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WHO REGIONAL STRATEGY ON SEXUAL AND REPRODUCTIVE HEALTH

Reproductive Health/
Pregnancy Programme

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ABSTRACT

The purpose of this document is to provide strategic guidance to Member States collaborating in the development and implementation of policies and programmes to improve the sexual and reproductive health of their populations.

It starts with a presentation of the RH challenges facing the Region and then goes on to clarify the concepts of Sexual Health, Reproductive Health and Safe Motherhood. After a summary of the underlying principles it goes into some detail about the goal, objectives and suggested targets. The approaches required to achieve these objectives are presented and discussed, with due allowance for differences in the situation of countries. National and international responsibilities are indicated and a framework for implementation proposed. Suggestions are also made for directions in resource mobilization. Monitoring and evaluation constitute the final section.

It is emphasized that the document is for use in developing national policies and programmes and therefore needs to be adapted as required.

Keywords

REGIONAL HEALTH PLANNING
STRATEGIC PLANNING
FAMILY PLANNING
MATERNAL WELFARE
REPRODUCTIVE MEDICINE
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Foreword

In recent years the challenge to health policy-makers and programme managers, in the European Region, has been to maintain and improve upon health care delivery in the face of increasing demand and diminishing resources. Countries have also had to respond to global initiatives such as “Health for all”, the International Conference on Population and Development (ICPD, 1994) and the Beijing Conference on Women, 1995. Therefore, the need arose for a regional framework to facilitate the formulation of policies and strategies for different health programmes. In 1998 country representatives at the biennial meeting of Focal Points for Sexual and Reproductive Health recommended that guidelines be prepared by the World Health Organization, Regional Office for Europe, to assist them in developing their national strategies.

The purpose of this document is to provide strategic guidance to Member States collaborating in development of policies and deliverance of programmes towards improving the sexual and reproductive health of their populations.

This document is the product of several consultations with national leaders, international agencies, nongovernmental organizations and other stakeholders. A large debt of gratitude is owed to these partners and to the many experts who have undertaken the task of writing and reviewing the papers.

WHO, Regional Office for Europe, recommends use of this strategic framework by governmental, intergovernmental and nongovernmental agencies and institutions in developing policies and programmes in the field of sexual and reproductive health, setting priorities for implementation and technical cooperation together with monitoring and evaluating progress made in this important field in the first decade of the third millennium.

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Justification and background

WHO globally has made reproductive health a priority area, underlined in the World Health Assembly Resolution of May 1995 (WHA48.10). This Resolution "URGES Member States to further develop and strengthen their reproductive health programmes, and in particular:

- to assess their reproductive health needs and develop medium and long term guiding principles on the lines elaborated by WHO, with particular attention to equity and to the perspectives and participation of those to be served and with respect for internationally recognized human rights principles;
- to strengthen the capacity of health workers to address, in a culturally sensitive manner, the reproductive health needs of individuals, specific to their age, by improving the course content and methodologies for training health workers in reproductive health and human sexuality, and to provide support and guidance to individuals, parents, teachers and other influential persons in these areas; and
- to monitor and evaluate, on a regular basis, the progress, quality and effectiveness of their reproductive health programmes, reporting thereon to the Director General as part of the regular monitoring of the progress of Health for all strategies".

Since 1995 a number of further resolutions and recommendations were issued, resulting in concrete WHO supported projects in the field of sexual and reproductive health (SRH).

In 1999, a new WHO Cabinet project in the field of reproductive health "Making Pregnancy Safer" (MPS) was launched, aiming at identifying the key interventions in decreasing maternal morbidity and mortality worldwide. The MPS programme represents WHO's strengthened contribution to the global Safe Motherhood Initiative, aiming to reduce maternal and perinatal morbidity and mortality in all regions of the world. It focuses on health outcomes and on the importance of improving health systems to attain long term, sustainable and affordable results.

SRH are areas of special concern in the European Region, particularly in central and even more in eastern Europe. There are unacceptable discrepancies in the SRH status of the population in western, central, and eastern Europe. This makes SRH a highly relevant area for health improvement within the framework of the European HEALTH21 Target 1: Solidarity for Health in the European Region. Although increased external assistance has been provided to the countries of central and eastern Europe (CCEE) and newly independent states (NIS) during the 1990s, the total amount in the health field remains inadequate.

In the process of social and economic transition, several countries have experienced rising unemployment, increases in poverty, disintegration of social networks and severe budget cuts for the health and social sectors, all of which are having a devastating impact on the health of their populations. At the same time problems like adolescent pregnancy, sexual abuse, SRH needs of refugees, migrants and other vulnerable groups need to be addressed throughout Europe. Therefore, this strategy is designed by and for *all* 51 European Member States.

Sexual and reproductive health in Europe: current situation

1. Overview

The striking feature of the health scene in the WHO European Region is the contrast in health and health care status between the market economies of the west and the transitional economies of the east. This discrepancy is particularly prominent in the area of reproductive health. As stated above, the disparity is a reflection of the economic decline in central and eastern Europe which followed the political changes of 1989/1990, resulting in negative economic growth in most countries of the subregion. Particular impact was in the newly established Commonwealth of Independent States where productivity in 1996 was only half that in 1989. In the health sector as a whole the gap soon became evident, with declining life expectancy and rising mortality in the east. In reproductive health, indicators showed relatively high maternal and infant mortality rates, a high and rising incidence of sexually transmitted infections and high abortion rates in contrast to the low prevalence of contraceptive use.

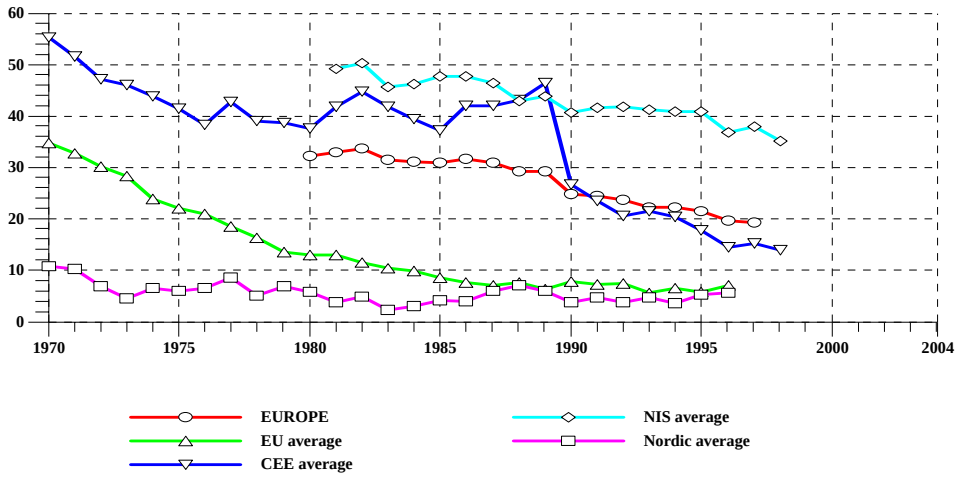
Within this disproportionate burden of ill health certain population groups are at particular risk. First and of greatest concern among these groups are the adolescents. A large proportion of the induced abortions in the subregion are in the adolescent group; the increase in sexually transmitted diseases (STDs) affects the group to a large extent; and the growing number of sex workers are in this category, putting them at risk for the emerging epidemic of HIV/AIDS. Migrants constitute another population group at high risk of reproductive morbidity. Unwanted pregnancy is common, with its attendant risks of induced abortion and obstetric complications. Migrants are also at risk of STDs and HIV/AIDS as some of them are forced into unprotected sexual relations. There is a high rate of violence against women, including sexual assault such as rape.

2. Programme areas

Maternal mortality

Maternal mortality rate (MMR) in newly independent states (NIS) is still around 40 per 100 000 live births, compared to the European Union (EU) where the level is below 10. Although abortion is legal in almost all European countries, many women do not have access to safe services. It is estimated that 25–30% of maternal deaths in NIS countries are due to (unsafe) abortion. Furthermore, lack of access to essential obstetric care and low quality of service provision lead to otherwise preventable maternal deaths.

Fig. 1. Maternal deaths in Europe: all causes/100 000 live births – general improvement but still big differences



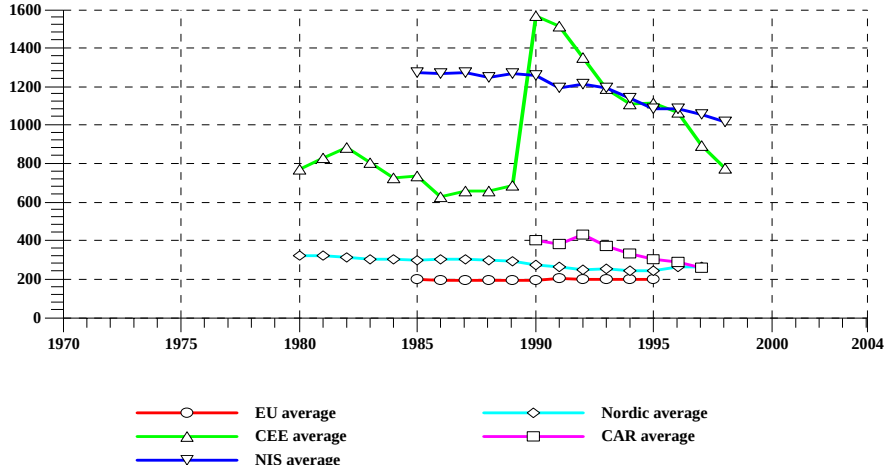
Perinatal and neonatal mortality

Perinatal mortality varies in Europe from 5 to 20 per 1000 births. Neonatal mortality (per 1000 live births) ranges from 6 to 21 in the NIS, from 3 to 7 in the CCEE, and from 2 to 5 in western Europe.

Induced abortion

Central and eastern Europe show the highest abortion rates in the world. In the Russian Federation 2.8 million abortions are reported annually. Even these high reported numbers are often an underestimation of reality as the coverage of the reporting systems is generally diminishing. In Armenia, for example, the reported rate in a recent national survey, conducted by the WHO Regional Office for Europe, exceeded the rate reported to the Ministry of Health five times.

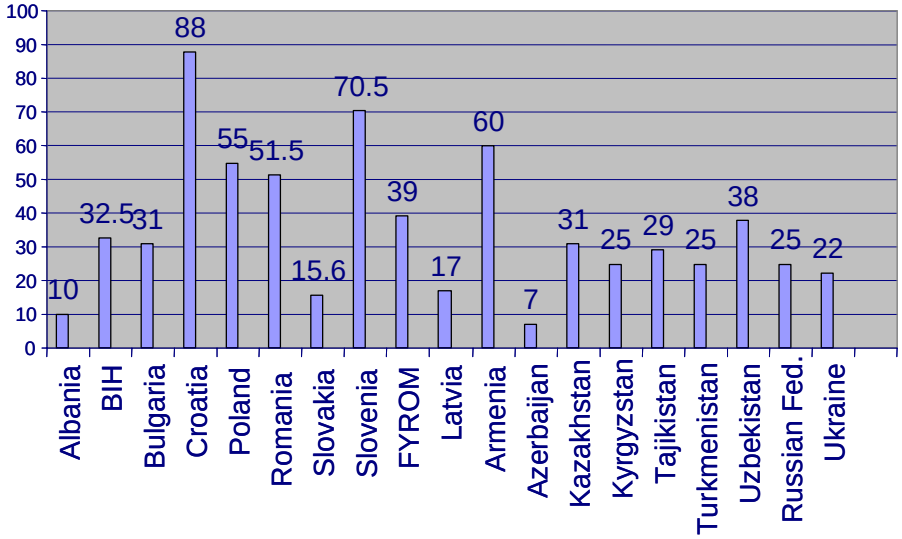
Fig. 2. Abortion per 1000 live births, 1980–1998 – decreasing trends



Contraception

The high incidence of abortion reflects the very low level of knowledge about modern contraception, limited access to contraception and poor quality of services. Modern contraception is also hardly affordable to large parts of the population in central and eastern Europe. Contraceptive prevalence rates in Europe range from around 10–70%.

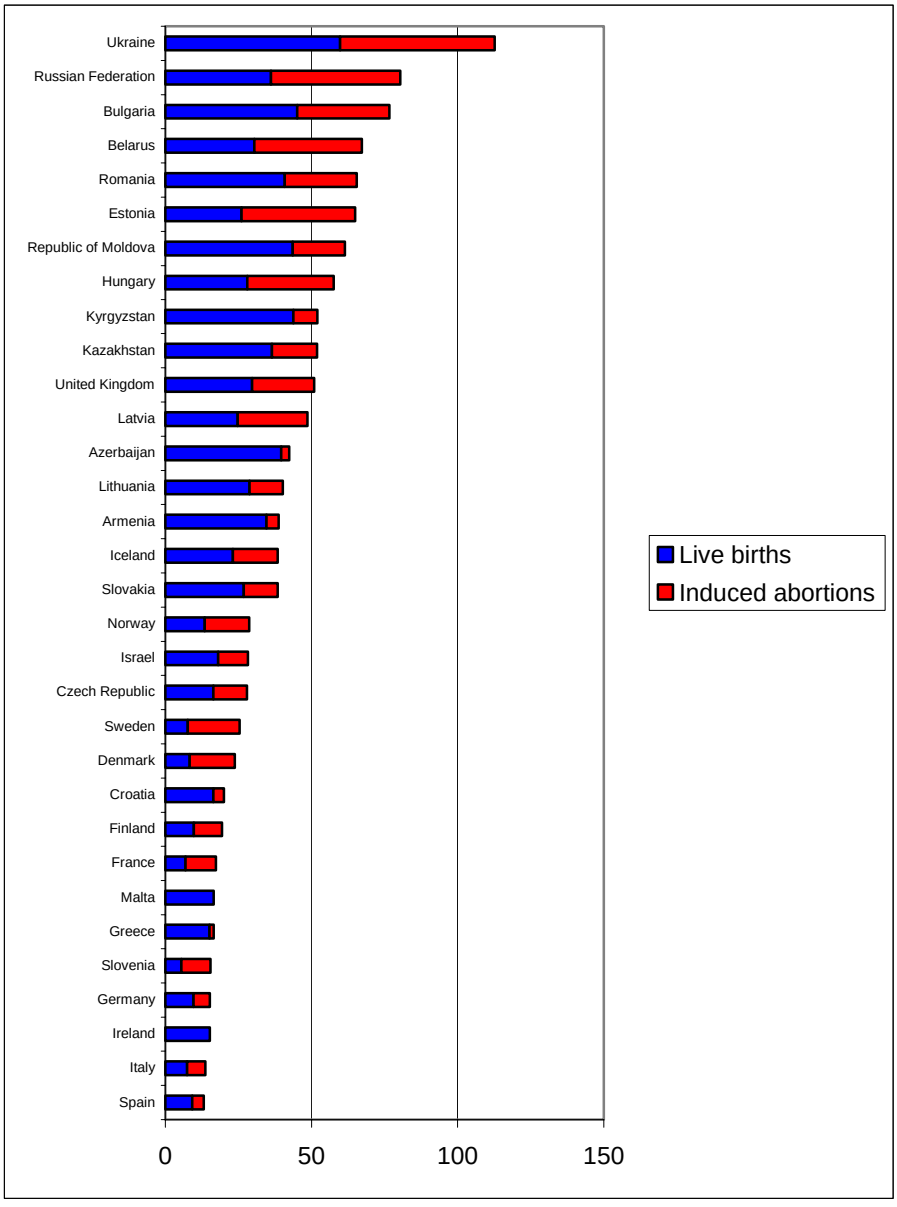
Fig. 3. Contraceptive prevalence rate in %



Adolescent sexual and reproductive health

This is a serious issue, both in the central and eastern parts of Europe and in the west. For example, the adolescent pregnancy rate now tends to be between 12 and 25 (per 1000 aged between 15–19) in most western European countries, but the rate is 47 in the United Kingdom, where it is a major social and health concern. However, the United Kingdom rate is less than half of the reported rate in the Russian Federation (102 per 1000). Adolescents tend to become sexually active at earlier ages but proper sex education and sexual health services are largely lacking.

Fig. 4. Live births and induced abortions per 1000 women aged 15–19 years

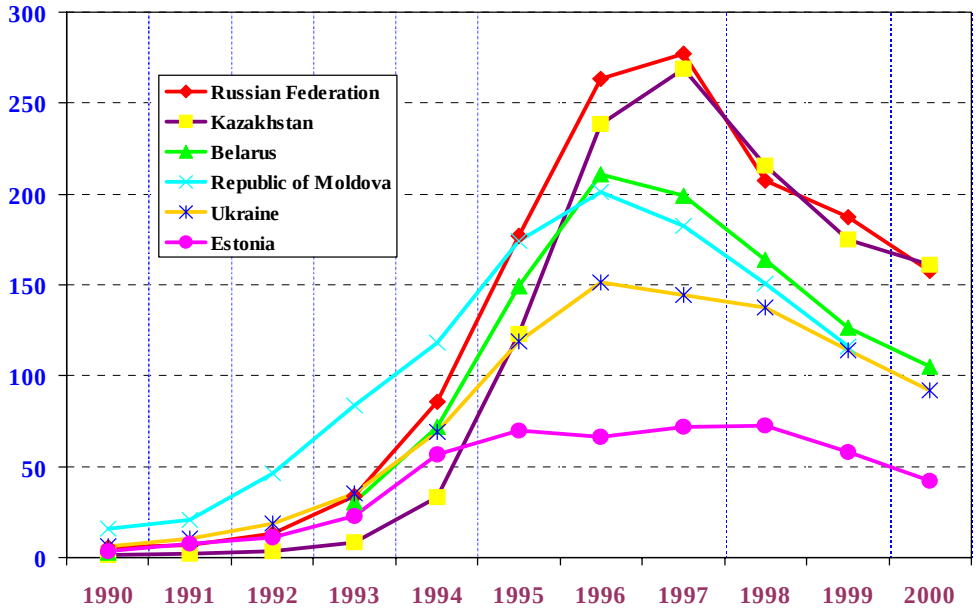


Sexually transmitted infections (STIs)

The incidence has increased alarmingly in large parts of central and eastern Europe in the past decade. Particularly the incidence of syphilis, which is fairly well documented, is now extremely high in several NIS countries: 262 per 100 000 inhabitants in the Russian Federation in 1997, and 245 in Kazakhstan (compared to 0.7 in western Europe). Cases of congenital syphilis, which

had become rare, are now increasing again. Sexually transmitted infections (STIs) are particularly a serious problem among adolescents, where infection rates tend to be higher than in the general population.

Fig.5. Annual incidence of syphilis in BEL, EST, KAZ, MDV, RUS and UKR 1990–2000 (rate per 100000)



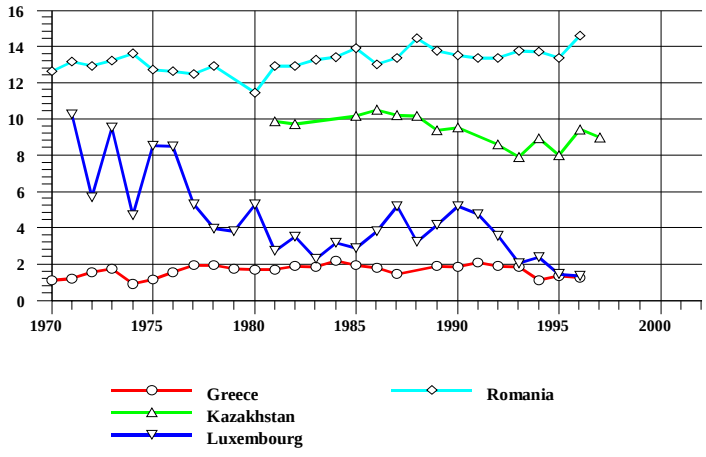
HIV/AIDS

Western Europe still accounts for nearly 90% of new AIDS cases reported in the WHO European Region. However, in eastern Europe, annual numbers of reported new HIV infections have increased dramatically since 1995, reaching a level of 124 cases per 1 000 000 population in 1999 in the Russian Federation, and of 115 in Ukraine.

Cervical cancer

One of the STIs, human papilloma virus (HPV), plays an essential role in the genesis of cervical cancer. Mainly due to the lack of population based screening programmes, mortality related to cervical cancer has increased in many countries in CCEE.

Fig.6. Standardized death rate, cancer of cervix, all ages, per 100 000



Infertility

The prevalence of infertility in eastern Europe and NIS was estimated by WHO in 1991 to be 10%, within the same range as for western Europe. However, recent observations have raised questions about the impact of STIs and post abortion complications, both of which increased in the 1990s, on the current magnitude and nature of infertility in the Region. Questions have also been raised about the effect of environmental hazards. There is a dearth of data on recent experience and it has been recommended that more studies be carried out. It has also been suggested that a standardized approach be adopted in the management of the infertile couple. It will be necessary for countries to take steps to assess and manage the problem. The high cost of diagnostic and treatment interventions add to the need for public health efforts to prevent infertility.

Refugees and displaced persons

During the last 10 years, wars in nine European countries have caused large increases in refugee and internally displaced populations. These are often women and children. Traditionally humanitarian assistance has focused on food, shelter and prevention of communicable diseases. Only recently have efforts started to also focus on their SRH needs.

Migrants

In western Europe between 5% and 10% of the population are migrants. Usually their SRH needs are much more pressing than those of the rest of the population, as can be concluded from several essential SRH indicators.

Sexual abuse, violence against women, and trafficking of women

Even though these have always been serious problems, there is growing evidence that the worsening of social and economic conditions in large parts of Europe have led to increases in forced sexual contacts, prostitution and trafficking of women.

Sexual and reproductive health of aging people

In most European countries, the percentage of elderly people in the population is substantially increasing. Health services should respond to the SRH needs of aging women and men. This includes problems related to menopause, andropause and reproductive tract cancers appearing later in life. Also, lack of social coverage excludes many people from taking the necessary preventive measures against complications due to hormonal decrease.

All the problems mentioned demonstrate that sexual and reproductive health should be given explicit attention in national and regional health policies and programmes within Europe.

Clarification of concepts

The terms “sexual health” and “reproductive health” are often not fully understood. Sometimes they are even confused with “reducing population growth”. Therefore, the meaning of these concepts needs some clarification. The following definitions are recommended:

1. Sexual health

While recognizing that it is difficult to arrive at a universally acceptable definition of the totality of human sexuality, the following definition is presented as a step in this direction: Sexual Health is

the integration of somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching, and that enhances personality, communication and love…… Thus the notion of sexual health implies a positive approach to human sexuality, and the purposes of sexual health care should be the enhancement of life and personal relationships, and not merely the counselling and care related to procreation or sexually transmitted diseases" *(WHO 1975).*

2. Reproductive health

Within the framework of WHO's definition of health as a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, reproductive health addresses the reproductive processes, functions and systems at all stages of life. Reproductive Health implies that people are able to have a responsible, satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice, and to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant *(WHO 1994).*

In this internationally accepted definition (ICPD, Cairo 1994) of reproductive health, the areas of sexual health (responsible, satisfying and safe sex life), reproductive freedom (access to information, methods and services) and safe motherhood (safe pregnancy, childbirth and healthy children) are included.

Finally, the term "reproductive health" also includes, and aims to integrate:

- Safe motherhood

  Safe motherhood aims at attaining optimal maternal and newborn health. It implies reduction of maternal mortality and morbidity and enhancement of the health of newborn infants through equitable access to primary health care, including family planning, prenatal, delivery and postnatal care for mother and infant, and access to essential obstetric and neonatal care *(WHO 1994).*

The above-mentioned areas, that in combination make up the field of reproductive health, should be integrated in policy and programme development, service delivery and information, education and communications (IE&C).

Guiding principles

Guiding principles for the improvement of health in general, and SRH in particular, have been adopted or reconfirmed at international assemblies and conferences and laid down in international documents. Especially important for this strategy are the ones contained in the World Health Declaration, adopted at the Fifty first World Health Assembly in May 1998; HEALTH21, the health for all policy framework for the WHO European Region (WHO, Copenhagen 1999); the Report of the International Conference on Population and Development (Cairo, 5–13 September 1994); and the "Overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development," presented to the General Assembly of the United Nations, 1 July 1999.

Guiding principles provided by these sources that are particularly relevant in improving SRH in the European Region are:

- Health is a fundamental human right. Everyone has the right to the highest attainable standard of physical and mental health. Member States should take all appropriate

measures to ensure, on the basis of equality between men and women, universal access to health care services, including those related to reproductive health care, which includes family planning and sexual health.

- Implementation of the recommendations in this Strategy are the responsibility and sovereign right of each country, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized international human rights.
- Commitment to the ethical concepts of equity, solidarity and social justice and to the incorporation of a gender perspective in SRH strategies. This includes solidarity in action between countries, between groups in countries, and between sexes.
- Ensuring that all health services are based on scientific evidence, of good quality and within affordable limits, and that they are sustainable for the future.
- Ensuring the availability of the essentials of primary health care as defined in the Declaration of Alma-Ata.
- Active participation by and accountability of individuals, groups and communities, and of institutions, organizations and sectors in health development are promoted and facilitated.

Goal, objectives and suggested targets

1. Goal

The goal of the Strategy is to support Member States in their efforts to ensure sexual and reproductive rights, to substantially improve the SRH status of the people, to generate solidarity in Europe in order to reduce the wide gap in SRH status in western versus central and eastern Europe, and to reduce inequities in SRH within European countries.

The following objectives and targets have been set for the period 2000–2010.

2. Objectives and targets

2.1 For the field of reproductive choice:

Objective 1: *To increase the knowledge of individuals and couples on their right to make free and informed choices on the number and timing of children and to promote the goal of every child being a wanted child.*

Objective 2: *To reduce induced abortion.*

Objective 3: *To improve the accessibility of contraceptive services for all who want to use them.*

Objective 4: *To widen the range of contraceptive options offered to all who want to use it.*

Objective 5: *To increase the active participation and responsibility of men in informed decision-making on SRH issues and to promote use of male contraceptive methods.*

Meeting these objectives will subsequently lead to a reduction of the need for women to rely on abortion as a method of fertility regulation. Reproductive choice, as a right of individuals and

couples, has until now hardly been translated into measurable indicators. Most indicators that have been used refer to the *outcomes* of reproductive choices, or the lack of it (birth rate, teenage pregnancy rate, contraceptive prevalence rate, abortion rate, etc.). Other types of indicators are suggested here to measure the *right to choose*.

The following quantitative and qualitative targets, related to these objectives, are to be met:

Objective 1: Reproductive Rights, including informed choice:

- Ensure that legislation provides for free exercising of internationally endorsed reproductive rights.
- Ensure that the percentage of the population that knows about their right to make free and informed choices on reproductive behaviour, as measured in reproductive health surveys, has reached at least 75%.
- Ensure the concept of reproductive rights has been included in school curricula and out-of-school programmes for youth.
- Ensure that the percentage of the population that knows about family planning, including contraceptive methods, has reached at least 75%.
- Ensure that all facilities providing induced abortion services have included contraceptive counselling, advice, and contraceptive delivery or referral for contraception to an alternative provider.
- Ensure that dual protection (from pregnancy and infection) is understood and practiced by all those at risk.

(see also targets for objectives 2–4)

Objective 2: Reduce induced abortion by providing adequate RH services so that:

- Resort to abortion as a family planning option is eliminated.
- Family planning is integrated in primary health care policies and programmes.
- Legal obstacles to contraceptive choices are removed.

Objective 3: Improve accessibility of contraceptive services so that:

- Contraceptives have been included in the essential drug list.
- Contraceptive services are provided as part of primary health care.
- Policies that guarantee confidentiality and anonymity of contraceptive services have been formulated and adopted into practice.
- Appropriate arrangements have been made guaranteeing that age (e.g. adolescents), gender, marital status, ethnicity, knowledge of languages, income level, and other criteria do not make services inaccessible to those who need them.
- Legal or regulatory restrictions to wide availability of contraceptives have been lifted, allowing for alternative distribution mechanisms, such as social marketing and community based services.

- Arrangements are made, if needed with assistance of third parties, guaranteeing that no individual or couple is forced to spend more than 2% of their income on prevention of unwanted pregnancy.
- For underprivileged/low income groups, measures are taken to provide contraception free of charge or at reduced cost.

Objective 4: Widen the range of contraceptive options so that:

- Each contraceptive service point (CSP) is able to explain and offers a choice of at least three different modern methods of contraception, or (in case of surgical contraception) knows where to refer clients to.
- Each CSP offers the possibility of using "Emergency Contraception".
- Standards have been set, based on international evidence based research, regarding contra-indications to the use of each contraceptive method.
- Legal prohibitions on permanent methods of contraception have been abolished.

Objective 5: Encourage male involvement so that:

- Legal and other barriers to male sterilization are lifted.
- SRH services for men are made available.
- Evidence on the causes of the increase in male infertility has been collected.

Outcome indicators of improved reproductive choice

In terms of *outcomes* of enhanced reproductive choice each country will have to define its own targets, based on the local situation analysis. The following targets are suggested, as a general guide, to be reached by the year 2010.

Reduction of the **induced abortion rate** (per 1000 women 15–44) as follows:

- Countries with a rather low abortion rate (10–20) should reduce the rate by 20%.
- Countries with an intermediate abortion rate (21–50) should reduce the rate by 30%.
- Countries with a high abortion rate (more than 50) should reduce their rate by 50%.

(*Note*: Documented abortion rates in Europe vary from 6.5 to 78 per 1000 women. Because of underreporting actual rates may be higher.)

Increase the prevalence of use of **reliable methods of contraception** as follows:

- Countries with a rather high use rate (60–70%) should increase the rate by 10%.
- Countries with an intermediate use rate (40–60%) should increase the rate by 20%.
- Countries with a low use rate (less than 40%) should increase the rate by 40%.

(*Note*: Throughout Europe, about 80% of women of fertile age who are in a sexual union are in need of contraception.)

2.2 For the field of safe motherhood:

Objective 1: *To reduce the levels of maternal mortality and morbidity. Infant morbidity/mortality is part of the IMCI strategy.*

Objective 2: *To reduce the levels of perinatal and neonatal mortality and morbidity.*

Objective 3: *To substantially increase the level of knowledge in the general population on issues related to pregnancy and childbirth.*

The following targets related to these three objectives are suggested:

Objective 1: Maternal mortality and morbidity

- Reduction in **maternal mortality ratios** (MMR= per 100 000 live births) as follows:
  - countries with a relatively low MMR (10–20) should reduce the rate by 20%
  - countries with an intermediate MMR (21–40) should reduce their rate by 30%
  - countries with a high MMR (more than 40) should reduce their rate by 40%.

(*Note*: Throughout Europe, MMR varies from 5 to 74. However, there are differences in definition and in reporting quality.)

- Reduction in maternal **mortality due to induced abortion** to less than 5 per 100 000 live births.

(*Note*: In all western countries this rate is currently under 2 per 100 000.)

- Achievement of substantial increases in the proportion of women who can access basic maternal care in priority countries, where MMR is more than 40 per 100 000 live births. Per 500 000 population at least one health centre should provide essential obstetric care. Age specific information should be kept to facilitate monitoring adolescent pregnancies.

For **maternal morbidity**, only intermediate indicators are sufficiently standardized. For this reason, the following targets are suggested:

- The proportion of pregnant women who are attended by a skilled birth attendant for reasons related to pregnancy is at least 98%.
- The proportion of births attended by trained health personnel is at least 98%.

(*Note*: Throughout Europe this percentage currently varies from 90% to 100%.)

- Reduction of the prevalence of anaemia (haemoglobin level below 110g/l) in pregnant women as follows:
  - countries with a relatively low prevalence (10–20) should reduce the rate by 30%
  - countries with an intermediate prevalence (21–50) should reduce their rate by 40%
  - countries with a high prevalence (more than 50) should reduce their rate by at least 50%.

(*Note*: Prevalence data is largely lacking. There are differences in definition; the WHO definition cited above should be adopted throughout Europe.)

- Reduction of the prevalence of severe, life-threatening anaemia (level below 70g/l), through focused efforts, by at least 70%.

Objective 2: Perinatal and neonatal mortality and morbidity

- Reduction of the **perinatal** mortality rate (PMR) as follows:
  - countries with a relatively low PMR (<10) should reduce the rate by 20%
  - countries with an intermediate PMR (10–19) should reduce their rate by 30%
  - countries with a high PMR (20 or more) should reduce their rate by 40%.
- Reduction in the **neonatal** mortality rate (NMR) as follows:
  - countries with a relatively low NMR (<5) should reduce the rate by 20%
  - countries with an intermediate NMR (5–9) should reduce their rate by 30%
  - countries with a high NMR (10 or more) should reduce their rate by 40%.

(*Note*: Throughout Europe, PMR varies from 1–15. However, there are differences in definitions and in reporting quality.)

- The proportion of newborn infants that are exclusively breastfed up to 4 months is at least 60%.

(*Note*: Currently this % varies heavily throughout Europe, from about 30% in some countries to over 90% in others.)

- The percentage of the population that knows about essential issues related to pregnancy and childbirth has reached at least 90%.

The field of sexual health is essentially composed of three major areas:

- **an environment that facilitates full enjoyment of sexuality as a human potential**
- **to be free from sexual coercion, abuse and violence**
- **to be protected against, and to receive appropriate management of health problems related to sexual life**

In this broad area of sexual health there are several issues and special target groups that have to be addressed.

2.3 For the field of STI/HIV control:

Objective 1: *To reduce the incidence and prevalence of STIs.*

Objective 2: *To reduce the incidence of HIV infections.*

Objective 3: *To reduce the incidence of cervical cancer.*

Objective 4: *To substantially increase the level of knowledge in the general population on issues related to STIs/HIV.*

The following targets related to these four objectives are suggested:

Objective 1: Incidence and prevalence of STIs

- Reduction of the **incidence of syphilis** (per 100 000 total population) as follows:
  - countries with a relatively low incidence of syphilis (30–50) should reduce the incidence by 30%
  - countries with an intermediate incidence of syphilis (51–100) should reduce the incidence by 50%

– countries with a high incidence of syphilis (more than 100) should reduce the incidence by 75%.

(*Note:* In 1998, the average incidence of syphilis in NIS countries was almost 200, and in EU countries: 1.5.)

- Reduction of the prevalence of curable STIs to less than 10% of the population.
- Effective management of at least 80% of STI cases brought for treatment.

Objective 2: Incidence and prevalence of HIV/AIDS

- Dual protection (from unwanted pregnancy and transmission of STI/HIV) by female or male condom usage is at least 30% of contraceptive use.
- HIV testing is recommended to pregnant women during antenatal care.
- The incidence of mother to child transmission of HIV is reduced through appropriate management of each HIV positive pregnant woman.

Objective 3: Incidence and prevalence of cervical cancer

- Screening programmes for early detection of cervical pre-cancer, and for management of invasive cervical cancer are implemented.

(*Note:* Age-standardized death rates from cervical cancer in Europe vary between 2 and 11 per 100 000 women.)

Objective 4: Increase knowledge in the general population on issues related to STIs/HIV/AIDS

- The topics of STI/HIV prevention and symptoms have been included in school curricula, mass media, health and non-health sector activities.

2.4 In relation to sexual abuse and violence:

Objective: To reduce sexual abuse and violence (domestic and other), and its consequences.

The following targets related to this objective are suggested:

- Adopt a broad definition of sexual violence to include non-consensual sex.
- A database on sexual abuse and violence is created in all countries.
- An infrastructure where victims can seek help and protection is established.

2.5 In relation to trafficking of women:

Objective 1: To strengthen prevention measures related to trafficking of women.

Objective 2: To provide optimal protection to victims of trafficking.

The following targets related to these objectives are suggested:

- Public information campaigns are implemented, informing women and society about potentially criminal ways of recruiting women for work abroad.

- Ensure that victims of trafficking, working as sexual slaves, are not being prosecuted, nor being expelled from the country, and are sufficiently protected, if they want to be a witness in criminal cases against trafficking.

2.6 In relation to breast cancer:

Objective 1: *To strengthen screening and early detection of breast cancer.*

Objective 2: *To increase women's knowledge and ability for self-examination.*

The following targets related to these objectives are suggested:

- At least 90% of women at risk are medically examined annually for breast cancer.
- Mammography is promoted for diagnostic purposes among high-risk groups.
- In all primary health care centres the ability to diagnose breast pathology is available.
- Educational programmes informing women on how and when to do self-examination of the breasts are operational.

(*Note:* There is wide variation in the criteria used for screening in the Region. Each country will need to determine its own approach. Technical advice may be obtained from WHO or International Agency for Research on Cancer (IARC).

2.7 For the field of adolescents' sexual and reproductive health

Objective 1: *To inform and educate adolescents on all aspects of sexuality and reproduction and assist them in developing the life skills needed to deal with these issues in a satisfactory and responsible manner.*

Objective 2: *To ensure easy access to youth friendly SRH services.*

Objective 3: *To reduce the levels of unwanted pregnancies, induced abortions and STIs among young people.*

The following targets related to these three objectives are suggested:

Objective 1: *Educate adolescents on sexuality and reproduction. Ensure:*

- Education on sexuality and reproduction has been included in all secondary school curricula.
- Educational programmes on sexuality and reproduction, aiming at out-of-school youths, have been adopted and implemented.

Objective 2: *Ensure easy access to youth friendly services.*

- For every 100 000 young people (age 10–24) in the population, at least one specialized "youth-friendly" SRH service is available.
- All "youth-friendly" services are confidential, do not require parental consent, and are offered free of charge or at reduced user fees.
- Young people are actively involved in all educational and service activities aimed at improving their SRH.

Objective :. Reduce unwanted pregnancies and STIs among young people.

In terms of ***outcomes*** of enhanced adolescent SRH, the following targets are suggested:

- At least 75% of young people protect themselves against unwanted pregnancy and STI transmission during their first sexual contact.
- At least 90% of young people protect themselves against unwanted pregnancy and STI transmission during subsequent sexual contacts.
- Reduction of the **teenage pregnancy rate** (per 1000 women aged 15–19) as follows:
  - countries with a rather low rate (15–25) should reduce the rate by 20%
  - countries with an intermediate rate (26–50) should reduce the rate by 30%
  - countries with a high rate (more than 50) should reduce the rate by 50%.

(*Note*: Documented teenage pregnancy rates in Europe vary between 12 and 83. Because of underreporting actual rates may be higher.)

2.8 In relation to refugees and displaced persons:

Objective: *To protect the SRH of refugees.*

The following targets related to this objective are suggested:

- Refugee populations are provided with emergency reproductive health services, equipment, drugs and contraceptives from the onset of humanitarian interventions in crisis situations.
- Counselling addressing sexual abuse and violence, and their consequences, is offered in refugee settings.

2.9 In relation to migrant populations:

Objective: *To decrease inequities in the SRH status between migrants and resident population.*

The following targets related to this objective are suggested:

- Accessibility to SRH services are organized without cultural, religious, racial or language barriers.
- Migrant communities are adequately informed on their rights within the social security and health systems of their host countries.

2.10 In relation to aging people:

Objective: *To improve the sexual health of aging people*

The following targets related to this objective are suggested:

- All women and men are informed about emotional, physical and hormonal changes during aging, and about the possibilities to prevent complications related to this process.
- For low-income groups – measures are taken to ensure access to treatment, preventing the complications of hormonal changes.

Strategies

Improving SRH requires a wide variety of activities, at different levels, and by a multiplicity of actors. Apart from the health sector, other sectors of society have to be involved. The following strategies are recommended:

1. Strengthening health promotion

1.1. Develop personal skills

SRH is determined to a large extent by behavioural factors. The objective of health promotion is to enable men and women, boys and girls, "to increase control over, and to improve, their health" (Ottawa Charter, 1986). People should be enabled, through information and education, to acquire and maintain behaviour that promotes their own reproductive health. Home, school, work and community are all settings where these skills can be acquired, but the health system also has a role.

1.2. Reorient health services

Health professionals, health service managers and health policy-makers should work together to orient the health system in favour of the positive pursuit of reproductive health as much as the treatment of ill health.

1.3. Strengthen community action

Communities should be empowered to set priorities, make decisions, plan and implement strategies which help them to achieve optimum reproductive health. Human and material resources in the community should be assessed and facilitated to promote self-help and social support. This implies an environment that is conducive to community action.

1.4. Create a supportive environment

An atmosphere should be created in which self-protection is an established practice, "the way society organizes work should help create a healthy society" (Ottawa Charter). In the case of reproductive health, cultural practices become particularly important and should be taken into account.

1.5. Develop suitable public policies

Policy-makers in all sectors and at all levels should be aware of the implications of their decisions for (reproductive) health. In particular they should seek to promote the status and health of women through such measures as human rights legislation and financial credit facilities.

2. Strengthening health systems and services (see Annex 1)

2.1. Health care reforms

Two types of reforms will be needed in the health system: those that respond and adapt to overall health reform actions and those that are directed at SRH services. Reforms should not only be reflected in legal changes, but also in the practice of organizing and implementing service delivery. The broad measures taken in the process of health care reforms have been applied differently in different countries, but the main themes of reform are decentralization and privatization. Strategies to strengthen reproductive health systems and services have to take into

account the national approaches to reform so that SRH services are at best improved, and at least protected from deterioration.

Within SRH services the critical organizational issue is whether or not to integrate the provision of the various components of the service. Specifically, the traditional separation of family planning (FP) from STI services should be re-examined with a view to providing the two in one setting. This is particularly appropriate where dual protection (from pregnancy and from STIs) is envisaged. Similarly, family planning should be integrated in abortion and in delivery of services. It will require reorientation of current staff and some adjustment in facilities. General practitioners, not hitherto involved in providing SRH services in some countries, will need reorientation and training. *Primary health care* will assume a central positioning within the system and the community.

2.2. Legal reform

Effective delivery of reproductive health care often depends on the national legal setting, which may directly or indirectly enhance or hinder access. Protection of human rights, informed decision-making and confidentiality may all have a bearing on what can or cannot be provided in health care. The removal of obstacles in accessing services is therefore a principal approach in improving health care.

2.3. Accessibility and quality of services

The primary purpose of approaches in this area is to ensure access of clients to good clinical care. By securing privacy and confidentiality, removing cultural barriers and providing special services for vulnerable groups such as adolescents, access is assured and maintained. Standards of care need to be reviewed to achieve improvement, and guidelines for this may be obtained from WHO. Training and retraining are essential for the private as well as the public sectors. Above all, steps should be taken to audit performance from time to time and to take corrective measures as necessary.

2.4. Information, education and communication (IE&C)

Within the strategy of strengthening SRH systems and services, special attention will be given to IE&C. Much experience has been accumulated in introducing SRH education in schools, and in the use of various techniques and technologies, including electronic media, to disseminate information and increase widely the awareness of the community about SRH issues and services. Similarly, communication with target groups regarding interventions and their involvement in all phases of development and implementation has been found to be an essential effectiveness factor. Current strategies for IE&C will be examined to determine their potential for improving impact on knowledge, attitudes and behavioural skills, and their impact on the use of services.

2.5. Capacity building: training of professionals

The training and retraining needs of professionals, in both education and service delivery, arise from the reorientation of the reproductive health service, in particular the integration of FP with STI services and the delegation of SRH responsibilities to primary level. Specific areas of (re)training will therefore include public health measures, clinical practice and new laboratory methods. New curricula need to be developed as appropriate.

2.6. Gender equity

Inequalities in health status can result from belonging to one or other sex if attention is not paid to gender equity. Public education and services for reproductive health therefore need to take into account the needs of both women and men.

The gender-based power balance favours men, so that decision-making power on SRH issues often lies with men. Societal "norms" demand that men and boys, as well as women and girls, conform to gender-based roles. The involvement of men is therefore critical and cuts across all strategies to improve SRH. At the same time there are health concerns in SRH which relate uniquely to men and need to be addressed in the provision of SRH services.

2.7. Monitoring and evaluation

A national system to monitor progress in the implementation of the various strategies is necessary. Periodic surveys on reproductive health and related issues will give an insight into the effectiveness and efficiency of the different approaches adopted and may lead to reformulation of policies.

3. Building partnerships

3.1. Public sector: intersectoral collaboration

Education is the most important public sector area of collaboration in support of SRH. There is overwhelming evidence that formal education holds the key to the assurance of equal status for women. Formal education also provides clear access to young people at the time when they are vulnerable but receptive to guidance in matters of sexual and reproductive health and development. It is essential that in SRH education the needs and responsibilities of both women and men are addressed. Other sectors should also be involved, such as Social Services and Labour.

3.2. Private sector

The private sector, including nongovernmental organizations (NGOs), is an important partner and efforts should be made to involve this resource in RH care. Private medical care and NGOs are both relatively recent additions to the health sector in the NIS. Deliberate efforts need to be directed towards working with them as a potentially effective partner with the public sector in the delivery of RH care.

4. Research

The generation of knowledge is an essential element in strategies to improve health promotion and care. Countries are encouraged to examine their health research systems to improve upon and strengthen their capacity to establish a sound knowledge basis for policy and practice. A viable health research system should be able to achieve:

- knowledge generation;
- knowledge management;
- financing of research; and
- capacity-building for research.

Fortunately, the infrastructure for research is already advanced in most cases in the European Region. There is, however, a need for capacity building in some parts and these needs should be identified and addressed.

National and international responsibilities

1. Country level

National governments and other national organizations/institutes, including NGOs, are primarily responsible for the implementation of the Strategy. Improving SRH requires active involvement of different sectors, national networks and mechanisms for appropriate coordination to be established. National governments are encouraged to adapt the Strategy and develop operational programmes, in line with national needs and priorities. WHO country offices will support national programme development and the implementation process through technical assistance and liaising with other involved international agencies.

2. International level

Technical and financial collaboration with a wide range of international governmental and nongovernmental agencies and institutions is essential. The European Commission, and other European institutions, are to play important roles in this respect. Involvement and collaboration with existing European organizations and networks in implementing the strategy will be encouraged. The following ones are particularly relevant in this respect:

- collaborative programmes of the European Union (EU), including PHARE, TACIS and others;
- bilateral east-west collaborative programmes between countries;
- internationally operating specialized NGOs, including IPPF/EN;
- networks of professional organizations, including schools of public health, universities, research institutes and others;
- associations of professionals working in the field of SRH, including European Association of Gynaecology and Obstetrics and European Midwives Association; and
- youth and women's organizations.

WHO will facilitate collaboration and partnerships among Member States and other key players.

Implementation framework

The matrix (Annex 1) presents a framework for planning priority actions in the health system, based on a situation analysis which should be the starting point. This framework suggests a large variety of possible interventions. The strategic objectives are listed in the first column. Action areas, and approaches that contribute to reaching these objectives, are given in the following columns. As levels of SRH vary widely throughout the Region, not all possible interventions are applicable or needed in each individual country to reach the health objectives mentioned. Interventions should be selected and tailored to the needs of each country.

Resources for improving SRH

1. Resource needs

The Cairo Programme of Action estimated that, in the developing countries and countries with economies in transition, the implementation of proposed programmes in reproductive health would cost US $17 000 million in 2000, US $18 500 million in 2005, US $20 500 million in 2010 and US $21 700 million in 2015. Although the cost estimates have not fallen, the contribution has fallen short of demand. Countries in the Region will have to review their needs as part of the new strategies. As stated in the Programme of Action, it is estimated that up to two thirds of the costs will have to be met by the countries themselves. Guidance on the assessment of needs and setting of priorities can be obtained from WHO.

2. Sources

Governments, as the primary providers of resources, will consider what measures are required to meet the SRH needs, applying the usual options of taxes, insurance and prepayment, user fees, and community support (mainly in kind). The allocation or reallocation of resources may be more important than the mobilization of new funds.

The private sector has become an important contributor to resources. Private facilities rely on direct payment and should be accepted as part of the resource base for RH care. Similarly, nongovernmental organizations, such as family planning associations, provide services that would not otherwise have been available. In this connection, the different components of the RH programme will have a different resource base with the public sector taking the lead in these aspects; such as public health and data collection, which cannot easily be delegated to private practice or NGOs.

The international ("donor") community have shown their desire to assist countries in their chosen programmes and they remain a critical resource for the implementation of programmes. The United Nations agencies should be prevailed on to collaborate: UNFPA, UNICEF, UNAIDS and the World Bank have a particular interest in the field. But bilateral agencies and philanthropic foundations have an increasingly important role to play. In the European Region, the European Commission is an important resource.

The World Health Organization has defined its role clearly. It will provide technical support in designing and applying programmes; it will help to develop projects that can be funded by donors; and it will, in some cases, provide financial support, especially when the activities concerned, or lessons there from, have potential to be extrapolated to other situations. Above all, WHO is a suitable forum for intercountry development of ideas and scientifically sound programmes.

3. Process

The assessment of needs is the first step in the resource mobilization process and WHO can offer guidelines for this exercise. Training in the costing of programmes can also be provided to a limited extent. Proposals for resource mobilization can receive technical support in their preparation and, if these are sound, there are prospects for support internally and externally.

Monitoring and evaluation

Progress in the implementation of strategies and attainment of objectives needs to be checked on a regular basis. This requires indicators of the status at a given time and each country will have to determine which measurements are appropriate. WHO has proposed a list of 17 indicators for global monitoring (see below) and this may be used as a starting point for selection of national indicators.

Evaluation is the periodic in-depth systematic analysis of experience. It provides opportunities to review the implementation of programmes, identify problems and suggest future directions. The aim is to recall the objectives and to determine the extent to which the objectives are being achieved through the programme activities. This facilitates any measures being taken to increase the chances of attaining the desired outcomes. Several methodologies are available for evaluation and selection will depend on relevance and feasibility.

The Rapid Evaluation Method (REM) has been advocated since 1993 by WHO as a "participatory and motivational" approach in which health service providers from different levels work together on a rapid and comprehensive assessment of the situation. It has been applied to maternal and child health and family planning programmes in several countries.

In a survey, information is gathered on selected parameters in a cross section of a population over a defined period. Several exercises have been carried out on reproductive health in Eastern Europe, for example in Armenia and Georgia. Birth surveys were pioneered in England as early as 1948 and have been repeated in other countries.

Whatever method is chosen for evaluation, the exercise is a critical component of any national strategy on reproductive health and should be included in the design of programmes from the beginning, including suggestions for measurable indicators.

Reproductive Health Indicators for Global Monitoring

1. Total fertility rate

Total number of children an average woman would have by the end of her reproductive life if she experienced the currently prevailing age-specific fertility rates throughout her childbearing life.

2. Contraceptive prevalence rate

Percentage of women of reproductive age* who are using (or whose partner is using) a contraceptive method** at a particular point in time.

* Women of reproductive age refers to all women aged 15–49 who are at risk of pregnancy, i.e. sexually active women who are not infertile, pregnant or amenorrhoeic.

** Contraceptive methods include female and male sterilization, injectable and oral hormones, intrauterine devices, diaphragms, spermicides and condoms, natural family planning and lactational amenorrhoea, where cited as a method.

3. Maternal mortality ratio

Ratio of the number of women dying from pregnancy related causes to the number of live births, expressed as annual number of maternal deaths per 100 000 live births.

4. Antenatal care coverage

Percentage of women attended, at least once during pregnancy, by skilled birth attendant* (excluding trained or untrained traditional birth attendants) for reasons related to pregnancy.

* Skilled birth attendant refers to doctors (specialist or non-specialist) and/or persons with officially recognized midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications. Both trained and untrained traditional birth attendants (TBAs) are excluded.

5. Births attended by skilled health personnel

Percentage of births attended by skilled birth attendant* (excluding trained or untrained traditional birth attendants) for reasons related to pregnancy.

* Skilled birth attendant refers to doctors (specialist or non-specialist) and/or persons with officially recognized midwifery skills who can manage normal deliveries and diagnose or refer obstetric complications. Both trained and untrained TBAs are excluded.

6. Availability of basic essential obstetric care

Number of facilities with functioning essential obstetric care* per 500 000 population.

* Basic essential obstetric care should include availability of essential medicines, for example parenteral antibiotics, intramuscular oxytocin, magnesium sulphate for eclampsia and equipment for the manual removal of placenta and retained products.

7. Availability of comprehensive essential obstetric care

Number of facilities with functioning comprehensive essential obstetric care (EOC)* per 500 000 population.

* Comprehensive essential obstetric care should include basic EOC plus availability/equipment for caesarean section, anaesthesia and blood transfusion.

8. Perinatal mortality rate

Number of perinatal deaths* per 1000 total births.

* Deaths occurring during late pregnancy (at 22 completed weeks gestation and over), during childbirth and up to seven completed days of life.

9. Low birth weight prevalence

Percentage of live births that weigh less than 2500 g.

10. Positive syphilis serology prevalence in pregnant women

Percentage of pregnant women (15–24 years of age) attending antenatal clinics whose blood has been screened for syphilis, with positive serology for syphilis.

11. Prevalence of anaemia in women

Percentage of women of reproductive age (15–49) screened for haemoglobin levels with levels below 110 g/l for pregnant women and below 120 g/l for non-pregnant women.

12. Percentage of obstetric and gynaecological admissions owing to abortion

Percentage of all cases admitted to service delivery points, providing in-patient obstetric and gynaecological services which are due to abortion (spontaneous and pre admission induced, but excluding planned termination of pregnancy).

13. Reported prevalence of women with female genital mutilation (FGM)

Percentage of women interviewed in a community survey reporting themselves to have undergone FGM.

14. Prevalence of infertility in women

Percentage of women of reproductive age (15–49) at risk of pregnancy (not pregnant, sexually active, non-contracepting and non-lactating) who report trying for a pregnancy for two years or more.

15. Reported incidence of urethritis in men

Percentage of men (15–49) interviewed in a community survey reporting episodes of urethritis in the last 12 months.

16. HIV prevalence among pregnant women

Percentage of blood samples taken from women aged 15–24 and tested for HIV during routine sentinel surveillance at selected antenatal clinics which test positive for HIV.

17. Knowledge of HIV related prevention practices

The percentage of all respondents who correctly identify all three major ways of preventing the sexual transmission of HIV (abstinence, barrier contraceptive methods and avoidance of drug abuse by injection) and who reject three major misconceptions about HIV transmission or prevention.

Annex 1

IMPLEMENTATION FRAMEWORK

Strengthening Health Systems and Services

Reproductive Choice

SRH Area and Objectives	1. To increase knowledge of the population on reproductive choice and rights	2. To reduce induced abortion	3. To improve accessibility of family planning services and access to contraception	4. To provide a wide range of safe affordable contraceptive options	5. To increase male participation and responsibility
Health System Reform	Include reproductive choice in national and regional Health Systems Reform Policy	Integrate family planning in primary health care policies and programmes	Integrate family planning, STI-, and HIV policies and programmes	Develop sustainable policies on contraceptive availability for all who are in need	
Legal Reform	Include contraception in list of essential drugs	Remove legal obstacles to contraceptive choices (e.g. sterilization male/female; emergency contraception)	Remove legal obstacles to access services for minors	Maintain or improve legal access to safe abortion services	Licence PHC workers to deliver contraceptive services
Quality of Service	Improve accessibility by integrating contraception in PHC services	Improve coherence by integrating contraceptive, abortion, and STD/HIV services	Improve quality of client centred counselling Improve quality of abortion services according to evidence based principles	Introduce or strengthen “youth friendly” services	
IE&C and advocacy	Introduce or extend reproductive rights and contraceptive education through schools, universities, military services, NGOs, and other appropriate institutions	Involve target groups at all stages of IE&C activity development	Use mass media in IE&C campaigns	Involve PHC in contraceptive education	Advocate the right to free and informed reproductive choice
Training of professionals	Develop/strengthen national and regional family planning training centres Introduce regular re-certification of practitioners	Include family planning curricula in medical schools and universities	Educate and train GPs, Ob/Gyns, dermatologists, midwives and nurses on issues of reproductive choice	Include client centred counselling training in medical curricula Set minimum training requirements for practising professionals	
Gender Equity	Inform women on their legal right to choose	Focus reproductive health education in and out of schools as much on boys as on girls	Direct public education on reproductive health and available services at both women and men	Make sure reproductive health services are relevant and accessible for both women and men	
Monitoring and Evaluation	Adopt/implement internationally accepted (WHO) definitions and classifications Develop computer software for monitoring	Develop a valid and reliable national system to monitor progress in family planning	Improve the quality and completeness of abortion reporting	Periodically implement surveys on abortion, contraception and related issues	Develop and implement systems for monitoring client satisfaction

Safe Motherhood

SRH Area and Objectives	1. To reduce maternal mortality and morbidity	2. To reduce perinatal and neonatal mortality and morbidity	3. To increase knowledge on pregnancy and childbirth in the population	4. To reduce unsafe abortion
Health System Reform	Prioritize maternal and child health in health financing Guarantee access to maternal and neonatal emergency services	Shift emphasis from curative to preventive care	Institutionalize collaboration between different levels of care	Bring number and content of ante- and postnatal visits in line with evidence based necessity
Legal Reform	Create legal frameworks for responsibilities of different medical professionals, and for different levels of obstetrical and perinatal care	Create or improve legal frameworks for parental leave and hazards at the workplace		
Quality of Service	Set, enforce and monitor standards of good practice Assure availability and optimal use of essential equipment in neonatal care	Use technical (WHO) guidelines in standardizing procedures	Promote ante-natal consultation and make it affordable	Create audit systems for maternal, peri- and neo-natal mortality and morbidity Introduce new, safer (evidence based) techniques for performing abortion
IE&C and advocacy	Create maternal health information centres Provide special information for vulnerable groups (adolescents, migrants, minorities)	Include safe motherhood in health education in schools	Involve NGOs in IE&C on safe motherhood Develop maternal and child health promotion policies Promote and educate on breastfeeding	Promote healthy lifestyle for pregnant women
Training of professionals	Identify (advanced) training needs of professionals	Improve training of professionals at all levels, incl. PHC	Introduce regular re-certification of medical professionals	Train abortion service providers in use of new, safe abortion techniques, post abortion care and family planning
Gender Equity	Respect women's attitudes on clinical procedures Involve partners in prenatal care and delivery	Protect pregnant women against hazards at the workplace	Provide for sufficient maternal leave, or paternal leave as an alternative	Create supportive environments for breastfeeding women
Monitoring and Evaluation	Develop a valid and reliable national system to monitor progress on safe motherhood	Adopt/implement internationally accepted (WHO) definitions and classifications	Monitor anaemia and RTIs in pregnant women	Monitor pathologies in pregnant women according to results of national audits

STI/HIV/AIDS Control

SRH Area and Objectives	1. To reduce the incidence and prevalence of STIs	2. To reduce the incidence of HIV infections	3. To reduce the incidence of cervical cancer	4. To increase the knowledge on issues related to STIs/HIV
Health System Reform	In policy development give high priority to: 1. Awareness raising and prevention 2. Easy access to services (in PHC) 3. Integration of STI and HIV/AIDS prevention	Minimize institutional separation of STI diagnosis and treatment	Where possible and feasible, replace hospitalization of STD patients by outpatient care	Integrate STI/HIV in comprehensive RH Implement confidential systems for partner tracing and notification services
Legal Reform	Remove legal barriers to integration of STI services in PHC	Do not use STI/HIV status as a criterion for obtaining visa, passports, jobs, etc		Include client's rights (confidentiality; anonymity; partner notification, etc.) in legal measures on STI/HIV/AIDS
Quality of Service	Use WHO guide lines in management of STD and HIV/AIDS patients Improve the quality of screening for cervical cancer	Introduce national guidelines for all medical specialists and all types of health care Prevent maternal to foetal transmissions		Include IE&C in health care settings
IE&C and advocacy	Raise awareness of STI/HIV risks among general public, using mass media Pay special attention to high-risk groups (CSW, MSM, prisoners etc.)	Encourage people to take responsibility in protecting their own and their partner's sexual health	Involve both the Ministries of Education and of Health in public education	Involve target groups in development of IE&C activities Use peer education in STI/HIV prevention
Training of professionals	Implement continuous education of service providers on new medical developments regarding STI/HIV	Provide adequate training for service providers in counselling and addressing behavioural change	Provide cross-sectional training to GPs, Ob/Gyns, dermatologists, neonatologists and others	Provide adequate training in STI/HIV case management Teach PHC workers on diagnosis of cervical cancer
Gender Equity	Focus safer sex education in and out of schools as much on boys as on girls Encourage and enable CSWs to refuse sexual intercourse without use of condoms	Direct public education on STI/HIV prevention and available services at both women and men	Emphasize male responsibility in all prevention activities Promote protection against STI/HIV (use of condoms) to both women and men	Make sure STI/HIV/AIDS services are relevant and accessible for both women and men Give special attention to women in abusive situations, who might be infected
Monitoring and Evaluation	Develop a valid and reliable national system to monitor progress on STI/HIV/AIDS control	Adopt/implement internationally accepted (WHO) definitions and classifications	Systematically use monitoring for improvement of screening programmes for cervical cancer and case management	Initiate research on behavioural aspects of STI/HIV risks Require registration of STI/HIV cases by all health care providers (incl. private sector)

Sexual Abuse and Violence

SRH Area and Objectives	**To reduce sexual abuse and violence and its consequences**			
Health System Reform	Create counselling/ therapeutic support as well as safe shelters for victims of sexual abuse and violence	Provide adequate coordination of all activities related to sexual abuse and violence		
Legal Reform	Review or adopt legislation preventing and protecting the interests of victims of sexual abuse and violence			
Quality of Service	Sensitize service providers on recognizing signs of abuse	Guarantee psychologically sensitive and medically/legally appropriate management of abuse cases		
IE&C and advocacy	Raise public awareness on issues of sexual abuse and violence	Inform and educate people on possibilities of avoiding abuse	Inform people on existing possibilities of getting support in the cases of abuse	
Training of professionals	Provide special training on counselling victims of sexual abuse and violence			
Gender Equity	Ensure gender sensitive approaches to victims of sexual abuse and violence			
Monitoring and Evaluation	Create a data base on sexual abuse and violence	Include issues of sexual abuse and violence in SRH surveys	Use the results of research and monitoring of sexual abuse and violence for awareness raising, prevention and case management	

Trafficking of Women

SRH Area and Objectives	1. To strengthen prevention measures on trafficking of women	2. To protect victims of trafficking		
Health System Reform				
Legal Reform	Avoid prosecution of women that have been forced into prostitution abroad	Protect victims of trafficking from being expelled from the country		
Quality of Service	Support NGOs that deal with this issue	Provide optimal safety for victims who want to bring their case to court		
IE&C and advocacy	Inform women and society on the risks of falling victim to trafficking			
Training of professionals				
Gender Equity				
Monitoring and Evaluation				

Breast Cancer

SRH Area and Objectives	1. To strengthen screening and early detection	2. To increase self examination by women		
Health System Reform	Integrate an adequate system of screening for breast cancer			
Legal Reform				
Quality of Service	Regularly perform mammography on women at high risk	Organize psychological support for breast cancer patients		
IE&C and advocacy	Inform and educate women on issues related to breast cancer	Start or strengthen educational activities teaching women self examination		
Training of professionals	Train PHC workers in diagnosing breast pathology	Train medical professionals in counselling that is sensitive to the impact of breast cancer on sexual health		
Gender Equity	Teach men how to support their partner in case of breast cancer			
Monitoring and Evaluation	Systematically use monitoring for improvement of screening programmes and case management			

Adolescents

SRH Area and Objectives	1. To inform and educate adolescents on all relevant aspects of sexuality and reproduction	2. To ensure easy access to youth friendly SRH services	3. To reduce levels of unwanted pregnancy, abortion and STI	
Health System Reform	Actively involve young people in organization and implementation of youth SRH activities Develop a clear policy on improving SRH of adolescents	Integrate SRH activities in comprehensive health and social programmes for young people (incl. substance abuse, sports, cultural activities, etc.)	Create partnerships between the government and NGO initiatives in addressing SRH needs of young people	
Legal Reform		Remove legal barriers for minors to access contraceptive, abortion, and other SRH services	Review, and if appropriate, adapt legal age of consent	
Quality of Service	Establish specialized youth SRH information and service centres	Create an atmosphere in service centres that is appealing to young people	Provide counselling that is confidential, and sensitive to young people's needs	
IE&C and advocacy	Introduce or improve sex education in and out of schools, using interactive methods, and start with it before young people become sexually active Creatively use new media (internet) in providing SRH information to young people	Focus SRH education on knowledge, values and building behavioural (interaction) skills Provide services where large groups of young people meet	Develop and distribute SRH IE&C materials for different age groups	
Training of professionals	Train and sensitize health, educational and other professionals on adolescents SRH needs	Initiate education of parents on guiding young people's sexual development Advocate for sexual and reproductive rights of young people	Initiate education of parents on guiding young people's sexual development	
Gender Equity	Include gender issues in IE&C activities for young people	Focus educational work with girls on strengthening self confidence and on negotiation and decision-making skills	Develop educational activities that focus on the SRH needs and responsibilities of boys	
Monitoring and Evaluation	Initiate or improve national monitoring of adolescent pregnancy, abortion, and STI incidence	Implement qualitative research on sexual behaviour and perceptions of young people (incl. boys) and use the results for developing and improving youth services and IE&C		

Refugees and displaced persons

SRH Area and Objectives	**To protect the SRH of refugees and displaced persons**			
Health System Reform	Plan for the provision of comprehensive SRH services, integrated into PHC, as the refugee situation permits			
Legal Reform	Observe and respect the legal rights of refugees, based on international and human rights instruments			
Quality of Service	Provide emergency SRH services at early stages of refugee situations, using the "Minimal Initial Service Package (MISP)" Provide services that are sensitive to the cultural values of refugees			
IE&C and advocacy	Advocate for the abolition of traditional harmful sexual practices among refugees (FGM)			
Training of professionals	Train refugee relief workers in applying the "Field Manual for RH in refugee situations"			
Gender Equity	Pay serious attention to the possibility of trauma caused by sexual and gender based violence			
Monitoring and Evaluation	Use the "eight steps approach" in the "Field Manual for RH in refugee situations" for surveillance and monitoring			

Migrant Population

SRH Area and Objectives	**To decrease inequities in SRH status between migrants and resident population**			
Health System Reform	Involve migrants in planning of SRH promotion programmes	Include SRH issues in social orientation programmes for new immigrants		
Legal Reform	Remove legal and administrative barriers for (illegal) migrants to access SRH services			
Quality of Service	Review and decrease cultural barriers to SRH services	Respect different values in SRH counselling and service delivery		
IE&C and advocacy	Provide culturally appropriate SRH IE&C materials in languages of migrants	Pay special attention to the IE&C needs of adolescent migrants		
Training of professionals	Train migrant health personnel in SRH counselling and service delivery	Train sexual education teachers in dealing with diversities in sexual values		
Gender Equity	Actively address all types of gender discrimination among migrant populations, which are violations of internationally accepted gender equity rights			
Monitoring and Evaluation	Include “country of origin” as a variable in monitoring and evaluation systems	Initiate qualitative research on SRH issues among migrant groups, and use results for improving IE&C and services		

Aging people

SRH Area and Objectives	**To improve the sexual health of aging people**			
Health System Reform	Make hormonal and other treatment for aging people available for low income groups	Organize screening programmes for prostate pathology for aging men		
Legal Reform				
Quality of Service	Provide services focusing on the special sexual health needs of aging people			
IE&C and advocacy	Inform and educate women and men on the influence of aging on sexual health and on possibilities for prevention	Educate men on signs of prostate pathology		
Training of professionals	Include sexual health implications of aging in the medical curriculum	Train PHC workers in sensitively counselling aging people on sexual health Train PHC workers on examining men for prostate pathology		
Gender Equity	Address both the needs of aging women and aging men in sexual health programmes			
Monitoring and Evaluation	Encourage research on the sexual health consequences of aging and effectiveness of preventive interventions	Use the results of research for improving sexual health care of aging people		

Annex 2

LIST OF ACRONYMS

CCEE	Countries of central and eastern Europe
CSP	Contraceptive service point
CSW	Commercial sex worker
EU	European Union
FGM	Female genital mutilation
GP	General practitioner
HIV	Human immunodeficiency virus
HPV	Human papilloma virus
IARC	International Agency for Research in Cancer
ICPD	International Conference on Population and Development (Cairo 1994)
IE&C	Information, education and communication
IMCI	Integrated Management of Childhood Illness
IMPAC	Integrated Management of Pregnancy and Childbirth
IPPF(/EN)	International Planned Parenthood Federation (European Network)
MISP	Minimal Initiative Service Package (for refugees)
MMR	Maternal mortality rate
MSM	Men having sex with men
NGO	Nongovernmental organization
NIS	Newly independent states
NMR	Neonatal mortality rate
Ob/Gyn	Obstetrician/Gynaecologist
PHC	Primary health care
PMR	Perinatal mortality rate
RTI	Reproductive tract infection
RH	Reproductive health
SRH	Sexual and reproductive health
STD	Sexually transmitted disease
STI	Sexually transmitted infection
WHO	World Health Organization

Annex 3

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