World Health Organization
REGIONAL OFFICE FOR Europe

SDG target 3.7: by 2030, ensure universal access to sexual and reproductive health care services, including services for family planning, information and education, and the integration of reproductive health services into national strategies and programmes.

SDG target 5.6: ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences.

Fact sheets on sustainable development goals: health targets

Sexual and Reproductive Health

Universal access to sexual and reproductive health (SRH) is key to improve the quality of life for everyone *(1)*. Despite great improvements for women and teenagers in access to SRH care in the WHO European Region, inequalities between and within countries persist and are considered an "unfinished agenda" and a challenge to the attainment of the Sustainable Development Goals (SDGs), particularly those targeting health security and reducing inequalities *(1)*. Action is necessary across sectors and settings to improve and maintain SRH and well-being.

Overview

The concept of SRH was put forward at the International Conference on Population and Development in 1994, where reproductive health was defined as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system, and to its functions and processes"*(2)*.

SRH implies a wide range of health issues, including family planning; maternal and newborn health care; prevention, diagnosis and treatment of sexually transmitted infections (STIs), including HIV *(3)*; adolescent SRH; cervical cancer screening; infertility prevention and management *(1)*. These services aim at preventing poor SRH, such as complications of pregnancy and childbirth, unintended pregnancies, unsafe abortions, complications caused by STIs, sexual violence and women dying from avoidable cancer *(4)*.

SRH and SDGs: facts and figures

Since the early 2000s, many Members States of the WHO European Region have made substantial progress towards improving key SRH indicators *(1)*.

- Perinatal mortality has declined by nearly a quarter, from 9.5 perinatal deaths per 1000 in 2000 to fewer than 7.4 in 2013 *(1)*.
- The average estimated maternal mortality rate also saw a decreased by more than half, from 33 maternal deaths per 100 000 live births in 2000 to 16 in 2015 *(5)*.
- The contraceptive prevalence rate, using modern methods, increased slightly from 55.6% in 2000 to 61.2% in 2015, largely as a result of increased usage in eastern and southern Europe (*1)*.
- The abortion rate fell from 489 abortions per 1000 live births in 2000 to 228 in 2013 *(1)*.

However, challenges remain for SRH in the WHO European Region:

- The Health behaviour in school-aged children study showed that 21% of adolescents at 15 years of age are sexually active, and many risk STIs or unplanned pregnancy by not using condoms or effective methods of birth control *(6)*.
- Unsafe abortion accounts for up to 20% of all deaths during pregnancy in several countries, with Member States of central and eastern Europe estimated to have the highest abortion rates in the world *(7)*.
- HIV incidence In the European Region has nearly doubled from 3.5 per 100 000 in 2000 to 6.7 in 2013 *(1)*.
- An increased number of *Chlamydia trachomatis* infections have been reported in countries of the European Union and European Economic Area *(8)*, while these infections are considered to be undereported in the Commonwealth of Independent States.
- Despite advances in screening and vaccinations, cervical cancer remains as the second most common cancer among women aged 15–44 years, with more than 28 000 women dying from cervical cancer in the European Region every year *(9)*.
- One in six couples in Europe is affected by infertility. Where the cost of treatment is partially covered by social systems, patients seek treatment early, increasing its effectiveness; however, where the cost of treatment is paid to a large extent by the couple, there are delays in treatment and in its effectiveness *(10)*.
- Unmet family planning needs, based on the most recent data available, range from 5% to nearly 23% in WHO European Region Member States *(11)*.
- Many people in the Region still lack information on sexuality, family planning, pregnancy and childbirth, STIs, infertility, cervical cancer prevention and menopause *(4)*.
- The increasing burden of noncommunicable diseases has direct consequences for SRH, and links to SRH, influencing the SRH choices of men and women and hindering progress that has been made to date in the field of SRH *(12)*.
    - In adolescents, negative body image, for example being overweight, has been associated with riskier sexual behaviours *(12)*.
    - Obesity during adolescence has been associated with an increased risk of infertility and uterine cancer later in life *(12)*.
    - Some noncommunicable diseases represent health risks for the use of some contraceptive methods *(12)*.
    - Noncommunicable diseases, such as diabetes mellitus, cardiovascular diseases and chronic respiratory diseases, increase the risk of adverse maternal and fetal outcomes, as do the four shared risk factors (tobacco use, physical inactivity, unhealthy diets and the harmful use of alcohol) *(12)*.

The educational sector is a platform where SRH should be promoted through the delivery of effective sexuality education (*13*).

- Holistic sexuality education gives children and young people unbiased, scientifically correct information on all aspects of sexuality. At the same time, it helps them to develop the skills to act upon this information. Such education should also incorporate concepts of human rights and gender equality *(1)*.
- Research shows that programmes sharing certain key characteristics can help in promoting safer SRH practices: abstaining from or delaying the start of sexual relations; reducing the frequency of unprotected sexual activity; reducing the number of sexual partners; and increasing the use of protection against unintended pregnancy and STIs during sexual intercourse *(14)*.

Gender inequality shapes SRH behaviours and outcomes and these effects are magnified when combined with other social and economic inequalities *(15)*.

- In 2004, death and disability related to SRH accounted for nearly one third of the disease burden for women of reproductive age around the world *(16)*.
- Gender inequality fosters harmful practices such as female genital mutilation, which not only has no health benefits for girls and women but also gives rise to serious complications such as problems urinating, infections, complications during childbirth and increased risk of newborn deaths. Although there are no reliable data on the prevalence of female genital mutilation in the WHO European Region, it is estimated that hundreds of thousands of women living in Europe have been subjected to the practice *(17)*.
- One in every four women in the European Region has been subjected to intimate partner violence during her lifetime *(18)*.
- Working with men and boys to challenge gender inequalities can have a positive impact on the health and well-being of women and girls. It is also important to recognize that men and boys also have health vulnerabilities. There is a growing recognition that improvement of the SRH of boys, an area that has largely been neglected, is crucial for the improvement of that of girls. It is more common for boys to have casual relationships or "one-night stands" and to have multiple sex partners, putting them at higher risk of contracting STIs *(19)*.

Discrepancies in SRH status among different population groups within and between countries have long been recognized in relation to place of residence (urban versus rural), wealth quintile, level of education and ethnicity; although major progress has been achieved, inequalities within and among countries is one of the major challenges in the European Region.

- The estimated maternal mortality rate for non-Western women is 25 times greater in some countries of the European Region than in others, and perinatal mortality is up to 10 times higher *(5)*. An excess risk for maternal mortality for women of non-Western origin compared with that of host women has been reported in several European studies, which may be related to issues such as ability to access care through language or other barriers (Box 1) *(20,21)*.
- Maternal health risks, poor pregnancy outcomes and sexual health problems are more common in Roma women than in non-Roma women living in the same country in the European Union *(22)*.
- The overall wealth and income distribution of a country is among the factors that appear to be relatively strongly associated with teenage birth rates across Europe. In addition, a higher rate of spending of the gross domestic product on social and family benefits, and higher proportions of economically active women, correlate positively with abortion levels *(23)*.
- Although the percentage of teenage pregnancies has been declining over the years in the European Region, the Commonwealth of Independent States report double the number of teenage births than the European Union (Fig. 1) *(24).*

Commitment to act

In September 2016, Member States in the WHO European Region renewed their commitment to the vision of a region in which all people, regardless of sex, age, gender, sexual orientation, gender identity, socioeconomic condition, ethnicity, cultural background and legal status, are enabled and supported in achieving their full potential for SRH and well-being; a region where human rights related to SRH are respected, protected and fulfilled; and a region in which countries, individually and jointly, work towards reducing inequities in SRH and rights *(1)*.

Box 1. Leaving no one behind...

Barriers for migrant women accessing SRH services: migrant women are often at a higher risk of poor SRH than non-migrant women. In the WHO European Region, evidence shows that migrant women experience a higher risk of unintended pregnancies, pregnancy complications, STIs, as well as sexual and domestic violence and female genital mutilation.

Barriers in access to SRH services for migrants and refugees are complex and multifaceted, documentation status being one of the main determinants *(21)*. However, there are several core issues that can be considered and need to be tacked *(21)*:

- lack of awareness of access rights and know-how for navigating the health system;
- lack of awareness of access rights by health professionals;
- language barriers;
- financial barriers;
- acceptability of SRH services (for socioeconomic, political or cultural reasons);
- availability of SRH services; and
- quality of care.

The WHO Regional Office for Europe's 2016 Action plan for sexual and reproductive health provides a rights-based and comprehensive framework to maintain and improve SRH *(1)*. Member States are invited to adapt the action plan at the national level, in line with international commitments and with international and regional human rights treaties. Country-specific context, national legislation, available capacities, priorities and specific national circumstances should be incorporated.

The action plan has three closely interlinked goals, each of which comprises several objectives to be met by undertaking key activities *(1)*.

Goal 1: enable all people to make informed decisions about their sexual and reproductive health and ensure that their human rights are respected, protected and fulfilled.

This can be achieved by adopting, protecting and promoting legislation regarding SRH rights; providing comprehensive sexuality education and information for all, throughout the life-course; preventing and responding to sexual violence by addressing gender inequality and cultural norms from a rights-based perspective.

Goal 2: ensure that all people can enjoy the highest attainable standard of sexual and reproductive health and well-being.

This requires the adoption of people-centred SRH care services that are capable of addressing the needs of all and that provide access for the vulnerable, disadvantaged and hard-to-reach groups.

Goal 3: guarantee universal access to sexual and reproductive health and eliminate inequities.

The scope and reach of SRH services should be expanded to encompass adolescents and population groups with specific needs, and SRH should be integrated into public health strategies and programmes (Box 2).

Box 2. Intersectoral action

School-based sexuality education: between 1992 and 2009, Estonia introduced school-based sexuality education and youth counselling centres addressing sexual health matters. The results of two research studies show positive associations between the implementation of the programmes and improvements in sexual health indicators among young people *(25–27)*:

- increased usage of condoms and reliable contraceptive methods;
- decline of abortion rate among those aged 15–19 years by 61% and the fertility rate by 59%;
- decline of annual registration of new HIV cases among those aged 15–19 years from 560 in 2001 to 25 in 2009;
- decline of new syphilis cases from 116 in 1998 to two in 2009; and
- decline of gonorrhoea cases from 263 in 1998 to 20 in 2009.

Monitoring progress

The WHO Regional Office for Europe is developing a joint monitoring framework for the SDG, Health 2020 and noncommunicable diseases indicators[1] to facilitate reporting in Member States and to provide a consistent and timely way to measure progress. SRH compromises all Health 2020 targets *(28).* The following, as proposed in the global indicators framework of the United Nations Economic and Social Council *(ECOSOC)*, will support monitoring progress in SRH *(29)*.

ECOSOC indicators

3.7.1. Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods

3.7.2. Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group

5.2.1. Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age

5.2.2. Proportion of women and girls aged 15 years and older subjected to sexual violence by persons other than an intimate partner in the previous 12 months, by age and place of occurrence

5.3.1. Proportion of women aged 20–24 years who were married or in a union before the age of 15 and before the age of 18

5.3.2. Proportion of girls and women aged 15–19 years who have undergone female genital mutilation/ cutting, by age

5.6.1. Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care

5.6.2. Number of countries with laws and regulations that guarantee women aged 15–49 years access to sexual and reproductive health care, information and education

Health 2020 core indicators

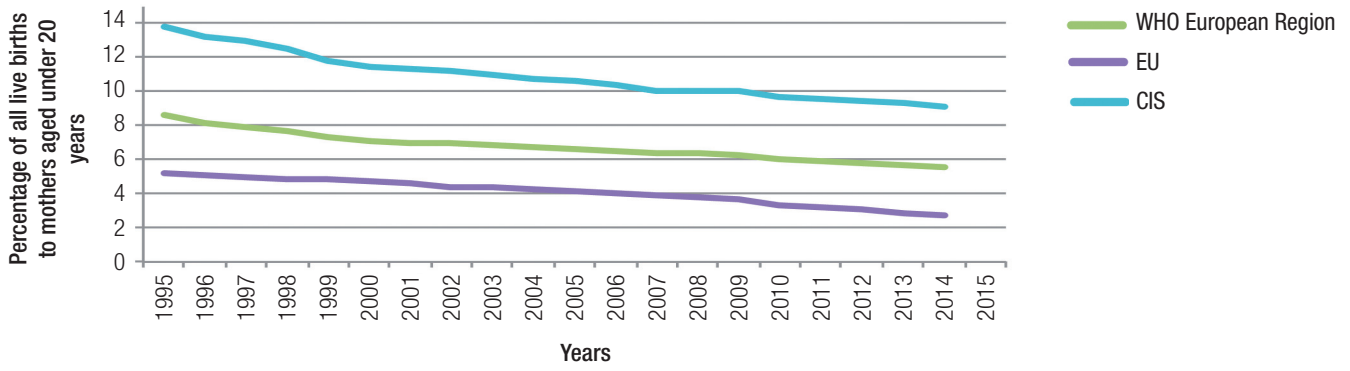
(8) 3.1.a. Infant mortality per 1000 live births, disaggregated by sex

Health 2020 additional indicators

5.1.a. Maternal deaths per 100 000 live births

[1] EUR/RC67/Inf.Doc./1: joint monitoring framework: proposal for reducing the reporting burden on Member States.

Fig. 1. Trends in percentage (%) of all births to mothers under the age of 20 years in the European Region, 1995-2014



Notes: No reported data on Turkey; last reported data were 2008 for Albania, 2012 for Greece, 2013 for Italy, 1999 for the Russian Federation, 2012 for Tajikistan, 1991 for Turkmenistan, 2011 for Ukraine; EU: European Union; CIS: Commonwealth of Independent States.

Source: European Health Information Gateway *(24)*.

WHO support to its Member States

WHO Regional Office for Europe provides support to Member States to improve and maintain SRH in line with its Action plan for sexual and reproductive health *(1)* and other key action plans, resolutions and strategies by:

- providing technical assistance for conducting a situation analysis of present needs;
- assisting countries in evaluation of implementation of the national SRH strategies, programmes and action plans;
- assisting with the development of monitoring frameworks;
- providing technical assistance for reaching specific objectives most relevant for the country; and
- strengthening collaboration and coherence among relevant United Nations agencies at national and regional levels.

The WHO Regional Office for Europe works actively through a multidisciplinary and office-wide approach with other programmes such as child health and early child development; nutrition and physical activity; mental health; tobacco, alcohol and illicit drug use control; gender and human rights; health systems; and health information.

Partners

WHO collaborates with the following partners to achieve the goal to improve and maintain SRH:

- Aga Khan Foundation
- Council of Europe
- Deutsche Gesellschaft für Internationale Zusammenarbeit (German Federal Enterprise for International Cooperation)
- European Commission
- European Federation of Sexology
- European Society of Contraception and Reproductive Health
- International Planned Parenthood Federation, European Network
- Joint United Nations Programme on AIDS/HIV
- Swiss Agency for Development and Cooperation
- United Nations Children's Fund
- United Nations Development Programme
- United Nations Population Fund Regional Office for Europe and Central Asia
- UN Women

- United States Agency for International Development
- WHO collaborating centres on sexual and reproductive health in the WHO European Region
- World Bank.

Resources

- Action plan for sexual and reproductive health
  http://www.euro.who.int/__data/assets/pdf_file/0018/314532/66wd13e_SRHActionPlan_160524.pdf?ua=1
- Strategy on women's health and well-being in the WHO European Region
  http://www.euro.who.int/__data/assets/pdf_file/0020/314534/66wd14e_WomensHealthStrategy_160519.pdf?ua=1
- Global strategy for women's, children's and adolescents' health (2016–2030)
  http://www.who.int/pmnch/media/events/2015/gs_2016_30.pdf
- Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets
  http://www.who.int/reproductivehealth/publications/general/RHR_04_8/en/
- Draft global health sector strategy on sexually transmitted infections 2016–2021
  http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_33-en.pdf?ua=1
- Global plan of action to strength the role of the health system in addressing interpersonal violence
  http://www.who.int/topics/violence/UNFPA-GAP2-violence.pdf
- Action plan for the health sector response to HIV in the WHO European Region: DRAFT 5.4 (2016)
  http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/publications/2016/action-plan-for-the-health-sector-response-to-hiv-in-the-who-european-region.-draft-5.4-2016

Key definitions

- **Unsafe abortion.** A procedure for terminating an unwanted pregnancy either by people lacking the necessary skills or in an environment lacking the minimal medical standards or both *(7)*.
- **Cervical cancer**. Cancer that forms in tissues of the cervix (the organ connecting the uterus and vagina). Human papillomavirus (HPV) is the primary cause of cervical cancer. Over three quarters of sexually active women get it at some point in their lives. There are over 100 types of HPV, but two types (16 and 18) cause 70% of cancers *(9)*.
- **Sexually transmitted infections.** Infections spread predominantly by sexual contact, including vaginal, anal and oral sex. Some STIs can also be spread through non-sexual means such as via blood or blood products. Many STIs (including chlamydia, gonorrhoea, hepatitis B, HIV and syphilis) can also be transmitted from mother to child during pregnancy and childbirth. More than 30 different bacteria, viruses and parasites are known to be transmitted through sexual contact *(3)*.
- **Comprehensive sexuality education.** An age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information to enable learning about the cognitive, emotional, social, interactive and physical aspects of sexuality. Sexuality education provides opportunities for individuals to explore their own values and attitudes and to build decision-making, communication and risk-reduction skills about many aspects of sexuality *(13)*.

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