitation as a special facility is seriously under-represented (less than 2% of total beds), and in 1997 the number was reduced even further owing to the cuts. And women, who are in particular need of it, can no longer afford to be away from work or to pay the additional costs of rehabilitative in-patient treatment.

The aftercare treatment of cancer patients has also been drastically curtailed (to some 10% of the levels in previous years). This particularly affects breast-cancer patients, who in the past have often made use of such facilities to regain their physical and mental strength.

Comparable combined approaches to rehabilitation are currently unavailable in Germany on an out-patient basis.

3.6 Violence Can Make You Ill - The Connections Between Violence and Health

Karin Wieners and Hildegard Hellbernd, TU Berlin; translated by Teresa Gehrs

The World Health Organisation (WHO) considers violence to be one of the greatest health risks faced by women and girls throughout the world. According to a study carried out by the World Bank in 1994, women between the ages of 16 and 44 lose one out of every five healthy years of their life due to violence (cf. Heise et al. 1994).

In Germany a broader discussion is only now slowly beginning to take place around the subject of the connections between violence and the health of women and girls. The removal of the taboos surrounding violence and the creation of refuge and counselling centres run exclusively for and by women has for a long time been one of the main aims of the Women's Movement and, in particular, the Women's Refuge Movement. Descriptions of the state of health of battered women and girls, indications of lack of sensibility with regard to problems encountered within the area of medical and therapeutic care, and demands for care structures suitable for women, are seldom made within the context of a fundamental discussion of women's health (Nebenbauer et al. 1998). In the area of research into women's health, analysis of the connections between violence and health is slowly gaining more attention. Initial studies

are frequently carried out by female academics who have become involved in the so-called anti-violence debate (cf. Günther 1991 among others, Helffrich 1997, Kavemann 1997; Hagemann-White 1998).

Descriptions of the possible consequences of violence are only occasionally available from the area of medical research and care carried out in Germany (Olbricht 1997, Böllert et al. 1999). These descriptions focus almost exclusively on sexual abuse of girls and boys and on rape. It is astonishing that, up until now, in the area of medicine violence has never or rarely been considered as the possible cause of injuries suffered by and complaints from which women suffer. This is all the more astonishing in view of the fact that a multitude of studies and a series of guidelines on the care of battered women have become available as a result of research carried out throughout the world, in particular in the United States of America.²⁰

In the following pages we will firstly outline the central findings of the research carried out into violence against women and girls (Chapter 1). We will then present the results of research on health-related effects of violence against women and girls (Chapter 2) as well as outline the situation in medical care. In this context we will describe a pilot project on violence against women which has been set up at the Benjamin Franklin University Clinic in Berlin (Chapter 3). In conclusion, we will provide a brief overview of support services available for women and girls who have experienced violence.

3.6.1 Violence against women and girls

It can be credited mostly to the New Women's Movement that a wide range of information on the causes and forms of violence against women and girls has become available in Germany. Work experience with battered women in women's refuges, secure accommodation, and counselling centres has shown how varied are the forms of violence and the types of threats and injuries women and girls experience, and how radically they can impact their lives.

In order to comprehend the different facets of violence committed against women and girls, Carol Hagemann-White introduced the term "Violence in gender relations". Today this term has become widely established, particularly in research. It includes any type of injury caused to the physical and/or mental integrity of one or several persons which is connected with the sexuality of the victim and the perpetrator, and which is caused while the person in a stronger position is taking advantage of the person in a weaker position within a power relationship (Hagemann-White 1992).

In recent years a large part of the discussion on violence against women focused on sexual violence against women, domestic violence²¹, and the area of the sexual abuse of girls and boys. The majority of refuge, support, and counselling services available today can be found in these areas.

In the following pages we will briefly present the findings and, as far as possible, data available on domestic violence, sexual violence, and sexual abuse. The distinction between sexual violence and domestic violence is made partly for reasons of clarity, and partly because

²⁰ Osattin/Short (1998) give an overview of guidelines and further education and training options available in the USA. With regard to the international debate, compare also the Population Reports (1999, 27/4).

²¹ We use the term „domestic violence“ in the following pages because it is gaining increasing acceptance in discussions. Other terms which are used as a synonym for this form of violence are: „violence within the victim's immediate social circle“, „violence in marriage and partnerships“ and „violence in the family, marriage, and partnerships“. Compare Schweikert 2000 for the discussion of terms and concepts.

it reflects the development of discussions and research. The term "sexual violence" will be described in the following pages as a form of violence in the context of domestic violence and, will also be used as an independent term as well.

Domestic violence

At a very early stage the Women's Movement revealed that a large part of the violence against women was committed by men who were known to, friends with or married to them. At the same time the Women's Movement also showed that women could not feel safe within their own home. Instead their home represented a place where violent acts were committed against them (cf. Berliner Frauenhaus 1978, Hagemann-White et al. 1981, Nini et al. 1995, Brückner 1998). Schweikert (2000) developed a very broad definition of domestic violence. She describes domestic violence as "a one-off act or the associated, continued, and repeated acts of a man against a woman within a former or a current (...) long-term relationship, within any (...) other intimate relationship, within a narrow family or related relationship, which injure(s) the physical and/or psychological integrity of the victim, and which serves or serve as a means of exercising power and control over the woman (...)" (Schweikert 2000: 73).

In general, domestic violence is not a one-off, extraordinary occurrence. It is much more a question of a complex and, for the woman, a daily system of maltreatment in which blatant and subtle forms of violence, verbal degradation, humiliation, and exploitation are closely interwoven. Women who have experienced domestic violence talk of physical, psychological, and sexual attacks. They tell of degradation and humiliation, of economic exploitation, and of the rigid control of their social contacts. Forms of violence which have been combined under the term domestic violence and described in the literature (compare Brückner 1998, Egger et al. 1995), include:

Physical violence. This includes, for example, slapping, hitting with the fists or with objects, kicking, strangling, tying up, and violent attacks which can result in death.

Sexual violence. This includes coercion up to and including rape or forced prostitution.

Psychological violence. This includes threatening to harm the woman or her children, insults, humiliation, engendering feelings of guilt, the withdrawal of food, and intimidation.

Economic violence. This includes a ban on the woman going out to work, forced labour and the man having sole power to use financial resources; in brief, the creation and maintenance of economic dependence.

Social violence. This is described as the endeavours of a man to isolate a woman socially by forbidding her to make contact with other people or by controlling her contacts (cf. BIG e.V. 1997).

Accounts given by battered women have shown that domestic violence generally develops its own dynamic. Different phases are described which are characterised by the building up of tension, violent outbursts, and the making of excuses by the man. If these phases are repeated, the situation escalates. The violence increases and, over the course of time, the man ceases to make the excuses he had made in the beginning.²² Most studies show that the woman is in most danger when she wants to leave the relationship. This is when most murders occur (cf. Schweikert 2000).

²² Leonore Walker, a US-American psychologist, describes these phases as "cycles of violence" (1983).

A rough estimate can only be made of how many women in Germany experience domestic violence. Up until now no representative study into this taboo area of violence against women, one which has always been shrouded in myths, has been available. However, the German Bundestag's Commission on Violence starts with the assumption that violence within the family is "by far the most widespread form of violence that a person experiences in the course of his or her life", and that it is "the least investigated and, both in its frequency and severity, the most underestimated form of violence" (Schwind et al. 1990:701). According to the Bavarian Ministry of Social Affairs, approximately four million women from all social strata are battered by their partner or husband every year (Federal Bureau of Statistics 1998). An investigation of violence against women in East Germany concludes that, despite the different life situations and political situations, there was scarcely any difference in the extent of domestic violence against women in East and West Germany (Schrötle 1998, Diedrich 1996).

Experiences from women's refuges, counselling centres, and secure accommodations show that any woman can be affected by domestic violence, irrespective of her level of education, nationality, income, religion, age or ethnic affiliation. Both victims and perpetrators come from all social strata. However, younger women, pregnant women, and women with partners who have very traditional ideas of what a woman's role is, or who are very jealous, are particularly affected (Brückner 1998).

Sexual violence against women

In the early 1970s sexual violence against women, in particular rape, was the first form of violence brought to the public's attention by the New Women's Movement. Today, in addition to rape by a perpetrator unknown to the victim, the term "sexual violence" also includes the exercising of subtle or blatant pressure by a husband or partner to perform sexual acts, sexual harassment in the workplace as well as sexual infringements within a dependent relationship (e.g. by a doctor, therapist, carer or teacher)²³. A broad consensus exists among those involved in the feminist debate on violence that sexual violence is more a question of power and subjugation than one of sexuality.

Only limited information is available on how many women in the Federal Republic of Germany are the victims of sexual violence every year. According to a study carried out by the Criminological Research Institute of Lower Saxony (KFN) in 1992, one out to seven woman aged between 20 and 59 is the victim of rape or of sexual coercion at least once in her life (Wetzels/Pfeiffer 1995). According to data available for the GDR, 20% to 25% of women are victims of rape or attempted rape during of their lives (cf. Starke 1990). Few rapes are reported to the police, and most of those that are reported have been committed by strangers. However, only about 30% of all rapes are committed by strangers (cf. Wetzels/Pfeiffer 1995:13; Brückner 1998:15). This means that rapes committed by a partner or friend, remain mostly undiscovered and unreported to the police.

Most of the data available on sexual harassment in the workplace originate from an investigation published in 1991 that was sponsored by the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (cf. Holzbecher et al. 1991). The 2000 or so women questioned were employed in various areas of work. More than 70% of them stated that they had been sexually harassed by colleagues, superiors or customers/clients/patients. 3% of the women questioned stated that they had been threatened or had been forced to perform a sexual act.

²³ In the debate in Germany, the term "sexual violence" is sometimes used as a generic term to describe all forms of violence against women and girls.

Sexual violence in dependent relationships, such as in a psychotherapeutic setting (Reimer 1996), or in a care institution for the elderly or the handicapped, is still treated as an important issue only among experts or in self-help groups. Among the wider public an awareness of the extent of the violence that, in particular, handicapped or elderly women have to face, is slowly growing (on this issue, compare Böhmer 2000; Degener 1996).

Sexual abuse of girls and boys - Sexual traumatisation

From the end of the 1980s until the beginning of the 1990s, much of the attention for violence against women was focussed on the issue of the sexual abuse of girls and boys. Revelations of the extent of this form of violence is today still triggering off varied and controversial debates (cf. Günther et al. 1991; Enders 1990, Kavemann 1996).

Acts of sexual abuse range from touching of a sexual nature to all forms of sexual intercourse. Experts define sexual abuse as "a sexual act performed by an adult with a child who, due to his or her emotional and intellectual development, and due to the unequal power relationship existing between the adult and the child, is not in a position to agree to perform these sexual acts in a free and informed manner. When a child is being sexually exploited, an adult uses his or her position of power and his or her authority, or the dependency of the child, in order to persuade or to force the child to co-operate. One of the key moments during the performance of an act of sexual exploitation or violence is when the child is committed to secrecy. The child is thus rendered speechless, defenceless, and helpless" (Sgroi citing Wüstenberg 1992:133).

Children of all age groups are affected by abuse, but 80% of the victims are girls. Wüstenberg estimates an annual figure of almost 300,000 cases for the former West Germany (Wüstenberg 1992:135). At the beginning of the 1990s, the Federal Government estimated an annual figure of 82,000 cases (cf. Weber/Rohleder 1995:15). Professionals involved in this area assume that the ratio of reported or detected to unreported or undetected acts of abuse is 1:20. The estimated number of unreported or undetected cases is even higher for boys (Smaus 1994).

Sexual abuse takes place within families, regardless of their social stratum, as well as within foster families and children's homes. According to the Federal Criminal Police Office, only 20% to 30% of acts of abuse are committed by strangers. The more well-known that the perpetrator and the victim are to each other, and the closer that they live together, the greater is the likelihood that the abuse will be repeated and will continue for years.

3.6.2 The effects of violence on the health of women and girls

Insights on the effects of violence on women's health come mainly from refuge, counselling, and support initiatives for girls and women affected, from empirical studies, which are mostly linked to these initiatives, as well as from monitor research accompanying individual projects²⁴. These findings provide information on the situation of female service users who have disclosed to be affected by violence. Knowledge is increasingly becoming available from the area of feminist psychotherapy and as a result of addiction work done with women (Hilsenbeck 1997, Vogt 1999). Over the past number of years an awareness of violence as a possible cause of stress, illness, and poor health has slowly grown. Up until now very few medical care approaches deal with injuries, complaints, and organic damage as the consequence of abuse (Olbricht 1997, Beckermann 1998, Böllert et al. 1999, Peschers 2000).

²⁴ Compare Hinze 1993, Egger et al. 1995. Conclusive reports are available from Hagemann-White et al. 1981, Modellprojekt Frauenhaus Berlin; Günther and others 1991, Beratungsstelle und Zufluchtswohnung für sexuell mißbrauchte Mädchen, Helfferich et al. 1997, Anlaufstelle für vergewaltigte Frauen.

The available results show that violence affects the health of women in various ways, and that it has, or can have, short-, medium- and long-term consequences (cf., among others, Hagemann-White 1998; Arbeitskreis Frauengesundheit in Medizin, Psychotherapie und Gesellschaft e.V. 1997). Somatic, psychosomatic, and psychological consequences were among those described, and it is on these consequences that we will be concentrating here.

Conspicuous injuries, which were the direct result of physical attacks, were mentioned as one of the somatic consequences. These included in particular stab wounds or wounds caused by blows, cuts and burns, broken bones, haematomae, and injuries to the face, jaw, breast, and arm. These injuries could lead to the woman being permanently physically handicapped, for example, having impaired eyesight or hearing, or to the impaired suppleness. In the worst case women suffer fatal injuries (Enders 1990, Hagemann-White et al. 1981, Abott et al. 1995).

Head and back pains as well as pains in the breast area, the feeling of choking, difficulty in breathing, gastro-intestinal disorders, and abdominal pains constitute the main somatic and psychosomatic disorders which battered women have frequently complained of. Up until now little research has been carried out into the extent of the connection between these disorders and women's experience of violence²⁵. There is every reason to believe that chronic strain, fear, and uncertainty as, for example, described by women who face domestic violence, are manifested in these disorders. Olbricht (1997) describes the possible connections between psychosomatic disorders among adult women and sexual abuse during childhood. Accordingly, the most common complaints are of abdominal pains, eating disorders, and breathing disorders. Abdominal pains include, among others, (sometimes intense) pains of uncertain origin in the lower abdomen, non-occurrence of periods or disorders related to these, disorders which occur during pregnancy, and frequent miscarriages. These complaints have often been caused by injuries that the women have suffered. "It is not surprising that these women's bodies are not able to function properly. These inappropriate sexual acts, which are often performed in a violent manner, affect a child who usually does not yet know what sexuality is and whose sexual development has not yet begun or has not yet been completed" (Olbricht, 1997:103). Eating disorders include vomiting, nausea, difficulty in breathing, and other disorders up to and including bulimia. Eating disorders can be "interpreted as an attempt to gain at least a minimum amount of independent control over one's own body, and, at least by ingesting food, to determine what is and what is not allowed inside one's body" (loc cit.). Breathing disorders include feelings of pressure in the breast area, hyperventilation syndrome, and asthma. These symptoms could be caused by memories associated with experiences of incest.

Findings related to the psychological consequences of violence come mainly from therapeutic work done with women who have suffered sexual violence, from work done with sexually abused children as well as from research into trauma. Women affected by violence talk of symptoms such as nightmares, depression, disorders related to concentration, sleeping and eating disorders, feelings of fear, humiliation, and self-criticism (cf. Kretschmann 1993:62).

From work done with abused girls and boys exist descriptions of conspicuous psychological disorders which include confused fears, regressive behaviour, loneliness, self-inflicted injuries, suicide attempts, phobias, doubts about the way in which they perceive the world, and disrupted relationships. In contrast to the way in which the debate has progressed in the USA, in Germany it has taken some time for the term post-traumatic stress disorder (PTSD) to

²⁵ A series of studies carried out in Great Britain and the United States of America prove that women who have been the victims of violence in their childhood or as an adult, are more likely to suffer physical health effects, suffer more frequently from physical symptoms, and are ill more frequently than women who have not experienced violence. (Compare Heise 1994, Stark, E., Flitcraft, A. 1996, McCauley et al. 1995, McCauley et al. 1997, Population Reports 1999, 27/4.)

become generally accepted as a description for these consequences of maltreatment²⁶. In the interim, a whole series of descriptions of sexual violence as trauma have become available (cf. Böllert, among others, 1999). They indicate that phenomena such as depression, schizophrenia, identity crises, and feelings of alienation must be regarded as a way in which women and children try to cope with their experience of violence. Studies carried out in Great Britain and the United States of America indicate that girls who have been abused and women who have been raped make up the largest group of people who suffer from post-traumatic stress disorder (cf. Heise 1994:20).²⁷

In the USA, attempts are being made for the first time to describe experiences of domestic violence as trauma. Walker (1984) recorded findings on traumatic experiences of violence and on the reactions of victims of violence to their position as battered women (battered women syndrome). She refers to four phases, which constitute the reaction. The first phase is marked by shock, disbelief, suppression, fear, and confusion. This reaction is closely connected with the fact that the violent act is inconceivable or that possible behavioural options cannot be examined. The second phase is marked by growing dependency, passivity, and subjugation to the perpetrator's demands. In the third phase victims develop the unrealistic hope that the violence will come to an end and that the attacks are not as serious as they had first thought. However, if the threats continue on a regular basis, then the victim increasingly begins to withdraw into herself, constituting the fourth phase. She does not attempt to escape, even if escape is possible. The victim realises that she is helpless and capitulates when faced with a situation which she perceives as hopeless. In her description, Walker stresses that, in contrast to many other types of traumatic acts of violence, domestic violence often lasts for many years, and that for many months and years women are exposed to a process of systematic psychosocial disdain, degradation, and dehumanisation. Psychosomatic and psychological disorders which are connected to this experience, are feelings of helplessness, depression, anxiety attacks, sleeplessness, and fears related to the future. Walker interprets alcohol and drug use as attempts by women to escape their unbearable situation for at least a short period of time (Neubauer et al. 1998).

The descriptions of the possible effects of violence on the health of women and girls outlined here should under no circumstances be generalised or considered as constantly recurring reactions. If violence does affect the health of women and girls, and the way which it does, depends on many factors, such as their individual life experiences, the availability of social assistance, their own capacity to cope with it, and their strengths. This is what Kretschmann, for example, stresses in relation to the trauma of rape: "for all victims it means a psychological and emotional collapse, and one which has nothing to do with their previous psychological make-up. However, attempts to bear, comprehend, and deal with the trauma have to be connected to the specific biographical experiences involved. This is why it is important to make a distinction between the event and the subjective form in which it is processed, if we want to avoid the danger of excessively generalising and individualising" (1993:69). It is true for the whole debate on the connections between violence and health that "the broad term violence, which includes a wide variety of forms of violence, ways of making threats, and of inflicting injuries (...) (must) be balanced against the resources and powers that women have for dealing with it" (Hagemann-White 1998:147).

²⁶ In the USA, the term PTSD was included in the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association (DSM III) as early as 1980. The main reason why this term was included in DSM III was because of findings related to the situation of holocaust victims and of Vietnam War veterans. The meaning of this term was extended following Herman's 1993 descriptions of experiences of sexual violence. Traumatization was included in the diagnosis of PTBS in the "Diagnostic and Statistical Manual of Psychological Disorders", which appeared in German in 1984.

²⁷ Rape victims attempted suicide nine times more, and suffered twice as much from serious depression as women who had not been raped (loc cit.).

3.6.3 Violence as an issue of medical care

Up until now, in the area of medical care violence has only occasionally been recognised as the possible cause of injuries, disorders, and illnesses. The first debates and practical activities aimed at improving care took place in the area of sexual abuse and sexual violence. In June 1999 the Working Group of Academic and Medical Experts published guidelines drawn up by the German Society for Child and Youth Psychiatry and Psychotherapy on classification, diagnosis, and intervention in cases of "neglect, battery, and abuse". In 1997, instructions on "how to conduct medical examinations following possible sex crimes" had already been elaborated at the Women's Clinic of the University of Freiburg and at the Forensic Institute of the State Criminal Office in Baden-Württemberg (Bäßler et al. 1997). At its fifty-third congress, held this year, the German Gynaecology and Obstetrics Society finally made the issue of "Sexual Violence against Women and Girls" one of its main themes. Within the framework of this congress the first findings of a study into sexual violence were also presented. Data taken from 3000 women and girls who had been examined as the victims of sex crimes at the Berlin-Charlottenburg University Clinic during the period 1967-1983, was analysed (Peschers 2000).

However, on the whole these developments cannot hide the fact that, all in all, in the area of medical care, awareness and knowledge of the causes, forms, and consequences of violence is very poor. If women affected by violence are able to find adequate help, then it is only by chance, while their being able to do so is dependent on the individual actions of the doctor who is treating them (cf. Gut 1997, May 1997).

The results of one of the first empirical studies into how general practitioners deal with problems associated with domestic violence were presented in Berlin in 1999 by Heike Mark (cf. Mark 1999). 65 general practitioners practising in two districts in Berlin were questioned. The study showed, among other things, that, measured against official estimates, only one in ten cases of domestic violence was recognised as such by those questioned. One third of those questioned stated that they had never treated a battered woman in their practice. The fact that health disorders are not recognised as being caused by violence and are therefore not adequately treated, represents an extremely high risk for women. The study also showed that two thirds of the general practitioners did not feel adequately informed about the problems associated with domestic violence. Mark assumes that perception of domestic violence could be raised and that doctors would be more capable of intervening in such cases if related guidelines were available. She also bases this assumption on the fact that a clear majority of those questioned can imagine themselves acting as contacts for female patients who have been affected by domestic violence.

The first pilot project aimed to improve medical care available for battered women was inaugurated in October 1999 at the Benjamin Franklin University Clinic in Berlin: the S.I.G.N.A.L. Intervention Project to Combat Violence Against Women. The Clinic has set itself the goal of becoming the first hospital in Germany to offer opportunities for intervening in the area of medical care, and of becoming identified as a refuge for women who experience domestic violence. Each letter of the acronym S.I.G.N.A.L. stands for a way of treating a female patient, and is aimed at care and medical staff. **S** stands for Speak to the patient; **I** stands for an Interview during which simple, concrete questions are put; **G** [not literally translatable] stands for a thorough examination of old and new injuries; **N** stands for Note down and document all findings and information so that they can be used in court; **A** [not literally translatable] stands for the clarifying of the patient's current requirements with regard to protection; **L** [not literally translatable] stands for the offering of a guide containing numbers which can be dialled in case of emergency and information on support options that

might be required. The central component of this project is the training given to the staff of the Clinic in order to make them aware of the problems associated with domestic violence and to prepare them for their new area of responsibility. The experimental project has initially been established in the First Aid/Emergency department but, in the long term, is to be extended to all wards and departments in the Clinic.

Since March 2000 the project has been under scientific supervision and evaluation. Over a two-year period, in addition to recording findings on how the project develops, its implementation, and effects, they will also be gathering data on care requirements as well as on the consequences of violence on the health of patients.

The S.I.G.N.A.L. Intervention Project is conceived by its initiators as a standard venture for intervention in the area of medical care. Since it was initiated, other clinics throughout the whole of Germany have shown an interest in the experiment. However, it remains to be seen if this initial project will become firmly established and if it will be expanded within the area of hospital care as well as in the area of care provided by general practitioners. It also remains to be seen what the effects of this project will be with regard to the type of care available to battered women. In order to facilitate a general discussion and exchange of information on individual experiences by interested people working in the health service a "S.I.G.N.A.L." study group is currently being organised in Berlin²⁸.

3.6.4 Assistance available to women and girls affected by violence

A large amount of the psychosocial and health care available to women is provided in institutions or within the framework of projects which have developed out of the Women's Movement. These institutions and projects originated in West Germany in the mid-1970s and in the former East Germany from 1990 onwards²⁹. In addition to refuges of a general nature, such as women's centres and meeting places for women, these institutions include specific institutions such as refuges for women and girls, secure accommodation, and various specialised counselling centres for women and girls affected by violence (cf. Brückner 1998).

In the mid-1990s approximately 400 women's refuges existed in Germany, of which 120 were located in the former East Germany. Above all, they offer women who experience domestic violence protection and support. No data is as yet available on the number of places of refuge and counselling centres which exist throughout the whole of Germany. However, it can be safely assumed that, at least in all of the larger cities, a relatively well-developed infrastructure for women affected by violence exists.

17 refuges and places of secure accommodation as well as several Wildwasser³⁰ groups were in existence in 1992 throughout Germany for girls who had experienced sexual abuse. The Wildwasser groups work mainly with women and older girls who were abused in their childhood. In addition, a number of voluntary counselling centres exist, most of which are members of the Kinderschutzbund (NSPCC), a national, independent association whose goal is the protection of children against abuse. In recent years, particularly in the larger cities, autonomous counselling centres for women who have been raped have been set up; some of

²⁸ See list of addresses in the country report.

²⁹ To our knowledge, up until 1984 a refuge for "people in crisis" founded by Caritas, as well as some initiatives started by the church, existed in some of the bigger cities in the GDR, but no institutions set up solely for women and girls who had experienced violence were in existence there.

³⁰ The first self-help groups which were founded in the 1980's as a result of sexual abuse called themselves "Wildwasser" groups.

these centres also offer therapeutic help. In 1995 a refuge for women who have been raped originated in the rooms of the University Women's Clinic in Freiburg (cf. Helfferich 1997).

These projects are of central importance within the framework of the care provided for women and girls who have been affected by violence. They create publicity for the problems associated with violence against women and girls, contribute to removing the taboos surrounding this issue, help women and girls who are isolated as a result of the violence they have experienced to break the cycle of violence and offer support. The main working principles in most of the projects are empowerment, the provision of information on the available resources, and the strengthening of each participant's potential for helping herself. Because they possess thorough knowledge of the specific problems associated with the situation of women and girls who have experienced violence, the people in charge of these projects are able to offer unbiased and non-bureaucratic advice and protection. At the same time these projects also provide the impulse for an improvement in the care and support provided in other relevant areas. One example of this is the way in which the police act when investigating cases of domestic violence (cf. Schweikert 2000 on this issue).

In addition to projects which were founded in order to cater directly to the needs of women and girls affected by violence, since the middle of the 1990s new strategies in the area of violence against women and girls have developed. In several German states "round tables" and intervention projects were established, most of which were conceptually based on the "Domestic Abuse Intervention Project" established in the USA (cf. Senatsverwaltung für Arbeit, Berufliche Bildung und Frauen 1999; Heiliger/Hoffmann 1998). The work carried out within the framework of these projects promotes and strengthens in an indirect way opportunities for women affected by violence for acting and taking control. Their aim is to change the basic societal conditions which legitimate violence, to work on extending the opportunities for sanctions on both a civil law and a criminal law level and to offer further education to members of the police force and the judiciary. Unfortunately, up until now very few women and men involved in the drafting of health-related policies and the provision of health care have been included in the intervention projects. As a result, very little advantage has been taken of the opportunities for prevention and intervention existing within the framework of medical care.

3.6.5 Prospects and requirements

Only a small part of the complex connections that exist between violence and health could be treated within the framework of this part of the Länder Report. Certain aspects were only touched upon or could not be dealt with. Aspects which we have not taken up as the possible consequences of violence are, for example, poverty and homelessness (cf. May 1999, May 2000 on these aspects). The special position of female migrants involved in violent relationships has not been considered either (cf. David 2000, among others, on this aspect).

The findings presented on the form and extent of violence against women, on the health-related consequences as well as on the situation with regard to care show that, in the last 30 years, there has been a significant growth in knowledge of the related problems. These findings also show that a wide variety of refuges and institutions for the provision of support which women and girls can turn to have been established as a direct result of the Women's Movement. As a consequence, a wide range of new concepts and approaches for supporting, advising, and carrying out therapeutic work with women and girls have been established.

However, it has also to be said that a great deal of action is required in the area of research as well as in the area of health and, in particular, medical care. Most of the people involved in the area of research into health and even more so in the area of medical research have closed their eyes to the problems associated with violence against women and girls. Despite the huge extent of the violence against women and girls, this subject, which pertains to the central cause of the health problems experienced by women, has been almost completely excluded from both areas of research. Research carried out by women into health issues has in recent times begun to focus on a connection between violence and health. This type of work must be supported and developed.

In the area of care, networking between the women's projects and the institutions which provide medical and health care is long overdue. Evidence from the USA proves that medical practitioners, first aid wards as well as nurses who provide domestic care could play an important role in the provision of support to women and girls. Further training similar to that provided for the police should be provided for doctors as well as for those involved in nursing and care. This would increase their awareness of the problems associated with violence against women and girls, and would highlight opportunities for taking action. Practice-oriented guidelines on care and intervention should also be developed.

Support options should be established in the area of regulated care, while work on anti-violence initiatives should be expanded and safeguarded. The fact that a plurality of options is required with regard to the heterogeneous structure of the groups of women who experience violence needs to be taken into account. It is to be hoped that one of the main focuses of the "Plan of Action to Combat Violence Against Women", which was adopted by the Federal Government towards the end of 1999, will be on health and health care.

It remains to be hoped that the issue of domestic and sexual violence will receive more attention from all of those involved in the promotion of health and health care and that, as a result of this, a problem which was caused due to the structures existing within society will receive greater attention.

Literature:

Abott, J.; Johnson, R.; Koziol-McLain, J.; Lowenstein, S. (1995): Domestic Violence against women. Incidence and prevalence in an emergency department population. In: Journal of the American Medical Association 273, Nr. 22, 1763-1767.

Arbeitskreis Frauengesundheit in Medizin, Psychotherapie und Gesellschaft e.V. (AKF) (Hg.) (1997): Wege aus Ohnmacht und Gewalt. Frauengesundheit zwischen Menschenrechten und Grenzverletzung. Dokumentation der 3. Jahrestagung des AKF. Bünde.

Beckermann, M. (1998): Die gynäkologische Untersuchung und Begleitung von sexuell traumatisierten Frauen. In: Bremische Zentralstelle für die Verwirklichung der Gleichberechtigung der Frau (Hg.): Sexuelle Gewalt. Ursache für spezifische körperliche Beschwerden von Frauen und Mädchen. Dokumentation einer Fortbildung für Gynäkologinnen/Gynäkologen im Herbst 1996 in Bremen.

Berliner Frauenhaus für misshandelte Frauen. (1978): Frauen gegen Männergewalt. Erster Erfahrungsbericht. Frauenselbstverlag Berlin-West.

Bäßler, G.; Birmelin, G.; Hilgarth, M. et al. (1997): Merkblatt zur ärztlichen Untersuchung nach fraglichen Sexualdelikten, Landeskriminalamt Baden-Württemberg.

BIG e.V. Berliner Initiative gegen Gewalt gegen Frauen. Koordinationsstelle des Berliner Interventionsprojektes gegen häusliche Gewalt (Hg.) (1997): Gewalt gegen Frauen im häuslichen Bereich. Alte Ziele - Neue Wege. Berlin.

- Böhmer, M. (2000):** Erfahrungen sexualisierter Gewalt in der Lebensgeschichte alter Frauen. Frankfurt aM: Mabuse-Verlag.
- Böllert, K.; Behrend, I.; Dinse, D.; Falkenberg, K. et al. (1999):** Gewalt verrückt die Seele. Eine Untersuchung zu Hilfsangeboten im psychosozialen und medizinischen Bereich für sexuell traumatisierte Frauen in Mecklenburg-Vorpommern. Selbsthilfe- und Therapiezentrum "Dolgener See" (Hg.).Dolgen/Mecklenburg.
- Brückner, M. (1998):** Wege aus der Gewalt gegen Frauen und Mädchen. Frankfurt a.M.: Fachhochschul Verlag.
- Brückner, M. (1996):** Frauen und Mädchenprojekte. Von feministischen Gewissheiten zu neuen Suchbewegungen. Opladen: Leske + Budrich.
- Brückner, M. (1983):** Die Liebe der Frauen. Über Weiblichkeit und Misshandlung. Frankfurt a.M.: Fischer Taschenbuchverlag.
- David, M.; Borde, T.; Kentenich, H. (Hg.):** Migration - Frauen - Gesundheit. Perspektiven im europäischen Kontext. Frankfurt a.M: Mabuse-Verlag
- Degener, T. (1995):** Behinderte Frauen in der beruflichen Rehabilitation. In: Hessisches Netzwerk behinderter Frauen und Hessisches Koordinationsbüro für behinderte Frauen (Hg.): Rechtsgutachten, Kassel.
- Diedrich, U. (1996):** Sexuelle Misshandlung in der DDR: Verdrängung eines Themas und seine Folgen. In: Hentschel, G. (Hg.). Skandal und Alltag: Sexueller Missbrauch und Gegenstrategien. Berlin: Orlanda Frauenverlag, 53-67.
- Egger, R.; Froeschl, E.; Lercher, L. (et al.) (1995):** Gewalt gegen Frauen in der Familie. Wien: Verlag für Gesellschaftskritik.
- Enders, U. (Hg.) (1990):** Zart war ich, bitter war's. Sexueller Missbrauch an Mädchen und Jungen. Erkennen - Schützen - Beraten. Köln: Kölner Volksblatt Verlag.
- Günther, R.; Kavemann, B.; Ohl, D. (1991):** Modellprojekt Beratungsstelle und Zufluchtswohnung für sexuell missbrauchte Mädchen von "Wildwasser" - Arbeitsgemeinschaft gegen sexuellen Missbrauch an Mädchen e.V., Berlin. Schriftenreihe des Bundesministeriums für Familie und Jugend, Bd. 10. Stuttgart: Kohlhammer.
- Gut, G. (1997):** Frauen auf der Suche nach Hilfe im medizinischen System. In: Innere Sicherheit durch Prävention. Gesundheitliche Folgen und gesellschaftliche Kosten von Gewalt. Diskutiert am Beispiel der Gewalt gegen Frauen und Mädchen. Anhörung der Fraktion Bündnis 90/Die Grünen am 28. Oktober 1997, (Hg.) Fraktion Bündnis 90/Die Grünen im Abgeordnetenhaus Berlin. 10-14.
- Heise, L.; Pitanguy, J.; Germain, A. (1994):** Violence against women: The hidden health burdens. Washington. World Diskussion Papers 255.
- Hagemann-White, C. (1992):** Strategien gegen Gewalt im Geschlechterverhältnis. Bestandsanalyse und Perspektiven. Pfaffenweiler: Centaurus.
- Hagemann-White, C.; Gardlo, S. (1997):** Konflikte und Gewalt in der Familie. Ein Bericht über die erste Fachtagung des interdisziplinären Netzwerkes europäischer ForscherInnen zu Konflikt und Gewalt in der Familie. Loccum, 24.-27.8.97. Zeitschrift für Frauenforschung 15 (3), 73-96.
- Hagemann-White, C.; Kavemann, B.; Kootz, J. (et al.) (1981):** Hilfen für misshandelte Frauen. Abschlussbericht der wissenschaftlichen Begleitung des Modellprojekts Frauenhaus Berlin. Schriftenreihe des Bundesministeriums für Jugend, Familie und Gesundheit, Bd. 124. Stuttgart: Kohlhammer.
- Hagemann-White, C. (1998):** Gewalt gegen Frauen und Mädchen - welche Bedeutung hat sie für die Frauengesundheit? S.142-154. In: Arbeitskreis Frauen und Gesundheit (Hg.): Frauen und Gesundheit(en) in Wissenschaft, Praxis und Politik. Bern et al.: Verlag Hans Huber, 63-73.
- Heiliger, A.; Steffi Hoffmann (Hg.) (1998):** Aktiv gegen Männergewalt. Kampagnen und Maßnahmen gegen Gewalt an Frauen international. München: Frauenoffensive.

- Helfferrich, C.; Hendel-Kramer, A.; (Hg.) (1996):** Hilfen für Vergewaltigte Frauen. Theoretische Konzepte und praktische Hilfen. Dokumentation der Arbeitstagung 1995. Freiburger Institut für Gesundheitswissenschaften.
- Helfferrich, C.; Hendel-Kramer, A.; Tov, E. (et al.) (1997):** Anlaufstelle für vergewaltigte Frauen. Abschlussbericht der wissenschaftlichen Begleitforschung. Schriftenreihe des Bundesministeriums für Familie, Senioren, Frauen und Jugend, Bd. 146. Stuttgart: Kohlhammer.
- Herman, J. L. (1993):** Die Narben der Gewalt. Traumatische Erfahrungen verstehen und überwinden. München: Kindler.
- Hilsenbeck, H. (1991):** Feministische Gruppenarbeit mit "Psychotikerinnen" 36-46. In: Hoffmann, D. (Hg.): Frauen in der Psychiatrie. Schriftenreihe im Psychiatrie-Verlag. Bonn.
- Hilsenbeck, P. (1997):** Traumatherapie - mit Mut und Achtsamkeit. In: AKF (Hg.): Wege aus Ohnmacht und Gewalt. Frauengesundheit zwischen Menschenrechten und Grenzverletzung. Dokumentation der 3. Jahrestagung des Arbeitskreises Frauengesundheit in Medizin, Psychotherapie und Gesellschaft e.V., 45--74
- Hinze, L. (1993):** Bericht zum Forschungsprojekt "Individuelle und soziale Bedingungen für Gewalt gegen Frauen". In: Leitstelle für Frauen- und Gleichstellungsfragen Sachsen-Anhalt (1993): Gewalt in der Familie. 7-15.
- Holzbecher, M.; Braszeit, A.; Müller, U. (et al.) (1991):** Sexuelle Belästigung am Arbeitsplatz. Schriftenreihe des Bundesministeriums für Jugend, Familie, Frauen und Gesundheit, Bd. 260. Stuttgart: Kohlhammer.
- Kavemann, B. (1996):** Möglichkeiten und Grenzen präventiver Arbeit gegen sexuellen Missbrauch von Jungen und Mädchen. In: Neue Praxis 2.
- Kavemann, B.; Leopold, B.; Schirmacher, G. (1999):** Projekt WiBIG: wissenschaftliche Begleitung Interventionsprojekte gegen häusliche Gewalt. Zwischenbericht. Berlin, unveröff. Projektbericht.
- Kretschmann, U. (1993):** Das Vergewaltigungstrauma: Krisenintervention und Therapie mit vergewaltigten Frauen. Münster: Westfälisches Dampfboot.
- Mark, H. (1999):** Häusliche Gewalt. Umgang mit ärztlichen Praxen, die Opfer häuslicher Gewalt wurden. Befragung niedergelassener Ärztinnen und Ärzte in den Berliner Bezirken Hohenschönhausen und Lichtenberg. Magisterarbeit im postgradualen Studiengang Public Health/Gesundheitswissenschaften, Technische Universität Berlin.
- May, A. (1997):** Misshandlungen, Misshandlungssysteme, gesundheitliche Folgen häuslicher Gewalt. In: Innere Sicherheit durch Prävention. Gesundheitliche Folgen und gesellschaftliche Kosten von Gewalt. Diskutiert am Beispiel der Gewalt gegen Frauen und Mädchen. Anhörung der Fraktion Bündnis 90/Die Grünen am 28. Oktober 1997, Abgeordnetenhaus Berlin. 4-9
- May, A. (1999):** Misshandlung macht arm? In: Franke, M., Geene, R., Lubert, E. (Hg.): Armut und Gesundheit. Materialien zur Gesundheitsförderung Bd.1, Berlin: Gesundheit e.V. Berlin. 52-88
- Mc Cauley, J. et al. (1995):** The "Battering Syndrome". Prevalence and Clinical Characteristics of Domestic Violence in Primary Care Internal Medicine Practices. In: Annals of Internal Medicine 1995, Vol 123, Nr.10, 737-746.
- McCauley, J. et al. (1997):** Clinical Characteristics of women with a history of childhood abuse. Unhealed wounds. Journal of the American Medical Association 277 (17): **1362-1368.**
- Neubauer, E.; Steinbrecher, U., Drescher-Aldendorff, S. (1998):** Gewalt gegen Frauen: Ursachen und Interventionsmöglichkeiten. Schriftenreihe des Bundesministerium für Familie, Senioren, Frauen und Jugend. Bd. 153. Stuttgart: Kohlhammer.

- Nini, M.; Bentheim, A.; Firle, M. et al. (1995):** Abbau von Beziehungsgewalt als Konfliktlösungsmuster - Abschlussbericht - 1994. Opferhilfe Hamburg e.V. in Zusammenarbeit mit Männer gegen Männergewalt e.V. Schriftenreihe des Bundesministeriums für Familie, Senioren, Frauen und Jugend, Bd. 102. Stuttgart: Kohlhammer.
- Olbricht, I. (1997):** Folgen sexueller Traumatisierung für seelische Entwicklung und das Körpergefühl von Frauen. In: AKF (Hg.): Wege aus Ohnmacht und Gewalt. Frauengesundheit zwischen Menschenrechten und Grenzverletzung. Dokumentation der 3. Jahrestagung des Arbeitskreises Frauengesundheit in Medizin, Psychotherapie und Gesellschaft e.V., 100-113.
- Osattin, A.; Short L. (1998):** Intimate Partner Violence and Sexual Assault. A Guide to Training Materials and Programs for Health Care Providers. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Atlanta
- Peschers, U. (2000):** Sexuelle Gewalt: Frauenärztinnen und Frauenärzte wollen ein Tabu brechen. Presseerklärung anlässlich zum 53. Kongress der Deutschen Gesellschaft für Gynäkologie und Geburtshilfe, München. http://idw.tu-clausthal.de/zeige_pm.htm?pmid=21942
- Population Reports (1999):** Ending Violence Against Women, 27 (4), Serie L, Nr.11, Population Information Program, John Hopkins University School of Public Health, Baltimore.
- Schrötle, M. (1998):** Politik und Gewalt im Geschlechterverhältnis: eine empirische Untersuchung über Ausmaß, Ursachen und Hintergründe von Gewalt gegen Frauen in ostdeutschen Partnerschaften vor und nach der deutsch-deutschen Vereinigung. Dissertation Giessen, erscheint 1999.
- Senatsverwaltung für Arbeit, Berufliche Bildung und Frauen (1999):** Eingreifen bei häuslicher Gewalt. Europäische Erfahrungen bei der Verbesserungen von Hilfeangeboten für Frauen, die von Gewalt betroffen sind. Dokumentation der Fachtagung zu Interventionszentralen im Europäischen Raum am 30.10.1998 in Berlin.
- Schweikert, B.(2000):** Gewalt ist kein Schicksal. Ausgangsbedingungen, Praxis und Möglichkeiten einer rechtlichen Intervention bei häuslicher Gewalt gegen Frauen unter besonderer Berücksichtigung von Polizei- und zivilrechtlichen Befugnissen. Schriften zur Gleichstellung der Frau, Bd. 23. Baden-Baden: Nomos Verlagsgesellschaft.
- Schwind, H.-D.; Baumann, J. et al. (Hg.) (1990):** Ursachen, Prävention und Kontrolle von Gewalt: Analysen und Vorschläge der Unabhängigen Regierungskommission zur Verhinderung und Bekämpfung von Gewalt, Bd. II. Berlin: Duncker & Humblot.
- Smaus, B. (1994):** Physische Gewalt und die Macht des Patriarchats. In: Kriminologisches Journal 2
- Stark, E.; Flitcraft, A. (1996):** Women at Risk. Domestic Violence and Women's Health. Thousand Oaks/California: Sage Publications.
- Starke, K. (1990):** Partnerstudie III - Partnerschaft und Sexualität 1990. Zentralinstitut für Jugendforschung, Leipzig.
- Statistisches Bundesamt (Hg.) (1998):** Gesundheitsbericht für Deutschland. Gesundheitsberichterstattung des Bundes. Stuttgart.
- Vogt, I. (1999):** Prämissen einer frauenspezifischen Suchtarbeit. Ergebnisse aus der Forschung. In: Frauen-Sucht-Gesellschaft. Dokumentation der Fachtagung am 28. Januar 1999 in der Katholischen Akademie Trier. Ministerium für Kultur, Jugend, Familie und Frauen, Rheinland Pfalz. 5-31
- Walker, L. (1983):** The battered women Syndrom Study. In: Finkelhor, D., Gelles, R., Hotaling G.: The dark side of families. Beverly Hills: Sage.
- Weber, M.; Rohleder, C., (1995):** Sexueller Missbrauch. Jugendhilfe zwischen Aufbruch und Rückschritt. Münster: Votum.

Wetzels, P.; Pfeiffer, C. (1995): Sexuelle Gewalt gegen Frauen im öffentlichen und im privaten Raum. Ergebnisse der KFN-Opferbefragung 1992. KFN-Forschungsbericht Nr. 37, Hannover.

Wüstenberg, W. (1992): Sexueller Missbrauch an Mädchen und Jungen und die Aufgaben der Sozialarbeit und Sozialpädagogik, in: Straumann, U. (Hg.): Beratung und Krisenintervention, Köln: GwG-Verlag.

3.7 Women's Health Research in Germany

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3.7.1 The Development of Women's Health Research in Germany: From the women's health movement to public health

Women's health research in Germany has two essential origins: On the one hand it emerged from social science gender research, on the other its political and practical roots lie in the women's health movement. In medicine research concerning the health situation of women focused on the analysis of diseases and problems connected with the reproductive health of women (i. e. conditions of menstruation, pregnancy and birth and their respective gynecological illnesses) concentrating on the development of medical-technological procedures. Since the 1970s the upcoming women's health movement criticized that the technical progress-orientated high technology medicine tended to incapacitate women from self-determination over their own bodies. Women get pathologized because of their biology and are seen as patients requiring treatment. Women's health and women's therapy centers, and later also birth houses, emerged in order: to inform women about their rights and chances to give them capabilities to take decisions and actions, and to open up alternative ways to get medical treatment and care.

For the women's health movement, the critical argument regarding medical science' understanding of women's health is that in their view the health of women is connected with the personal, social and cultural life circumstances. The scientific base was provided by the emerging field of women's social science research which focused on gender relations in science and society and uncovered existing gender inequalities and injustices. Therefore the women's movement pleads for gender mainstreaming in health.

In this context, theoretical concepts were developed in women's health research where the health of women was placed in the foreground and illnesses, as well as physical or psychological deficits and malfunctions, were moved into the background. Burden and resources for health and well-being of women should be determined in work and life conditions. With this approach, women's health research was from the beginning aligned with public health science, and contributed to important developments like health promotion.

Above all, women's health research took up themes which had been especially neglected in previous research and women's health care, or had been treated one-sidedly because of a male-determined, androcentric perspective. These questions concern the reproductive health of women, including critical analysis of modern reproductive technology, and themes, where discrimination or unequal treatment is very obvious. Examples for these questions are:

- The influence of women's work and living conditions in the job and family on their physical and psychosocial health, especially the health of mothers with small children;
- Research on violence against women;
- Investigations concerning drug consumption and drug dependency and its background in the medical system;

- Research and development of practical models on health promotion in women;
- Inquiries of effects of the social transformation after the reunification of East and West Germany on the health of women.

Women's health research also received a certain impetus through the foundation of public health research networks in Germany (For overviews see, for example: Begenau/Helfferich 1997: Arbeitskreis Frauen und Gesundheit im Norddeutschen Forschungsverbund Public Health 1998). Demands for women's health research were formulated within this context (Helfferich/v.Troschke o. J.; Maschewsky-Schneider 1996). The long-term goal was to establish women's health research in the framework of public health research. There was a certain success, as the promotion of various women-specific projects, (i. e. for the health care of pregnant women with special risk factors, for female migrants or for birth houses), and the establishment of three chairs which represent the women's health focus in the postgraduate courses in public health (Berlin, Bremen, Bielefeld). Independent from this, chairs were established in various departments at a number of universities and universities of applied sciences, especially in the social sciences, which included women's health as one of their work focus points (for example, in Osnabrück, Hamburg, Dortmund, Freiburg, Frankfurt). Special chairs for women's health were established at some medical schools or are in set-up (Münster, Hannover, guest professor at the medical school in Magdeburg). Women's health is also dealt with in some areas of the newly established field of nursing science.

Although women's health topics were included in various research programs in the last few years (besides public health, i. e. in rehabilitation science, the VW-Foundation, and in reproductive medicine), there is very little which is directly orientated on women (i. e., Lower Saxonian Federal Research Fund: Women and Gender Research in the Natural Sciences, Technology and Medicine, programs of the Ministry for Families, Seniors, Women and Youth). In German research programs, there is no obligation like in the USA to consider women's health themes in promotion programs. Nevertheless agreements exist on how to systematically regard gender issues in theory, methods and study design of health-related research (for provisional version see Mastroianni et al. 1994; the recent version of these guidelines are accessible in the internet under the following address:http://grants.nih.gov/grants/funding/women_min/guidelines_update.htm). The claim to include more female experts in decision-making bodies for research promotion has as yet not nearly been realized.

In the context of the "Answer to the federal government concerning the Social Democrat Party's major inquiry on women specific health care" (Deutscher Bundestag 1997) was taken an inventory. It demonstrated the continuing deficit in women's research and target group-directed health care of women. The inventory includes central sectors of health care and research by/about women, such as:

- knowledge of the health status of women in Germany concerning health promotion and prevention;
- the relation between social conditions (for example, poverty and social situations) and health;
- health care in the medical system;
- the situation of women in East German states;
- the health situation of female foreigners;
- the living situation and health of women with disabilities and
- women in medicine and women in research.

Altogether the inventory points out that the knowledge of women's health in many sectors is very poor, that health care services do not sufficiently consider gender-specific differences and specialties, and that considerable research deficits remain. On the background of these results a report concerning the health status of women in Germany was commissioned in order to improve the level of knowledge in the Federal Republic of Germany.

In order to remedy deficits in research and care, women's health research has to begin with topics that are particularly significant for the health of women, as well as those where unequal treatment and the resulting mistakes are very obvious. Fundamentally, women's health research should ensure that all research and health care sectors are analyzed how far they lead to inequalities or mistakes in the health care of women. The point of view is stronger on comparison and differences between women and men and on answering questions concerning the differences and commonalities in the health of women and men. The goal is an appropriate health care according to the needs and necessities of each gender and to avoid mistakes in treatment.

In this sense, the gender mainstreaming concept of the European community is also applicable to health research and care. Methods for research-but also for the development of models of health care-are to be developed in order to guarantee a systematic assessment of the influences of measures on the health of women and men (gender impact). As another task instruments must be established, which examine the research designs and research results in view of gender bias (Eichler, 1998, and see below). By these means research is oriented on questions concerning the special features of women's will be transferred into gender-sensitive health research.

In the past decades, women's health research in Germany has produced a range of findings, which cannot be described here in detail. In the following, three central areas should be cited which are important for further development:

1. An overview of the concept and thematic sectors of women's health reporting for Germany whose publication will be at the end of the year 2000.
2. The important connection between the social situation of women and their health.
3. The concept of gender-sensitive research and its significance for future public health research.

3.7.2 Women's health reporting

Health reporting in general describes the health situation of the population or of certain population groups to determine priorities of treatment in regard to the health situation and to care. It additionally can help to improve health policies, by making relevant planning facts available for politics, administration and the public health service (Kellerhof 1996)

- A couple of overviews and reports asked repeatedly for a systematic women's health reporting for Germany (Helfferich et al. 1995; Agenda "Frauen und Gesundheitswissenschaften" 1994; Begenau et al. 1996). Reasons, why a women specific health reporting is considered imperative, are:
- Women and men differ with regard to the illnesses and the health restrictions from which they suffer;
- Differing factors determined by their health-related habits, are effective in the work and living conditions of women and men (i. e. differences concerning their engagement in paid and family work);

- Both sexes differ with regard to physical conditions which affect health; like concerning the reproductive health of women, i. e. the areas of pregnancy, birth, menopause, as well as the connection between, for example, hormonal factors and chronic illnesses like cardiovascular diseases or osteoporosis;
- Based on diverse experiences of socialization and living conditions, women and men deal differently with illness and stress; women, for example, seem to react more sensitively to physical and psychological impairments and have a more strongly developed sense of precaution than men;
- Women and men make use of different sectors in the public health service, and they are differently perceived and treated by health professionals; i. e. women are prescribed more psychotropic drugs than men.

In 1996 the Federal Ministry for Families, Seniors, Women and Youth gave a grant to a group of female scientists to prepare a report on the health situation of women in Germany which simultaneously established the connection to initiatives within as well as outside of Europe.

A gender-specific view on the existing conditions of health and disease needs to simultaneously reconsider the existing approaches to health reporting and to develop major themes for a gender-sensitive reporting. Essentially for this is the perception of health itself. Women's health reporting orientates itself not primarily on a medical disease concept, but rather on a social environment understanding of health and illness. This means to adequately consider the close relationship between the work and living conditions of women, their health status and their needs of health care in the reporting. Women's health reporting is enrolled, following the guidelines of the Ottawa Charta (WHO 1986) to consider health reporting and health promotion as a socially conscious responsibility. A central role plays the strength of women and their abilities to support their own health needs.

A further central idea in the representation of data and results for specific diseases is to pay attention to hidden prejudices about illness in women. As to heart attacks, it is discussed if different disease symptoms in women and men could be a possible cause for inadequate diagnoses of women's heart attacks. Concerning the practice of increasingly prescribing psychotropic drugs to women is questioned as a gender-specific process attribute of psychological illnesses.

East - West differences are of great significance for the reporting, i. e. on the specific circumstances of women in the old and in the new German states, as well as on the differences and similarities of women's health status. Health advantages and disadvantages for East German women connected to the social change are portrayed in various sections of the report. Another important point of view is the question, how far the social and living situation affects the health status and if they are linked to specific health treatments.

The topics in the report are oriented on women's specific needs of medical care. The theoretical framework of central ideas build the background of the report. The current state of knowledge is incorporated in the report, and the results were described with special reference to Germany. The choice of themes was based on a range of criteria: the catalog of indicators for women's health reporting drawn up by WHO (1994), because an international comparability will be possible with this; and cross-sectional approaches to realize the social environment orientated concept (i. e. a life-course oriented approach, or focusing on resources relating to disease or disability).

The following thematic areas were chosen for the report:

- Social demographic and social economic indicators for the work and living conditions of women in the family and on the job;
- Differences in the health situation of women and men, with regard to causes of death and illnesses with special relevance for women;
- Women's health-related ways of living, their conceptions of health and health-related acting;
- Violence against women;
- The reproductive health of women in the course of life, as, for example, family planning, conception, pregnancy and birth;
- Women's work on the job and in the family and its health effects;
- The health of women in midlife;
- Women in special circumstances, as for example women with disabilities or addicted to drugs;
- Women-centered approaches in health promotion and health care.

The report on the health status of women in Germany covers a wide variety of themes; but it can't include all health-relevant subject areas. The report is oriented on the precondition of concentrating on adult women, which means older women and children or adolescents are only included in some sections. Another reason for the exclusion of subjects was the poor database in many areas. A lot of the research results don't systematically consider gender-specific differences. This is the reason, why information relating to women's health situation wasn't available for all relevant themes, i. e. for some descriptions of illnesses, the medical care, rehabilitation and expenses in medical care.

The report on the health situation of women in Germany shows, which concepts are useful for women's health reports. The report has orientating function for gender-sensitive reporting. It points out research deficits in relation to the health of women and in which areas further reporting is urgently required. Above all the reported data and analyses show a way to improve the health care of women and how to utilize care-services in an effective and goal-directed manner.

3.7.3 Social situations and the health of women

In women's health research, the reflection of women's social situation and effects on their health status was important from the very beginning. The living conditions play an outstanding role in the maintenance of health or the emergence of disease. In contrast to biomedical models with their fixation on individual risks and behaviors, the significance to health and/or disease was pointed out as major influencing factors for diseases.

Various aspects of living conditions and experiences and their importance to health were analyzed on the basis of a life-style approach (see for example Klesse et al. 1992). This includes the consideration of socioeconomic differences, individual areas of life (as for example, outside employment) as well as the integration into various social roles and their influence on the health of women. The complexity of these living conditions was taken into account in regard to the resulting differences in demands and resulting ambivalences (see Klesse et al. 1992; Jahn et al. 1998). The dealt topics consider particularly female living situations which were, up to now, only insufficiently considered in general research (see Helfferich 1994). Beyond that, the existing research results are subjected to a critical analysis from a gender-perspective. Despite existing research results concerning the connection between social situations and the health of women still numerous deficits exist, caused through pending analysis as well as by unsolved methodological questions.

The relationship between social situation and health is scientifically evident. People in poorer social living situations have a shorter life expectancy and a poorer health status (see for example Steinkamp 1999). This social gradient appears for women and men; however, gender-specific differences exist in the strength and in the consistency of the relations and, until now, couldn't be explained sufficiently (see for example Babitsch 1998a; Matthews et al. 1999). One reason for this result lies in the measurement of the social situation of women, which has an effect on the description of the relationship between social inequality and health (see moreover Arber 1989; Babitsch 1998b). The question of an adequate description of social inequality has not been solved. However, there are various alternatives for the description of the social status of women. One is the demand to determine the social status of women not, like usual, through the status of the husband/partner (see for example Arber 1989). Others ask for the inclusion of continuing determinants of social inequality (such as, for example, purchasing power, family position (see for example Macran et al. 1996) of the description of complex social situations (Babitsch 1997).

The results of women's health research, with its analyses of specific living situations of women, provided important findings on underlying structures as well as differences between various social groups of women, such as women out of the lower social classes, single-mothers or older women (i. e. Helfferich 1994). Another example is the study by Klesse and colleagues (1992), who investigated health-related behavior and health in socially disadvantaged women. This study is based on a concept of life course, investigating the impact of social conditions (for example, familial situation, socialization, life history) on health (Maschewsky-Schneider 1993). An important result of this study is that women in different social situations differ not only in their health status, but also in their resources and strains. An important factor for coping with every-day-hassles is the existence of life and coping perspectives.

Babitsch (1997) came to similar results and demonstrates, that differences in health persist not only between women from different social situations, but also between women with similar social situations. Specific profiles of health-related life styles and health status could be found in women who lived in different social situations.

An increasingly significant area of women's health research is the analysis of the relationship between employment and family work on women's health. Studies show that resources and strains on health are associated with the integration of job and family (Jahn et al. 1998; Bammann et al. 1999). The results show that the areas of women's lives are complex and depend on coping and resolution strategies.

Paid work is of increasing importance in women's life. This is apparent in two developments: first, higher employment-rate of married women and mothers, and second, shorter phases of staying at home during the lifecourse. Women, particularly the women of the younger generation, want both: a family as well as a career (Oechsele & Geissler 1991).

There has been broad research about the effects of occupation on health (i. e. exposure to substances like asbestos, the quality of the work sites and the specific working conditions like shift work) in the health sciences, but not much research does exist, which centers on work and women's health. There is a lack of research concerning the impact of typical female occupations, of family work and the interaction between employment and family work on women's health. Last but not least the gender-specific job market should be considered as a structural framework for career possibilities. when dealing with its effects on the health of women.

Furthermore, there are clarifying approaches and models to describe the effects of various roles on health (see for example Baruch & Barnett 1986). At the beginning, all these approaches and models were quantitatively orientated (focusing on the number of different roles), nowadays the qualitative aspects seem to be of greater importance: not the number of the roles, but rather the quality of the roles (strains and resources they are connected with) are relevant for women's health. These considerations are based on a model of resources and strains, which includes a compensation between straining and promoting aspects in various roles. This is validated by current study results from the research areas "work and health" and "social situations" (see for example Babitsch 1997; Jahn et al. 1998).

Women's health research has demonstrated, "how the living conditions of women in our society and the respective burdens, discrimination and contradictions influence their health, their well-being and their health behavior." (Maschewsky-Schneider 1994: 30). Gender-specific differences in health status between women and men were ascertained, which are closely linked to living situations and the way of life. Moreover, the reported findings contribute to a sophisticated consideration of the social and health situations of women, by which similarities as well as differences between women can be ascertained.

3.7.4 Methods of gender-sensitive health research

For German-language areas there are no guidelines that ensure appropriate attention to gender issues for health research. There is, however, a range of initiatives in various work sectors, for example in the German Epidemiological Association (DAE), to develop corresponding guidelines and recommendations as basis for research. As precondition investigators should accept the necessity of the gender-sensitive ways of approach. Quality assurance is here a central point to convince researchers of the necessity of gender-sensitiveness: through gender-sensitive reporting gender bias will be avoided and achieved results are of a better quality.

Three assumptions are important for the formation of gender bias³³:

The assumption of equality of women and men, where this does not exist. An example is the rehabilitation procedures for men and women after a heart attack. The courses of disease and health care are very different with men and women; nevertheless a uniform set of criteria is permitted.

The assumption of diversity between women and men, where this (possibly) does not exist. Example: Thus various investigations show that women have more complaints than men, it is not clarified, if women really have more complaints or if they just are more capable to notice complaints earlier and to express them.

The different interpretation of factors appearing in both sexes; i. e. symptoms are judged differently, depending on if they appear in women or in men.

On this basis, various forms of gender bias can be identified (Eichler 1991 and 1997):

Androcentricism and Overgeneralization: The adoption of the male perspective, in the sense that research and health care follows a male-determined view. Males are taken as the norm against which females are assessed, accepting of justifying male dominance. Results, approaches, and methods of studies exclude or underrepresent woman or are transferred on to women without scrutiny. Through this, inadequate conclusions can be drawn.

³³ The first two assumptions are based on Ruiz & Verbrugge (1997), the third on Eichler (1997)

Gender Insensitivity: To ignore sex and gender as important issues or variables in a context in which they are, in fact, significant. There is a lack of consciousness in the research and health care that both genders must be considered/analyzed separately.

Double Standards: Different treatment or evaluation of the same or identical situations, traits or behaviors on the basis of sex. Differing methods, approaches, concepts or health care guidelines are used in research, evaluation or health care of women and men.

A handbook developed by Eichler et al. (1999) for the Canadian Ministry of Health (Health Canada) demonstrates how to introduce gender-specific needs and interests in research and practice, and helps to check, how far results are gendersensitive.³⁴ The publication of this very detailed handbook for German speaking countries is in preparation. In the context of the project "Gender Bias - Gender Research"³⁵ a shortened questionnaire was developed to examine health-sciences' results in German speaking countries. This questionnaire has been established to ascertain the descriptively identifiable aspects of gender bias-for instance, on the linguistic level, in the conception of random sampling, in gender stratification or in statistical and graphic presentation of the results.

Short Questionnaire to Ascertain Gender Bias in Empirical Work

Title, Abstract	<ul style="list-style-type: none"> • Does the title name both sexes? • Does the abstract/outline name both sexes?
Research question	<ul style="list-style-type: none"> • If the phenomenon under consideration affect both sexes, were both sexes adequately investigated? When no, was that justified? • Which is the unit of analysis (women, men, households)?
Research design	<ul style="list-style-type: none"> • Does the research focus takes sex explicitly into account? • Do the main variables take the potentially different situations of women and men into account?
Research method and data collection	<ul style="list-style-type: none"> • Is there information given in the methods part as to whether the instruments are applicable to both sexes? • Is the sex of all participants in the study reported?
Data analysis and interpretation	<ul style="list-style-type: none"> • Are the data analyzed by sex? • Do the conclusions take sex-specific circumstances into account? • If only one sex is considered, are conclusions drawn in general terms?
Visual representation	<ul style="list-style-type: none"> • Are both sexes represented in images and tables? • Do the size and placement of the images correspond to the actual importance of the sexes in the given context?
Language	<ul style="list-style-type: none"> • Are both sexes mentioned? • Which terms are used in the text (male/female/neutral)? • Which terms are used in tables/illustrations?

³⁴ The basis is the manual of the Canadian Ministry of Health (Health Canada) in the version of November 1999. This project is still not concluded; changes are possible. The final version will attend to gender bias in research, policy and programs.

³⁵ The project "Gender Bias – Gender Research: The development and application of methodological standards for gender specific research in public health" is carried out within the Berlin Center of Public Health (BZPH) and is funded by the State Ministry for Education, Research, Science and Technology under the funding code 01EG9821TPN11.

Gender bias can occur in a variety of ways in each phase of the research process—from the formulation of the research questions, through the collection of data, to the conclusions. Therefore, each individual phase should be critically tested on whatever bias can appear, to avoid gender bias in view of the scientific quality of the results.

The significance of Eichler's methodology to avoid gender bias in public health lies in the fact, that she presents an instrument which helps to regard all public health areas whether women (and men) are represented in suitable methodological and theoretical ways. This is of great importance for health care, prevention, health promotion, for health care and for rehabilitation, because advances in research will only be possible, when sex and gender differences are considered and adequate models of health care developed.

Literature:

Agenda "Frauen und Gesundheitswissenschaften" -- Bilanz und Perspektiven für die Forschung. in: Helfferich, C., v. Troschke, J. (Hrsg.): Der Beitrag der Frauengesundheitsforschung zu den Gesundheitswissenschaften/ Public Health in Deutschland. Koordinierungsstelle Gesundheitswissenschaften/ Public Health, Freiburg.

Arbeitskreis Frauen und Gesundheit im Norddeutschen Forschungsverbund Public Health (Hrsg.) (1998): Frauen und Gesundheit(en) in Wissenschaft, Praxis und Politik. Bern, Göttingen, Toronto u. a., Huber.

Arber, S. (1989): Gender and class inequalities in health. Understanding the differentials. In: Fox, J. (ed.): Health inequalities in European countries. Aldershot: Gower Press, 250-279.

Babitsch, B. (1997): Soziale Ungleichheit und Gesundheit bei Frauen in Westdeutschland. In: Ahrens, W.; Bellach, B.M.; Jöckel, K.H. (Hrsg.): Messung soziodemographischer Merkmale in der Epidemiologie. RKI-Schriften 1/98. München: MMV Medizin Verlag, 95-112.

Babitsch, B. (1998a): Soziale Ungleichheit und Gesundheit. Eine geschlechtsspezifische Betrachtung. In: Arbeitskreis Frauen und Gesundheit im Norddeutschen Forschungsverbund Public Health: Frauen und Gesundheit(en) in Wissenschaft, Praxis und Politik. Bern; Göttingen; Toronto; Seattle: Verlag Hans Huber, 63-73.

Babitsch, B. (1998b): Geschlechtsspezifische Betrachtung sozialer Ungleichheit und Gesundheit vor dem Hintergrund unterschiedlicher Operationalisierung der sozialen Schicht. Jahrestagung der Deutschen Gesellschaft für Sozialmedizin und Prävention und der Deutschen Gesellschaft für Medizinische Soziologie, 29. September - 1. Oktober, Marburg (Vortrag).

Bammann, K.; Babitsch, B.; Jahn, I.; Maschewsky-Schneider, U. (1999): Weibliche Lebensverläufe und Gesundheit - Ergebnisse einer Untersuchung nationaler Surveydaten 50-69jährige Frauen aus Ost- und Westdeutschland. Soz. Präventivmed 44: 65-77.

Baruch, G; Barnett, R. (1986): Role Quality, Multiple Role Involvement, and psychosocial well-being in midlife women. Journal of Personality and Social Psychology 51 (3): 578-585.

Begenau, J., Helfferich, C. (Hrsg.) (1997): Frauen in Ost und West. Zwei Kulturen, zwei Gesellschaften, zwei Gesundheit(en)? Schriftenreihe der Arbeitsgruppe "Frauen und Gesundheit" der DGMS. Freiburg, jos fritz.

Begenau, J.; Bodnar, I.; Rauchfuß, M. (1996): Soziopsychosomatisch orientierte Begleitung in der Schwangerschaft. Unveröffentlichter Forschungsbericht.

Deutscher Bundestag, 13. Wahlperiode (1997): Antwort der Bundesregierung auf die Große Anfrage der Abgeordneten Antje-Marie Steen, Anni Brandt-Eisweiler, Dr. Marlies Dobberthien, weiterer Abgeordneter und der Fraktion der SPD. Drucksache 13/5214. Frauenspezifische Gesundheitsversorgung.

Eichler, Margrit mit Diana Gustafson und Monika Pomepetzki (1999): Moving Toward Equality: Recognizing and Eliminating Gender Bias in Health. Toronto: Health Canada, Arbeitspapier.

- Eichler, Margrit (1991):** Nonsexist Research Methods: A Practical Guide. New York: Routledge.
- Eichler, Margrit (1997):** Feminist Methodology. In: Current Sociology, 1997, Vol. 45 (2), S.9-36.
- Eichler, Margrit (1998):** Offener und verdeckter Sexismus. Methodisch-methodologische Anmerkungen zur Gesundheitsforschung. In: Arbeitskreis Frauen und Gesundheit im Norddeutschen Forschungsverbund Public Health (Hrsg.): Frauen und Gesundheit(en) in Wissenschaft, Praxis und Politik. Bern, Göttingen, Toronto u. a. (Huber). S. 34-49.
- Gavranidou, M. (1993):** Wohlbefinden und Erwerbstätigkeit im Familienverlauf. In: Nauck, B. (Hrsg.): Lebensgestaltung von Frauen. Eine Regionalanalyse zur Integration von Familien- und Erwerbstätigkeit im Lebenslauf. Weinheim; München: Juventa Verlag, 235-260.
- Helfferich, C. (1994):** Quo vadis, Frauengesundheitsforschung? Zeitschrift für Frauenforschung 12 (4), 7-19.
- Helfferich, C.; Schehr, K.; Müller, G.:** Länderbericht für die WHO - Regional Office for Europe- Bundesrepublik Deutschland (Abschlussbericht) gefördert von der Fritz und Hildegard Berg-Stiftung im Stifterverband für die Deutsche Wissenschaft. Freiburg 1995.
- Helfferich, C., v. Troschke, J. (o.J.):** Der Beitrag der Frauengesundheitsforschung zu den Gesundheitswissenschaften/Public Health in Deutschland. Schriftenreihe der Koordinierungsstelle Gesundheitswissenschaften/Public Health an der Abteilung Medizinische Soziologie der Universität Freiburg, Bd.2
- Jahn, I.; Bammann, K.; Pohlabein, H; Brüske-Hohlfeld, I; Gerken, M; Wichmann, H.E.; Jöckel, K.H. (1999):** Tätigkeiten in Reinigungsberufen und im Reinigungsgewerbe. Lungenkrebs bei Frauen. Gesundheitswesen 61: A101-102.
- Jahn, I.; Maschewsky-Schneider, U.; Babitsch, B.; Bammann, K. (1998):** Zur Bedeutung der Eingebundenheit von Frauen in Erwerbs-, Haus- und Familienarbeit für ihre Gesundheit. Ergebnisse aus einer Befragungsstudie in Bremen. In: Arbeitskreis Frauen und Gesundheit im Norddeutschen Forschungsverbund Public Health: Frauen und Gesundheit(en) in Wissenschaft, Praxis und Politik. Bern; Göttingen; Toronto; Seattle: Verlag Hans Huber, 74-88.
- Kellerhof, M. (1996):** Ein wenig Theorie vorweg. In: Akademie für öffentliches Gesundheitswesen in Düsseldorf (Hg.): Hamburger Projektgruppe Gesundheitsberichterstattung - Praxishandbuch Gesundheitsberichterstattung. Schriftenreihe Band 18.
- Klesse, R.; Sonntag, U.; Brinkmann, M.; Maschewsky-Schneider, U. (1992):** Gesundheitshandeln von Frauen. Frankfurt am Main: Campus.
- Macran, S.; Clarke, L.; Joshi, H. (1996):** Women's health. Dimensions and differentials. Soc. Sci. Med. 42 (9): 1203-1216.
- Maschewsky-Schneider, U. (1993):** Gesundheitskonzepte und Gesundheitshandeln von Frauen. In: Gawatz, R.; Novak, P. (Hrsg.): Soziale Konstruktion von Gesundheit. Wissenschaftliche und alltagspraktische Gesundheitskonzepte. Ulm: Universitätsverlag, 195-213.
- Maschewsky-Schneider, U. (1994):** Frauen leben länger als Männer. Sind sie auch gesünder. Zeitschrift für Frauenforschung 12 (4): 28-38.
- Maschewsky-Schneider, U. (Hrsg.) (1996):** Frauen - das kranke Geschlecht? Mythos und Wirklichkeit, Leverkusen, Opladen (Leske + Budrich)
- Mastroianni, C.;Faden, R.;Federmann, D. (Hrsg.):** Women and Health Research. Ethical and legal issues of including women in clinical studies. Vol.1. National Academy Press (Washington, D.C.), im Appendix B, S. 233-236
- Matthews, S.; Manor, O.; Power, C. (1999):** Social inequalities. Are there gender differences?. Soc. Sci. Med 48 (1): 49-60.

- Oechsele, M.; Geissler, B. (1991):** Kontinuitätserwartungen und Lebensplanung junger Frauen. In: Glatzer, W. (Hrsg.): Die Modernisierung moderner Gesellschaften. 25. Deutscher Soziologentag 1990. Opladen: Westdeutscher Verlag: 60-63.
- Resch, M. (1998):** Frauen, Arbeit und Gesundheit. In: Arbeitskreis Frauen und Gesundheit im Norddeutschen Forschungsverbund Public Health: Frauen und Gesundheit(en) in Wissenschaft, Praxis und Politik. Bern: Verlag Hans Huber, 89-100.
- Ruiz, Teresa M.; Verbrugge, Lois M. (1997):** A Two Way View of Gender Bias in Medicine. In: Journal of Epidemiology & Community Health, 51 (2), S.106-109.
- Schneider, U. (Hrsg.) (1981):** Was macht Frauen krank? Ansätze zu einer frauenspezifischen Gesundheitsforschung, Frankfurt/New York (Campus)
- Steinkamp, G. (1999):** Soziale Ungleichheit in Morbidität und Mortalität. In: Schlicht, W.; Dickhuth, H.H. (Hrsg.): Gesundheit für alle. Fiktion oder Realität? Schorndorf: Hoffmann, 101-154.

4. Brief Description of the Structure of the Health Care System in the Federal Republic of Germany

Vera Lasch, Brigitte Hantsche; translated by Teresa Gehrs

4.1 General Facts

In the Federal Republic of Germany, health insurance is an integral part of a comprehensive social security system, comprising also unemployment and accident insurance, and the pension scheme. A fifth pillar, private nursing insurance, was added to the system in 1994. The claims, benefits, and underwriters of the insurance are regulated in the Social Security Code. The principle of territoriality holds for the insurance, i.e. obligation to insure and entitlement under a policy refer to the area of application of the law. There exist two types of insurance: the statutory insurance scheme and voluntary membership of a social insurance scheme. The statutory insurance scheme is compulsory for all members of the groups of people included in the law, whether they desire it or not. Wage and salary earners (up to a certain level of income) are as a rule compulsorily insured. Family members who can be exempted from contributing are spouses up to a certain level of income and children who have not yet attained the age of 18. The rules on statutory insurance and voluntary membership are different, for example, with regard to pension and health insurance. The funds for social security are principally furnished from the contributions of its members and their employers; in principle, government grants play a compensatory role. According to the statistical abstract of 1997, in the year of 1994 health insurance companies contributed almost half of the funding, employers and the state contributed just over an eighth each, and the remainder was covered by private households, the pension insurance fund, private companies, and accident insurance. Contributions to the pension insurance scheme are stipulated by law (20.3% of gross remuneration goes towards pension insurance, 6.5% towards unemployment insurance, and 1.7% presently goes towards private nursing insurance, with the exception of provisions for the miners' insurance scheme. The premiums for health insurance are regulated by the charter of the respective health insurance company.

4.2 Organisation of the Health Service

In the German health service the statutory health insurance companies, which are independent public-law corporations, have a decisive say in the structure of the health service and a formative mandate. Around 90% of the population are insured with statutory health insurance companies. Most of the remaining 10% are members of a private health insurance company, whereas around 0.9% of the population are not insured at all (results of the sample census in April 1994, Daten des Gesundheitswesens 1995, published by the Federal Ministry for Youth, Family Affairs and Health). The range of benefits offered by statutory health insurance companies (GKV) significantly determines the scope and standard of the health care system. Statutory health insurance companies finance the largest portion of total expenditure within the health service. Policy on the health service is seen as a joint task of the federal states and local authorities, statutory health insurance companies, pension insurers, private health insurance companies, charitable organisations, employees in the health service, and their respective professional associations. The principle of benefit in kind and solidarity holds for benefits provided by statutory health insurance companies. This means that, in the case of illness, the insured person is given the medical services and benefits s/he requires. These services and benefits are stipulated by statutory health insurance companies and their suppliers (doctors, hospitals, and pharmacies) and are contractually obligatory. Benefits are therefore delivered according to medical requirement, rather than according to the amount contributed by the insured. Contributions depend on the insured person's ability to pay. Private health insurance

companies have a different system, whereby the amount of contributions made influences the range of benefits available.

Both the principle of self-administration and that of a structured insurance hold for the health insurance companies. There is not one unified insurer but altogether 8 different types of insurance companies that are oriented towards regions, professions or lines of business (Übersicht über das Sozialrecht: 125, published by the Federal Ministry of Labour and Social Affairs, Cologne).

The obligation to render services extends over promotion of health, the prevention, early diagnosis, and treatment of diseases, care in pregnancy and maternity, as well as entitlement to sickness benefit and other aid. Promotion of health includes programmes to prevent diseases (e.g. courses giving nutritional guidance, programmes to cure smokers from addiction, and coping with stress), promotion of self-help groups, albeit not their basic funding. Also included here are preventive medical check-up services in the form of both out- and in-patient health cures, especially in-patient mother-and-child preventive health cures.

Insured persons over the age of 35 years are entitled to a medical examination every two years for the early diagnosis of heart, circulatory, and kidney diseases, and diabetes. Women over the age of 25 years and men over 45 are entitled to a test for the early detection of cancer once a year. Early diagnosis examinations for children are also obligatory services.

The following are included in the comprehensive treatment package: medical and dental treatment, provision of pharmaceutical products, dressings, medicine and aids, domestic nursing and domestic help, hospital treatment, treatment for artificial insemination, medical and supplementary rehabilitation, as well as endurance testing and work therapy. The provision of those persons requiring care and attention is covered by private nursing insurance.

Access to the health service initially takes place via the out-patient system. This system is characterised by a free choice of doctors. Members have the possibility to visit general practitioners, specialists or out-patient departments of hospitals or university clinics. General practitioners can refer patients to specialists. Hospital treatment is provided if the health problem can not be solved within the out-patient system.

On average, 340.8 doctors serve 100 000 inhabitants (1996), although the city states of Hamburg, Berlin and Bremen have a significantly higher number of doctors available. There are 74.9 dentists available per 100 000 inhabitants. Regional classification of specialist provision according to various different specialist areas and gender does not exist.

112 660 doctors have set up practices, whereas 135 341 work in hospitals. 30 195 doctors work for the authorities (boards of health, public-law corporations).

Of those 279 335 doctors, 179 107 are male and 100 228 are female (1996). Of those 174 784 doctors who state an area of specialisation (specialists) 51 826 are female. The majority of specialists are general practitioners (22 139 male doctors and 11 051 female doctors). The proportion of women varies according to the individual area of specialisation. There are extremely few women doctors among specialists who require long periods of training or in traditionally male areas (e.g. internal medicine and surgery) - women make up only 10% of those employed in surgery and 25% of those in internal medicine. There are 13 710 gynaecologists, 4 725 of whom are women. If we consider only specialists for obstetrics and gynaecology in the specialist departments of hospitals, of the 3 566 specialists only 918 are

women. With regard to senior consultants in hospitals, 854 are women as opposed to 11 026 men. There are 4 269 women senior physicians and 16 868 men (as of 1995).

As in other European countries, these roughly classified data show that, although around half of medical students are women, the number of women who actually go on to work in the medical profession do not relate to the numbers of women who train to become a doctor, and that the fraction of women in leading positions in the medical profession is extremely small. For out-patient care, this means that women are not always free to choose a female doctor. The small number of women specialists in the field of clinical gynaecology is very problematic since most women in Germany give birth in hospital. Unlike gender distribution among doctors, women dominate other areas of the health service -the healing and assistant professions.

2 325 hospitals are available in Germany for in-patient treatment. These are mainly run on a public or charitable basis. 207 hospitals have only beds for psychiatric or psychiatric/neurological diseases. On average there are 745.9 beds available per 100 000 inhabitants. 54.5 beds serve 100 000 inhabitants in the field of psychiatric or psychiatric/neurological diseases. (These figures all relate to the year of 1995). Insured persons are required to pay a daily additional contribution for hospital treatment lasting up to 14 days. Since in-patient treatment makes up the largest part of treatment costs, the number of beds has been reduced, length of stay in hospital has been shortened, and the area of out-patient operations has been expanded. The average length of stay in hospital is now 11 days, whereas in psychiatry and psychosomatics it is over 40 days. Addictions and cures for addiction require on average 23 days. 1 in 5 inhabitants go to hospital once a year on average (as of 1995).

In addition, there are 1 373 prevention and rehabilitation facilities that provide an average number of 225.4 beds for 100 000 inhabitants. Unlike general hospitals, most rehabilitation facilities are privately run. Rehabilitation health cures also require a supplementary payment. This is also the case for health cures for mothers and mothers and children.

4.3 The German Health Reform Act

In 1989, the German Health Reform Act was passed in order to curb cost expansion in the health system. The ensuing German Health Structure Act led to an immediate measure in the form of budgeting the most important areas of benefits in statutory health insurance, as well as the restriction of the number of doctors by means of more stringent demand guidelines. These measures led to a shortage of benefits offered (less funding for health promotion, budgeting for pharmaceutical products, limitation of, for example, massages and physiotherapy, more stringent requirements in granting health cures and rehabilitation benefits), and an increase in the amount paid by the insured, e.g. for dentures and orthodontic treatment, for aids (e.g. glasses), and pharmaceutical products, and higher supplementary payments for health cures and rehabilitation benefits. Moreover, sickness benefit was reduced to 70% of income (as opposed to 80% previously).

In addition, a Psychotherapy Act was passed at the start of 1998 which aims to ensure the quality of training programmes and which stipulates that a certain number of lessons must be attended for the programme. Supplementary contributions for patients are also included in the act.

4.4 Discussions about the Health System

- The argument put forward about the "explosion of costs" is controversial. Calculations show that this suggested rise in relation to the gross national product does not exist. It is feared that such terms will make "disease" an accusation. It is also feared that increasingly more benefits will be excluded from the standard service or will be subject to higher supplementary contributions as, for example, with dentures. These phenomena will lead to average earners receiving benefits to only a limited extent, or with a great amount of individual renunciation, or via additional private insurance. Since medical care is becoming more strictly regulated through the range of benefits and fee scale, it seems obvious that unequal treatment is increasingly emerging between the different groups of patients.
- Some problems that existed in the past still persist today. These include the need for better and locally-based cooperation between different specialists, as well as the problem of deficits in care for chronic and long-term illnesses - since the health system is geared towards acute cases. This deficiency of care triggered the creation of self-help groups. However, interlinking professional support and treatment is lacking in self-help groups which primarily render psycho-social support and disseminate information.
- Standards of care are stipulated by health insurance companies and professional organisations of the medical profession. Thus some sorts of medicine, curing professions, and certain types of therapy could be excluded from coverage, meaning that some of these may no longer be covered by the health insurance company or cannot be reimbursed. Conflicts between consumers arose in the areas of natural medicine, homoeopathic therapy, and other therapies (e.g. body therapies and certain cancer therapies).

Part II

5. Organizations within the Women`s Health Movement¹

5.1 Associations, networks, registered societies, foundations

5.1.1 coordination and information centres

Name of the organization:

Nationale Kontakt- und Informationsstelle zur Anregung und Unterstützung von Selbsthilfegruppen (NAKOS)

(National contact- and information centre for activating and supporting self-help groups)

Address:

Albrecht-Achilles-Str. 65 - 10709 Berlin

Sekretariat: Frau Renate Spiewok

phone: 0049-30 / 891 40 19

fax: 0049-30 / 893 40 14

e-mail: nakos@gmx.de

internet: www.nakos.de

Contact:

Wolfgang Thiel

Aims:

central national institution to inform the population about self-help groups
information about addresses of nationwide and local/regional self-help associations
development and establishment of specialist and infrastructural support and promotion of self-help groups

organization of specialist exchange, e.g. further education and conferences

cooperation with associations, ministries, municipalities, health insurance institutions, media;

Main emphasis of activity:

the activity is restricted to forms of self-help work and therefore does not include the specified contents of self-help; specified information concerning diseases or problems is not available.

Members of the organization:

NAKOS is not an organization of members, but an institution of consultation and service

Year of foundation: 1984

Legal form: non-state institution

Responsible organizations:

Deutsche Arbeitsgemeinschaft Selbsthilfegruppen e.V., Friedrichstr. 28, 35392 Gießen;

Paritätisches Bildungswerk - Bundesverband e.V., Heinrich-Hoffmann-Str 3, 60528 Frankfurt/Main

¹ The organizations themselves are responsible for these presentations.

Financing:

public sponsoring (BRD and the state of Berlin), sponsoring by the associations of the health insurance companies

Regional institutions:

The Deutsche Arbeitsgemeinschaft Selbsthilfegruppen e. V. is responsible for the following regional institutions with similar aims,
Selbsthilfe-Büro Niedersachsen der Deutschen Arbeitsgemeinschaft Selbsthilfegruppen e.V.

Bödekerstr. 85 - 30161 Hannover
phone: 0049-511 / 39 19 28
fax: 0049-511 / 39 19 07

KOSKON – Koordination für Selbsthilfe-Kontaktstellen in NRW der Deutschen Arbeitsgemeinschaft Selbsthilfegruppen e.V.,
Friedhofstr. 39 - 41236 Mönchengladbach
phone: 0049-21 66 / 24 85 67
fax: 0049-21 66 / 24 99 44

Study groups:

open, not formalized associations with local/regional self-help and support institutions;
co-operation with the existing study groups

Publications: (available only in German)

information about the organization

- NAKOS. Lokale/regionale Selbsthilfegruppen – Unterstützungsstellen in der Bundesrepublik Deutschland. Rote Adressen 1997/98. (Local /regional self-help groups)
- NAKOS. Bundesweite Selbsthilfevereinigungen und relevante Institutionen. Grüne Adressen 1997 / 98(Nationwide self-help associations and relevant institutions)
- NAKOS Info. Info Börse. Service, Betroffenenensuche, Literatur und Tagungen- (information, literature, conferences)

Leaflets and information about structure, aims and tasks are available at the contact institutions of self-help groups.

Extract from a selected publication: see our internet service

Name of the organization:

Frauenhauskoordinierungsstelle- Paritätischer Gesamtverband e. V., Frauenkoordinierungsstelle
(women's refuges coordinating institution)

Address:

Heinrich-Hoffmann-Str. 3 - 60528 Frankfurt am Main
phone: 0049-69 / 67 06 / 252 / 260 / 294
fax.: 0049-69 / 670 62 88
e-mail: eva.bordt@paritaet.org
internet: www.paritaet.org

Contact:

Ms. Eva-Maria Bordt (contact for women-specific issues)

Aims:

leading organization of the independent welfare which works in all areas of social work

Main emphasis of activity:

the member organizations work in the areas of healthcare, prevention and rehabilitation.
Women-specific work: women's houses, centers for women's healthcare, institutions for advice service concerning eating disorders, centers for childbirth's preparation and birth's houses.

Members of the organization:

national member organizations such as Pro Familia, Deutsche Gesellschaft für Familienplanung, Sexualpädagogik und -Beratung e. V. (German society for family planning, sexual pedagogy and advice concerning sexual problems), women's self-help group.

regional women's centers, centers for women's therapy, institutions for advice service for women and institutions which offer EQUAL education for women

institutions for health cures which belong to the Deutsche Müttergenesungswerk (association for the healthcare for mothers), so far as they realize women-specific programmes for healthcare and rehabilitation.

EQUAL provincial associations and EQUAL health cure institutions of the Müttergenesungswerk:

addresses available at the organization: see address of the organization

Number of members: more than 9000 member organizations

Year of foundation: 1924

Legal form: registered society

Financing: public funds, membership fees, donations, income for service

Regional institutions: information available at the EQUAL regional associations

Specialist groups:

specialist group women's houses

Specific knowledge offered by the organization:

women's- and health policy, function of the coordination of women's refuge

5.1.2 Nature healing

Name of the organization

**Patienteninformation für Naturheilkunde
(patient information for Nature healing)**

Address:

c/o UFA-Fabrik
Victoriastrasse 10-18 - 12105 Berlin
phone: 0049-30 / 76 00 87 60
fax: 0049-30 / 76 00 87 61
e-mail: pi@datadiwan.de
internet: www.datadiwan.de/patienteninformation

Contact:

Alexandra Groß

Aims:

The Patients' Information on Naturopathy is a charitable registered society with the aim to give patients orientation in the growing offer of natural and unconventional techniques of diagnosis and treatment. We advise our patients of the possibilities and limits of various naturopathical procedures. We also offer addresses of physicians, clinics, specialist associations and self-help groups and suggesting literature. Due to our presence in the internet: "www.datadiwan.de" you can be thoroughly informed and get into direct contact with our cooperating partners (physicians and specialist associations).

Main emphasis of activity: -

Advice service:

possibilities and limits of various naturopathical methods
addresses of physicians, clinics, specialist associations and other advice-centres
specific advice: women specific health problems and possibilities of their naturopathical treatment

Network

- Information by publishing scientific studies in the internet e.g. on acupuncture, cancer, homeopathy, nutrition, border areas of the sciences, hypnosis, life's energy research, problems of transplantation, environmental medicine,...
- Networking with cooperating partners.
- Establishment of document-oriented forums of discussion

Evaluation

Assesment of the different methods of naturopathical treatment

Research topics:

- networks of communication for research on naturopathy
- methodology of medical evaluation
- evaluation of choosen naturopathical treatments

Members of the organization:

A social manager, an engineer, an oil producer, two students, a physician, 7 persons

Year of foundation: 1997 - it emerged from the Medical Association for Naturopathy

Legal form: non-profit making, registered association

Financing : public money; subscriptions, donations, financial contributions and commissions

Regional institutions: none at the moment

Specialist groups: none at the moment

Specific knowledge offered by the organization:

- knowledge of alternative methods of healing and treating health problems
- all fields of naturopathy,
- one of the biggest data banks on ways of naturopathical treatment in German language;
- knowledge of methodology in research and evaluation of naturopathical treatment
- knowledge of the latest research and its strategies in naturopathy;
- knowledge of naturopathical methods, especially in gynaecology;
- knowledge of unconventional therapies for women's health disorders,
- (like visualisation or non-medical,
- holistic ways of therapy: techniques of breathing, rolfing...)

Publications: (available only in German)

online-publications in the internet (www.datadiwan.de)

the diwan magazine (an online-periodical, that is dedicated to the holistic approach towards medicine and the border areas of science)

research-prize in the nature healing and physiotherapy (brochure)

conference-documentation: 2nd Einsiedler Symposium 1995: „Frauen-willige Opfer der Medizin?“ (Women-willing victims of medicine? In: [www.datadiwan.de/netzwerk/Stiftung Paracelsus Heute](http://www.datadiwan.de/netzwerk/Stiftung_Paracelsus_Heute)

you can choose a passage from our publications:

please find us at <http://www.datadiwan.de>

Questions and interests:

extension of the networking within the field of women's health

closer international cooperation in the field of women's health

5.1.3 Professional associations and comparable organizations

Name of the organization:

Bund Deutscher Hebammen e. V. (BDH)
(association of German midwives)

Address:

Postfach 1724
Steinhäuser Straße 22 - 76006 Karlsruhe
phone: 0049-721 / 981 89-0
fax: 0049-721/981 89-20
e-mail: info@bdh.de; Info@hebammenverband.de
internet: www.bdh.de; www.hebammenverband.de

Contact:

President: Frau Magdalene Weiß
Secretary: Frau Ingrid Pellin

Aims:

The Bund Deutscher Hebammen (BDH e. V.) (association of German midwives) is a professional organization of the midwives and consists of 16 midwives state associations with 12 800 members. It represents the interests of midwives working as employees or self-employed as well as teachers and students of midwifery. The roots of the association reach back to 1885.

The association of German midwives with its member associations according to its statutes has the following tasks:

- Promotion of the professional and economic interests of the midwives.
- Modification of the training-contents according to the needs.
- Representation of the midwives in authorities of the federal government and the states in regard to all issues connected with the profession of midwifery.
- Representation of the matters of the midwives at representative bodies, authorities, unions, courts, health insurance companies, further professional or other organizations as well as in public.
- Involvement in the elaboration of draft bills in the field of health and midwifery.
- Running of a legal department and of an expert witness committee for giving advice to the members.
- Fostering of international relations in the area of midwifery.
- Training for the midwives on state and national level also in cooperation with the gemeinnützigen Hebammengemeinschaftshilfe e.V. (HGH) (charitable midwifery joint aid), which is the organ for further training of the BDH.
- Exchange and networking with other women-oriented associations and organizations.

Objectives:

Strengthening the professional profile of the midwife
increasing the acknowledgement in public
the acceptance in regard to other professional groups
the consolidation of the professional image of the midwife in society
the guarantee of basic care through midwives for all women who are pregnant, give birth and who have recently given birth
Midwives work and act according to ethical guidelines. The rights and human dignity of the woman always are central. Midwives never refuse the necessary help to any woman –

independent of race, culture, world view and position in society. The welfare of women and families is the aim of our societal engagement. We critically observe the development in the fields of birth assistance, reproductive medicine and genetic research. We undertake research about our own work for securing the quality and shape our trainings. We fight for our acknowledgment in society and just reward.

Only a few pregnancies are risk cases which require the care of a specialized medical doctor. Pregnancy and birth are no illness but a normal, although a profound, process in the life of a woman. We promote health and the welfare of woman and child, give advice in regard to prenatale diagnostic, undertake medical check-ups, help in cases of pregnancy troubles and prepare the woman for birth, not only physically. We act according to the following principle: As least as possible of technology, instead much knowledge and humanity.

We give advice to the woman in the selection of place and nature of the birth and give support to her in all phases. Also afterwards we are at her and the child's disposal independent of whether she decides for staying in hospital or at home after birth.

We observe the development of the child, look after the mothers, give guidance in regard to breast-feeding and baby care and are ready to listen to the women's anxieties and worries. Family-life has changed a lot. We, the midwives, support the family in coping with these changes, also beyond the period after birth.

Central aim of the association of German midwives is that as much as possible of women who are pregnant, give birth and who are mothers, benefit from the preventive character of this health service.

Main emphasis of activity:

To look after and support the professional and economic interests of all midwives and Entbindungspfleger (male nurses who work in the area of obstetrics), in accordance with the political and confessional neutrality.

To run a legal advice bureau and a commission of female experts for the advice of the members.

To represent the Interests of midwives towards female representatives of the people, authorities, trade unions, courts, health insurance companies, other organizations of professions or any other groups and in the public.

To cultivate the international relationships and exchange of experience in the area of the work of midwives.

To support the members concerning dissemination of information and help in the work of public health education.

Nationwide and regional further education for midwives in the interest of mother, child and family.

Members of the organization:

16 midwives state organizations which have midwives and midwife-trainees as individual members.

Addresses of the member-organizations:

Hebammenverband Baden-Württemberg e.V.

chairwoman
Ursula Jahn-Zöhrens
Alte Dobler Straße 2 - 75323 Wildbad
phone: 0049-70 81 / 37 87
fax: 0049-70 81 / 38 40 73
e-mail: Ujahn-zoehrens@t-online.de

chairwoman
Andrea Bosch
Urchstraße 7 - 70190 Stuttgart
phone: 0049-7 11 / 262 11 04
fax: 0049-7 11 / 262 11 04
e-mail: Andreabosch@gmx.net
internet: www.hebammen-bw.de

Bayrischer Hebammenverband e.V.

chairwoman
Karen Brandl
Am Kastanienbaum 1 - 86720 Nördlingen
phone: 0049-90 81 / 233 68
fax: 0049-90 81 / 64 02
e-mail: Bhlvbrandl@t-online.de

chairwoman
Christine Just
Haßfurter Straße 5 - 91056 Erlangen
phone: 0049-91 31 / 468 55
fax: 0049-91 31 / 468 38

Berliner Hebammenverband e.V.

chairwoman
Marion Brüssel, Barbara Kreß
office:
Erkelenzdamm 33 - 10999 Berlin
phone: 0049-30 / 694 61 54
fax: 0049-30 / 61 60 93 54
e-mail: Berliner_Hebammen_Verband@t-online.de

Hebammenverband Brandenburg e.V.

chairwoman
Manuela Neubüser
Große-Hagen-Str. 8 - 14712 Rathenow
phone: 0049-33 85 / 50 18 50
fax: 0049-33 85 / 50 18 50

chairwoman
Kerstin Voigt
Suderoder Straße 54 - 13129 Berlin
phone: 0049-30 / 47 47 34 00
fax: 0049-30 / 47 47 34 01
e-mail: Kerstin-Ina-Voigt@gmx.net

Hebammenlandesverband Bremen e.V.

chairwoman
Antje Kehrbach
Friedrich-Karl-Straße 11 - 28205 Bremen
phone: 0049-421 / 49 82 90
fax: 0049-421 / 49 82 90

chairwoman
Irmhilde Fuhrmann
Rostockerstr.6 - 27804 Berne
phone: 0049-44 06 / 67 77
e-mail: i.fu@gmx.de

Hebammenverband Hamburg e.V.

chairwoman
Rita Hülsemann
Nissenstraße 12 - 20251 Hamburg
phone: 0049-40 / 48 54 31
fax: 0049-40 / 46 96 03 65
e-mail: Hebammenverband.hamburg@t-online.de

Susanne Steppat
Hellkamp 80 - 20255 Hamburg
phone: 0049-40 / 43 27 27 27
internet: www.midwife.de

Landesverband der Hessischen Hebammen e.V.

chairwomen
Anke Wiemer
Elisabethenstr. 1 - 63579 Freigericht
phone: 0049-60 55 / 57 81
fax: 0049-60 55 / 57 81

chairwoman
Ute Petrus
Zur Kütte 12 - 36211 Alheim
phone: 0049-56 64 / 939 00 81
fax: 0049-56 64 / 939 00 82,
e-mail: Upetrus@aol.com

Hebammenverband Mecklenburg-Vorpommern

chairwoman
Sigrid Ehle
Seehofer Str. 22 - 19055 Schwerin-Wickendorf
phone: 0049-385 / 56 37 72

chairwoman
Andrea Hübel
August-Bebel-Str. 41 - 18055 Rostock
phone: 0049-381 / 45 30 05

Landeshebammschaft Niedersachsen e.V.

chairwoman
Elmire Frick
Dalldorf Nr. 19 - 29562 Suhlendorf
phone: 0049-58 20 / 15 90
e-mail: Hebammenverband.niedersachsen@t-online.de
internet: www.hebammen-niedersachsen.de

chairwoman
Margaretha Brinkema
Hauptstraße 143 - 26842 Ostrhauderfehn
phone: 0049-49 52 / 44 88
fax: 0049-49 52 / 94 21 27

Landesverband der Hebammen Nordrhein-Westfalen e.V.

chairwoman
Angelika Josten
Im Cäcilienbusch 12 - 53340 Meckenheim
phone: 0049-22 25 / 159 56
e-mail: aosten@hebammen-forum.de

chairwoman
Doris Kreft
Damm 248 - 32479 Hille
phone: 0049-57 03 / 12 20
e-mail: DorisKreft@aol.com

Hebammen-Landesverband Rheinland-Pfalz e.V.

chairwoman
Inge Kohlhaupt
Bensheimer Ring 15c - 67227 Frankenthal
phone: 0049-62 33 / 610 26
fax: 0049-62 33 / 610 26

chairwoman
Marina Kuss
Fritz-Ohlhof-Str.37 - 55122 Worms
phone: 0049-61 31 / 38 22 78

Saarländischer Hebammenverband e.V.

chairwoman
Edith Gabel-Moritz
Im Neuland 6 - 66787 Wadgassen
phone: 0049-68 34 / 492 21

chairwoman
Monika Greitzke
Am Homburg 103 - 66123 Saarbrücken
phone: 0049-681 / 30 14 04 30
fax: 0049-681 / 390 56 39
e-mail: Monikagreitzke@cs.com

Hebammenverband Sachsen e.V.

chairwoman
Birgitte Borrmann
Rosa-Menzer-Str.13 - 01309 Dresden
phone: 0049-351 / 310 12 63
fax: 0049-351 / 310 12 63

chairwoman
Birgit Höse
Krönertstr. 17 - 01705 Freital
phone: 0049-351 / 649 53 80
fax: 0049-351 / 649 53 80

chairwoman
Andrea Schuwardt
Rützengrüner Str. 2a - 08209 Schnarrtanne
phone: 0049-37 44 / 21 50 29

Hebammenverband Sachsen-Anhalt e.V.

chairwoman
Sabine Beneke
Fröbelstr. 9 - 39110 Magdeburg
phone: 0049-391 / 731 10 71

chairwoman
Cornelia Jung
Anhalter Str. 13 - 06193 Löbejün
phone:034604/77332

chairwoman
Ines Böhm
Baumweg 93 - 06130 Halle
phone: 0049-345 / 444 96 10
fax: 0049-345 / 208 20 21

Landeshebammenverband Schleswig-Holstein e.V.

chairwoman
Elke Poppinga
Up'n Knust 25 - 23619 Rehorst
phone: 0049-45 33 / 70 48 63
fax: 0049-45 33 / 70 48 69
e-mail: E.Pobbinga@hebammenverband-sh.de

chairwoman
Anne Reichmuth
Virchowring 56 - 24558 Henstedt-
Ulzburg
phone:0049-41 93 / 935 39
fax: 0049-41 93 / 96 76 46

Hebammenverband Thüringen e.V.

chairwoman
Siegrun Szumodalsky
An der Leite 11 - 99762 Rodishain
phone:0049-346 53 / 921 58

chairwoman
Anke Carl
In der Salschge 3 - 07751 Zöllnitz
phone:0049-36 41 /37 28 37
e-mail: Anke.Carl@t-online.de

An further organization, similar to the BDH e. V. is the Hebammengemeinschaftshilfe (HGH) e. V., (midwives joint help) a society which is registered as charitable. Today, it is mainly the organ for further education in the BDH.

Its tasks belong mainly to the following areas:

Further education courses for midwives working as employees or self-employed, concerning the different fields of their work.

Research work by midwives as a further task of the HGH. The HGH is the organizer of of the "Workshop zum wissenschaftlichen Arbeiten" (workshop about scientific work) which takes place once a year. It offers financing in order to start research projects and publications.

As well, the HGH is editor of several publications.

Address:

Hebammengemeinschaftshilfe e.V.
Badenstedter Str. 201 - 30455 Hanover
phone: 0049-511 / 49 25 80
fax: 0049-511 / 749 95 27

An organization which is similar to the BDH is the:
Gesellschaft für die Qualität in der außerklinischen Geburtshilfe e.V. (QUAG)
(society for quality in birth assistance out of clinics)

c/o Anke Wiemer
Elisabethenstr. 1 - 63579 Freigericht
phone: 0049-60 55 / 57 81
fax: 0049-60 55 / 57 81
e-mail: AnkeWiemer@aol.com

Task and aim of the organization is the capture and evaluation of data of birth assistance out of clinics.

According to the Hebammengesetz of the 04. 06. 1985 (Midwife Act), to look after the women during regular pregnancy, birth and the following weeks belongs to the work of a midwife. If irregularities occur, the midwife consults gynaecologists or paediatricians. Every woman can consult a midwife for help. The help of midwives is paid by the statutory health insurance funds.

Addresses of self-employed working midwives can be found at the following accommodation addresses:

the regional institutions of the BDH
Familienbildungsstätten oder ähnliche Institutionen (Institutions for family-education)
your doctor
hospitals - leaflets on the wards for birth
health insurance companies and pharmacies

Number of members: 13042 (September 2000)

Year of foundation: 1885 (the origins of the work of the organization)

Legal form: charitable registered society

Financing: membership-fees

Regional institutions:

Specialist groups:

working groups of the BDH on the following topics:

- congress
- evaluation of the situation of clinically active midwives
- midwives and Naziregime
- midwife-led delivery room
- teachers for midwifery
- leading midwives in training-delivery rooms
- theory and quality
- internet-homepage
- midwives who also look after a certain number of patients in a hospital
- normal birth
- university for applied science

Specific knowledge offered by the organization: Representation of the midwives' interests

Publications:

available only in German;

publication organ of the BDH: Hebammen Forum – das Magazin des Bundes Deutscher Hebammen (midwife forum – the magazine of the association of German midwives); comes out monthly

Publications of the HGH: available only in German, Band 5 available in English (!!)

Band 4

Praxis im Wandel (changing practice)

Vorträge vom 5. Workshop zur Hebammenforschung im deutschsprachigen Raum.

ISBN 3-934021-04-2, 12,- DM

Band 5

Erfolgreiches Stillen, 3. edition. 1998

„Successful Breastfeeding“ available in English (!!)

translated by Ilse Dall, Jule Friedrich

96 pages

ISBN 3-934021-05-0, 15,- DM

Band 6

Praxis im Wandel II, 2. Auflage (changing practice II) 1996

Table of „A Guide to Effective Care in Pregnancy and childbirth“

Mechthild Groß, Christine Loytved.

37 pages

ISBN 3-934021-06-9 15,- DM

Band 7

Das CTG in der Diskussion – neue Ergebnisse. 1998

Ans Luyben

90 pages

ISBN 3-934021-07-7 15,- DM

Band 8

Leitfaden Schwangerschaft – Geburt – Wochenbett (guide pregnancy, birth, after birth) 1999

Margrit Haack, Martha Halbach, Irmengard Huhn, Rita Pahsmann, Monika Steger, Annelise Tometten-Iseke.

253 pages ISBN 3-934021-09 18,- DM

Band 9

Beratung zur pränatalen Diagnostik. Eine Arbeitshilfe. (Advice for prenatal diagnostic. An aid) will be published in 2000

200 pages

ISBN 3-934021-09 18,-DM

Bestandsaufnahme der qualitativen und äußeren Rahmenbedingungen der Hebammenausbildung in Deutschland. (evaluation of the qualitative and external conditions of the midwifery-education in Germany) 1998

Monika Zoege

ISBN 3-934021-00-x 22,- DM

Name of the organization:

**Lachesis e. V. Bundesverband für Heilpraktikerinnen
(federal association of female alternative medical practitioners)**

Address:

Forellensteig 4 - 14542 Werder/Havel
phone: 0049-33 27 / 66 84 80
fax: 0049-33 27 / 66 84 90
e-mail: info@lachesis.de
internet: www.lachesis.de

Contact:

managing director: Renate Lodtka,
consultation of surgeries and public relations: Elisabeth Schonauer-Schütz,
phone: 0049-30 / 781 33 73

Aims:

support of women-orientated medicine
support of the exchange among female non-medical practitioners
preservation of the female tradition of healing
engagement for pro-women healthcare
development of prospects for a pro-women natural medicine

Main emphasis of activity:

development of women-specific ways of therapy
reworking of the homoeopathic pictures of medicine for women
research in and application of chinese medicine in the interest of women
review and documentation of the extended knowledge from experience of women
public relations work for our approach of feministic natural-medical healing

Members of the organization:

individual women who have the permission to practise healing without appointment or who want to support the aims of the organization as members

Services in the association:

seminars on the establishment of one's livelihood
seminars on surgery-management and existence securing
legal information
consultation on surgery-management and charging
reasonable group-insurances
regional and national trainings
meetings of the members including special training
catalogue with trainings that are offered by members and by the association (regional and national)
brochure with advertisements of practising members (regional and national)
manual with practising members including their therapeutic special fields and training-offers (regional and national)
stamp of the association for practising alternative medical practitioners
political representation for securing the profession/involvement in larger working groups
LACHESIS – journal of the association: twice a year

Number of members: 450 women

Year of foundation: 1987

Legal form: charitable registered society

Financing: membership fees

Regional institutions:

Regionalstelle West

(regional office west)

Sabine March

Kyffhäuserstr. 9 - 50674 Köln

phone: 0049-221 / 560 44 22

e-mail: west@lachesis.de

Regionalstelle Süd-Ost

(regional office south-east)

Stefanie Grimberg

Zugspitzenstr. 30 - 82041 Oberbiberg

phone: 0049-89 / 613 34 93

e-mail: sued-ost@lachesis.de

Regionalstelle Berlin/neue Länder

(regional office Berlin/“new“states)

Verena Becker

Kaiserdamm 4 - 14057 Berlin

phone: 0049-30 / 32 60 76 00

e-mail: ost@lachesis.de

Regionalstelle Nord

(regional office north)

Ingrid Stoll

Faberstr. 15 - 20257 Hamburg

phone: 0049-40 / 59 11 75

e-mail: nord@lachesis.de

Regionalstelle Süd-West

(regional office south-west)

Maike Schmitt

Klostergasse 5 - 79295 Sulzburg

phone: 0049-76 34 / 59 11 75

e-mail: sued-west@lachesis.de

Specific knowledge:

trainings in cooperation with Lachesis:

- „Alchemilla“- only self-governing training project for alternative medical practitioners in Germany since 1986. Three-year training with half-day lessons- Bartelstr. 12, 20357 Hamburg, phone: 0049-40-4303629
- training for becoming an alternative medical practitioner in the Frauenbildungshaus (women’s education centre) in Zülpich since 1984. Three year education, weekends and weeks. 53909 Zülpich-Eifel, Prälat-Frankenstraße 13, phone: 0049-2252/6577
- „Bonner Gesundheitsschule“ (health school of Bonn), training for alternative medical practitioners since 1995. Two and a half year training at weekends. 53115 Bonn, Baumschulallee 2a, phone: 0049-228/6650356
- „Artemisia“ – training for women who want to become alternative medical practitioners in Bremen. Anne Schmalbach and Barbara Krekeler. 28205 Bremen, Am Schwarzen Meer 165
- Frauenbildungshaus Osteresch (women education centre); Strautweg 4, 48496 Hopsten-Schale
- Su Wen – Training for becoming alternative medical practitioner in Nürnberg. Bali Schreiber and Elisabeth Benzing, Eschenauer Str. 25; 90411 Nürnberg.

Publications: (available only in German)

a catalogue with offers for further education for members

a list of practising colleagues containing their emphasis of therapy and offers of courses

documentation of the congress on women's nature healing, 1997 in Cologne

periodical of the society – circular:

Nr. 8/12-90 structures of associations

Nr. 9/5-91 our roots

Nr. 10 power and faint

Nr. 11 sensory and spirituality in everyday-working

Nr. 13 back

Nr. 14 breast

Nr. 15 pain

Nr. 16 genetic and reproductive technology

Nr. 17 working structures in the professional association

Nr. 19/20 climacterium

Nr. 21 addiction

Nr. 22 hormones

Nr. 23 grazy

Nr. 24 relationships in therapy

Nr. 25 Quality is our strength

Subscriptions for the LACHESIS-journal for 10,-DM per journal at the offices.

Name of the organization:

Deutscher Ärztinnenbund e. V.
(German association of female medical doctors)

Address:

Deutscher Ärztinnenbund
office:
Herbert-Lewin-Str. 1 - 50931 Köln
phone: 0049- 221 / 40 04-540
fax: 0049-221 / 40 04-541
e-mail: gsdaeb@aol.com
internet: www.aerztinnenbund.de

Contact:

Office:	Elke Timme, address as above
President:	Press officer:
Dr. Astrid Bühren	Gabriele Juvan
Hagener Str. 31 - 82418 Murnau	Luisenstr. 63 - 63067 Offenbach
phone. 0049-88 41 / 27 03 - 55 35	phone: 0049-69 / 82 36 52 18
fax. 0049-88 41-27 08	fax: 0049-69 / 82 36 52 19
e-mail: buehren@bgu.murnau.de	e-mail: 123juvan@compuserve.com

Aims:

We are a politically independent association of female doctors and female dentists existing nationwide. Head office is in Cologne. We have an integrated "Junges Forum" for female students of medicine and dentistry as well as female doctors and female dentists younger than 40 years. We want to represent visibly, audibly and forcefully the interests of our colleagues in the public.

We offer:

- the representation of female doctors in the political committees of our profession and in the medical self-government: Ärztekammer (Medical Council), Ärztetag (main assembly of the Ärztekammer),
- Kassenärztliche Vereinigung (regional association of SHI-accredited physicians)
- a forum for interdisciplinary discussions and solidarity
- representation of interests in the run-up to legislation
- scientific conferences and meetings with specific subjects concerning women and health
- book-therapy for sick children in hospitals (the campaign "Das Fröhliche Krankenzimmer")
- the periodical "Ärztin" (4 - 6 times a year)
- close co-operation with the MWIA

We award:

- the award "Silberne Feder" for literature for younger readers about health-education and how to cope with sickness
- the scientific award of the "Ingrid-zu Solms-Stiftung" for outstanding doctorates, postdoctoral qualifications or scientific publications

Main emphasis of activity:

We support:

- equal opportunities for female doctors in profession and society
- improvement of the situation of female doctors according to the Healthcare Reform Act, especially in the area of the establishment
- promotion of research on women's affairs and scientific work of female doctor at colleges and universities
- promotion of talented female doctors and medical psychotherapists by the "Ingrid-zu-Solms-Stiftung"
- further education in part-time work and adjustment of pension for the time of child-raising
- consideration of time for child-raising and child-caring in the pension funds of the medical council

Members of the organization:

female doctors from all special fields, female dentists and female students of medicine and dentistry

Number of members: At the moment there are 2000 members in 32 regional groups.

Year of foundation: 1924

Legal form: registered society

Financing: financing exclusively by membership subscriptions

Regional institutions:

A list of our regional groups (as at May 2000) is given below.

Baden Württemberg

Dr. Friederike Perl
Röntgemstr.35 - 73760 Reutlingen
phone (priv): 0049-71 21 / 222 04
fax (off.): 0049-17 11 / 44 88 49 86

Bayern-Nord

Dr. Jutta Schimmelpfennig
Dr.-Erich-Stahl-Str. 17 - 96138 Burgebrach
phone: 0049-95 46 / 61 96
fax: 0049-95 46 / 81 22

Bayern-Süd

Dr. Didona Roxana Weippert
Türkenbundweg 9 - 80689 München
phone: 0049-89 / 700 33 74
fax (priv): 0049-89 / 700 33 75

Berlin

Susanne Schroeder
Poßweg 13b - 14163 Berlin
phone: 0049-30 / 813 26 72

Bremen

Dr. Ursula Auerswald
Carl-Schurz-Str. 58 - 28209 Bremen
phone: 0049-421 / 349 91 98
fax (priv): 0049-421 / 346 98 33
fax (off): 0049-421 / 340 42 09

Bochum

Dr. Bettina Funke-Inkmann
Wasserstr. 461c - 44795 Bochum
phone: 0049-234 / 43 16 28
fax: 0049-234 / 462 93 97
e-mail: bf.inkmann@cityweb.de

Bonn

Dr. Ursula Sottong
Burgstr. 32 - 53842 Troisdorf
phone: 0049-22 41 / 40 83 26
fax (priv): 0049-22 41 / 40 36 29
fax (off): 0049-221 / 982 25 89

Dortmund

Dr. Ute Luckhaupt
Füssmannstr. 6 - 44265 Dortmund
phone: 0049-231 / 46 41 42
fax (priv): 0049-231 / 46 41 42

Essen

Dr. Dr. Uta Berger
Klinkenstr. 28 - 45136 Essen
phone: 0049-201 / 25 00 27
fax: 0049-201 / 269 61 66
e-mail: ufber@t-online.de

Gießen

Prof. Dr. Ingeborg Siegfried
Am Hain 2 - 35444 Biebertal
phone: 0049-64 09 / 78 72
fax: 0049-64 09 / 23 54

Hannover

Dr. Marlena Robin-Winn
Uhlandstr. 31 - 30629 Hannover
phone: 0049-511 / 58 00 08
fax (priv): 0049-511 / 59 25 90

Kiel

Dr. Karin Bucher
Elisabethstraße 68 - 24143 Kiel
phone: 0049-431 / 747 79
fax: 0049-431 / 747 77

Lübeck

Dr. Doris Hartwig-Bade
Moislinger Allee 7 - 23558 Lübeck
phone: 0049-451 / 260 77
fax (priv): 0049-451 / 858 37
e-mail: doris.hartwig-bade@dgn.de

Münster

Dr. Hedwig Wening
Rüschhausweg 151 - 46161 Münster
phone: 0049-251 / 86 90 90
fax: 0049-251 / 86 91 91

Braunschweig

Dr. Gitta Schneider-Sickert
Waldweg 4 - 38110 Braunschweig
phone: 0049-53 07 / 61 17
fax (priv): 0049-53 07 / 86 16
e-mail: schneidersickert@t-online.de

Düsseldorf

Dr. Marianne Esch
Kibbenheide 9 - 40822 Mettmann
phone: 0049-21 04 / 526 72
fax (priv): 0049-21 04 / 535 66

Frankfurt

Dr. Kirstin Börchers
Doomer Str. 45a - 63456 Hanau-Steinheim
phone: 0049-61 96 / 20 18 92

Hamburg

Dr. Doris Schmidt
Vielohweg 181 A - 22455 Hamburg
phone: 0049-40 / 551 13 14
fax: 0049-40 / 551 13 14

Kassel

Dr. Hannelore Feudenberg
Schloßbäckerstr. 59 - 34130 Kassel
phone (off): 0049-561 / 100 32 13
fax: 0049-561 / 650 44

Köln

Dr. Christine Lohmann-Mattonett
Redwitzstr. 74 - 50937 Köln
phone: 0049-221 / 44 57 04

Marburg

Dr. Susan Trittmancher/Dr. Kirsten Holsteg
Bahnhofstr. 30 - 35037 Marburg
phone: 0049-64 21 / 680 00
fax: 0049-69 21 / 77 47 12

Neumünster

Elke Burghard
Brachenfelder Str. 19 - 24534 Neumünster
phone: 0049-43 21 / 219 80
fax: 0049-43 21 / 294 67

Oldenburg

Dr. Ursula Eichelberg
Beethovenstr.14 - 26135 Oldenburg
phone: 0049-441 / 122 17
fax:0049-441 / 949 03 87

Ostwestfalen-Lippe

Dr. Claudia Czerwinski
Hindenburgstr. 1a - 32257 Bünde
phone: 0049-52 23 / 18 83 20
fax: 0049-52 23 / 170 46
e-mail: medusana@teleos-web.de

Rhein-Neckar

Dr. Gudrun Friedt-Weirich
O 6 – 7 - 68161 Mannheim
phone: 0049-621 / 222 00
fax (priv): 0049-621 / 129 16 15

Saarbrücken

Dr. Renate Dessauer
Eduard-Mörrike-Weg 9 - 66133 Saarbrücken
phone: 0049-681 / 81 41 55
fax (priv): 0049-681 / 81 41 56

Ulm

Dr. Erla Spatz-Zöllner
Neue Str. 101 - 89073 Ulm
phone: 0049-731 / 60 11 33
fax (priv):0049-731 / 615 67

Wiesbaden-Mainz

Dr. Brigitte Schuler
Lisztstr. 8 - 65193 Wiesbaden
phone: 0049-611 / 52 43 20
fax: 0049-611 / 30 92 44

Wuppertal

Dr. Marie-Louise Fasshauer
Waldhof 43 - 42283 Wuppertal
phone: 0049-202 / 51 02 82
fax: 0049-202 / 250 12 96

Junges Forum

Esther Gaertner
Am Richterbusch 22 - 44262 Dortmund
phone: 0049-231 / 41 29 57
fax: 0049-231 / 43 42 23 09
e-mail: esther.gaertner@cityweb.de

Naturwissenschaftlerinnen im DÄB

Dr. Gabriele Jaques
Carl-Ullrich-Str. 7 - 35393 Giessen
phone: 0049-641 / 545 23

Specialist groups:

book-therapy at the children's hospital: the campaign "Das Fröhliche Krankenzimmer", experimental project at the von Haunersche Kinderklinik, University of Munich, Lindwurmstraße 4 - 80337 Munich

co-operation with the study-group "Women's health " (contact by our office) Scientific conferences, e. g. 1999 in Gießen "Gender-specific aspects of heart and circulation diseases - Do women's hearts beat differently?" (contact by our office)

Specific knowledge offered by the organization:

Colleagues of all medical areas, that means female doctors of all special fields are organized in the Deutsche Ärztinnenbund; their workplaces are established practices as well as hospitals, research institutions and committees of health policy. Especially concerning questions of research on women's health, the Ärztinnenbund has a lot of competent members.

Publications: (available only in German)

the organization's periodical *ÄRZTIN* (4 - 6 times a year)

reports about conferences

Information: Leaflets of the relevant regional groups, statutes of the Deutsche Ärztinnenbund, leaflet "Das Fröhliche Krankenzimmer", leaflet Junges Forum

address of the employment agency of the Deutsche Ärztinnenbund

self-help group for female doctors with breast-carcinoma

addresses of training courses for doctors, who want to work again after a break

press survey of the DÄB (several years)

application documents for the "Ingrid-zu-Solms-Preis", the award of the Deutsche Ärztinnenbund for young female scientists

organization of scientific conferences about special subjects concerning female doctors and patients

Scientific conferences organized by the Deutsche Ärztinnenbund e. V.:

- | | |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 20. - 21. 09.1952 | Bad Pyrmont |
| 02. - 03. 05.1953 | Stuttgart: Ärztliche Aufgabe in der Arbeit an der Jugend
(the doctor's task in youth work) |
| 02. - 24. 04. 1955 | Berlin: Frauenarbeit und Gesundheit
(women's labour and health) |
| 05. - 07. 04.1957 | Bad Pyrmont: Ehefragen
(questions about marriage) |
| 05. - 07. 06.1959 | Wiesbaden: Das Jugendalter
(the adolescence) |
| 01. - 03. 09.1961 | Bayreuth: Die Frau in der heutigen Welt
(the woman in today world) |
| 24. - 27. 10.1963 | Kampen/Sylt: Das Kind in der technischen Welt
(the child in the technical world). |
| 23. - 25. 09.1965 | Berlin: Beeinflusst die heutige Lebensform die Gesundheit der Frau?
(modern way of life and women's health) |
| 24. - 26. 05.1967 | Regensburg: Fragen und Wünsche für die Ausbildung von Ärzten
und medizinischen Hilfskräften (questions and wishes concerning
the training of doctors and medical assistants) |
| 09. - 11. 10.1969 | Goslar: Wirkungen und Nebenwirkungen von Medikamenten:
Psychopharmaka Wirkungen und Nebenwirkungen von
Medikamenten: weibliche Hormone (effects and side effects of
psychotropic drugs and of medicine concerning female hormones) |
| 15. - 17. 10. 1971 | Saarbrücken: Der Behinderte in der Familie
(handicapped persons and the family) |
| 01. - 03.06.1973 | Bad Pyrmont: Kriminalität in moderner psychologischer und
medizinischer Sicht (crime in the eyes of modern psychology and
medicine) |
| 17. - 19. 10.1975 | Oberammergau: Vorsorge und Nachsorge in der Medizin
(prevention and after care) |
| 24. - 26. 09.1977 | Wiesbaden: Gefährdende Tendenzen in Kindergarten und Schule
(dangerous tendencies at kindergarden and school) |
| 18. - 21. 10.1979 | Malente: Gesundheitliche Aspekte im Frauensport
(health aspects in women sports) |
| 25. - 27. 09.1981 | Aachen: Psychosoziale Hintergründe des Schwangerschafts-
abbruches, (psycho-social background of abortion) |

- 30.09.-02.10.1983 Bad Harzburg: Differenzierung von Mann und Frau aus medizinischer und psychologischer Sicht (the difference between man and woman in the eyes of psychology and medicine)
19. - 22. 09.1985 Freudenstadt: Patienten machen sich selbständig (patients become independent)
17. - 20. 09.1987 Rosenheim: Die Frau in der modernen Arbeitswelt (woman in modern working world)
08. - 11. 06.1989 Münster: Zwischen Reproduktionsmedizin und Schwangerschaftsabbruch (between reproduction medicine and induced abortion)
06. - 08. 09.1991 Bamberg: Frauen zwischen Aggression und Depression / Ärztin 2000 (women between aggression and depression)
09. - 12. 09.,1993 Marburg: Prävention ist weiblich (prevention is female)
22. - 24. 09.1995 Lübeck: Mamma-Carcinom (breast carcinoma)
25. - 28. 09.1997 Potsdam: Risikosituationen in der Entwicklung von Kindern und Jugendlichen (risky situations in the development of children and adolescents)
16. - 19. 09. 1999 Wuppertal: Frauen im Alter - Medizin für eine Mehrheit (women at old age - medicine for a majority)
Gießen: „Schlagen Frauenherzen anders? Geschlechtsspezifische Aspekte von Herz-Kreislaufkrankungen bei Frauen (Do women's hearts beat differently? gender-specific aspects of heart and circulation diseases concerning women)

(reports about the conferences are available at the office against a fee)

Questions and interests relevant to the current situation:

The enforcement of really equal opportunities for female doctors, especially in science, research and practice

Name of the organization:

Deutsche Gesellschaft für Verhaltenstherapie e. V. (DGVT)
(German society for behavioural therapy)

Address:

Neckarhalde 55 - 72070 Tübingen
phone: 0049-70 71 / 94 34 - 0
fax: 0049-70 71 / 94 34 35
e-mail: dgvt@dgvt.de
internet: www.dgvt.de

Contact:

managing director: Waltraud Deubert
publishing director: Otmar Koschar
consultants of the committee for
training and further education : Günter Ruggaber, Martina Georg

Aims:

The Deutsche Gesellschaft für Verhaltenstherapie e. V. (DGVT) is a psychotherapeutic and health-political specialist association. The stipulated aims are the realization of a psycho-social care orientated towards the needs of the population and the promotion of behavioural therapy in research, teaching and practice. This is realized in following ways:

- by the permanent examination and discussion with and within the social policy
- by offers of training programmes and further education
- by events like workshops and specialist meetings
- by the Conference for clinical psychology and psychotherapy in Berlin (every two years)
- by the support of women-specific research work and the sensitization for psycho-social problems of women

In the periodical "Verhaltenstherapie und Psychosoziale Praxis (VPP)" the DGVT informs regularly about the update political and scientific discussions.

The publishing house of the DGVT offers a wide selection of books for persons who work in the area of psychotherapy and psycho-social matters in practice, research and teaching or who are still in training.

Main emphasis of activity:

- training and further education in behavioral therapy
- support of women-specific research and sensitization for psycho-social problems of women
- activity in health- and social policy (women-specific interests, Psychotherapists Act etc.)
- examination of ethical guidelines (especially concerning sexual abuse)
- promotion of anti-racist and intercultural work

Members of the organization:

persons, who work in the area of psychotherapy and psycho-social matters in practice, research and teaching or who are still in training

Number of members: about 5000 at the moment

Year of foundation: The DGVT was founded in 1968.

Legal form: charitable registered society

Financing:

by membership subscriptions, fees for participation in trainings or further education courses

Regional institutions:

Regional training- and further-education-structures within whole country. Department for training and further education: Günter Ruggaber/Martina Georg; phone: 0049-7071/9434
information: Karin Hamann; phone: 0049-7071/943413

Specialist groups:

women and psycho-social care

Contact:

Waltraut Deubert / Ulrike Schrof / Suse Stengel

DGVT-office

Postfach 1343 - 72003 Tübingen

phone. 0049-70 71 / 94 34 94

Team against racism and anti-Semitism in the psycho-social care

Contact: as above

Advisory council for ethical questions

Contact: as above

Team children and young person psychotherapists:

Karin Hamann (phone: see above)

Information, which is offered by the DGVT:

addresses of behavioural therapists having degree achieved at the further education courses of the DGVT. These addresses are provided to clients, patients, doctors and colleagues
permanently updated information about the Psychotherapists Act
information about sexual abuse in psychotherapy
organization of meetings for specialist women

Publications: (available only in German)

a large number of women-specific publications in the publishing house of the DGVT (a complete list is available by request)

DGVT-Arbeitsgemeinschaft "Frauen in der psychosozialen Versorgung" (Hrsg.): Sexuelle Übergriffe in der Therapie. Kunstfehler oder Kavaliersdelikt? 2. Aufl. Tübingen 1992.

(sexual pestering and assault in psychotherapy)

Gabriele Amann & Rudolf Wipplinger (Hrsg.): Sexueller Missbrauch. Überblick zu Forschung,

Beratung und Therapie. Ein Handbuch. Tübingen 1997. (auch auf europäischer Ebene interessant)

(sexual pestering and assault, survey of research, advice service and therapy; also interesting at the european level)

Sigrid Roterling-Steinberg: Selbstsicherheit - Ein lebenslanges Lernprojekt. Handlungsorientierte Frauenbildung. Tübingen 1997.
(self-confidence - a lifelong learning project, action-orientated education for women)

Irmgard Vogt & Monika Bormann (Hrsg.): Frauen-Körper. Lust und Last. 2. Aufl. Tübingen 1994.
(female body - lust and burdens)

Frauen gegen sexuelle Übergriffe und Machtmißbrauch in Therapie und Beratung (Hrsg.): Übergriffe und Machtmißbrauch in psychosozialen Arbeitsfeldern. Phänomene - Strukturen - Hintergründe. Tübingen 1995.
(women against sexual pestering and assault and misuse of power in areas of psycho-social work - phenomena, structures, background)

(All publications are available at the DGVT)

Name of the organization:

Bundesvereinigung für Gesundheit e.V. (BfG)
(Federal association for health)

Address:

Heilsbachstraße 30 - 53123 Bonn
phone: 0049-228 / 987 27 12
fax: 0049-228 / 642 00 24
PC:0049-228 / 987 27 23
e-mail: bfge.rg@bfge-2.de
internet: www.bfge.de

Contact:

Beate Robertz-Grossmann and Dr. Uwe Prümel-Philippsen

Aims:

The Bundesvereinigung für Gesundheit e. V. (national association for health) is a neutral institution for coordination and control. It is the umbrella organization of the free, non-state initiatives in the areas of “prevention and healthcare support”, which is sponsored institutionally by the Bundesministerium für Gesundheit (BMG, national ministry for health). By its programmes and by close co-operation with the Bundeszentrale für gesundheitliche Aufklärung (national center for information about health), it is a central “bridge” between the BMG and the non-state initiatives.

From the very beginning, the co-operation, as epitome of the varied ways of working together, is a declared aim of the BfGe.

Main emphasis of activity:

The most important tasks for co-operations with the aim of a network are:

- to run analyses and stock-takings
- to make possible the exchange of experience for special target groups
- to develop frameworks and recommendations
- to coordinate processes of planning, pilot projects and routine measures
- to run events, projects and activities in company

Number of members: Please find information enclosed.

Year of foundation: 1954

Legal form: charitable registered society

Financing: financing by different sources

Regional institutions:

Please find enclosed a list of the Landesvereinigungen für Gesundheit (provincial associations for health).

Specialist groups:

For specialist groups, which work about special subjects of women's health see the list of members or of Landesvereinigungen.

Specific knowledge offered by the organization:

For specific knowledge see the list of members or of Landesvereinigungen.

Questions and interests relevant to the current situation: mainly questions concerning the international context

5.1.4 Networks, registered associations, foundations in the field of health promotion

Name of the organization:

Internationales Zentrum für FrauenGesundheit gGmbH (IZFG)
(International centre for women's health)

Address:

IZFG Internationales Zentrum für FrauenGesundheit gGmbH
Alte Vlothoer Str. 47-49 - 32105 Bad Salzuflen
phone: 0049-52 22 / 63 62 96
fax: 0049-52 22 / 63 62 97

Contact:

Regina Stolzenberg, Dr. Christine Niehues

Aims:

To improve the physical and psychosocial health of women through developing and implementing of new services, through improvement of structures in the field of health and in society.

Fields of work:

Projects and concept-development, concentration of competences, impulses, consultation, networking and coordination, knowledge transfer, conferences, evaluation, demonstrating regional development.

Main emphasis of activity/of the projects:

gynaecological second opinion consultation hour
coordination centre women and health in North Rhine-Westphalia
regional information and contact centre for women and health, information phone service, and event-programme
organization of conferences
development and application of women friendly models for cure and rehabilitation

Number of members: 7 employees

Legal form: charitable foundation in the form of a Ltd.

Financing:

Covering for 3 years according to a shareholder-investment; further financing: project promotion funding by the state government; job creation scheme; own takings

Regional institutions: cooperation with associations and organisations in the region

Specific knowledge:

gynaecological-psychosocial competences through the collaboration of two female gynaecologists and through the connection to the clinic of gynaecological rehabilitation; new concepts of prevention (women's exercising-cure), women-specific health promotion and consultation, health sciences, quality-management (concept of best value), women's health movement in theory and practice.

Interests:

Implementation of analyses of requirements in the field of women's health and health care and development of corresponding offers. Broad interdisciplinary cooperation-alliances with organisations and institutions. Institutionalization of women-specific health services ad communal, regional and national level.

Name of the organization:

Dachverband der Frauengesundheitszentren in Deutschland e. V.
(umbrella organization of the women's health centres in Germany)

Address:

Dachverband der Frauengesundheitszentren in Deutschland e.V.
Goetheallee 9 - 37073 Göttingen
phone: 0049-551/ 48 70 25
fax: 0049-551 / 521 78 36
e-mail: DV-Frauengesundheitszentren@gmx.de
internet: www.fen-net.de/fgz/ingang.htm

Contact:

Rita Götze	Dachverband der Frauengesundheitszentren, address, see above
Angelika Zollmann	FFGZ Frankfurt Kasseler Str. 1a - 60486 Frankfurt phone: 0049-69 / 70 12 18 fax: 0049-69 / 77 71 09

Aims:

In the public as well as in specialist groups, this association supports a health care supply, which is suitable for women. In this sense it supports initiatives of the emancipatory women's health education and the psycho-social care and strengthening of patients. In public and in specialist circles the association demands structural improvements within the health system: e.g. de-pathologizing of femal life-phases as pregnancy and birth, climacterium and puberty, reimbursement of costs for alternative-medical forms of diagnosis and treatment, prevention-research (breast carcinoma, endometrioses and unwanted childlessness), breast cancer early diagnosis under secured quality and implementation and securance of existent, independent women's health advice centres, which strengthen the decision and action-competences of patients/women and girls.

Main emphasis of activity:

The umbrella organization represents the concerns of women's health centres (F/FGZ) on a federal level. Concerning recent topics in the field of women's/girl's health the organization in the name of the women's health centres gives out press releases and other text-material. It coordinates and disseminates information on services of the centres among the specialized public, educational institutions, media and interested women in all Germany.

Once up to twice a year the Dachverband organizes further trainings concerning women's health topics and to issues of project-coordination. Quarterly a member-women newsletter is published. Concerning the topic of breast health/breast-cancer a phone-advice service is existent.

Members of organization:

Feministisches Frauen Gesundheits Zentrum Berlin Bamberger Str. 51 - 10777 Berlin phone: 0049-30 / 213 95 97 fax: 0049-30 / 214 19 27 e-mail: ffgzberlin@snaflu.de internet: www.ffgz.de	Frauengesundheitszentrum Bochum (in founding-process) Alte Bahnhofstr. 40 - 44892 Bochum e-mail: fgz.ruhrgebiet@gmx.de internet: www.bo-alternativ/fgz.htm
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Frauengesundheitszentrum **Bremen**
Elsfletherstr. 29 - 28219 Bremen
phone: 0049-421 / 380 97 47
fax: 0049-421 / 38 26 71
e-mail: fgzbremen@AOL.com

Frauen- und Mädchengesundheitszentrum
Medea - Dresden
Prießnitzstr. 55 - 01099 Dresden
phone: 0049-351 / 849 56 79
fax: 0049-351 / 804 05 06

Frauen- und Mädchen-Gesundheitszentrum
Freiburg
Erbprinzenstr. 14 - 79098 Freiburg
phone: 0049-761 / 202 15 90
fax: 0049-761 / 202 15 91

Frauengesundheitsladen **Hamburg**
Elmenhorststr. 4 - 20767 Hamburg
phone: 0049-40 / 439 53 89
fax: 0049-40 / 38 61 12 53
e-mail: fgz-Hamburg@t-online.de

Feministisches Frauengesundheitszentrum
Hagazussa Köln
Roonstr. 92 - 50674 Köln
phone: 0049-221 / 23 40 47
fax: 0049-221 / 240 36 53
e-mail: hagazussa@koeln-projekte.de
internet: www.koeln-projekte.de/hagazussa

Frauengesundheitszentrum **München**
Nymphenburgerstr. 38 - 80335 München
phone: 0049-89 / 129 11 95
fax: 0049-89 / 129 84 18
e-mail: frauengesundheitszentrum@t-online.de
internet: www.frauen-netz.de/HIVpositiv

Frauengesundheitszentrum **Regensburg**
Untere Bachgasse 12/14 - 93047 Regensburg
phone: 0049-941 / 816 44
fax: 0049-941 / 89 34 73

Frauen- und Mädchengesundheits-
zentrum **Women life - Cottbus**
Max-Grünebaum-Str.9 - 03042 Cottbus
phone: 0049-355 / 729 30 05
fax: 0049-355 / 729 30 05

Feministisches Frauengesundheitszentrum
Frankfurt
Kasselerstr. 1a - 60486 Frankfurt
phone: 0049-69 / 70 12 18
fax: 0049-69 / 77 71 09
mailbox: Fem.Frauengesundheitszentr.
FFM@t-online.de
internet: www.netpool.org/socart/ffgz

Frauengesundheitszentrum **Göttingen**
Goetheallee 9 - 37073 Göttingen
phone: 0049-551 / 48 45 30
fax: 0049-551 / 48 70 60
e-mail: FGZ@FGZ-Goettingen.de
internet: www.FGZ-Goettingen.de

Frauengesundheitszentrum **Heidelberg**
Alte Eppelheimerstr. 38 - 9115 Heidelberg
phone: 0049-62 21 / 213 17
fax: 0049-62 21 / 16 07 06

Feministisches Kommunikationszentrum
ARANAT Lübeck
Steinrader Weg 1 - 23558 Lübeck
phone: 0049-451 / 408 28 50
fax: 0049-451 / 408 28 70
e-mail: aranat@w4w.de

Frauengesundheitszentrum **Nürnberg**
Fürtherstr. 154 - 90429 Nürnberg
phone: 0049-911 / 32 82 62
fax: 0049-911 / 32 82 62
e-mail: fgz@fen-net.de
internet: www.fen-net.de/fhz

Feministisches Frauengesundheitszentrum
Stuttgart
Kernerstr. 31 - 70182 Stuttgart
phone:0049-711 / 29 63 56
e-mail: info@ffgzstuttgart.de
internet. www.ffgzstuttgart.de

Frauengesundheitszentrum
Sirona - **Wiesbaden**
Dotzheimer Str. 9 - 65185 Wiesbaden
phone:0049-611 / 30 16 94
fax: 0049-611/1576765
e-mail: Frauengesundheitszentrum
Sirona@t-online.de

Members of the organization:

In the member-centres of the umbrella organization the following professions are represented:

Natural Healers, doctors receptionists, midwives, social education workers, social scientists, remedial education workers, education scientists, nurses, physiotherapist, psychologists, therapists with the following focusses: psychotherapy, NLP, gestalt-, musical- and body-therapy, biodynamic therapy as well as tax officer women and women educated in public relations. Additional trainings: Luna Yoga, self-healing-method WILDWUCHS etc.

Number of members:

Meanwhile in the 17 women's health centres between 20 and 4 employees are working.

Year of foundation: The association was founded in 1988.

Legal form: The association is a charitable registered society.

Financing:

The association is financed by membership subscription and special funds for projects (from foundations, ministries).

Regional institutions:

There are study-groups within the women's health centres. All centres work in regional women's and health networks.

Specialist groups:

Specialist groups for selected subjects are set up according to current requirements. They cooperate nationwide. At the moment there are fixed groups working on the topics: gynaecological illnesses, breast-health/breast-cancer, climacterium and contraception. Main emphasis of work: exchange of experiences on advice work, mutual further training, production of brochures and public relation.

Specific knowledge offered by the organization:

1. Gynaecological methods of diagnosis and treatment

In the consultations in regard to gynaecological topics information on biomedical methods of diagnosis and treatment are transferred. These information are rooted in the cooperation of gynaecologists and hospitals, medical specialist literature, conversations with patients on their experience with diagnosis and treatment and corresponding trainings of the employees.

2. Knowledge about alternative and supplementary methods of therapy and treatment for special health-problems:

The knowledge refers to general health promotion (prevention) and problems in the gynaecological area, respectively to those, which are connected with experience of sexual violence and / or psychic disorder like e. g. eating disorders.

Alternative methods of therapy and treatment: homoeopathy, Chinese medicine, anthroposophical medicine, natural medicine (e. g. Kneipp cure), change of eating habits, phytotherapy, psychotherapy.

Some of our colleagues are educated in these methods. They have data of experience about the effects of these methods. These methods which consider the body as a whole correspond with our holistic concept of consultation. Psychic, social, economical, ecological, biographical and cultural approaches of explanation of the origins of a disease are taken into account. Possibly, solutions concerning these subjects are aimed at, which are relevant for women looking for advice.

Example for alternative methods of treatment of cysts at the uterus:

In this case the strategy of the biomedicine is the permanent control in 3-months intervals. Especially in case of a HPV-infection according to the personal assessment of the gynaecologist at some point of time a conisation will be suggested. Alternatively the woman during a permanent control or instead of a conisation can apply holistic methods which e.g. can lead to a diminishing of the cyst. Corresponding suggestions: Luna yoga, Kneipp-baths, local massages with honey at the cervix, traditional treatments as homeopathy, acupuncture, etc.. Furthermore it can be helpful to clarify how far emotional distress as e.g. in relationships, in sexuality, according to border-violations, through family strain etc. are existent. Confrontation with oneself which leads to a psychological relaxation also can be a possible treatment.

3. To impart self-help techniques

Self-help methods can be acquired by the women and then apply independently according to the need (e.g. vaginal self-examination, breast-massage, breast self-examination, applications of nature healing and herbes). They open an access to the own body and promote the intuition in the own self-healing power.

4. Psychotherapeutic conversation, company, treatment:

In some centres there are colleagues, qualified for the following methods of psychotherapy:

psychoanalysis, gestalt therapy, musical therapy, hypnotherapy, behavioural therapy, conversational therapy and biodynamic body therapy.

Some of them offer treatment and consultation for women-specific psychological problems.

General psychosomatic disorders, gynaecological diseases, experience with sexual violence are examined in relation to the context of women-specific every-day-life and women-specific socialization.

Principles for all methods:

bias towards girls and women

holistic explanation

The methods work discoveringly, creatively and body-orientated. The self-healing powers are stimulated and supported in their development. The aim of the treatment is the strengthening of identity and autonomy.

5. Statements to women-specific issues in the national health-system. e.g.:

a) breast carcinoma:

critical assessment of mammography as a means for early detection for women under 50 years without findings:

- Quality assurance concerning mammography: The quality standard of mammography-equipments as well as of the education and experience of medical doctors and care-personnel is insufficient. Relatively often wrong false-positive and wrong-negative results are stated, which cause ailments, unnecessary operation and psychic stress for women caused by wrong positive or wrong negative diagnosis. Statistically viewed the chance to be cured could not be improved by reinforced mammography.
- Early detection: The methods of early detection in healthy women create fear, rejection and unsureness. They put the responsibility for a carcinoma on the women. Early detection also can lead to an extension of the “life-time after diagnosis” and a shortening of the “life-time before diagnosis”.

The umbrella organization demands higher investments in research of causes and in the psycho-social consultation and in the care of healthy and breast-sick women. It works for an equal treatment and cost-reimbursement for biomedical and holistic therapies.

b) the rights of female patients:

The female patients are not sufficiently taken into account while deciding in the case of treatment.

Women's health centres offer independent patient advice. The umbrella organization is working for the consideration of the women's needs in their role as patients.

c) hormone-therapy during the climacterium:

The tendency in the gynaecological practice to offer a hormone-treatment to women in the climacterium without complaints, or with intermediate complaints or as a prevention for osteoporosis or heart-attack, is equal to the medicalisation of a female life-phase. In this regard gynaecologists go beyond their area of responsibility since the climacterium is no illness.

Women's health centres work for strengthening the women's and girl's self-perception during their ripening-crises, and to set self-assertion and the clarification of societal devaluation of the women's body against the psychosomatic tendencies. Women's health centres are against overtreatment and risk-treatment of women in the climacterium.

Strategies of communal women's health promotion.

Women's health centres are institution of women's health promotion. They disseminate addresses of local offers in the medical, psychosocial and women's education field and offer themselves psycho-social support, care and advice for women and girls in regard to issues of contraception, healthy life-style (prevention), sexuality and gynaecological ill-health. They herewith fulfill a task that is not taken responsibility for by the public health system. All women's health centres participate in regional women's and health networks. In this frame they enter into the public discussion with their holistic and women-friendly concept of consultation as well as with critic and suggestions for improvements.

Publications:
only available in German

Wechseljahre. Aufbruch in eine neue Lebensphase, 10 DM
Ernährung, Bewegung, Hormonbehandlung, Naturheilkunde, Osteoporose. Vollständig überarbeitet und aktualisierte Auflage 1999. FFGZ Berlin
(*Climacterium*. Departure in a new life-phase)

Endometriose. Verstehen und Verändern. 10 DM
Was ist Endometriose?, Untersuchungs- und Diagnosemethoden der Schulmedizin, Umgang mit Schmerzen, Alternative Behandlungswege³. Auflage 1997 FFGZ Berlin
(*endometriosis* - orthodox methods, how to cope with pains, alternative methods)

Wenn's juckt und brennt.... Eine Selbsthilfebroschüre für Frauen mit Vaginalinfektionen. 7 DM: Der physiologische Idealzustand, die verschiedenartigen Vaginalinfektionen und deren Behandlungsweisen, Mykosen, vaginale Selbstuntersuchung, psychosomatische Aspekte, Erfahrungsberichte; FGZ Göttingen
(*vaginal infections* - physiology, different types of infection and therapy, mycoses, self-examination, psychosomatic aspects, experiences)

Brustkrebs – Informationen, Naturheilkunde, Homöopathie, Selbsthilfetipps. 13 DM
Auflage/edition 2000. FFGZ Stuttgart
(*breast cancer* – information, nature healing, homeopathy, self-help tips)

Zellveränderungen am Gebärmutterhals. Eine Broschüre zum PAP-Abstrich aus ganzheitlicher Sicht. 7 DM; Was bedeuten die PAP-Werte I - V?, Veränderungen an der Zervix, schulmedizinische Untersuchungs- und Behandlungsmethoden, Vorbeugung und unterstützende Behandlung, Psychosomatik, Erfahrungsberichte 2., erweiterte Auflage 1995; will be edited newly in 2001; FGZ Bremen
(*cervical cell-changes* - PAP-values, orthodox examination and therapy, prevention, psychosomatics, experiences)

new in 2001:

Erfahrungen mit Hysterektomie. Gründe für die Entfernung der Gebärmutter und Umgang mit den Folgen. 5 DM Bedeutung der Gebärmutter, Einstellung der Frauenärzte, Anlaß der Hysterektomie, Folgen der Hysterektomie². Auflage 1989 FGZ Heidelberg
(*hysterectomy* - importance of the uterus, disposition of gynaecologists, causes and consequences of hysterectomy)

Gynäkologische Operationen. Gebärmutterentfernungen-Organerhaltende Operationsmethoden-Möglichkeiten der Selbsthilfe. FGZ Heidelberg
(*gynaecological operations*. uterus removal – organ-maintaining operation methods-opportunities of self-help)

Verhüten mit dem Diaphragma. 4 DM; Geschichte des Diaphragmas, Zuverlässigkeit, Anpassung, Selbstuntersuchung, Diaphragma-Gel; FFGZ Berlin
(*contraception with diaphragm* - security, adaptation, self-examination, gel)

Rund um's Diaphragma. Eine sichere Alternative. 6 DM Allgemeines, Anwendung, Dia-Gel (Rezept), Diaphragma und Sexualität 3. überarbeitete Auflage 1990; FGZ Nürnberg
(*diaphragm as secure alternative; including recipe for a dia-gel*)

Rund um Schwangerschaft und Geburt. 8 DM Schwangerschaft und Geburt, Stillen, Hausgeburten, Klinikgeburt, vorgeburtliche Diagnostik, Kegelübungen, Impfungen 1. Auflage 1995 FGZ Nürnberg
(*pregnancy and birth - lactation, home and hospital birth, prenatal diagnosis, vaccination*)

Lesben und Kinderwunsch. (for free); FFGZ Köln
(*Lesbians and child-desire*)

Unerfüllter Kinderwunsch. 10 DM
Naturheilkundliche Behandlungsmöglichkeit; FFGZ Stuttgart
(*unfulfilled wish for children - possibilities of natural medicine*)

Die Abtreibungspille RU 486. Zur Entmystifizierung eines vermeintlichen Wundermittels. 2 DM, Wie wirkt die RU 486?, Welche Erwartungen haben Frauen an die Abtreibungspille, RU 486 - Im Interesse der Frauen? 1. Auflage 1994; FFGZ Frankfurt

Zähne. 8 DM
Mundhygiene, Amalgam-Sanierung, Entgiftung FMGZ Freiburg
(*teeth - hygiene, amalgam, detoxication*) –

Wissenwertes zum Thema: Gesunde Ernährung. 5 DM; FMGZ Freiburg
(*What you should know in regard to healthy nutrition*)

Der rote Faden durch das Labyrinth. 7 DM Bedeutung des Labyrinths, Labyrinth - Symbol für Prozesse, Praktische Erfahrungen mit dem Labyrinth 1. Auflage 1995 FGZ Nürnberg
(*labyrinth - meaning of labyrinth, symbol, experience*)

documentations: only in German

Frauengesundheit in Bewegung 1974-1999. Dokumentation zum 25. Jubiläum des FFGZ Berlin. for free. FFGZ Berlin
(*Women's health in movement 1974- 1999. Documentation for the 25th Jubilee of the FFGZ Berlin*)

Dokumentation zum 20-jährigen Bestehen des FFGZ Frankfurt/M.: 1978-1998. 10 DM; FFGZ Frankfurt.
(*Documentation for the 20th jubilee of the FFGZ Frankfurt 1978-1998*)

10 Jahre - Eine Dokumentation über 10 Jahre feministische Gesundheitsarbeit in München 1986 - 1996. 5 DM
FGZ macht Geschichte, Hintergrund der Arbeit, Themenschwerpunkte FGZ München
(*10 years of feminist healthcare work in Munich - documentation*)

Frauen und Gesundheit: Zeitschrift Frauen in der einen Welt. 15 DM; 2000; FGZ Nürnberg. (*Women and health: journal women in the one world*)

Poster: **Weiblicher Monatszyklus**. 10 DM; FGZ Göttingen
(poster: *female monthly cycle*)

Exhibition: **“Artificial hormones from the cradle to the grave”**

The exhibition informs about the function of endogenous hormones, contraception, menopause and alternatives to the hormone-therapy and about the history of artificial hormones.

The endangering of women's health and the profits of pharmaceutical industry are compared critically.

This exhibition can be hired from the FGZ in Göttingen.

Costs: 1000,- DM, plus fare for the speaker and costs of transportation.

The exhibition will be set out by the FGZ's collaborator and it will be opened with a lecture.

Press announcements:

All press announcements can be ordered at the umbrella organization.

Articles on women's health and women's health politics in diverse journals and book-series.

Extract from a selected publication:

20 Years of Women's Health Centers - 20 Years of Feminist Advice Service. Rita Götze; in Von der „Krankheit“ Frau zur Frauengesundheit. Dokumentation der 4. Jahrestagung des Arbeitskreises Frauengesundheit in Medizin, Psychotherapie und Gesellschaft e.V. (AKF); 8.-9. November 1997 in Bad Pyrmont, Bünde 1998 (From „illness“ woman to women's health. Documentation of the fourth annual meeting of the AKF in 1997)

- a) The self-help program of the FGZs is in general a result of the feminist analysis of the social position of women at the beginning of the women's movement and in particular of the women's position in gynaecology. The latter must be mentioned here in several points, in order to make the aims of feminist advice service more comprehensible:
- b) A look at the history of gynaecology makes it clear, that gynaecology is still dominated by men. In addition it is more monopolized by medical specialists than other areas of medicine. According to the non-medical practitioners act from 1939 non-medical healthcare professions are not allowed to work in gynaecology or obstetrics. There are only few places, where girls and women can find intensive advice, consultation, information or support concerning the proper women-specific subjects of gynaecology, sexuality and contraception.
- c) Since ancient times the female body has been regarded as tending towards sickness. This view has not changed in modern gynaecology. The phases in women's life such as puberty, menarche, pregnancy, birth, childlessness and climacteric are still considered and treated as illnesses.
- d) In opposition to men, most of the girls and women are medically, especially gynaecologically treated from their puberty to their old age. By the way, this causes considerable costs in the healthcare system.
- e) In gynaecology the treatment of somatic symptoms is mixed up with many aspects concerning the identity of the patient as a woman. Therefore the relationship between gynaecologist and patient is a special one and based on personal trust. First against the background of regular patientship the gynaecologist has possibilities to influence the patient's attitude towards sexuality, awareness of the own body and understanding of disease. In some cases this competence may be given to him by the patient herself because she has no other possibilities of conversation. It must be criticized that the general reality of girls' and women's lives is scarcely considered in this relationship (e. g. possible or experienced violation of sexual limits,

manifold strains). Disease-causing life's conditions are not taken into account, there is no work done to change them. Instead of that, resulting psychosomatic disorders are medicalized and treated.

- f) The gynaecology works with a concept of disease based on the measurability of a symptom. Symptoms are reduced to definite causes and measured appropriately (e. g. blood tests, X-ray treatment). Such approach results in that, that diseases are regarded only as physical disorders. Thus, the individual experience of woman can be brushed aside as non-real and imaginary. Exactly this personal knowledge and the awareness of one's own feelings are often signs leading to diagnosis and cure. They are the basis for the development of self-healing powers. Because gynaecology considers only those things as real, which can be measured, women lose the ability to be their own experts. The responsibility for health and well-being is handed over to so-called specialists. The result are treatments, considerably insufficient, wrong, harmful or simply exaggerated. In the case of gynaecological operations the loss of self-responsibility can lead to decisions, which are not really accepted and supported by patients. As a consequence, this can cause afterwards severe crisis in identity e.g. in case of breast's or uterus's loss. Operations, for which exists only little reason, can scarcely be avoided.
- g) Because of the above mentioned expropriation of the responsibility for the own body, because of the lack of information about medicalization, methods of diagnosis and operations, because of a hierarchichal relationship between doctor and patient, the possibility of autonomous decision is limited. These circumstances prepare the way to the proceeding standardization and technologization of the female body. Women are faced to more and more difficult decisions (e. g. reproduction medicine, prenatal diagnosis, induced abortion of a handicapped foetus).
- h) During the fertile phase of life heterosexual girls and women often do not have the necessary information and possibilities of discussion in order to decide on a method of contraception, which is adequate to their current situation. The pharmaceutic industry, with the help of gynaecologists, vehemently presses the pill to the market, so that alternative methods, which are not harmful, are scarcely spoken about in the public or are presented worse than they are. (...)

The feminist self-help concept

At the very beginning, in the development of each individual FGZ, there was women's own consternation. In the process of discussion and self-reflection women realized quickly, how important, helpful and healing is the solidarity among women. 20 Years ago women started to meet up in order to learn to be responsible for themselves in a quite new way, with the support of the group. Self-help was the starting-point and it still is an important basis of the work within the FGZs. While in the first years the emphasis was put on self-help groups of women having the same problems, today mainly support for self-help is offered. This basic position has influence on any kind of offer.

Self-help means at first to take over self-responsibility for one's own life's situation, disorders or disease. We are convinced that women themselves are the most competent ones to be concerned with the causes of their problems as well as to care for their physical, psychic and social well-being. The aim is to gain more competence in dealing (again) more autonomously with one's own sexuality and bodily fuctions and to act on one's own authority.(...)

Holism

In our advice service we consider the whole situation of woman's life and take into account the social, economical, ecological, psychic and physical factors. To us health does not only mean the simple absence of sickness, but a state of the greatest possible physical psychic and social well-being. Disorders of well-being and diseases of women are often a result of trying to cope with diverse, contradictory demands of women's reality and they are not states, for which the woman is responsible or guilty herself. They can indicate various facts. They can be cries for help, excessive demand, resistance, survival strategy, expression of an interior conflict or a blockade of energy. In our advice service we try to clarify the specific situation of every woman against the background of general social context.

Name of the organization:

Ärztliche Gesellschaft zur Gesundheitsförderung der Frau e.V. (ÄGGF)
(Medical Association for the Support of Women's Health)

Address:

Drögenkamp 1 - 21335 Lüneburg

Contact:

1. Chairwoman:

Dr. med. Gisela Gille

Drögenkamp 1 - 21335 Lüneburg

phone: 0049-41 31 / 73 37 46

fax: 0049-41 31 / 73 37 47

2. Chairwoman:

Dr. med. Cordula Layer

Tangstedter Weg 29 - 22397 Hamburg

phone: 0049-40 / 60 76 11 50

fax: 0049-40 / 60 76 11 52

Aims:

The Medical Association for the Support of Women's Health, registered association is a union of female doctors whose aim is to support health and sexual education of girls and young women at schools.

Main emphasis of activity:

Visiting prevention by information, motivation, competence strengthening, training the perception of one's own body signals.

(topics: bodily and mental development. Anatomy and physiology of the sexual organs. Acceptance of body. Menstruation. Hygiene. Sexuality and partnership. Contraception. Procreation, pregnancy and birth. Abortion. Sexually transmittable diseases. Early detection of cancer. Vaccinations. Climacteric.

Members of the organization: Female doctors.

Number of members: 37

Year of foundation: 1956

Legal form: Non-profit making association

Financing: Donations

Regional institutions: please ask the contact persons

Specialist groups : please ask the contact persons

Specific knowledge offered by the organization:

- knowledge of youth- and women's health
- knowledge of psychosexuality and sexual identity
- medical competences in health and sexual pedagogics
- conversation/talks with teenager

Publications:

Numerous publications in the medical press for specialist and laymen. Source of purchase: please ask the contact persons

Chosen titles: (available only in German)

- Gille, G.: German measles – Vaccination as an opportunity for a medical talk with prepubertal girls. *Sozialpädiatrie in Praxis und Klinik* 13, Nr.12 (1991)
- Layer, C.: Medical health, education of young girls at schools. *Sozialpädiatrie in Praxis und Klinik* 14, Nr.8 615-17 (1992)
- Gille G.: Youth enlightening - between information and indoctrination. *Dt. Ärzteblatt* 39 1960-63 (1995)
- Klapp, Chr.: Medical lesson as an addition to sexual education at school – a study of evaluation. (1995). In: *Settertobulte et al: Gesundheitsversorgung für Kinder und Jugendliche*, Roland Asanger Verlag, Heidelberg (1995)
- Gille G.: Girls' health under influence of puberty. *Das Gesundheitswesen*, Heft 10, Georg Thieme Verlag, Stuttgart (1995)
- Esser Mittag, J.: Gynecologicals of youth: Health support for young girls. *TW Gynäkologie*, 9 (1996)
- Klapp Chr.: Gynecological – psychosomatic informational offers for school girls. In: „Mythos Geburt“, edition psychosozial, Hrsg: Kentenich/Rauchfuß/Bitzer (1996)
- Gille, G.: „... despite my 16 children, I know nothing, absolutely nothing.“ From the special, problematical situation of women to a special need of advice. *Der Frauenarzt* 38: 1722-1728 (1997)
- Gille, G.: Pill, Power and Problems – where does it go to life – please? Questions to the gynaecologist as family doctor of the woman. *Geburtsh.Frauenheilkunde* 2000,60: M 20-24
- Klapp, Chr.: Welcome in the club of women – the need for advice of young girls in Puberty. *Korasion*, 15. Jahrgang, Februar 2000, 1-4

Questions and interests relevant to the current situation:

- the organization is actually thinking about working within international context.
- Who would like to work with us?(the best would be a person with family experience)
- Are there medical organizational structures abroad, aiming at similar goals?
- Are there any male medical colleagues in Germany, who would like to offer gender specific medical support of health and sexual education for boys?

Name of the organization:

**Arbeitskreis Frauengesundheit in Medizin, Psychotherapie, und Gesellschaft
e. V. (AKF)**

Address:

Verdener Str. 20 - 28205 Bremen
phone: 0049-421 / 434 93 40
fax: 0049-421 / 434 93 40
e-mail: AKF-mai@t-online.de
internet: www.akf-Info.de

Contact:

Dr. Claudia Czerwinski / Prof. Dr. Claudia Schumann

Aims:

Above all, women who work in the area of women's healthcare or are engaged in the area of self-help or advice service have joined together within this nationwide society. The aim of the co-operation is to emphasize mistakes relevant to women in medicine, psychotherapy and society, and to make interests of women visible, considered and taken into account. In addition, women shall be better informed about their body, its possible diseases, about mental and social factors which lead to diseases, for strengthening their own competences.

Main emphasis of activity:

gynaecology
psychotherapy, psychiatry, psychosomatics
self-help

Members of the organization:

Individuals: persons of different professions and persons engaged in the area of women's healthcare

Organizations; among others: Bund Deutscher Hebammen (midwives society), Dachverband der Frauengesundheitszentren (umbrella organization of the women's health centers)

Number of members: 460 (May 2000)

Year of foundation: November 1993

Legal form: registered society

Financing: membership subscriptions/donations/public project-funding

Regional institutions:

there are nine regional groups: Berlin, Braunschweig, Bremen, Hamburg, Hannover, Kassel, Köln, Marburg, München, Münster, Ostwestfalen-Lippe, Rhein-Main, Rhein-Neckar

Specialist groups:

gynaecology
psychotherapy, psychiatry, psychosomatics
self-help and advice service for women

Specific knowledge offered by the organization:

- knowledge about medical gynaecological subjects (operation on the uterus, mammography, climacteric, hormones)
- advice service for self-help groups
- further education for specialist women and female doctors in the area of psychotherapy and psychosomatics
- psychotherapy suitable for women
- therapy of women having experience with violence

Publications: available only in German

Informationen zur Gebärmutter-Operation (DM 5,00) (information about operation on the uterus)

Sexualität nach gynäkologischen Operationen - Ein Referat von Maria Krieger (DM 3,50) (sexuality after gynaecological operations)

Was hilft Frauen nach einer gynäkologischen Operation? Ein Referat von Maria Krieger (DM 3,50) (What does help women after gynaecological operations)

Stellungnahme zum Mammographie-Screening (DM %,00) (statement on mammography)

Vorl. Entwurf einer Orientierungshilfe für Patientinnen gyn. Praxen - "Mut zur Kritik" (DM 5,00)(draft of orientation help for gynaecological patients)

Mitglieds-Info (kostenpflichtig nur für Nicht-Mitglieder DM 3,50) (information for members - free for members only)

Tagungs-Dokumentation 1996 (report on the conference 1996)

Tagungs-Dokumentation 1997 ab Mai 1998
(report on the conference 1997 - available in May 1998)

Aktivitätenprofil (outline of activities)

Stellungnahmen Psychotherapiegesetz 9/97 DM 3,00 statement on the psychotherapy act)

Stellungnahmen Spargesetze und ihre Folgen für Frauen 2/97 DM 3,00 (statement on cost-cutting policy concerning women and its causes for women)

Documentation of the annual conference 1999 „Brust“ 2000 (breast 2000) – gesundheitspolitische Ein-und Aussichten (health political insights and perspectives), DM 10,- and transportation costs

Name of the organization:

medusana Stiftung gGmbH

Address:

Hindenburgstr. 1a - 32257 Bünde

phone: 0049-52 23 / 18 83 20

fax: 0049-52 23 / 170 46

Contact:

Dr. Claudia Czerwinski

Dr. Marion Meier

Ulrike Kowalewsky

Stefanie Rengers

Aims:

Instigation of interdisciplinary work in the area of healthcare for

a) youth work at and outside school

b) adult education

Main emphasis of activity:

prevention: general health subjects, gender specific health promotion in and with school

health education: main emphasis women's health, help for the organization of self-help groups

advice service and further education for key individuals and for teachers

further education in the field of health

Members of the organization:

1 managing director, 1 medical director, 1 pedagogic director, 2 employees for organization/administration

Number of members: advisory council: 5 members

Year of foundation: 1994

Legal form: charitable foundation in the form of a Ltd.

Financing:

organization uses mainly its own funds, projects are financed by public funds or money from other organizations (Drittmittel)

Regional institutions:

coordination: health promotion for girls at schools in the district of Herford

Specialist groups:

women's health

health promotion at school

Specific knowledge offered by the organization:

gender orientet, gender-democratic health education

gender orientet, gender-sensitive health promotion at school

teachers/medical doctors – cooperation at schools

Publications: available only in German

general leaflet

medusana foundation

school and health

reactions of the press

brochure about school and health (draft)

Grenzerfahrungen Teil I: HautNah. Ungewöhnliche Annäherung an eine leicht verletzbare Grenze. (Skinclose. An uncommon approach to an easy vulnerable border)

Grenzerfahrungen Teil II: Aufmerksamkeitsstörung/Hyperaktivität im Unterricht (hyperactivity in school-lessons)

Documentation: AG Mädchengesundheit: Gesundheit kann Spaß und schön machen (girl's health team: health can be fun and make beautiful)

school and health: teachers and medical doctors for prevention

Documentation of the conference: „school subject health? – Medusana turns 5“; 13th of August 1999

Questions and interests relevant to the current situation:

We wish to extend our bilateral co-operation at the European level in the field of women's health.

We wish to exchange information on gender oriented healthcare support at school.

5.2 Special health problems

5.2.1 AIDS

Name of the organization:

Netzwerk Frauen und AIDS
(Network Women and Aids)

The addresses of the key women:

Region Hamburg:

Birgit Stange
c/o AIDS-Hilfe Hamburg e.V.
Paul-Roosen-Straße 43 - 22767 Hamburg
phone: 0049-40 / 319 69 81
fax: 0049-40 / 319 69 84

Region Südwestliches NRW:

Harriet Langanke
Deutsche AIDS-Stiftung
Markt 26 - 53111 Bonn
phone: 0049-228 / 604 69 11
fax: 0049-228 / 604 69 99

Region Schleswig Holstein und Bremen:

Antje Aumüller
c/o AIDS-help in Bremen e.V.
Am Dobben 66 - 28203 Bremen
phone: 0049-421 / 70 28 19
fax: 0049-421 / 70 20 12

Region Bayern:

Doris Salzmann
AIDS-Hilfe Nürnberg/Erlangen/Fürth e.V.
Bahnhofstraße 13-15 - 90402 Nürnberg
phone: 0049-911 / 230 90 35
fax: 0049-911 / 23 09 03 45

Region Berlin, Brandenburg und Mecklenburg-Vorpommern: n.n.

Deutsche AIDS-Hilfe e.V.
Dieffenbachstraße 33 - 10967 Berlin
phone: 0049-30 / 69 00 87 38
fax: 0049-30 / 69 00 87 42

Region Baden-Württemberg Ost:

Bella Erlich
AIDS-Hilfe Stuttgart e.V.
Hölderlinplatz 5 - 70193 Stuttgart
phone: 0049-711/ 22 46 90
fax: 0049-711 / 224 69 99

Region Niedersachsen, Sachsen und Sachsen-Anhalt:

Ina Hauer-Bock
Klartext, Frauenberatungsstelle der
Braunschweiger AIDS-Hilfe e.V.,
Eulenstr. 5 - 38114 Braunschweig
phone: 0049-531 / 580 03 33
fax: 0049-531 / 580 03 30

Region Baden-Württemberg West:

Claudia Jehle
SkF-Treff Freiburg
Unterlinden 11 - 79098 Freiburg
phone: 0049-761 / 28 00 31
fax: 0049-761 / 305 70

Region Hessen und Thüringen:

Reinhild Trompke
AIDS-Hilfe Frankfurt e.V.
Friedberger Anlage 24 - 60316 Frankfurt/M
phone: 0049-69 / 43 97 04
fax: 0049-69 / 498 01 71

Region Rheinland-Pfalz:

Gisela Hilgefort
AIDS-Hilfe Trier e.V.
Saarstr. 48 - 54290 Trier
phone: 0049-651 / 970 44 16
fax: 0049-651 / 970 44 21

Region Saarland:

Francoise Welter
Aids-Hilfe Saar e.V.
Nauwieserstr.19 - 66111 Saarbrücken
phone: 0049-681 / 342 52
fax: 0049-681 / 311 12

Region Westfalen und Ruhrgebiet:

Julia Ellen Schmalz
AIDS-Hilfe Bielefeld e.V.
Artur-Ladebeck-Straße 26 - 33602 Bielefeld
phone: 0049-521 / 13 33 88
fax: 0049-521 / 133 33 69

Contact:

see addresses of the key women

Aims:

The network women and AIDS is a nationwide association of women which works in favour of women with HIV or AIDS. The network is the representation of interests of women and for women who have HIV or AIDS and for women who work in this context. It wants to create a lobby for women who are infected with HIV or who are ill. It also wants to offer a network of shelter.

This net is open to everyone who is interested and has the tasks to collect and disseminate information, to develop programmes and projects and to organize the exchange of experience concerning the subject women and AIDS.

Main emphasis of activity:

The net has the task to collect and disseminate information about the subject women and AIDS. It offers personal, practical and political help concerning all questions which are connected with women and AIDS.

Members of the organization:

active work in the network: about 30 women
passive "membership": at least 150 women

Number of members: about 180

Year of foundation: november 1992

Legal form: association without any legal form

Financing:

financing by donations, money from foundations, sponsoring and of the German Aids-aid

Regional institutions: please see the list given above.

Specialist groups:

workshops on special subjects, e. g. medical questions/design of studies are founded when they are needed. For contact, please see the list of adresses of regional institutions.

Specific knowledge offered by organization:

This question can be answered concerning special cases only.

Publications:

DHIVA, periodical of the Netzwerk Frauen und AIDS (available only in German)

Name of the organization:

Deutsche Aids-Hilfe e.V., Frauenreferat
(German Aids-help; Women´s Department)

Please see: “Netzwerk Frauen und Aids” (Network women and Aids)

Address:

Diefenbachstr. 33 - 10967 Berlin
phone: 0049-30 / 69 00 87 - 38 and - 39

Name of the organization:

Deutsche Aids-Stiftung
(German Aids-foundation)

Address:

Markt 26 - 53111 Bonn
phone: 0049-228 / 604 69-21
fax: 0049-228 / 604 69-99
e-mail: info@AIDS-Stiftung.de
internet: www.AIDS-Stiftung.de

Contact:

Public relations: Dr. Volker Mertens
Women and AIDS: Harriet Langanke

Aims:

The Deutsche AIDS-Stiftung gives financial help in individual cases to people who have HIV or AIDS and who are in a situation of emergency. In exceptional cases, we also sponsor projects under the condition that there is an immediate benefit for human beings with HIV or AIDS. Women specific subjects have been taken up recently as well.

Main emphasis of activity:

help in individual cases in the following areas:
convalescent holidays, lodging, household equipment, organization of leisure time, telephone, clothes, labour and further education / training, legal advice
sponsoring of projects in the following areas:
recovery, group activity, living with persons who are in charge of the sick persons, infrastructure

Members of the organization:

There are no members because this is a foundation and not a society.

Number of members: -

Year of foundation:

The Deutsche AIDS-Stiftung developed in 1996 from the merger of the foundation Deutsche AIDS-Stiftung "Positiv Leben" (founded in 1987) and the AIDS-Stiftung (founded in 1987).

Legal form: Stiftung des bürgerlichen Rechts (foundation according to the private law)

Financing:

donations, return on the foundation's capital; others (inheritances, fines, economic business)

Publications: (available only in German)

Documentation by the Nationale AIDS-Stiftung "Workshop Frauen und AIDS 1993"
(women and AIDS)

5.2.2 Eating disorders

Name of the organization:

Bundes-Fachverband Ess-Störungen e. V. (BFE)
(federal association for eating disorders)

Address:

Kurt- Schumacher- Str. 2 - 34117 Kassel
phone: 0049-561 / 711 34 93
fax. 0049-561 / 711 02 27
e-mail: kabera@t-online.de

Contact:

Cornelia Götz- Kühne

Aims:

The Bundes-Fachverband Eßstörungen e. V. (national association – eating disorders) is a nationwide umbrella organization of charitable sponsors of outpatient consulting- and therapy-institutions concerning eating disorders. The organization follows exclusively charitable aims based on political and confessional independency.

Main emphasis of activity:

This organization is an umbrella organization for independent sponsors concerning outpatient consulting-service and therapy for persons with eating disorders. The organization offers women-specific programmes.

Members of the organization:

The membership is offered to each charitable and legal corporation and person who.

- supports the aims of the organization
- puts the emphasis on the consulting and therapeutic activities for people with eating disorders
- follows only charitable aims
-
- In addition membership is offered to
- sponsors and associations of sponsors, institutions and measures
- the team of the institutions should be a multiprofessional one which has an adequate specialized competence concerning eating disorders and which follows in its ways and methods the humanistic psychology's concept of human being and the anti-diet-principle.
- the sponsors of the institutions guarantee that the collaborators are obliged to participate in a subject qualified supervision.

Members of the umbrella organization:

ANAD e.V.

Seitzstr. 8 - 80538 München
phone: 0049-89 / 24 23 93 60

Cinderella e.V.

Westendstr. 35 - 80339 München
phone: 0049-89 / 502 12 12

Bielefelder Zentrum für Eßstörungen e.V.

Markstr. 35 - 33602 Bielefeld
phone: 0049-521 / 659 29

Dick & Dünn e.V.

Innsbrucker Str. 25 - 10825 Berlin
phone: 0049-30 / 854 49 94

Dick & Dünn e.V.

Hallerhüttenstr. 6 - 90461 Nürnberg
phone: 0049-911 / 47 17 11

Die Boje e.V.

Möllner Landstr.61 - 22117 Hamburg
phone: 0049-40 / 731 49 49

Die Brücke - Eßstörungenbereich Beratungs- und Therapiezentrum e.V.

Durchschnitt 27 - 20146 Hamburg
phone: 0049-40 / 450 44 83

Walddörferstr. 337 - 22047 Hamburg
phone: 0049-40 / 668 36 36

Eß-o-Eß im Frauentreff e.V.

Kurt- Schumacher- Platz 5 - 24109 Kiel
phone: 0049-431 / 52 42 41

Frankfurter Zentrum für Eßstörungen e.V.

Hansaallee 18 - 60322 Frankfurt am Main
phone: 0049-69 / 55 01 76

Hamburger Zentrum für Eßstörungen e.V. Kabera e.V. Beratung bei Eßstörungen

Bundesstr. 14 - 20146 Hamburg
phone: 0049-40 / 450 51 21

Kurt- Schumacher- Str. 2 - 34117 Kassel
phone: 0049-561 /78 05 05

Kaskade e.V.

Hanssenstr. 6 - 37073 Göttingen
phone: 0049-551 / 48 69 05

Rostocker Stadtmission e.V.- Spiegelblick

Friedhofsweg. 11 - 18057 Rostock
phone: 0049-381 / 45 21 28

Waage e.V.

Eimsbüttelerstr. 53 - 22769 Hamburg
phone: 0049-40 / 491 49 41

Number of the members: 16 organization

Year of foundation:

The BFE had developed from the Bundesarbeitsgemeinschaft Eßstörungen and was founded in 1994 in Frankfurt.

Legal form: Non-profit-making institution

Financing: The BFE is financed exclusively by membership subscription and donations.

Regional institutions:

Eating disorders societies at regional level (e. g. Netzwerk Eßstörungen Hessen or the Arbeitskreise Eßstörungen Munich, Hamburg)

Specialist groups:

There are different specialist groups without a regular contact. Information about current groups is available at the office.

Specific knowledge offered by the organization:

The organization can inform on topics concerning the outpatient area of eating disorders.

Publications:

Publications are directly available at the individual member organizations

Extract from a selected publication: -

Questions and interests relevant to the current situation:

There is an interest in international research on eating disorders and in existing institutions and current publications in the individual countries as well.

Name of the organization:

Frankfurter Zentrum für Ess-Störungen e. V.
(centre for eating disorders in Frankfurt)

Address:

Hansaallee 18 - 60322 Frankfurt am Main

phone: 0049-69 / 55 01 76

fax: 0049-69 / 596 17 23

Contact:

Dr. Barbara Krebs

Aims:

The Frankfurter Zentrum für Eßstörungen deals with the outpatient treatment of eating disorders, with the causes and manifestations of these diseases and with scientific projects concerning these women specific disorders.

- anorexia nervosa (anorexia, wasting disease)
- bulimia nervosa (bulimia)
- adipositas (obesity)

Main emphasis of activity:

Prevention:

advice service/consultation for affected persons and their relatives, self-experience groups, youth work for girls with eating disorders, self-help groups, distribution of information in youth and adult educational institutions, creation of the network concerning eating disorders in Hesse and of the nationwide association.

Therapy / Advice service:

outpatient psychotherapy, which is depth psychological orientated and applies the methods of humanistic psychotherapy: individual and group therapy

Further education:

outpatient psychotherapy of eating disorders; aims of therapy, therapeutic emphasis, therapeutic difficulties, anti-diet programmes, formation of female identity, female puberty, experiences of sexual or emotional violence, female body, socially induced slimness-mania and beauty-mania, socio-political and socio-psychological causes of eating disorders, women-specific programmes of therapy etc.

Science / Research:

Qualifying and optimizing of outpatient psychotherapeutic treatment programmes concerning eating disorders.

Target group: young people during the puberty, mainly at the age between 20 and 40 years

Members of the organization:

qualified pedagogues, qualified psychologists, teachers, social workers, qualified sociologists with psychotherapeutic trainings in humanistic psychology, administration employees and officials etc.

Number of members: -

Year of foundation: 1986

Legal form: charitable registered society

Financing:

public funds from the city of Frankfurt am Main and the state of Hesse, money from some health insurance companies and therapies, donations, special funds for projects

Specific knowledge offered by the organization:

outpatient psychotherapy, which is depth psychological orientated, in the sense of anti-diet, which means the strict denial of diet and expert-programmes, imposed by someone else in the treatment of eating disorders,
treatment of eating disorders with the methods of humanistic psychotherapy
a women-specific programme, which places eating disorders in a socio-psychological and socio-political context and e. g. discusses critically the exaggerated social slimness and beauty ideals, which women are presented and exposed to,
the latest developments in research concerning eating disorders: clinical-medical programmes and psycho-social programmes,
concepts and programmes of outpatient treatment for girls with eating disorders
knowledge about women friendly outpatient therapy programmes concerning eating disorders
prevention at school

Publications:

(available only in German)

(all publications on the following list can be ordered at the Frankfurter Zentrum für Ess-Störungen)

Schriftenreihe Band 1, 1991

Bulimie und Borderline-Syndrom (bulimia, borderline syndrom)

Beziehungsproblematik adipöser Frauen (relationships' problems of women with obesity)

Fallbericht einer Bulimiepatientin (case report of a bulimia patient)

Eßstörungen oder die Sehnsucht nach Frau (eating disorders or the yearning for woman)

DM 13,-

Schriftenreihe Band 2, 1992 (at the moment not available)

Psychodrama in der Behandlung von Eßstörungen (psycho-drama in the treatment of eating disorders)

Sexueller Mißbrauch und Eßstörungen (sexual abuse and eating disorders)

Oh mein Papa... Eßstörungen und die Idealisierung des Männlichen (eating disorders and the idealizing of the male)

Texte und Berichte von Betroffenen (texts and reports by affected persons)

DM 17,-

Schriftenreihe Band 3, 1996

Körperdistanz und kompensatorische Nähe zum Vater (distance to the own body and compensatory closeness to the father)

Eßstörungen in der Pubertät (eating disorders during the puberty)

Der Kampf ist nur Metapher, aber der Sieg ist tödlich (the fight is only a metaphor, but the victory lethal)

Therapeutische Schwierigkeiten in der Behandlung von Eßstörungen (therapeutic difficulties in the treatment of eating disorders)

DM 13,-

Schriftenreihe Band 4, 1999

Ambulante psychotherapeutische Behandlung im Frankfurter Zentrum für Ess-Störungen. Reflexion zum Thema Ess-Störungen (out-patient psychotherapeutic treatment in the centre for eating disorders in Frankfurt. Reflection on the topic eating-disorders).

DM 30,-

Interests and questions relevant to the current situation:

programmes for outpatient therapy and treatment of women in France, Italy, Spain, Portugal, Britain, Greece and contact addresses

Name of the organization:

Aktionskreis Ess- und Magersucht Cinderella e. V.
(action circle compulsive eating and anorexia)

Address:

Westendstr. 35 - 80339 München
phone: 0049-89 / 502 12 12
fax: 0049-89 / 502 25 75

Contact:

Dipl.Psych. Ingrid Mieck
Dipl. Sozpäd. Sabine Schoberth-Bernard

Aims:

to help people with eating disorders (anorexia, bulimia, obesity)

Main emphasis of activity:

advice service/consulting for:

- affected persons,
- relatives,
- friends,
- specialists,
- media

information about therapy institutions
individual- and group-therapy
telephone and written consulting and advice service
nationwide information about addresses
sending out information
self-help groups

Members of the organization: full members, sponsoring members

Number of the members: about 70 members

Year of foundation: 1984

Legal form: charitable registered society

Financing: public subsidies, membership subscription

Regional institutions: only in Munich

Specific knowledge offered by the organization:

how to react in cases of eating disorders

Publications: (available only in German)

leaflet about the Aktionskreis (available at the office)
yearly newsletter „Rundbrief“
information material

Questions and interests relevant to the current situation:

international addresses, especially with consulting and therapeutic services

5.2.3 CANCER

Name of the organization:

Fördergemeinschaft "WIR ALLE" Frauen gegen Brustkrebs e. V.
(supporting community „We all“, Women agains breast cancer)

Address:

Alteburger Str. 248 - 50968Köln

phone: 0049-221 / 340 56 28

fax: 0049-221 / 340 56 29

e-mail: info@wiralle.de

internet: www.wiralle.de

Contact:

Chairwoman:	Dr. Elisabeth Elstner,
physiotherapist, osteopathy:	Silvia Weiss-Brummer,
gynaecologist:	Dr. Irena Freund,
plastic surgeon and holistic medicine:	Annie Koslowski,
lawyer.	Gudrun Hörster

Aims:

The Fördergemeinschaft offers individual and group consultation by arrangement before and after an operation on a breast carcinoma.

Regular information-evenings with experts for affected women and their relatives.

Subjects are:

- gynaecology
- physiotherapy / osteopathy
- advice concerning diet
- treatment of pain etc.

We demand lucidity of the treatment's methods and participation in the process of decision concerning the therapeutic measures (e.g. second opinion, information).

We demand a forum for women's healthcare and quality of life. This is important for women who have a breast carcinoma and for their relatives and friends.

We want the subject breast carcinoma no longer to be made taboo in the public.

The aim is a women's foundation, a center for diagnosis and therapy by women for women. We plan the association of German and international societies against breast carcinoma.

Main emphasis of activity:

At the moment: prevention and advice service

Prevention: elaboration and translation of information

Advice service: women-specific advice service for persons affected by a breast carcinoma

Members of the organization:

Dr. Elisabeth Elstner, the chairwoman is member of the AKF (study group for women's health in medicine, psychotherapy and society)

The Fördergemeinschaft consists of individual members (of different professions).

We co-operate with the Frauengesundheitszentrum Berlin (institution for women's healthcare), with the Brustkrebsverein Berlin (society against breast carcinoma), Regina Stolzenberg, with the Brustkrebsverein "Mut" in Münster, Ute Wülfing and Dr. Mechthild Kuhlmann. The Fördergemeinschaft is member of the AKF (see below).

Number of members: 195 members

Year of foundation: April 1997

Legal form: Fördergemeinschaft (supporting society)

Financing: financing by membership subscription, donations and benefit events

Regional institutions: study group, office; for contact see above

Specialist groups:

Subject of the specialist group: final medical report (catamnesis) – study on the reconstruction of the breast (mammoplasty) with own tissue.

Contact: Dr. Elisabeth Elstner; for address see above

Specialist knowledge offered by the organization:

Breast carcinoma

Publications: (available only in German)

a leaflet from 1997

a brochure which is available at the above mentioned address

Questions and interests relevant to the current situation:

We are interested in international information and contacts.

5.2.4 PSYCHIATRY

Name of the organization:

**Verein Psychiatrie Erfahrener (VPE) Hannover
(registered society of people experienced in psychiatry)**

Address:

VPE Hannover
Rückertstr. 17 - 30169 Hannover
phone: 0049-511 / 131 88 52

Contact:

Ursula Conraths, Doreen Pobanz

Aims:

The VPE Hannover is a self-help association of people, experienced in psychiatry with open offers and with established groups, e.g. the women's group. The women's group deals with everyday life's and psychic problems. The experience with the psychiatry can be discussed about as well as social, health and especially psychiatric politics.

Main emphasis of activity:

self-help of people, experienced in psychiatry; possibilities to offer one's own group and to introduce one's own ideas. Co-working at committees dealing with psychiatrical politics.

Membership:

Each person, which has experience with psychiatry
professions: pedagogues, referents for health's support, one physician, one pedagogue, one social pedagogue, different qualifications in the field of office work and of the crafts.

Number of members: about 166

Year of foundation: 1991

Legal form: registered club

Financing: donations, membership subscriptions, grants of the city of Hannover

Regional institution:

The regional institution is the VPE Hannover. At a transregional level there are the LPEN (the national association of people experienced in psychiatry, Lower Saxony) and the BPE (the federal association of people experienced in psychiatry).

Specialist groups:

- women's group
- borderline-group
- manic-depressive group

Specific knowledge offered by organization:

- knowledge of alternatives in the psychiatric treatment, like e.g. Soteria
- knowledge of the special situation of women in psychiatry
- knowledge of the political discussion at a communal and national level and contacts with decision-makers
- knowledge of capacities of self-help among people, experienced in psychiatry
-

Publications: (available only in German)

VPE-Report (published monthly)

brochure to 5 years of existing

Flyer:

- Presentation of the VPE Hannover
- Necessity of having a crisis intervention service – summing up
- basic principles for the politics of psychiatry

Name of the organization:

**IHRISS –Treffpunkt und Beratung für Frauen mit und ohne Psychiatrieerfahrung
(Centre for women who have or have not made experiences concerning psychiatric hospitals)**

Address:

IHRISS e.V.
Jeßstr.3 - 24114 Kiel

Contact:

Irmgard Wendorff

Aim:

stabilisation of women with mental health and psychological problems by increasing their competences of self help according to the empowerment model as well as working on their social integration

Main emphasis of activity:

to provide a place for women to get together, to train social skills, counselling, to create a network, public relations

Members of the organization:7 women

Year of foundation: 1992

Legal form: registered society

Financing: half by the state Schleswig-Holstein, half by the local government (city of Kiel)

Regional institutions:

IHRISS is the only regional and supra regional mental health centre specialised in women. There are other institutions providing services for outpatients that offer groups and rooms for women.

Study groups:

IHRISS participates in a special mental health study group of the DPWV (an independent German Welfare Society) as well as in some regional and supra regional study groups concerning the situation of women in mental health.

Specific knowledge offered by the organization:

Because of the stigma of being a mental health service user it is much easier for the women to overcome their personal barriers and use the service with IHRISS being offered as a centre that is officially for women who have or have not made experiences concerning psychiatric hospitals. The knowledge how to run a service like this as a therapeutic possibility can be offered as workshops at conferences.

training social skills- abuse and traumata as the work's background

Publications:

documentation of the activities in 1999 (available only in German)

5.2.5 Addiction

Name of the organization:

**Psychologische Praxis an den Barbarathermen
(psychological surgery at the Barbarathermen)**

Address:

Gilbertstrasse 67a - 54290 Trier

phone: 0049-651 / 436 11 40

fax: 0049-651 / 436 11 55

e-mail: UKarren-Derber@t-online.de

Contact:

Ulrike Karren-Derber

Aims:

Quality-development in the field of girl and women specific prevention, treatment and advice service on addiction.

Main emphasis of activity:

Presentation, documentation and evaluation of an in-service training course for the qualification of consultants and therapists on girl and women specific prevention, treatment and advice service on addiction.

Members of the organization: qualified psychologists

Number of members: 2

Year of foundation: 1998

Legal form: surgery-alliance

Financing:

Funds for research work are provided by the ministry for culture, youth, family and women in Rhineland-Palatinate.

Specific knowledge offered by the organization

- strategies of the research on women's health
- indication of women-specific consultation on addiction
- characteristics of women-specific consultation on addiction
- telephone advice service for children and young persons
- advice and treatment for women having a trauma
- advice and treatment for women suffering from eating disorders
- advice and treatment for medicine-dependent women
- development of projects concerning women-specific advice service on addiction

Publications: (available only in German)

U. Karren-Derber und Dr. Petra Hank 199.

Ergebnisse einer wissenschaftlichen Begleitung des Aufbaus eines frauenspezifischen Suchtberatungsangebotes in Rheinland-Pfalz.

(results of a scientific supervision of the establishment of women specific advice services in Rhineland-Palatinate), in: Frauen, Sucht, Gesellschaft. Dokumentation der Fachtagung am 28. Januar 1999 in der Katholischen Akademie Trier. Mainz: Ministerium für für Kultur, Jugend, Familie und Frauen.

Wissenschaftliche Begleitung von frauenspezifischen Suchtberatungsangeboten in Rheinland-Pfalz. 1997. Zwischenbericht (scientific supervision of offers of women specific advice services for addicts in Rhineland-Palatine, interim report).

(available at the address mentioned above for 6,- DM (stamps), payment in advance)

Interests relevant to the current situation:

exchange of information with women having similiar aims within Germany and abroad

Name of the organization:

Niedersächsische Landesstelle gegen die Suchtgefahren (NLS), Fachausschuß der Landesarbeitsgemeinschaft der Freien Wohlfahrtspflege in Niedersachsen (office of Lower Saxony against the dangers of addiction, specialist committee of the national association of free social welfare in Lower Saxony)

Address:

Niedersächsische Landesstelle gegen die Suchtgefahren
Podbielskistrasse 162 - 30177 Hannover
phone: 0049-511 / 626 26 60
fax: 0049-511/ 62 62 66 20

Contact:

secretary

Aims:

The NLS's aim is to promote the addict-help in Lower Saxony. The NLS supports and coordinates the activity of the professional and voluntary services for help. The NLS is a competent contact partner for ministries and authorities, for health and pension scheme holder as well as for associations in regard to planning and development of help-services for addicts.

The NLS collects data concerning the help for addicts, prepares them for planning and puts them at the disposal of political decision-makers and interested people.

The NLS promotes the activities of its members by organizational counselling, conferences, publications and information-processing.

Through the fields of prevention and qualitymanagement (concept of best value)/benchmarking, the NLS is working beyond the fields of the independent welfare work and addiction self-help. The NLS contributes to the dissemination of a modern social-management in the addiction-help and thus contributes to an effective application of the available taxes and fees. The NLS offers competent services for its members, for the authorities, social securities, companies and for the public in general. Since 1978 there is an office of the NLS with full-time employees. It's basically financed by the state of Lower Saxony

Main emphasis of activity:

- prevention of addiction
- help for addicts in self-help organizations
- out-patient and in-patient help for addicts
- public relations work
- internal company work for addicts
- women and addiction
- quality management/-securing (concept of best value)
- professional (re-)integration of addicts

These problems are considered and dealt with, if possible, from the gender specified point of view

Members of the organization:

Arbeiterwohlfahrt, Landesarbeitsgemeinschaft Niedersachsen, Körtingsdorf, 30455 Hannover

(worker's welfare organization, section Lower Saxony)

Caritasverband: Diözese Hildesheim e.V., Landescaritasverband für Oldenburg e.V., Diözese Osnabrück e.V.

(welfare organization of the catholic church, dioceses Hildesheim, Oldenburg)

Der Paritätische Niedersachsen, Fachbereich Suchtkrankenhilfe

(welfare organization, section for the help for addicts)

Landesverband der Jüdischen Gemeinden in Niedersachsen, Jüdische Wohlfahrt

(jewish welfare organization)

Blaues Kreuz in Deutschland e. V., Landesverband Niedersachsen

(Blue Cross)

Deutscher Guttempler-Orden, Landesverband Niedersachsen e.V.

(order of the Guttemplers)

Kreuzbund e.V., Selbsthilfe und Helfergemeinschaft für Suchtkranke

(society for help and self-help concerning addicts)

Freundeskreise für Suchtkrankenhilfe, Landesverband Niedersachsen e.V.

(private organization for the help for addicts, association of the state Lower Saxony)

Landesverband der Vereine für Sozialmedizin Niedersachsen e.V.

(provincial umbrella organization of societies for social medicine)

Niedersächsischer Landesverband für Elternkreise Drogenabhängiger e.V.

(association of parents of addicts)

Deutsches Rotes Kreuz, Landesverbände Niedersachsen und Oldenburg

(German Red Cross, Lower Saxony and Oldenburg)

Evangelische Landesarbeitsgemeinschaft für Suchtkrankenhilfe in Niedersachsen (ELIAS) für die Diakonischen Werke Braunschweig, Hannover, Leer, Oldenburg, Schaumburg-Lippe

(welfare organization of the Protestant church; working group addict-help in Lower-Saxony of the regions Braunschweig, Hannover, Leer, Oldenburg, Schaumburg-Lippe)

The addresses and phone-numbers of the listed organizations can be obtained at the NLS.

Number of members 12

Year of foundation: 1949

Legal form:

The NLS is a specialist committee of the national association of independent social welfare in Lower Saxony. It has an own board though.

Financing:

The NLS is financed mainly by public funds, especially by the Niedersächsische Sozialministerium (ministry for social affairs). In addition there are incomes by donations and fees.

Regional institutions:

At the regional level the member organizations run their out-patient and in-patient institutions for the help for addicts and the voluntary self-help groups. The NLS supports these institutions in regard contents, organization and by the coordinating activities.

Specialist groups:

The NLS has the following committees and working groups:

committees:

- self-help;
- out-patient-institutions;
- in-patient-help

working groups:

- special clinics for alcohol and medicine addicts
- women and addiction
- external advice service in places of detention
- long-term institutions for chronic addicts
- substitution company
- prevention of addiction
- quality (concept of best value)/benchmarking in advice centres for addicts
- in-patient therapy-institutions for anaesthetic addicts.
- In the committees and working-groups, gender-sensitive aspects are considered.

Specific knowledge offered by the organization:

Knowledge about the system of help with regard to questions concerning addiction in Lower Saxony.

Training courses and further education on subjects from the area of women-specific addiction.

gender-sensitive concepts in addiction-prevention

knowledge in regard to the structure of addiction-prevention in Lower-Saxony

Publications:

extensive offer of literature on addiction (elderly, children, media, politics), prevention, situation in Lower Saxony, annual report of the NLS

available at the NLS (in German only)

5.3 reproductive health

5.3.1 Sexuality

Name of the organization:

Pro Familia Deutsche Gesellschaft für Familienplanung, Sexualpädagogik und Sexualberatung e. V.

(Pro Familia German society for family planning, sexual-pedagogy and advice service concerning problems of sexuality)

Address:

Stresemannallee 3 - 60596 Frankfurt am Main

phone: 0049-69 / 63 90 02

fax: 0049-69 / 63 98 52

Contact:

Elke Thoß

Aims:

Pro Familia is a German society for family planning, sexual-pedagogy and advice service concerning problems of sexuality

1. Sexuality:

According to the fundamental rights to free development of one's personality and to human dignity every human being has a right to choose freely his or her sexual orientation, sexual relationships and to lead his/her life in accordance with it so far as none else's personal rights are violated. PRO FAMILIA, therefore, opposes social and legal discrimination of homosexual women and men and aims at freeing from taboo the sexuality of the physically or mentally handicapped and of old-aged people. Prevention and forcing back of sexual violence is also seen as a task of PRO FAMILIA.

Sexual well-being is an indispensable element of general well-being for both men and women. It presupposes the ability of experiencing sensuality with lust and love and an attitude which accepts equally the difference and equality between genders and which interpretes the irrational aspects of sexuality as an element of valuable addition. This can be realized only in the context of educational processes which not only aims at abstract information (sex education) but also supports self-confidence, contact ability, coping with fear, responsibility and the ability for both to tolerate and to reject wishes and demands of others.

Since all this must be acquired anewly by each generation, PRO FAMILIA supports sexual pedagogy as an integral element of the educational system.

Anxiety and inhibitions, a lack of ability to love or to feel lust and sexual violence can cause conflicts, life-crises and even manifest sickness. Sexually infectious diseases including AIDS belong into this context, too. Consequently, men and women have the right to get information, advice and help concerning questions and problems resulting from their sexual life.

2. Family Planning

PRO FAMILIA supports the realization of the human right to family planning, which was announced first by the United Nations 1968 in Teheran. According to fundamental rights, men and women can decide independently and responsibly about the number of their children and about the time of their birth. Since this is a universally valid right, it can only be restricted by other human rights and it must not be subordinated to other aspects, e.g. economic interests or political and ethical attitudes of majorities.

The right to family planning is based on both, on the well-being of the child, whose life's chances are thus improved, and on the fundamental right of men and women to autonomous decision on the question whether they want a pregnancy and whether they want to connect their life to one child or maybe several children. In addition to the right on contraception, it includes the right to childlessness and to help concerning problems of fertility.

The realization of these rights means not only to permit family planning but also to support it by the legal system and by political structures. Information and advice on the methods of family planning must be available for everyone.

It is a public task to put at disposal a large choice of methods of contraception which are safe, harmless and appropriate to different situations of life. It is also a public task to guarantee that the access to these methods is not restricted by financial causes or by insufficient supply.

On the other hand, the right to family planning is endangered by harmful environmental influences which can cause unintentional childlessness. In this area the protection against life's and work's conditions damaging fertility must have priority.

3. Abortion

According to PRO FAMILIA, as a consequence of the human right to family planning women have the right to decide themselves and on their own responsibility whether they bring an unintended child into the world or not. PRO FAMILIA sees it as a question of conscience which cannot be restricted by political control or force. Human life is worth to be protected before birth, but pressure, intimidation, lecture, imposing one's will, or even threat of penalty against women and against those who support them are wrong measures for that protection. Within the political discussion on abortion, in order to acknowledge the autonomy of unintentionally pregnant women in the written law, PRO FAMILIA supports the deletion of the paragraph 218 from the Criminal Code.

There must be an offer of advice service, information and help for those women who are not sure how to decide. These offers must consider different world-views. In the spectrum of institutions offering advice service, PRO FAMILIA represents a secular concept of human being, a concept which is determined by individuality, equality of rights and chances, autonomy and tolerance. This is based on the confidence in the ability of men and women to responsibility and self-help. The task of specialists and institutions is to offer services which strengthen these abilities.

In order to preserve an appropriate possibility of choice for unintentionally pregnant women, PRO FAMILIA also offers the advice service on abortion according to German law. On the one hand, an advice service enforced by threat of penalty is contradictory to the

scientifically founded rules and the ethical principles of advice service for conflict situations. The compulsory character of consultation denies the appeal to woman's responsibility. But on the other hand, even within compulsory advice some principles are accepted, e.g. the orientation of the advice to science and the respect for the final decision and responsibility of the woman (openness of result). Thus it is possible to offer an advice service which is technically and ethically acceptable, which is in tune with the PRO FAMILIA's principles and which satisfies at the same time the political guidelines in Germany, according to which the advice shall serve the protection of antenatal life.

4. Pregnancy and Birth

Concerning intended or later accepted pregnancy, the demand to accept the autonomy and majority of women during their pregnancy and birth is valid, too. Based on this principle, PRO FAMILIA supports extensive offers of information and advice service concerning aspects of health, psychology and social life of pregnancy, birth and being parents, which is directed to the men affected, too. On the other hand, it is a consequence of the opinions mentioned before, that PRO FAMILIA refuses the domination of specialists about pregnancy and birth and exaggerated medication during pregnancy and birth as well as administrative or legal regulations which despise the autonomy of the women. PRO FAMILIA fights against eugenic thinking concerning the care during pregnancy, supports the strengthening of the important part of midwives as a company before, during and after birth and demands the extension of qualified offers of out-patient birth or home birth.

It is a consequence of the guarantee of the constitution to protect mothers and families (that means parents and children) and of the ban of disadvantaging women that pregnancy and being parents must not lead to disadvantages in training, work and the general social conditions of life. There must be effective protecting laws (e.g. in industrial law) and compensations (e.g. child benefit) as well as supplementary services appropriate to the need (e.g. the looking after children). Women and men are entitled to get information and advice concerning these rights and benefits.

5. Exertion of political Influence

PRO FAMILIA is not only a service institution and a specialist society. In the opinion of PRO FAMILIA, the basic view concerning sexuality, sexual pedagogy and family planning is connected with a political task and the resulting representation of interests of people who seek information and advice.

PRO FAMILIA supports a sexual culture,

- where different ways of life concerning sexuality and partnership can develop and are respected,
- where the tension of the difference between genders leads to a controversy and not to suppression or
- levelling,
- where the decision about the own fertility as a consequence of sexual autonomy is an essential feature of social competence and is not defamed or even prosecuted,
- where the irrationality of sexuality is accepted and seen as an enrichment of culture, too.

PRO FAMILIA derives the authorization of this opinion from the practical experience of forty years' work, from the dialogue with people seeking advice and information and from the increasing scientific knowledge. Its political and technical integrity will be proved again and again in the dialogue with those who enlist the offers of advice and information.

The PRO FAMILIA-programme of autonomous family planning is intended to be unambiguously different to programmes of population-policy for the increasement or the lowering of birth-rates. Any measures who shall have an influence on the increasement of population without regarding the individual freedom of choice are contradictory to the human right of family planning. This human right can neither nationally nor internationally be deviated.

In the opinion of PRO FAMILIA, sexual policy is a general task which is related to every area of politics in which decisions about the general conditions and possibilities of sexual ways of life of men and women are made. In addition to population policy, there must be mentioned women's policy, health policy, family policy, education policy, legal policy and social policy, but also wage policy, where important principles for gender-specific chances of life are decided upon.

In the age of increasing international network Pro Familia exerts an influence on sexual-political demands and developments through international organizations as the Europe-Region of the International Planned Parenthood Federation.

At the same time ProFamilia reflects its own activity: it always must be justified on the basis of the interests, needs and fundamental rights of the individual human. The history of the movement of family planning - e. g. the closeness of some of its representatives to the "race hygiene" of National Socialism or to enforced sterilization in nations of the "Third World" - gives examples for that aim not always being realized. It is an essential matter of concern for PRO FAMILIA to consider these historical experience in its nowadays activities and in its task and aims which are directed into the future.

6. Information

Many questions about sexuality and partnership or difficulties with these need no advice or even treatment, but a qualified, understandable and extensive information.

In addition it must be respected, when people want to clear up their matters independent from institutions and their employees and just want to use their "pool of information". That means that information should be available not only in personal talks but also independent from any person or time.

Because of that, PRO FAMILIA publishes regularly information as for example:

- brochure series about the methods of family planning, body and sexuality and pregnancy (in German)
- brochures about the methods of family planning and healthcare services for foreigners in eleven languages
- the "PRO FAMILIA MAGAZIN" (periodical) which is the only German specialist periodical about family planning and sexual pedagogy with special subjects of emphasis and information about internal matters of the society (six times a year) and
- "PRO FAMILIA-Arbeitsmaterialien" and "Familienplanungs-Rundbriefe" as a help for the work of professions who work in the area of PRO FAMILIA.

These information is available at the institutions for advice service, the provincial offices or the national office.

In addition, some sexual-pedagogical libraries for media which are connected with PRO FAMILIA institutions for advice service offer a number of sexual-pedagogical media (books, films, videos, posters, games) to interested laymen and specialists.

7. Advice Service

Understanding of Advice Service

That people who normally come to PRO FAMILIA institutions for advice service normally are healthy and grown up people who have questions, doubts, problems with their contraception, sexuality, pregnancy or partnership and who therefore want to or must talk to a male or female advisor.

The advisors cannot and do not want to take the responsibility and the decision off them. They understand the dialogue as support, as a help for understanding and deciding. Sometimes it is sufficient to inform and to explain. Above all concerning psychological advice, for example when there are problems with partnership or sexuality, this is not sufficient. In such situations the advisors also use psychotherapeutic methods; there is no unambiguous borderline to psychotherapy. But in these cases, too, the persons seeking advice decide themselves with support of a specialist, which development the advice has, and they have to find solutions and decisions themselves. This is also true for the advice of adolescents.

On principle, the attendance of an advice service is voluntary, the persons seeking advice decide themselves, about what, how intensively, and how long they want to attend. One exception is the obligatory advice for women who think about an induced abortion.

Limits of Advice Service

Even professional advisors do not know about everything (e. g. special legal questions), cannot always help directly when it is necessary (e. g. concerning financial problems), cannot and do not want to make decisions for others (e. g. about induced abortion or pregnancy), have to refer to other services when they are confronted with special psychic and interhuman conflicts and crises, cannot always avoid disappointment and anxiety or the feeling to be misunderstood. But it does belong to the principles of advice service,

- to have time,
- to handle every request respect
- to encourage to take advantage of existing rights,
- to refer to other specialists, if they could maybe help better.

Offers of Advice Service

PRO FAMILIA offers medical, psychological and social advice

- about partnership, separating and divorce,
- about sexuality,
- about conception, sterilisation and unfulfilled wish for children,
- about intended and unintended pregnancy, induced abortion and birth.
- about further issues related to health in the fields of gynaecology and andrology

8. Sexual Pedagogy

Sexual pedagogy is more than sex education. Sexuality accompanies the human as a creative energy of life from the very beginning and thus it is more than genital experiencing which often is informally identified with sexuality.

Sexual pedagogy does not explain something to children and adolescents which was unknown to them before. It rather picks up something together with them which is always already there in different ways of expression and which thus is an element of every process of teaching and education, it may be intended or unintended, conscious or unconscious. Its primary matter of concern is to avoid that sexuality is left aside from processes of education and thus is made taboo, and that it is not “neutralized” or “postponed”. Because this would mean to leave children and adolescents alone with their sexuality and the connected experiences and thus with their uncertainty and anxiety, too.

Sexual pedagogical work means to offer sensitively and with a knowledge of the subject information, company and support in processes of learning concerning sexuality and partnership to the children and adolescents. Important aims of learning are the acceptance of the own body, behaviour appropriate to partnership, consideration and tenderness. This includes the development of self confidence, the acceptance of the difference between genders and a relation with equal rights between boys and girls, men and women. At the same moment, sexual pedagogy shall encourage to have a look at bad experiences, at doubts, shame and anxiety, at the “ugly” faces of sexuality (e. g. sexual violence) and it shall make sensitive for the negative results of moralizing exclusion and depreciation.

Sexual pedagogy which is understood that way presupposes that the attendance is voluntary at every moment and that every girl and every boy can always decide about the intensity of her or his participation.

The participation in sexual pedagogical programmes is voluntary at every point of time. Every girl or every boy always determines the degree of her or his participation her/himself. Sexual pedagogy in the sense described before will be difficult or even impossible in contexts where values as responsibility, tolerance, respect or equality of rights are not supported or even refused.

Also important for sexual pedagogy are development processes in the social surroundings of the affected children and young persons which only can be included by cooperation of the parents, educators and teachers.

PRO FAMILIA did pioneering work concerning the development of sexual-pedagogical group-work with girls and boys, parents and pedagogues. By now, the PRO FAMILIA-Sexual Pedagogy is accepted by different institutions, although it must again and again be put through against confessional resistance or resistance of conservative politics.

Today, PRO FAMILIA offers support with knowledge of the subject when pedagogues and youth- and parent-groups

- want to know more about sexuality and family planning,
- want to run events about that subject or
- plan a series of group discussions with adolescents to that area of subjects.

9. Medical treatment

At the PRO FAMILIA-Centers, there are offers of medical service concerning family planning in addition to the advice service; for example application of the coil and at some places sterilisation.

At the centers, an out-patient induced abortion is possible, too.

These centers are intended to be “pilot institutions” which want to influence the practice in hospitals and doctor’s practices by their work, too. This applies to the exclusive use of the most gentle medical methods and to a behaviour towards women and men which is respectful and accepts them.

10. Public Relations Work

PRO FAMILIA considers the commenting on processes of political decision which are connected with its work and its aims as a task. Thus it wants to support the right of women and mento autonomous relations of love and partnership and the general conditions which have to be developed for the realization of that right.

Subjects of public relations work are among others induced abortion, contraception, genetic technology, reproduction-technology, sexual pedagogy and sexualized violence.

11. Further Education and Further Training

The national association of PRO FAMILIA, individual state associations and advice centres regularly offer further education courses, further trainingsand trainings for additional qualifications. These courses are directed to people who already work for PRO FAMILIA and want to get used to different fields of work or to get further training and to other specialists in the health sector or the psochy-social sector.

12. Co-operation

The co-operation with other specialist organizations is important to PRO FAMILIA in order to communicate experience and impetus and to put the own work into an extended technical and social context. Thus PRO FAMILIA is member of the “Deutsche Paritätische Wohlfahrtsverband” (welfare organization for Germany), of the “Deutscher Arbeitskreis für Jugend- Ehe- und Familienberatung” (German study-group for advice about problems concerning youth, marriage and family) and of other associations who work in the areas of health, research in sexuality, and social work. The local advice service is embedded into a network of medical and psycho-social institutions. This is important on the one hand for the association’s policy and on the other hand for the own service, to which belong, for example, help for people who seek a possibility of therapy or advice and support from authorities, other institutions or specialists.

In addition, PRO FAMILIA wants to co-operate with groups and initiatives of the new social movement (especially the women’s movement and the health-movement).

Members of the organization: 16 regional associations with individual members

Number of members: 5700

Year of foundation: 1952

Legal form: independent, charitable society with federal structure.

Financing:

The work of PRO FAMILIA is mainly financed by public funds, that means municipal, provincial and national funds; about one third of the money comes from income by voluntary donations, personal share of clients, sale of contraceptives, cost share of the health insurances, membership fees and publications. The composition of the budget and the extension of public sponsoring is enormously different at the different places; this has immediate consequences on the type and the extension of the service, which the advice service institutions and the regional associations are able to offer.

PRO FAMILIA is a charitable organization. It orientates its income at the need and not at profit.

Regional institutions:

The local, provincial and district associations are organized as member-associations and responsible for more than 160 advice service institutions and PRO FAMILIA-Centers.

Specialist groups:

on request

Publications:

periodical "PRO FAMILIA MAGAZIN" (every two months)

Internet: www.profamilia.de

5.3.2 mother convalescence centre

Name of the organization:

**Müttergenesungswerk. Elly-Heuss-Knapp-Stiftung
(mother convalescence centre; Elly-Heuss-Knapp-foundation)**

Address:

Postfach 1260 - 90544 Stein
phone:0049-911 / 967 11 - 0
fax: 0049- 911 / 67 66 85
e-mail: info @ muettergenesungswerk.de
internet: www.muettergenesungswerk.de

Contact:

Secretary: Ms. Bettina Stoll

Aims:

within the institutions which are recognized by the Müttergenesungswerk health cures for both mothers and mothers together with their children are carried out. All over Germany 129 institutions are registered (1998).

Main emphasis of activity:

women-specific measures of prevention and rehabilitation; in addition to the medical help, there is a strong emphasis on psycho-social therapy

Members of the organization:

there are five organizations which support the Müttergenesungswerk:

- AWO (workers' welfare organization)
- DPWV (an umbrella organization for welfare institutions)
- DRK (Red Cross Germany)
- EAG (protestant association for mothers' healthcare)
- KAG (catholic association for mothers' healthcare)

Year of foundation: 1950

Legal form: foundation

Financing: donations from street- and door-to-door collections

Regional institutions:

health-cures are found at the agencies and offices for advice service of the welfare institutions Arbeiterwohlfahrt (workers' welfare institution), Caritas (welfare institution of the catholic church), Der Paritätische Wohlfahrtsverband (umbrella organization of welfare institutions), Deutsches Rotes Kreuz (Red Cross Germany), Diakonisches Werk (welfare organization of the protestant church), or women-organizations of both the catholic and the protestant church; for addresses see the local telephone books.

Specialist groups:

internal study-groups

Specific knowledge offered by the organization:

the annual statistics “Die gesundheitliche und soziale Lage der Kurteilnehmerinnen” (the social and health situation of cures’ participants):

This statistics on health cures is based on the evaluation of questionnaires about the cures and shows which strains are put on mothers nowadays, in which situations of life they are, and it presents research on the social and medical problems which are treated in a health cure for mothers. In addition, this knowledge helps to update permanently the programme of the work for mothers’ healthcare and enables to suit the offers to health and social situation of the participants and their children.

Publications: (available only in German)

brochure “MütterStärken” (strengthening mothers)

press-survey – published regularly with update articles

statistics on health cures

information for friends and people who support the organization

Müttergenesungswerk Yearbook 2000/2001 (a list of the institutions which are recognized by the Müttergenesungswerk and their main emphases)

5.3.3 PREGNANCY AND BIRTH

Name of the organization:

**Cara. Beratungsstelle zur vorgeburtlichen Diagnostik e. V.
(advice centre for prenatal diagnostic)**

Address:

Große Johannistraße 110 - 28199 Bremen
phone: 0049-421 / 597 84 95
fax: 0049-421 / 597 84 95
e-mail: cara-ev@t-online.de

Contact:

Ebba Kirchner-Asbrock
Gabriele Freck-Wulfmeyer

Aims:

The aim of the advice and specialists office is to question the increasing naturalness of applying antenatal examinations and tests, to set an alternative point of view against the increasing automatism in offering those tests as well as in enlisting them.

Main emphasis of activity:

The following emphases were developed from the fundamental aims of CARA e. V.:

- offers of advice service
- advice service for women and their male or female partners
- advice service for people who work in the system of psychosocial and medical help
- advice service for colleagues who are employed in public relations or education work
- offers of telephone advice service for all target groups as a low level offer

office for information and arrangement

- offers to find contacts with other institutions, groups etc. concerning further questions (e. g. after the birth of a handicapped child; a stillbirth or other similar cases): midwives, gynaecologists, self-help groups, parents groups:
- offices for advice service .
- Transmission of addresses, information, speakers, contacts, who are dealing with the subject critically.

regional and national network

- co-operation in workshops concerning this subject
- engagement in the network against selection by antenatal diagnosis
- technical exchange with other institutions, groups, who make offers concerning the handling of antenatal diagnosis

further education concerning the area of antenatal diagnosis

critical public relations work

The realization of this wide spread offer by CARA e. V. is restricted by the low number of personnel and the tight amount of money.

Members of the organization:

individual members
initiative supported by women

Number of members:-

Year of foundation: 1990

Legal form: charitable registered society

Financing: sponsoring by the Senator für Gesundheit in Bremen (minister for health affairs)

Regional institutions:

none

Cara is member of the network against selection through prenatal diagnostic

Specialist groups:

Netzwerk gegen Selektion durch Pränataldiagnostik (network against selection by antenatal diagnosis)

c/o Bundesverband für Körper- und Mehrfachbehinderte e.V.

Brehmstrasse 5-7 - 40239 Düsseldorf

Specific knowledge offered by the organization:

On the basis of CARA's basic understanding of the application of methods of antenatal diagnosis, the offer of advice service is directed to women or couples who want information about antenatal diagnosis, who look for help concerning their decisions or who already have made experiences with this diagnosis which weigh heavily on their minds or make them unsure (miscarriage after amniocentesis, indistinct/conspicuous results or late induced abortion because of conspicuous results).

The advice service is offered by female advisers from psychosocial professions. Beside the detailed information about the methods of antenatal diagnosis, it always includes the reflexion on the meaning, on the importance of the received information for the individual woman or the individual man, which effects they produce. Ethical questions and questions concerning the prospects of life as e. g. ideas / pictures of handicaps and sorrow are talked about and are intended to show different possibilities to the women / couples concerning a life as a relative / person responsible for handicapped children in this society.

Aspects of the advice service:

information about the methods of antenatal diagnosis (possibilities, risks, disadvantages, the time when it is done, waiting period, etc.)

the meaning of the information for the woman / the couple

ethical aspects

induced abortion after a diagnosis

precaution for pregnant women, information about precaution by midwives

further information and contacts e. g. with self-help groups

As a psycho-social advice service, CARA has psycho-social competence.

The quality assurance is guaranteed by means of the integration and thereby own reflexion by

- supervision
- intervision
- public discussion about the subject
- public discussion with specialists

Publications: (available only in German)

The brochure “Ist Schwanger sein ein Risiko?” (Is being pregnant a risk?).

Cara e.V.: Selbstverständnis, Informationen, Materialien, Adressen (self-portrayal, information, material, addresses); 28 pages, DM 8,-

Name of the organization:

Arbeitsgemeinschaft Gestose-Frauen e. V.
(working team gestosis-women)

Address:

Kapellenerstr. 67a - 47661 Issum or
Postfach 1253 - 47654 Issum
phone: 0049-28 35 / 26 28
fax: 0049-28 35 / 29 45
e-mail: gestose-Frauen@t-online.de
internet: www.gestose-frauen.de

Contact:

(secretary) Sabine Kuse
Doris van Kilsdonk

Aims:

information for affected persons, advice, further education
An EPH-gestosis (intoxication during early stages of pregnancy) is indicated by the following symptoms: oedemas, rising blood pressure (hypertension), protein in the urine. The most serious form of gestosis is the HELLP-syndrom with liver's insufficiency. Our experiences have showed that a good balanced diet which food high in protein, "high"-calorie and not at all low-salt one helps to ease the symptoms or even prevents the pains.

Main emphasis of activity:

Advice for pregnant women, who have or just have had gestosis. In addition to the regional meetings, a nationwide further education (lasting several days) takes place once a year.

Members of the organization: mainly affected women, midwives, doctors

Number of members:

about 460 members, 10 organizations concerned with birth and lactation period

Year of foundation: November 1984

Legal form: charitable registered society

Financing:

financing by membership subscriptions, donations and reimbursement of costs for offered service / information, small subsidies by medical health insurance companies

Regional institutions:

There is a list of regional institutions, which organize exchange of experience; they do not offer advisory service.

Ahrensburg: Birgit Hoffmann, Spechtweg 16, 22926 Ahrensburg

Altkreis Lübbecke: Heike Bergmann-Henke, Pr.Ströhen 316, 32369 Rahden

Bremen: Helga Helms, Heidbergstr. 14, 28239 Bremen

Dresden: Bärbel Arlt-Müller, Heinrich-Zille-Str. 11, 01219 Dresden

Freudenstadt: Silvia Eberhardt, Lerchenbergstr. 16, 72250 Freudenstadt

Heidelberg: Angelika Schmidt-Lang, Urnenstr. 16, 67071 Ludwigshafen

Kassel/Umgebung: Heike Knabe-Schneider, Steinbachstr. 43, 34320 Söhrewald

Leipzig: Veronika Albrecht-Birkner, Seb.-Bach-Str. 37, Hinterhaus, 904109 Leipzig

Münster: Kristin Prior, Beckumer Str. 144, 59229 Ahlen

Ravensburg: Dagmar van Lindt-Eßeling, Hugo-Hermann-Str. 69, 88213 Ravensburg
Reutlingen: Gertraud Rauch, Schlegelstr. 17, 72762 Reutlingen

Specific knowledge offered by the organization

no days with special rice-fruit diet
no low-salt food
late and just slight sinking of blood-pressure
detailed advice concerning influences of diet
special former diseases cause special forms of gestosis' symptoms
(e.g. immunologic causes)

Membership in the specialist societies

Deutsche Sektion der International Society for the Study of Hypertension in Pregnancy (ISSHP)
Deutsche Gesellschaft für Gynäkologie und Geburtshilfe, Abteilung Schwangerschaftshochdruck/Gestose (DGGG)
(German Section of the International Society for the Study of Hypertension in Pregnancy)
(German society for gynaecology and obstetrics, section for high pressure / gestosis)

Publications: (available only in German)

Informationsbroschüre "EPH-Gestose aus meiner Sicht" by Sabine Kuse, DM 12,30.
ISBN 3-9805324-2-9
(EPH - gestosis from my point of view)

"Ernährungsplan - ausführliche Version", DM 5,50. ISBN 3-98053241-0 (detailed version of diet-plan)

Doppelbroschüre: "Salz in der Schwangerschaft/Mütterliche Nährstoffaufnahme" DM 5,80.
ISBN 3-9805324-3-7 (salt during pregnancy, nutrients relevant for mothers)

Informationsbroschüre "Immunologische und thrombophile Ursachen für Prä-Eklampsie und HELLP-Syndrom" DM 12,10.
(immunological and thrombophilic causes of pre-eclampsy and HELLP-syndrom)

All listed brochures are available at the Arbeitsgemeinschaft Gestose-Frauen, please find the address above.

Selected extract from a publication:
(exceptional qualities of the salt and water balance during pregnancy)

Problems and interests relevant to the current situation:

There is an interest in contacts and in information from abroad - first of all concerning HELLP-syndrom.

Name of the organization:

Familienbildung und Frauengesundheit – Bundesverband e.V. (GfG)
(family-founding and women's health – federal association)

Address:

Postfach 22 01 06 - 40608 Düsseldorf or
Dellerstr. 5 - 40627 Düsseldorf
phone: 0049-211 / 25 26 07
fax.: 0049-211 / 20 29 19
e-mail: gfg@gfg-bv.de

Contact:

office: Lorraine Caukin, Christiane Schnurra,
national chairwoman: Ines Albrecht-Engel,

Aims:

The GfG (nationwide society for the preparation for birth) wants to accompany women and men in our society during the phase of radical change when they become parents. The GfG also wants to strengthen their competence. In Germany, the support during pregnancy and the company of parents are mainly medically orientated. This one-sided orthodox medical orientation does only partly justice to the needs of women. In addition, pregnant women and young parents are deprived of the right of decision in managing their own affairs. We want to strengthen women in their responsibility for their own affairs and in their autonomy of choice by information about the manifold possibilities, e. g. of antenatal diagnosis, of the choice of the birth's location and course and of their own power for bearing. We realize these aims in various ways:

We help parents during the transition to family with a wide range of courses: holistic courses as a support during pregnancy, preparation for the birth and for the role of parents. Beside a new form of working with the body, the special approach of women who prepare others for birth was and is to engage the couples and the group in communication with each other, in order to strengthen their own competence and their own responsibility by the exchange of experience. For this purpose the GfG developed a programme for the further education of women who prepare others for birth.

Another course shall give the possibility to parents to find contacts for their manifold questions and feelings directly after the birth of their child. During the course on the one hand information is offered, on the other hand there is the possibility to exchange experience. The work with the body (gymnastics to recede the consequences of pregnancy) has a new approach which was developed by women of the GfG. In this context, we offer the further training as Familienbegleiter/in GfG (people who accompany families after the birth of their children).

We want to change the conditions "around birth" in our society in that way that not only medical aspects are considered at the beginning of the life but also the emotional and psycho-social aspects of pregnancy, birth and the first period with the new born child.

The GfG has achieved these aims above all by means of interdisciplinary co-operation. The GfG does not define itself as a professional association but as a group representing the interests of people who will be or just have become parents. That is why, according to us the co-operation with all professions "around birth" is indispensable.

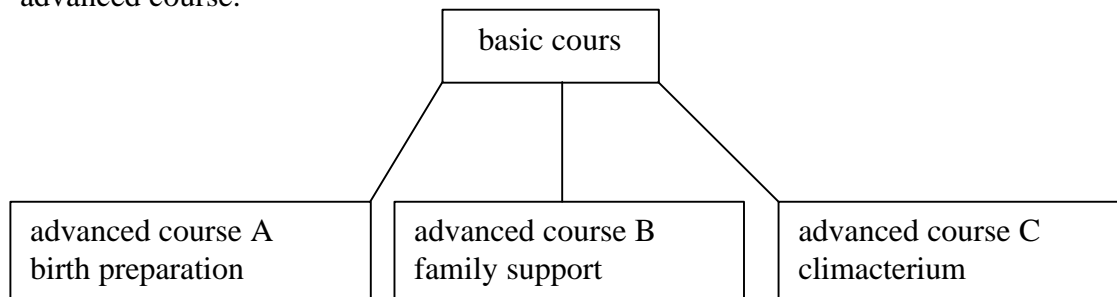
Main emphasis of activity:

Prevention by considering the psychic constitution and the social aspects during this crucial phase of radical change in the life. Also by the support of the health of the body by body awareness of one's body, gymnastics for the relief of the strain, advice concerning diets, etc.

education: additional trainings (further education) of the GfG

The concept of the training:

The GfG offers three different trainings in the field of family founding and women's health. They are offered in form of a modular system and consist of a basic class and an advanced course.



- The basic course serves as a first module for the advanced classes, but in addition to this offers an independent training as a basis qualification for leading holistic courses on family founding and health promotion.
- The advanced course health preparation qualifies for leading birth preparation classes for women and couples.
- The advanced course family accompanying enables to lead classes in back-formation/new-finding and in parent-child-relationship after birth.
- The advanced course climacterium qualifies for leading classes for women in the climacterium.

Learning goals and learning understanding

The aim is that the participants of the trainings are being enabled to acquire and impart knowledge and experiences that are relevant for their target groups in health and family education. These contents can e.g. be brought into birth preparation groups, in family accompanying courses and in women's groups on special topics.

Prerequisites for this are the acquisition of knowledge and the training of professional, methodical and communicative competences. The training of the GfG is based on the assumption of a basic competence of the participants, i.e. on the specific capabilities and experiences that everybody brings into the education.

Through an accepting and trusting atmosphere during the training in fixed groups the participants are enabled to learn without anxiety, to try novelties, to create contents independently and to find the own way autonomously. Of high importance are the strengthening and development of self-confidence and self-esteem under the inclusion of self-reflection, i.e., the gains of a realistic self-assessment of own strengths and weaknesses and the repeated clarification of the own ethics, view of human being and socio-political opinions.

Organization of the training

The training units– basic and advanced classes – are conceived as supplementary to job or family in form of private studies and presence units. In addition to this there are regional working groups (peer groups) and practice-reflection-classes, which are organized independently and at the own expense. All trainings take place in fixed groups. Basic course, advanced course and practice units consist altogether in about 1050 lessons.

basic course	372 lessons
presence class	16 days with 12 overnight stays = 128 lessons
1 orientations seminar	1 X 1 day
4 weekendseminars	4 X 2,5 days
1 blockseminar	1 X 5 days
private studies	
peer groups	24 lessons
	4 X 6 hours in regional working groups
sitting in on courses	14-20 lessons
private studies	about 200 lessons in an instructed private study (literature, essays)
advanced course	664 lessons
presence class	15 days with 12 overnight stays = 120 lessons
4 weekendseminars	4 X 2,5 days
1 blockseminar	1 X 5 days
private studies	
Peer groups	24 lessons
	4 X 6 hours in regional working groups
sitting in on courses	14-20 lessons
private studies	about 500 lessons in an instructed private study (literature, course concept, essays)
practice-phase	16 lessons
2-4 self-organized meetings for practice-reflection	

further education:

The certificates of the GfG are connected with the constant duty to participate in further education and updating training courses. On the one hand, the GfG offers these courses itself, on the other hand, in co-operation with its regional organizations (e. g. centers “around birth”). In addition, a Further-Training-Calendar containing all relevant offers of training in the area of parents’ support is published twice a year.

Members of the organization:

Individual members: Geburtsvorbereiterinnen (birth preparation assistance), midwives, physiotherapists, doctors, psychologists, social pedagogues, etc.

Member organizations: nearly all initiatives and associations in the area of parents’ self-help, support for young families, etc.

Number of members: 875

Year of foundation: 1981

Legal form: charitable registered society

Financing: membership fees, fees for further education courses, funds for projects, donations

Regional institutions:

regional organizations in Baden-Württemberg, Bavaria, Berlin / Brandenburg, Hamburg, Lower-Saxony, Rhineland-Palatinate, Saarland.

Further associated members of the GfG are:

- a) societies and nationwide organizations (see the list of members),
- b) the “centers around birth” (see the list of members).

Specialist groups:

Frauengesundheitspolitik, Familienbildung: Vorstand: Ines Albrecht-Engel, Burckhardtstr. 32, 34346 Hann. Münden, phone: 0049-5541/46 61 – fax 50 76

women’s healthcare policy, family education: board:

Ausbildungsrat: Helen Heinemann, Am Damm 33a, 22175 Hamburg, phone: 0049-40/6 40 26 94

Education council:

Körperarbeit: Edeltraut Edlinger, Zugspitzstr. 11, 82061 Neuried. phone: 0049- 89/7 55 52 49

Thea Vogel, Holbeinstr. 57, Physical education:

Stillen: Brigitte Maas, Laurwegstr. 11 Lactation:

Kaiserschnitt: Ines Albrecht-Engel s. o. und Gabriele Kemmler, Händelstr. 2, 60318 Frankfurt,

phone: 0049-69/59 35 28 Caesarian section:

Pränatale Diagnostik: Antenatale diagnosis:

Geburtshäuser: Hanne Beittel, Suarezstr. 31, 14057 Berlin. phone: 0049-30/3 21 26 80

sowie Elisabeth Geisel und Gabriele Kemmler(birth’s houses):

Internationale Kontakte: Elisabeth Geisel, Hainholzweg 17, 37085 Göttingen, phone: 0049-551/5 6647 – fax 5 66 48

Specific knowledge offered by the organization:

- Information on debate on nationwide relevant pro-women questions in the healthcare system, especially concerning the areas of the following life’s phases: pregnancy, birth, lactation period and climacteric.
- Knowledge about medical problems, especially in the area of the following phases of life: pregnancy, birth, lactation period and climacteric.
- Knowledge about strategies for local support of women’s health, especially for the foundation and organization of “centers around birth”, for regional advice-brochures and guides for pregnant women and parents as well as for the support of pro-women, pro-family and pro-baby conditions in the hospital, foundation of Geburtshäuser (special locations for birth) etc.
- Knowledge about development of organizations and projects, especially experience with EU-projects and national projects.

Publications: (available only in German)

Three times a year, the GfG publishes a circular with a special subject for members and subscribers.

A booklet with information for pregnant women and contact addresses for courses for the preparation for birth (see the enclosed xerocopy) are available at the GfG or at individual events.

The GfG hires out and sells video-tapes about birth and parenthood, especially produced by the Dutch firm Stichting Lichaamstaal.

Books by the GfG women on the following subjects:

“Geburtsvorbereitung –Handbuch für werdende Mütter und Väter”, Ines Albrecht-Engel (Hg.). rororo 19392-2(a guide for birth’s preparation, a guide for future mothers and fathers)

“Kaiserschnitt-Geburt”, Ines Albrecht-Engel/Dr. med.Manfred Albrecht. Rororo 19740-5) (Caesarian section)

“Wo bringe ich unser Kind zur Welt?” Ines Albrecht-Engel. Rororo 60200-8 (where do I bear our child?)

“In Wellen zur Welt”, Ines Albrecht-Engel (Hg.), Mediana Verlag
in waves to the world)

“Kaiserschnitt – Narben an Seele und Bauch”, Th. M. de Jong/G. Kemmler. Fischer (Caesarian section - scars on soul and belly)

“Tränen nach der Geburt”, Elisabeth Geisel. Kösel (tears after birth,)

“Gute Hoffnung – Jähes Ende”(good hope – sudden end), Hannah Lothrop. Kösel“Das Stillbuch”, Hannah Lothrop. Kösel(book about lactation)

“Die Lust neu entdecken”, Petra Otto. rororo 601507) (to discover lust anew)

Articles:

Albrecht-Engel, Ines. “Geburt in der Bundesrepublik”In: Dr. med. Mabuse 110. Nov./Dez. 1997. S. 30ff. (birth in BRD)

Albrecht-Engel, Ines. “Geburt in der Bundesrepublik Deutschland”. In: Gebären – Ethnomedizinische Perspektiven und neue Wege. Curare Sonderband 8/1995. Schiefenhövel, W., Sich, D. Gottschalck-Batschkus, Chr.E. (Hg.)(birth in BRD – ethnomedical perspectives and new ways)

Albrecht-Engel, Ines. “Tragen, Betten, Wiegen – Ein kulturhistorischer Vergleich und Überlegungen zur heutigen Situation. In: Ethnomedizinische Perspektiven zur frühen Kindheit. Curare Sonderband 9/1996. Gottschalck-Batschkus, Chr.E., Schuler, J. (Hg.) Dealing with babies - a cultural-historical comparison and thoughts about the current situation)

Available at all book shops.

Questions and interests relevant to the current situation:

At the international level, the GfG founded a network in co-operation with other organizations: ENCA, European Network of Childbirth Associations. The office of the ENCA is at the moment located at our office in Düsseldorf.

EU

At the moment, the GfG works on a EU-project for the training of Geburtsvorbereiterinnen (birth preparation assistance) in St. Petersburg, Russia.

The GfG has finished an EU project for the training of Geburtsvorbereiterinnen (birth preparation assistance) in St. Petersburg, Russia and is preparing at the moment a Europe-wide project for the education of people becoming parents in regard to alcohol consumption in the frame of birth preparation classes.

Name of the organization:

**ReproKult. Frauen Forum Fortpflanzungsmedizin
(Reprocult. Women Forum Reproductive Medicine)**

Address:

Margaretha Kurmann
dep. for prenatal diagnostic/reproductive medicine
Große Johannisstr. 110 - 28199 Bremen
phone: 0049-421 / 597 84 80
fax: 0049-421 / 597 84 81
e-mail: frauen@reprokult.de
internet: www.reprokult.de

Contact:

Contact partners vary with different thematical fields. Please ask at the above contact-address.

Aims of the organization:

According to the developments in reproductive medicine, women of different professional fields joined together in ReproKult for integrating women and socio-political perspectives and to activate the public discussion. While research, economy and parts of the medical doctors press for the application of new technologies and the loosening of legal regulations, ReproKult demands a broad public debate under inclusion of the societal context and the social effects.

Main emphasis of activity:

New developments in reproductive technologies and their social and socio-political implications (e.g. egg cell donation, preimplantation diagnostic, phylocell research).

Members of the organization:

Working context of women from different active registered societies and institutions, from women health work, from fields of psychosocial care, the interest representation of handicapped women, from research, politics and media.

Year of foundation: 1999

Legal form: working-alliance

Financing: none

Regional institutions: federal alliance, no regional offices

Specialist groups:

thematically changing working groups, e.g.: production and commercialization of egg cells, preimplantation diagnostic, prenatal diagnostic, embryo-research, image of man

Specific knowledge:

Multidisciplinary competences from research, politics, advice services and interest representation influence the discussion of ReproKult and in this way make it possible to realistically assess reproductive medicine, its tendencies and effects. The elaborated positions are integrated into the socio-political discussion and further developed.

Publications: available only in German

Information brochure ReproKult Women Forum Reproductive Medicine, May 2000

5.4 Violence

Name of the organization:

**Landesarbeitsgemeinschaft niedersächsischer Frauen-Notrufe
(regional umbrella organization of emergency call services for women in Lower Saxony)**

Address:

Notruf für vergewaltigte Frauen und Mädchen
(emergency call service for raped women and girls)
Goethestrasse 23 - 30169 Hanover
phone: 0049-511 / 33 21 12
fax: 0049-511 / 388 05 10

Contact:

Mrs. Klecina, Mrs. Zahn, Mrs. Baron

Aims:

The Landesarbeitsgemeinschaft niedersächsischer Frauen-Notrufe (regional umbrella organization of emergency call services for women in Lower Saxony) is an umbrella organization of diverse emergency call services for cases of sexual violence against women and girls. The aim is the specialist exchange of experiences, cooperation and coordination and the joint public relations work concerning the whole subject of sexual violence - sexual pestering at work, sexual coercion, rape etc.

Main emphasis of activity:

The main emphasis of the individual associations within the organization can be characterized by the following activities: prevention; courses in self-assertion and self-defence; individual advice (from immediate help in crisis to longer-term therapeutic treatment); groups concerned with the subject sexual abuse and / or rape; support in reporting the cases to the police and to the court; further education for people, who distribute information; public relations work

Members of the organization:

Members of the Landesarbeitsgemeinschaft niedersächsischer Frauen-Notrufe are individual organizations, who are financed independently.

Number of members: At the moment there are 8 organizations represented in the LAG.

Year of foundation: about 1989

Legal form: regional association

Financing:

The Landesarbeitsgemeinschaft niedersächsischer Frauen-Notrufe receives no money. The represented organizations are mainly financed by several sources: local authorities and or the state of Lower Saxony, donations, membership subscriptions, fines

Regional institutions: none

Specialist groups:

Specialist group for feminist therapy and advice service

Specific knowledge offered by the organization:

the current developments in research on background, causes, forms and consequences of sexual violence against women and girls; methods and difficulties of psychotherapeutic treatment; legal situation and possibilities in proceedings concerning criminal offence abusing sexual autonomy; feminist therapy and advice service

Publications: (available only in German)

brochure "Aus unserer Sicht - sexuelle Gewalt gegen Frauen" (,From our point of view - sexual violence against women'); available at the organization

Selected extract from a publication:

The brochure of the Landesarbeitsgemeinschaft is the result of the co-operation of nine emergency call services in Lower Saxony concerning violence against women, lesbians and girls. This co-operation has been existing for several months. This brochure is no scientific essay and does not claim completeness.

We tried to define our place here and now and to take into account results of research, too. The brochure is designed in this way, that every chapter can be read separately, e. g. to make clear a special aspect. But the whole brochure can as well be read from beginning to end like a book and thus give a survey over the whole problem.

Emergency call services are feminist projects, which have their origin in the independent women's movement. They work specifically on the problem of sexual violence against women and girls. They have a considerable - although not considered by politics - tradition and they are steady part of the women's movement. During the course of their history a lot of things did change. For example the different services put their emphasis on different subjects. Some services still work on the subject sexual violence against adult women, whereas others work with women, who were exposed to sexual abuse in their childhood. Others work with similar problems concerning girls. Additionally there are special institutions for girls e. g. "Wildwasser" oder "Violetta". A note to that point: of course, we are aware of sexual violence against boys; nevertheless this brochure is concerned with girls and women exclusively, because emergency call services are directed only at them and work with them and for them.

We want to make sexual violence against women and girls visible and public, we want to help these affected persons and to fight the problem.

5.4.1 Projects and organizations in the field of violence and health

Advice centres and places of refuge for women and girls who are affected by violence

Advice and support for women and girls who are confronted with violence, is mainly offered in Germany by women's and girl's refuges, emergency call centres as well as girl's and women's advice centres. Furthermore support is offered by institutions of ProFamilia (see above). The offer of Pro Familia often also embraces psychological consultation, prevention in schools and consultation for relatives.

The addresses and phone numbers of the ProFamilia institutions can be obtained in the local phone-books or at the ProFamilia offices in Frankfurt.

Address:

ProFamilia Deutsche Gesellschaft für Familienplanung, Sexualpädagogik und Sexualberatung e.V.

(ProFamily German society for family planning, sexual education and sexual consultation)

Stresemannallee 3 - 60596 Frankfurt a.Main

phone: 0049-69 / 63 90 02

fax: 0049-69 / 63 98 52

Girl's and women's refuges

Girl's and women's refuges are anonymous institutions. The phone-numbers for urgent cases can be obtained at the local police-emergency call, in some regions also through the local phone-books.

Information on the activities of women's refuges and on special aspects of violence against women can also be obtained at the women's refuge coordination centre of the Paritätische Gesamtverband e.V.

Address:

Frauenhauskoordinierungsstelle des Paritätischen Gesamtverbandes e.V.

(women's refuges coordinating centre)

Heinrich Hoffmann-Str.3 - 60528 Frankfurt/Main

phone: 0049-69 / 670 62 52 or 670 62 60

fax: 0049-69 / 670 62 88

5.4.2 Projects and organizations in the field of violence and medical care

Project group „S.I.G.N.A.L.“ – Berlin

The project group S.I.G.N.A.L was initiated by the university clinic Benjamin Franklin, Berlin; the „Frauenzimmer“ e.V., refuge apartments for women in need, Berlin; by the GUT-training, Berlin as well as the parliamentary party Bündnis 90/Die Grünen in Berlin. The task of the project group is the dissemination of the SIGNAL intervention programme against domestic violence against women in health institutions as clinics, hospitals and surgeries and also to accompany the introduction actively. The name S.I.G.N.A.L represents the steps of the intervention programme (in German language):

- S speak to the patient, signal your readiness
- I interview with concrete questions
- G thorough examination of old and recent injuries
- N note and document all findings and statements, so that they are usable at the court
- A clarify the current need for protection
- L manual with emergency call services and offerings for support

The aim is to establish a new standard in the medical and psycho-social care of women who have experienced violence. Institutions of the health system are seen as an important intersection point between victims of domestic violence and further supportive opportunities as women's refuges, refuge apartments, advice centres, police and justice.

The project group is working actively for linking up feminist know-how of decades of anti-violence work with the knowledge and experience of medical institutions. Through cooperation, networking and exchange of experiences the situation and care of women with violence-experience should be improved sustainably.

contact to the project-group:

Angelika May, Frauenzimmer e.V.
Eberstrasse 32 - 10827 Berlin
phone: 0049-30 / 787 50 15
fax: 0049-30 / 787 50 16

The intervention programme S.I.G.N.A.L. is being tested at the university clinic Benjamin-Franklin since October 1999. Since March 2000 it is accompanied scientifically for two years.

contact to the project in the clinic:

Gabriele Dittmann
Dekanat des Klinikums
Hindenburgdamm 30 - 12200 Berlin
phone: 0049-30 / 84 45 40 74
fax: 0049-30 / 84 45 44 51
e-mail: dittmann@medizin.fu-berlin.de

contact to the scientific company over:

Technische Universität Berlin
Institut für Gesundheitswissenschaften, TEL 11-2
Prof. Ulrike Maschewsky-Schneider, Hildegard Hellbernd, Karin Wieners
Ernst-Reuter-Platz 7 - 10587 Berlin
phone: 0049-30 / 31 42 19 69
e-mail: wieners@ifg.tu-berlin.de or
hellbernd@ifg.tu-berlin.de

Shelter for raped women in the university-clinic Freiburg

The shelter for raped women in Freiburg is a women's project backed by a charitable registered society. According to its physical connection to a clinic and the cooperation of the staff with medical doctors of the clinic, it shapes a new form of support and care. The shelter offers women, who were raped, round the clock, by women to women and physically connected to the gynaecological clinic all diverse necessary support in one: from overnight stays over crisis intervention and consultation to therapy; from forensic examination to trial-company.

contact:

Anlaufstelle für vergewaltigte Frauen Freiburg

c/o Universitäts-Frauenklinik

Hugstetter Str. 55 - 79106 Freiburg

phone: 0049-761 / 285 85 85

5.4.3 cooperation and intervention projects against violence against women

In various cities of Germany in the 90s round tables and intervention projects came up with the aim to develop new strategies in the work against violence. The projects mainly put a focus on the establishment of network structures between refuge-, advice- and support projects for mistreated women, justice and police.

Members of the health system are, according to our knowledge, not involved in the current intervention projects.

In Rhineland-Palatinate an intervention project is currently founded which is directed against violence in close-knit social relationships.

It is aimed at integrating the health sector from beginning on. According to information of the ministry for culture, youth, family and women, the aim of the project is the efficient battle of male violence in close-knit social relationships. Especially the situation and the protection of affected women is aimed to be improved by a changed strategy of criminal prosecution institutions, women's refuges, emergency calls, women's advice centres, youth welfare departments and active representatives in the field of health with the aim of close coordination and cooperation.

By coordinating advice- and crisis intervention centres in the violence-field and established medical doctors, medical out-patient departments in hospitals, first aid-institutions as well as therapists, the networking and cooperation between health and the violence-field is planned to be reached.

Further information on the intervention project in Rhineland-Palatinate:

Ministerium für Kultur, Jugend, Familie und Frauen

Frau Dr. Heine-Wiedenmann

Diether von Isenburg Str. 9-11 - 55116 Mainz

phone: 0049-6131-164196

e-mail: dagmar.heine-wiedenmann@mkjff.rlp.de

5.4.4 Training in the field of therapeutic care

Shelter- and advice centres, which work with victims of sexual violence, reflect a big deficit in specialized therapists. In Rhineland-Palatinate already in 1997 a training-series was developed which aims at encouraging interested psychotherapists for working with victims of sexual violence.

The training-series was established by the inclusion of specialists of different disciplines. In addition to psychotherapeutic special knowledge, the socio-political dimension of sexual mistreatment as well as the work of different involved professional groups are given attention.

The training is offered since 1997/98 continuously. It is designed for two years, embraces 12 units and is finished with a certificate. The training programme can be obtained over:

Ministerium für Kultur, Jugend, Familie und Frauen

Dr. Heine-Wiedenmann

Diether von Isenburg-Str. 9-11 - 55116 Mainz

phone: 0049-61 31 / 16 41 96

e-mail: dagmar.heine-wiedenmann@mkjff.rlp.de

Information regarding contents:

Dr. Bosse

phone: 0049-61 31 / 23 46 28

5.5 Migrant Women

Name of the organization:

**Ethno-Medizinisches Zentrum e. V., Gesundheitsförderung mit MigrantInnen
(Ethno-medical centre; health promotion with migrants)**

Address:

Königstr. 6 - 30175 Hannover
phone: 0049-511 / 16 84 10 20
Fax: 0049-511 / 45 72 15
e-mail: emz@online.de

Contact:

Ramazan Salman;
Taner Yüksel

Aims:

The declared aim of the Ethno-Medizinische Zentrum is the improvement of the health care supply for female migrants.

Main emphasis of activity:

The practical application of the ethnological medicine:
Interdisciplinary co-operation of collaborators from medical, social and psychological areas of work and research contributes to the quality assurance in health care supply for migrants.

The Ethno-Medizinische Zentrum tries to guarantee this quality by the composition of the members, of the board, of the collaborators and of the cooperation's partners.

Recognizing the necessity of ethno-medical supply at institutions in the social sector as well as in the health sector and in the area of judiciary in Germany and appreciating the success of the Zentrum, the Niedersächsische Sozialministerium (ministry for social affairs in Lower Saxony) has been providing the Zentrum with an institutional sponsoring since 1992.

In addition, since 1991 the Niedersächsische Ausländerbeauftragte des Ministeriums für Bundes- und Europaangelegenheit (foreigner's representative at the ministry for affairs concerning the nation and Europe in Lower Saxony) has been providing money for project. The Ethno-Medizinische Zentrum works thus on behalf of the regional government to improve the health care supply for migrants.

There is a brief outline of how this task is being realized by the Ethno-Medizinische Zentrum:

Further education and training:

Ethno-medical-socio-cultural orientated offers of further education for people who work in the social, health and judiciary sectors.

The main foci of these subject-specific offers of further education are:

- training, instruction and experience of intercultural communication
- broadening of knowledge about socio-cultural backgrounds
- the known and the unknown
- practical instructions and practice-orientated programmes for the work with female migrants

- transcultural identity
- language training courses and self-awareness: “language and foreign language”
- transcultural (psycho) diagnosis
- health care supply for female migrants
- migration and psyche

Offers of consultations:

- networking consultation
- One of the essential tasks is the networking advice service. That means the passing on of information to the standard supply system. The Ethno-Medizinische Zentrum plays the role of the mediator for migrants. It supports and helps people seeking consultation and advice in cases of sickness, when they have problems with the German health care system or are looking for suitable self-help groups, doctors or psychotherapists who speak a foreign language.
- consultation for people who distribute information and represent the organization
- AIDS advice service
- There is a telephone and anonymous AIDS consultation point in Hannover, Hildesheim und Braunschweig (Turkish language)
- phone consultation in Turkish language on the topic „addiction“

Employment of interpreters in the social and health sector

Successful communication is the basis for diagnosis and therapy in social, psychosocial and medical institutions.

The progress of many migrants in foreign language makes often the sufficient communication with doctors, nurses and social workers impossible. Additionally, during their standard training, very few of the employees in the social and health sector have the possibility to learn about the specific, cultural-bound ways of migrants' behaviour and thinking.

Concerning the minimum health care supply for migrants we consider it to be urgently necessary to engage interpreters and cultural mediators. The use of interpreters at the beginning of a treatment is of fundamental importance for diagnosis and therapy.

The Ethno-Medizinische Zentrum has developed a nationwide, unique programme for interpreters and has been offering a corresponding service since 1990. By now, there are 160 interpreters for 49 languages and dialects at its disposal.

The interpreter project has been sponsored by the foreigner's representative of Lower Saxony since 1992.

Research:

Up to now, research work has been done on target group specific programmes for AIDS-prevention concerning young migrants and also on consultation's offers. Permanently, the data about specific healthcare offers for migrants are being gathered, the quantity of enquiry is documented at the Ethno-Medizinische Zentrum. We make suggestions for new projects and support others with our know-how.

Further publications on the topics intercultural help for addicts, transcultural psychiatry, oral prophylaxis for migrants.

The declared aim of the Ethno-Medizinische Zentrum is to bring the existing institutions into contact with each other. This bringing together is relevant for both private and state institutions in Germany and other European countries.

By means of the permanent exchange with institutions, societies and organizations, existing offers are registered and recognized needs are made out.

members of the organization: private persons and specialists from the social and health sector

number of members: about 100

Year of foundation:

The society was founded in 1988 by specialists gathered around the social-physician Jürgen Collartz (Medizinische Hochschule Hannover).

Legal form: The Ethno-Medizinische Zentrum is a registered society.

Financing:

The Ethno-Medizinische Zentrum is financed by institutions, by money from the Niedersächsische Sozialministerium (ministry for social affairs in Lower Saxony) and in addition by the city Hanover. Another part of the costs is covered by membership fees and private donations.

Specific knowledge offered by the organization:

The Ethno-Medizinische Zentrum delivers experts for further education, training courses, lectures etc. concerning the subjects:

- health-women-migration
- AIDS-women-migration
- prevention of addiction-women-migration

Publications: (available only in German)

In the documentation of the conference "...weil ich ein Mädchen bin - Lifestyle und Gesundheit von Mädchen" (because I am a girl – lifestyle and health of girls) of the network women/girls and health in Lower Saxony 1997

address: Landesvereinigung für Gesundheit Niedersachsen e.V. :)

Ute Sonntag

Fenskeweg 2 - 30165 Hannover

phone: 0049-511 / 350 00 52

5.6 Girls

Name of the Organization:

**Netzwerk Frauen/ Mädchen und Gesundheit Niedersachsen
(Network Women/Girls and Health, Lower Saxony)**

Address:

Landesvereinigung für Gesundheit Niedersachsen, e.V.
Fenskeweg 2 - 30165 Hannover
phone:0049-511 / 350 00 52
fax: 0049-511 / 350 55 95
e-mail: lv-gesundheit.nds@t-online.de
internet: www.gesundheit-nds.de

Contact:

Ute Sonntag

Aims:

The network “Women/Girls and Health, Lower Saxony”, a combining of women of institutions, associations and initiatives as well as interested single persons has been founded 1995 as a first country-wide network.

The proved discrimination of women and girls (also) in and by the health system – in a comprehensive sense demands new ways and directed measures to meet this development in a constructive way. Founding the network “Women/Girls and Health, Lower Saxony” was meant to integrate interested girls/ women , activities, organizations and institutions broadly, aiming at establishing the support of womens/girls health at a communal level. It is meant to arouse one´s own initiative, to acquire competences and to build up an infrastructure which supports the health of women/girls.

Main emphasis of work:

The network wants to work at the following tasks, based on the declaration of Vienna from 1994 (the declaration of WHO):

- To present a forum in Lower Saxony, that makes an exchange of experiences and information possible,that develops perspectives and chances of translating on a social and health political level as well as doing directed public relations.
- The awareness of the discrimination ofwomen and especially the double discrimination of women with special needs (handicapped women and women with psychic illnesses) has to be raised at a communal, regional and country-wide level and finally get broken off.
- to support key persons, initiatives and groups from communal, regional and country-wide structures and institutions to translate results of the women´s health research into their area.
- To promote solidarity, cooperation and acting together.

Members of the organization: Single members and organizations

Number of members: over 130

Year of foundation: end of 1995

Legal form: network

Financing:

No own resources; supported by the Landesvereinigung für Gesundheit, the ministry for women, employment and social affairs in Lower Saxony.

Specialist groups:

corresponding to our topics

Specific knowledge offered by the organization:

- supporting women's health at the communities
- advice in regard to networking-strategies on a communal, regional and state level

Documentations of the network's conferences: available only in German

Network women/girls and health in Lower Saxony, conference documentations, editor: ministry of women, employment and social affairs in Lower Saxony, Landesvereinigung für Gesundheit Niedersachsen, until 1999 also Institute Women and Society.

Nr.1: founding conference – not available anymore (1995)

Nr. 2: forms of activity – contents – perspectives, health in between cultures, migrants and health promotion in the community; mental illness in Women and health promotion (1996)

Nr. 3: ...because I am a girl. Lifestyle and health of girls (1997)

Nr.4: Communication and self-determination of women in the health system (1997)

Nr. 6: Pregnancy – reached a lot and gained nothing (1998)

Nr. 7: Elderly women: joy or frustration? (1999)

Nr.8: Women, work and health (1999)

Publications: available only in German

Sonntag, Ute; Helbrecht-Jordan, Ingrid, 1997:

Netzwerk Frauen/Mädchen und Gesundheit Niedersachsen. (Network women/girls and health in Lower Saxony) In: Altgeld, T.; Laser, I.; Walter, U. (Hrsg.): Wie kann Gesundheit verwirklicht werden? (How can health be realized?) Weinheim: Juventa, S. 209-214

Helbrecht-Jordan, Ingrid; Sonntag, Ute 1997:

Investitionen in die Gesundheit von Frauen. Der Beitrag des Netzwerkes Frauen/Mädchen und Gesundheit Niedersachsen zu einer geschlechtsbewußten Gesundheitsförderung. In: ifg. Zeitschrift für Frauenforschung. Heft ¾. (Investments in the health of women. The contribution of the network women/girls and health in Lower Saxony to a gender-sensible health promotion.)