

CAUSES AND CONSEQUENCES: WHAT DETERMINES OUR SEXUAL AND REPRODUCTIVE HEALTH?



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As the countdown to the formal deadline for the Millennium Development Goals in 2015 grows nearer, it is apparent that gross inequalities in health, including sexual and reproductive health (SRH), are present both across and within regions and countries, globally and in Europe. While it is true that the majority of Member States in the WHO European Region have much to celebrate when it comes to progress in improving SRH and increasing access to SRH services, it is also true that even in the most affluent countries of the Region, social injustice exists, with select groups at greater risk of poor SRH outcomes and limited access to SRH services. This social gradient holds true across all health fields and in all societies; the most disadvantaged experience poorer health and shorter life expectancy. In order to address this social injustice, there is an urgent need to move beyond examining the different statistics that highlight these disparities (e.g. maternal mortality, neonatal mortality, contraceptive prevalence rate, abortion rate, adolescent pregnancy rate, number of antenatal care visits, HIV and sexually transmitted infections incidence and prevalence) and ask, “What determines our SRH?”

In fact, the answer is quite complex. While genetic susceptibility plays a small role, it is our environment and the conditions in which we live and work that have the greatest impact and effect on our health. Increasingly, social factors such as geographic location, education, employment, economic status, religion, culture, social exclusion, gender and ethnicity are being identified as the underlying causes of these health disparities. Individually or in combination, these factors undermine more than just SRH health, but also development, sustainability and overall community wellbeing. Public policies that fail to act on these adverse social conditions help contribute to unfair and avoidable inequities in SRH between groups. For example, a pregnant, unmarried adolescent girl will likely face social stigma because of her pregnancy. Although she attends school, she may not have the financial means to be able

to attend antenatal care or to obtain the appropriate information about pregnancy services. If she happens to reside in a country where public policies penalize adolescent pregnancy or prevent youth friendly health services, she becomes even more marginalized, with limited ability to access SRH services. All of these aspects combine to greatly reduce both her and her unborn child’s opportunity for positive health outcomes.

However, SRH and other health inequities are not inevitable – quite the contrary. Health inequities are a problem for all countries and require actions that move beyond treating adverse health and SRH outcomes to tackle the underlying causes that contribute to them. Across Europe, more and more countries are introducing policies that address the social determinants of health, but translating these policies into action remains a challenge. Doing this successfully requires that action across all five of the key building blocks of the “social determinants approach” recommended by the WHO Commission on Social Determinants of Health is taken. This entails involvement of multiple sectors at all levels (international bodies, governments and civil society), with concerted action across the following five themes:

1. Governance to tackle the root causes of health inequities: implementing action on social determinants of health;
2. Promoting participation: community leadership for action on social determinants;
3. The role of the health sector, including public health programmes, in reducing health inequities;
4. Global action on social determinants: aligning priorities and stakeholders; and
5. Monitoring progress: measurement and analysis to inform policies and build accountability on social determinants.

Addressing the social determinants of health can appear overwhelming.

However, with political will, considerable progress can be made. This issue of *Entre Nous* highlights what progress and challenges have been made in the European Region in tackling this very important issue. It is our hope that long after you have completed reading the articles you will continue to ask yourself “What determines our SRH?” It is only in continually asking this question that we will be able to address the root causes and decrease SRH inequities. From our side, the WHO Regional Office for Europe will continue defining goals and targets of the New European Health Policy, Health 2020, gathering best practices and assisting countries in promoting equity and championing the principles of human rights.

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SOCIAL DETERMINANTS OF SEXUAL AND REPRODUCTIVE HEALTH: A GLOBAL OVERVIEW

The World Health Assembly and the World Health Organization (WHO) affirm that “sexual and reproductive health is fundamental to individuals, couples and families, and the social and economic development of communities and nations” (1).

In many countries, however, improvements in sexual and reproductive health (SRH) related outcomes have often been slow despite significant investment. Social and economic inequalities have come to the attention of the international community as an important factor driving many health inequalities. Social, demographic, economic and geographic differences within a population are important underlying factors that influence access to high quality health care and thus health status.

At the global level, the world’s poorest countries often struggle with resource constraints that limit investment in the health infrastructure. As a result, developing countries bear the highest burden of disease, including maternal mortality, reproductive cancers, and sexually transmitted infections (STIs) while also facing high population growth.

Globally, the magnitude of poverty’s impact on SRH is astounding:

- Of the 20 million unsafe abortions that occur each year, 19 million are estimated to take place in developing countries. The consequences of unsafe abortion are also highly variable. Women living in Sub-Saharan Africa are 75 times more likely to die than a woman living in a developed country (2).
- The annual incidence of STIs ranged from 109.7 million new cases in the Africa region to 25.6 in the Eastern Mediterranean region. As a comparison, incidence in the European Region was estimated at 44.6 (3).
- Approximately 80% of cervical cancer cases occur in low-income countries and this is expected to increase to 90% by 2020 (4). Cervical cancer is the second most common cancer among women living in the developing world, and is also the single

largest cancer-related cause of life years lost in these countries (5).

Observed imbalances in access to resources result in a cycle of disadvantage at the individual level. Evidence demonstrates that less advantaged population groups are more vulnerable to exposure, less likely to access health care, and have worse health outcomes. Migrant populations, adolescents, and ethnic minorities are often difficult to reach through the existing health infrastructure, and face a variety of legal, social and cultural barriers to accessing SRH services. For many vulnerable groups, issues surrounding language, cultural attitudes, perceptions of health service availability, and provider attitudes make accessing services, if they are available, a challenge (6).

Women in many developing countries also face increased economic vulnerability which combines with low levels of education and a reduced social status – thereby resulting in them having little autonomy to make decisions on how or when to seek medical care or family planning services. Underutilization of health services by women has been well documented with factors related to underutilization of health services grouped into three categories (7). The first includes service factors such as affordability, accessibility, and adequacy of the health system to meet women’s needs. The second group addresses user constraints, such as social mobility, lack of financial resources, and greater demands on women’s time, and information asymmetries of health information between women and men. The third group identifies institutional factors, including men’s decision-making power and control over health budgets and facilities, local perceptions of illness, and stigmatization and discrimination in health settings.

The following examples illustrate the breadth of gender’s influence on SRH, but also highlight how multiple social determinants often compound to have an even greater impact.

- STIs are often more easily transmitted to women from men. Infection with

human papillomavirus can lead to the development of genital cancers, while STIs are the main preventable cause of infertility (8). Infertility is often blamed on the woman, and women may suffer similar negative consequences including humiliation and physical abuse.

- Women in developing countries are more likely to suffer from chronic disability resulting from unsafe abortion or complicated pregnancies. When a woman develops an obstetric fistula, she not only faces the physical suffering associated with the condition, but may also face divorce, social exclusion, malnutrition, and increased poverty.
- Environmental factors play an important role in women’s susceptibility to rape and gender based violence (GBV). For example, women are often placed in vulnerable situations while waiting for transportation at night, collecting water, or using latrines.
- Where early marriage and/or childbearing is prevalent, girls who are exposed have less education and schooling opportunities, less household and economic power than older married women, less exposure to modern media and social networks, are at great risk of GBV, and face greater health risks, such as exposure to HIV and/or having their first birth at a young age (9).
- GBV is rooted in gender inequality. A WHO multi-country study on GBV found that the prevalence of women who have suffered physical violence from a male partner ranged from 13% in Japan to 61% in provincial Peru. In terms of sexual violence, Japan also had the lowest level at 6%, and Ethiopia had the highest at 59% (10).

Education is an important mediating factor with regard to women’s SRH outcomes. Increased women’s education is not only linked to fertility decline, but also facilitates the diffusion of ideas regarding childbearing, contraception, and

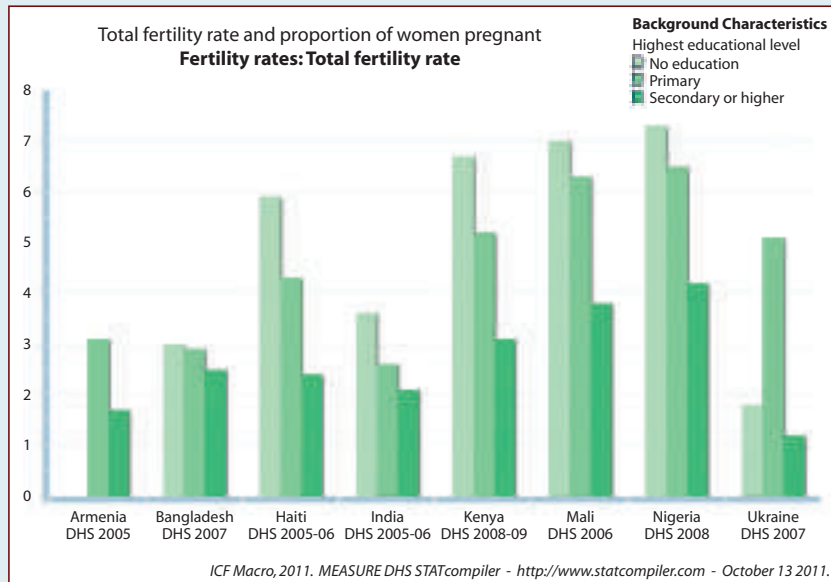


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Figure 1. Total Fertility Rate by Highest Educational Level, Selected Countries.



the social status and value placed upon women. As shown in Figure 1, fertility tends to decrease as household educational level increases. For example, girls with secondary education in Bangladesh, were nine times less likely to be married by their 18th birthday (11). While wealth and educational status are closely related, some analysis indicates that education may moderate the effect of wealth on contraceptive use (7).

A Closer Look at the Social Determinants of Unintended Pregnancy

Worldwide, 40% of all pregnancies are unintended (12). The burden of unintended pregnancy disproportionately affects the poor, in almost all countries. Higher rates of unintended pregnancy have also been observed among young people, the uneducated, ethnic minorities and migrants compared to more advantaged groups. Vulnerability to unintended pregnancy is strongly influenced by access to and use of effective contraception and by exposure to unwanted sex through child marriage and sexual violence.

Women are particularly susceptible to unwanted sexual activity. Sexual violence and child marriage are two common ways women are exposed to sexual activity

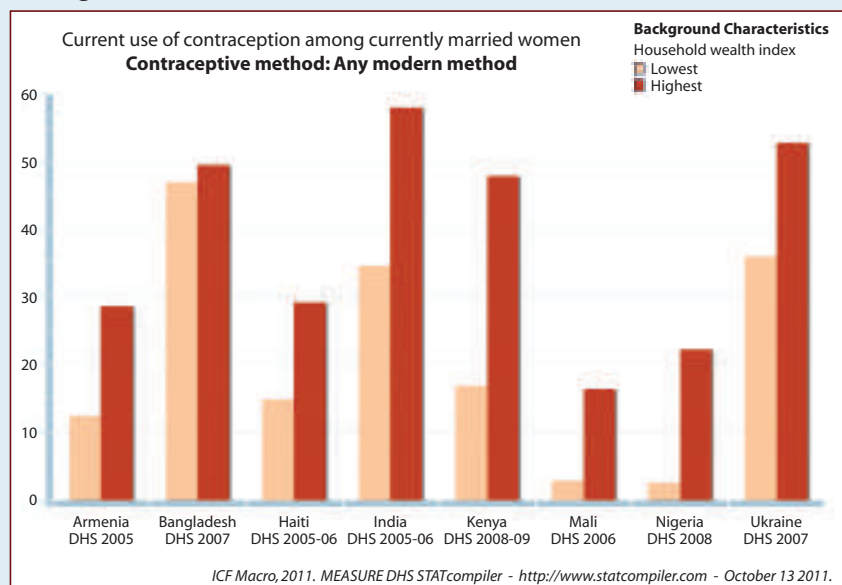
without full and informed consent. Beyond the potential consequences of STIs and unwanted pregnancy, evidence suggests that sexual coercion negatively affects victims' general mental and physical well-being. Sexual violence is also associated with risky behaviours such as early sexual debut and multiple partners (11, 13). Key factors associated with higher levels of sexual violence and coercion

include armed conflict and legal systems that fail to prosecute sexual violence or protect women's civil rights (13). A recent analysis in 20 countries with the highest prevalence of child marriage found four factors were strongly associated: education of girls, age gap between partners, geographical region and household wealth (13).

For women who are sexually active, modern contraception is the best protection from an unintended pregnancy. In most developing countries, wealthy individuals are more likely to adopt modern contraception than the poor. This relationship is illustrated in Figure 2 with data from selected developing countries. In all the countries shown, modern contraceptive use is significantly higher among women in the highest wealth quintile versus those in the lowest.

Health services are responsible for providing women with essential information to make an informed choice and sufficient instruction for correct method use. Yet women often receive differential treatment from providers. Studies from Ghana and Nepal using "simulated patients" indicate that lower-class, uneducated and younger clients receive poorer treatment (14,15). Clients of lower socioeconomic

Figure 2. Use of a Modern Method of Family Planning Comparing the Lowest and Highest Wealth Quintiles, Selected Countries.



SOCIAL DETERMINANTS OF SEXUAL AND REPRODUCTIVE HEALTH: A GLOBAL OVERVIEW (CONTINUED)

status and adolescents are especially susceptible to restrictive provider practices, as they have fewer options for where to access services (16).

The low status of women in many countries restricts their ability to make decisions within the household. One way Demographic and Health Surveys capture this dynamic is by asking women if they are able to decide for themselves to seek health care. In the 30 countries where data were available, an average of only 37% of women report they are able to seek their own care. In 26 of 30 countries, a smaller proportion of women in the poorest households were able to seek care. The rich–poor gap ranges from less than 1 percentage point in Bangladesh (2004) to 32 percentage points in Peru (2000) (17).

Women with an unintended pregnancy are faced with a difficult decision, one of which may be abortion. Deciding whether to terminate an unintended pregnancy is influenced by many factors, including the availability and accessibility of induced abortion services, the social acceptability of childbearing and induced abortion, and support from social structures. The decision made will have social, financial and health consequences that are not equally experienced among women.

“Unsafe abortion” is defined as a procedure for terminating pregnancy carried out by attendants without appropriate skills, or in an environment that does not meet minimum standards for the procedure, or both (18). Unsafe abortion is a major cause of maternal mortality, accounting for an estimated 13% of maternal deaths worldwide (2). In 2005, an estimated 5 million women were hospitalized for treatment of complications from unsafe abortion (19). The highest estimated rate of unsafe abortion is in Latin America and the Caribbean, where there are 33 unsafe abortions per 100 live births, followed by Africa (17 per 100 live births) and Asia (13 per 100 live births) (20). Rates of unsafe abortion are highest among young women, with almost 60% of unsafe abortions in Africa occurring among women under age 25 (21).

A number of studies have documented higher complication rates and mortality resulting from unsafe abortion among women of low socioeconomic status (22). Women from more affluent households are more likely to obtain an induced abortion from a physician or nurse, while poor women living in rural areas are more likely to use a traditional practitioner or self-induce an abortion.

Unintended childbearing detrimentally affects women and children. Women who have an unintended pregnancy are more likely to delay antenatal care or have fewer visits and experience maternal anxiety, depression and abuse (23). Unintended children are more likely to experience symptoms of illness, less likely to receive treatment or preventive care such as vaccinations, less likely to be breastfed and more likely to have lower nutritional status, have fewer educational and development opportunities and are at increased risk of infant mortality (23–25).

Improving pregnancy outcomes will require interventions specifically designed to achieve equity in the availability of all related health services, especially targeting the poor and disadvantaged for access to contraceptive and skilled birth attendant services. Such efforts will be most effective when combined with addressing upstream determinants, such as improving education for women and the effective functioning of the health sector and of government services in general.

What can be done?

The varying levels of inequality present in a population have an important impact on SRH outcomes. Differences in control over and access to resources determine both physical and financial access to health services. Power dynamics also influence quality of clinical care received by a client. Additionally, individual health-related behavior is often influenced by norms surrounding social position, ethnicity, and gender. At the structural level, the socioeconomic and political environments interact with an individual’s position - social class, gender, ethnicity, and income. The intermediary

determinants of health include factors that may directly influence biological exposure or susceptibility, such as living conditions and working conditions, as well as behavioral, biological, and psychosocial factors. Health inequities observed in a population are driven by a complex relationship between social determinants, and are mutually reinforced through multiple feedback channels.

While the challenge is significant, progress can be made in SRH with increased attention to the social determinants. There are a growing number of programmes that have been successful at designing interventions that address social determinants and contribute to improved SRH. Programmes that have been successful have taken a targeted approach such as fostering community participation, encouraging governments to support more equitable policies, and improving data collection to better understand health disparities. In order to meet the objectives set forth in the Millennium Development Goals, greater attention must be paid to inequities and the social and economic structures that contribute to them.

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SOCIAL DETERMINANTS OF HEALTH AND MILLENNIUM DEVELOPMENT GOAL (MDG) 5: IMPROVING MATERNAL HEALTH

The following is an excerpt from the report “Progress towards Millennium Development Goals 4, 5, and 6 in the WHO European Region: 2011 Update.”

MDG 5 aims to improve maternal and reproductive health. Its targets are:

- A) to reduce by 75%, between 1990 and 2015, the maternal mortality ratio;
- B) to achieve, by 2015, universal access to reproductive health.

Globally, progress towards MDG 5 is insufficient. In 2008, there were approximately 358 000 maternal deaths worldwide, representing only a 34% decline compared to 1990 (1). Maternal mortality diminished by 2.3 % per year globally between 1990 and 2008, which is far short of the 5.5% annual reduction necessary to achieve target A (1).

In the European Region, the estimated average maternal mortality ratio (MMR) decreased from 44 deaths per 100 000 live births to 21 between 1990 and 2008 (1). This represents only a 52% decline when compared to 1990. The annual reduction of 4.1% is also below the 5.5% needed to reach the target (1).

Maternal mortality (MM) is influenced by interlinked social determinants that prevent pregnant women from accessing the health services they need and are entitled to as a basic human right. These determinants, of which the health system is one, collude to result in the “three delays”, which—when considering maternal mortality globally—are understood to encompass:

- Delay in seeking appropriate medical help for an obstetric emergency for reasons of cost, lack of recognition of an emergency, poor education, lack of access to information, administrative barriers and gender inequality;
- Delay in reaching an appropriate facility for reasons of distance, infrastructure and transport; and

- Delay in receiving adequate care when a facility is reached, for reasons such as, but not limited to, shortages of qualified staff or because electricity, water or medical supplies are not available (2).

Delays will be characterized differently depending on the country context and where a woman or adolescent girl finds herself within that context (i.e. her socioeconomic position, geographic location, being of an ethnic minority group or irregular migrant experiencing social exclusion).

Due to these social determinants, inequities in MM between countries are stark in the European Region. According to estimates from 2008 the country with the highest estimated MMR was Kyrgyzstan (with an estimated ratio of 81) and the lowest estimated ratio was in Greece (with an estimated ratio of 2) (1). Romania had the fastest rate of decline, with an 84% change in MMR between 1990 and 2008 (1).

Inequities in MM also persist within countries. Rural populations tend to have higher MM than their urban counterparts. Ratios and risk vary widely by ethnicity, education and wealth status, and remote areas bear a disproportionate burden of deaths. Within urban areas, the risk of MM and morbidity can also differ significantly between women living in wealthy and deprived neighborhoods (3). In western Europe, where MM is generally low, there is evidence of significantly higher risks for migrant and refugee populations (4). Gender inequities, addressed by MDG 3, undermine progress to address MM and morbidity.

Proportion of births attended by skilled health professionals

One of the indicators for monitoring progress towards MDG 5 target A is the proportion of births attended by skilled health personnel. In the European Region as a whole, overall percentages of births attended by skilled health personnel are generally high when compared to countries in other regions of the world (5). In

the Region, the percentage of births assisted by skilled health personnel between 2000 and 2010 was 98%, compared to 66% globally (5).

Despite most countries in the Region having almost all births attended by skilled health personnel, there is evidence of inequities within countries and concerns about quality of the services provided. Available data indicate that socially disadvantaged groups (including populations with lower socioeconomic status, ethnic minority groups and socially excluded migrants) and rural populations have poorer access (5-7).

These inequities in the proportion of births attended by skilled health personnel reflect global trends. For instance, according to the report *Progress for children: Achieving the MDGs with Equity*, in all regions worldwide women from the richest 20% of households are more likely than those from the poorest 20% of households to deliver their babies with the assistance of skilled health personnel (8).

Contraceptive prevalence rate (CPR) and the unmet need for family planning

An estimated one in three maternal deaths globally could be prevented if women who desired contraception could have access to it (9). Hence, CPR and the unmet need for family planning are two of the indicators used to monitor progress towards MDG 5 target B, which is to achieve by 2015 “universal access to reproductive health”.

Contraceptive prevalence is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used. It is usually reported for married or in-union women aged 15 to 49. The CPR for the European Region was 70.7% for the 2000-2010 period (5). Evidence suggests that contraceptive prevalence (using any modern method) has generally increased across the European Region since 1990 (10).

Women with unmet need for family

Table 1. ANC coverage (%) in select European Member States, by place of residence, wealth quintile and education level of mother (20).

Country	Year	ANC coverage					
		Place of residence		Wealth quintile		Educational level of mother	
		Rural	Urban	Lowest	Highest	Lowest	Highest
Albania	2008-2009	96.2	99.1	93.3	99.3	96.9	99.4
Azerbaijan	2006	63.3	89.7	53.2	95.3	63.8	93.5
Turkey	2008	84.2	94.7	76.1	98.6	78.3	99.3
Ukraine	2007	98.1	98.7	96.7	98.9	97.8	99.1

planning are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the birth of their next child. An average of 9.7% of women (of reproductive age who were married or in a union) had an unmet need for family planning in the European Region during the 2000-2009 period (5).

As with other MDG 5 indicators, differences can be seen across the social gradient and by location; that is, women with higher incomes, education levels, and urban rather than rural residence tend to have higher use of contraceptives and lower unmet need for family planning. An example of urban versus rural differences comes from Turkey, where in urban areas the percentage of women using a method of family planning is higher (74%) than that of women residing in rural areas (69%) (11).

Multidimensional social exclusion processes—such as those affecting ethnic minorities and migrants—can also contribute to lower CPR. There is evidence that the more pronounced the social exclusion (i.e. crossing social, political, economic and cultural domains), the lower the prevalence. For instance, in Bulgaria, 65% of richer and more educated Roma women use any family planning method, compared to 31% among all interviewed Roma women (12). Several studies suggest that migrants tend to underuse contraceptive methods compared to non-migrant populations in Europe;

this is largely due to poor family planning information in migrants' home countries and inadequate outreach services within the health services of the destination country (4, 13).

Low CPR and the unmet need for family planning can contribute to higher rates of abortion. Although records in many countries are not comprehensive, evidence suggests that eastern Europe and central Asia has one of the highest abortion rates in the world (14). Cultural considerations in some population groups, including reliance on traditional methods of birth control such as withdrawal, can contribute to higher rates of abortion. The average induced abortion rate in countries of western Europe is low, but there is evidence that requests for abortion are higher among women with low socioeconomic status, particularly if they also have migrant status (13).

In some countries of the European Region, abortion still causes more than 20% of all cases of maternal mortality (15). In most of the Member States of the European Region law permits abortion to save a woman's life and in more than half of the countries abortions on request are permitted. Despite this, it is estimated that half a million unsafe abortions were performed in 2008 in the European Region, causing 7% of maternal deaths (15). Exposure to unsafe abortion is socially determined and linked to weak health systems. Globally, a woman with low income residing in a rural area is three times more likely to suffer from compli-

cations due to unsafe abortion and 50% less likely to receive medical treatment, compared to women in an urban area with a high income (16). Lack of quality equipment, facilities and care may enhance the risk of post-abortion complications. Stigma and psychosocial considerations (including those influenced by age and cultural beliefs), as well as irregular migrant status, can also be risk factors for unsafe abortion.

Adolescent birth rate

The adolescent birth rate, defined as the annual number of births given by women aged 15–19 years per 1000 women in the age group, is an indicator for MDG 5 target B. Pregnant women under 20 years of age face a considerable burden of pregnancy-related death and complications. When compared to women aged 20–29 years, the risk of dying from pregnancy-related complications is twice as high for girls/women aged 15–19 years and five times higher for girls aged 10–14 (17). Many health problems are particularly associated with negative outcomes of pregnancy during adolescence. These include anaemia, sexually transmitted infections, postpartum haemorrhage and mental disorders such as depression (15).

Taken as a whole, the European Region had an average adolescent birth rate of 24 for the 2000-2008 period (5). According to the latest data available, San Marino has the lowest adolescent birth rate (1 per 1000) and Turkey (56 per 1000) has the highest. Adolescent birth rates have decreased in countries across the European Region (5). In the Caucasus and central Asia, the adolescent birth rate declined from 45 in 1990 to 29 in 2008 (18).

Adolescent fertility is influenced by a range of social and cultural factors. These include but are not limited to gender inequities, low education levels, household poverty and lack of job prospects, stigmatization about seeking services, and early marriage (13). These factors compound, resulting in more socially disadvantaged adolescents having less access to needed services and less awareness about sexual and reproductive health (SRH)

SOCIAL DETERMINANTS OF HEALTH AND MILLENNIUM DEVELOPMENT GOAL (MDG) 5: IMPROVING MATERNAL HEALTH (CONTINUED)

and rights. Adolescents living in poverty are particularly vulnerable. Evidence from developing countries globally suggests that an adolescent from a household in the poorest quintile is 1.7 to 4 times more likely to give birth than an adolescent from the wealthiest quintile (13).

Social and cultural factors play an important role in shaping young people's sexual behaviour. Factors such as gender stereotypes, social expectation with regards to reputations, and the existence of penalties and rewards for sex from society are strong determinants of behaviour. Stereotypes can lead to refraining from planned or rational behaviours in sex practice (i.e. using a condom) and can give limited space for young girls to adopt a proactive attitude in negotiating sex practices within a societal paradigm of femininity and masculinity (19).

Antenatal care coverage

Antenatal care (ANC) is an indicator for MDG 5 target B. A minimum of four ANC visits is recommended for optimal benefits. Globally, although 80% of pregnant women received ANC at least once during the 2000–2010 period, only 53% received the minimum of four ANC visits (5).

For the European Region as a whole, an average of 97% of women received ANC from skilled health personnel at least once during pregnancy during the 2000–2010 period (5). In only Azerbaijan and Tajikistan did fewer than 90% of women have at least one visit during pregnancy, with coverage being 77% and 89% respectively (5). Many countries do not have comprehensive data on the minimum of 4 visits. However, available records points to inequities.

In many countries globally, women from the poorest households are less likely to receive ANC than women from the wealthiest households (5). While varying considerably by country, in the European Region differences in ANC coverage can be seen by place of residence, wealth quintile and education level of mother (see Table 1). For instance, in Azerbaijan, ANC decreases from 93.8%

among those in the highest education level to only 63.8% among women in the lowest education level. Almost all women (95.3%) of women in the highest wealth quintile receive ANC, compared to only 53.2% of women in households in the lowest wealth quintile (20).

Other aspects of social exclusion also influence ANC coverage rates. Inadequate social protection, at times linked to lack of necessary documentation, is one of these. Lack of financial coverage for basic health services contributes to higher maternal mortality ratios among Roma women, especially when family planning and antenatal care services are not covered. Reports from the former Yugoslav Republic of Macedonia show that Roma mothers often lack health insurance and cannot afford the co-payment and informal costs linked to regular ANC, delivery and postnatal care (21).

Migrant women can also face challenges in access to ANC (13). Even when socioeconomic and educational background is taken into account, migrant women seem to be less likely to seek and/or receive adequate ANC and have good pregnancy outcomes. This is especially the case when the legal status of a migrant in a country is unclear, and when women perceive local policies and social attitudes towards them as negative.

Policy considerations

In the European Region, actions where particular attention will be required to accelerate progress towards MDG 5 include:

- Increase government political and financial commitment for SRH and rights. Ensure an enabling legal and policy framework to overcome access barriers, ensure quality, and strengthen the Reproductive, maternal, neonatal and child health (RMNCH) continuum of care. Facilitate that health reforms are designed to expand delivery of SRH services, including through strengthened family planning (FP) and service integration in primary health care.
- Improve financing of the maternal

and perinatal components of basic benefit packages. Secure sufficient investments for SRH through increased awareness among decision-makers of the contribution of health, including SRH, to the social and economic prosperity of countries.

- Ameliorate data collection and monitoring and evaluation systems, with mechanisms in place to ensure the effective use of data on maternal health, FP, SRH behaviour and the needs of vulnerable populations. National information systems should account for the health status and needs of adolescents and young people (including pregnant adolescents and, linked to MDG 6, the numbers of adolescents and young people living with HIV).
- Ensure quality of SRH services for all populations. Control for quality in the RMNCH continuum of care, including for referrals and follow-up allowing for effective coverage. Increase attention to the production and continuous capacity-building of professionals with the right skills mix and ensure their equitable availability for all population groups.
- Ensure access to and availability of essential medicines and commodities for SRH. Provide adequate well-maintained equipment at all levels of maternal/perinatal and SRH care.
- Create a demand for services through appropriate communication for behavioural change. Communication should be gender-, age-, literacy-level, culturally and contextually appropriate (reflecting thorough knowledge of the target population's evolving needs), and address men and traditional leaders. Due attention is also required to providers' practices and attitudes, including towards adolescents and socially excluded populations, that may obstruct patients' access to services.
- Establish multi-sectoral linkages and integrate actions to address gender inequalities and other social determinants of SRH into policies, programmes, and laws within and

beyond the health sector. Strengthen partnership and coordination between various stakeholders and donors working in SRH areas, child health, gender equality and the empowerment of women.

- Increase government support for the active involvement of civil society and communities in the design, provision and evaluation of SRH policies and programmes. In keeping with this, efforts can also be scaled up to move beyond the historical approach to promoting SRH that focuses on the deficit model towards one that also embraces the assets model and hence accentuates resources of individuals and communities. A participatory approach is a key part of this change.
- Ensure the rights of adolescents to age-appropriate information, confidentiality and privacy, and access to services and commodities. Reinforce the Convention on the Rights of the Child principle of evolving capacities of the child for autonomous decision-making and informed consent. Identify and reduce the barriers for (pregnant) adolescents to access HIV/SRH services, including safe abortion and post-abortion care services where abortion is legal. Enforce laws and policies that directly protect most-at-risk adolescents, decriminalize the behaviours that place them most at risk, and ensure that they have access to the services they need and are protected from stigma.
- Address the links between non-communicable diseases (NCDs) and MDG 5. NCDs increasingly affect women and children across the RMNCH continuum of care. For instance, obesity in women increases the risk of gestational diabetes, pre-eclampsia, pregnancy-related hypertension, induced labour, caesarian sections and stillbirths. The RMNCH continuum of care provides several opportunities to prevent, diagnose and treat NCDs. The Global Strategy for Women's and Children's Health recommends that health services for

NCDs be provided as part of an integrated approach to promote women's and children's health.

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THE MILLENNIUM DEVELOPMENT GOALS, SOCIAL DETERMINANTS AND SEXUAL AND REPRODUCTIVE HEALTH: AN OVERVIEW IN EUROPE

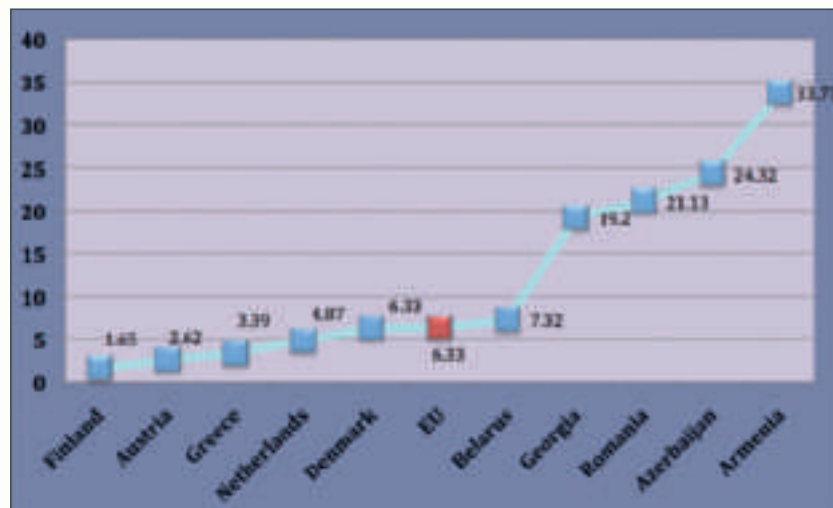
The social determinants of health are directly linked to development and therefore will directly contribute to Europe's ability to reaching, or not, the set Millennium Development Goals (MDGs) for the year 2015. Beyond that year, the health sector will transform these goals into a new challenge, called "Health 2020".

As an essential part of the WHO Regional Office for Europe's Member States public health landscape, sexual and reproductive health (SRH) is particularly sensitive to the social determinants of health. These determinants influence to which extent a man or woman of reproductive age can benefit from SRH services in his or her country and thus, his or her SRH health outcomes. In this article we will highlight how these factors impact both the supply and demand side of SRH services and how this contributes to the accessibility, quality and affordability of offered SRH services.

Culture, ethnic diversity and age

The countries that make up the European Region are diverse, with many different ethnicities, cultural practices and age groups. All of these factors have a relationship with how SRH is perceived and practiced. For example early marriage and childbearing may be more common among certain ethnic groups. Such practices may impact negatively on SRH as studies have shown that women who experience pregnancy and childbirth at a young age are at increased risk of morbidity and mortality (1, 2). From a supply side such groups may be excluded from SRH services due to issues such as lack of cultural sensitivity and/or language barriers that limit the interaction between the client and care provider. Age may also affect the ability to access or receive services. While adolescents may feel uncomfortable accessing traditional SRH health services for information about SRH, societal attitudes and beliefs towards sexuality of adolescents can also limit access to care through policies that prevent Youth Friendly Health Services or fail to recognize the rights of adolescents to also have positive SRH.

Figure 1. Maternal mortality rate in selected western and eastern European countries, latest available data (3).



Economic and social status

The relationship between poor SRH and poverty has been well established; not only is the burden of ill SRH outcomes greater in low resource settings, but also greatest among the populations in the lowest wealth quintiles in these low resource countries. Throughout Europe varying rates of utilization of antenatal care and maternal mortality rates are seen (figure 1 and 2). The correlation between income and poor SRH indicators is easy to interpret; higher maternal mortality rates are seen in countries with lower incomes level and greater utilization of antenatal care services among higher income groups compared to lower income groups. However, the relationship between poverty and poor SRH utilization and outcomes is complex and may reflect a variety of other issues that influence these inequities, such as: inability to access services due to opportunity costs; social exclusion due to discrimination and marginalization of select lower socio-economic or ethnic population groups; inability to demand equal and fair treatment from providers due to feelings of exclusion; and inequitable distribution of SRH services favouring higher income areas (urban vs. rural). All of these factors interact together to create a complex environment that ensures that those who are most vulnerable to poor SRH outcomes

experience continued missed opportunities for equitable access to care.

Migration and internally displaced populations (IDPs)

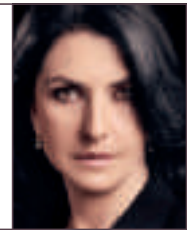
While not traditionally thought of as a social determinant of health, experience in the European Region with migrants and IDPs has clearly shown that migration is an important determinant that must be considered when addressing SRH programmes and policies and improving SRH outcomes for individuals and communities. Armed conflicts disrupt health services and IDPs in countries with territorial disputes are often underserved in the field of SRH services and at increased risk to adverse SRH outcomes. Such conflicts also pose a threat to the implementation of the national SRH agenda of countries, weakening the health systems ability to deliver services and its responsiveness for well implemented quality control mechanisms.

Programmatic and policy gaps

Many countries in the eastern part of the European Region find themselves in a transitional period, moving away from a centrally planned economy towards a merit-based society in a system of free market mechanisms. In this era of financial crises and donor fatigue it is paramount to rely more and more on each



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Figure 2. Use of antenatal care by different socio-economic groups in the European Region, latest available data (3).

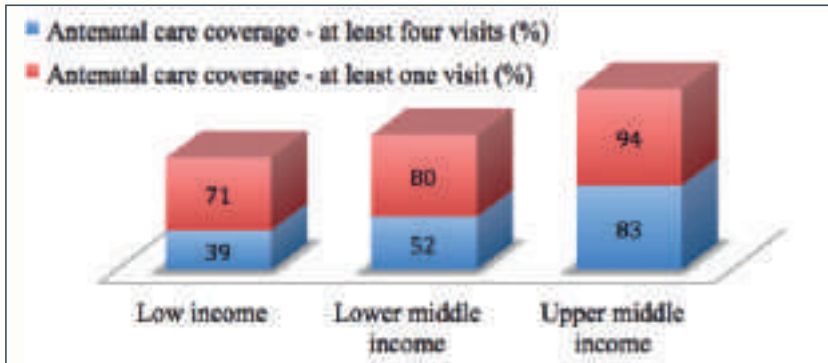
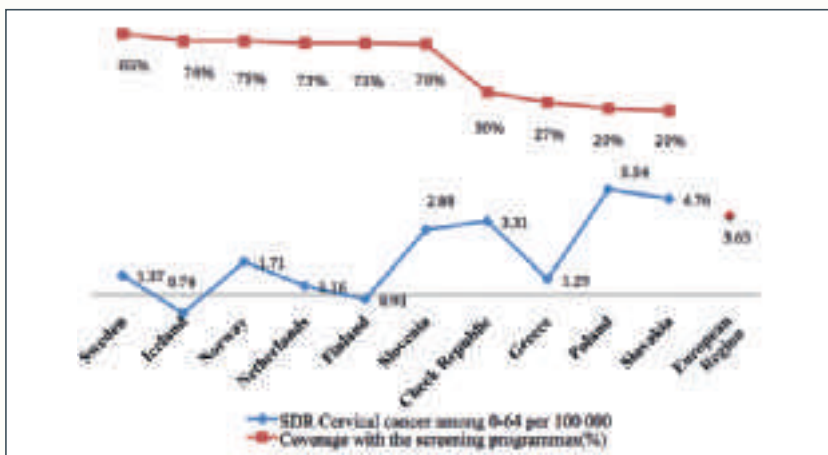


Figure 3. Age-standardized death rate (SDR) of cervical cancer among 0-64, per 100 000 and the coverage rate within the national screening programmes in selected countries, latest available data (3).



country's own resources, local public-private partnerships, creative co-financing schemes of federal, regional and municipal governments and strengthening of the medical insurance infrastructure (increasing the insurance base can lead to inclusion of more SRH services in the basic care package). Such actions require coordination among the stakeholders of the existing donor, government and civil society community in order to ensure programmatic and policy gaps are minimized and that synergy exists between sectors. For example, national policies that address reproductive tract cancers need to recognize that lack of organized population-based preventive and early detection services leads to negative SRH outcomes. Implementation of screening and early detection, a very cost-efficient measure, into each country's primary

health care system will help close this gap and improve outcomes. Taken this one step further and incorporating health education on reproductive tract cancers and screening into the education sector helps strengthen the efforts and coverage of the health system. Countries who have recognized these gaps and have implemented well organized national screening programmes with a high coverage rate achieve much better outcomes in terms of cervical cancer morbidity and mortality (figure 3).

Conclusion

National ownership of an area like SRH can only be reached through increased political commitment and strong continuous lobbying for SRH and rights of individuals and populations. Essential to this commitment is recognition by all key

stakeholders of the relationship between social determinants of health and SRH. Reducing inequities in SRH requires involvement not only of the health systems but also education, labour and social sectors. Advocacy about these inequities should occur at all levels and across all sectors in order to diminish the health risks faced by all populations, particularly vulnerable and marginalized groups. Europe has an ambitious agenda wishing to ensure universal access to SRH services for all its citizens, relying on European standards of care. It is time to act, learn from each other's best practices and implement the commitments that have been made in 2000 on the UN MDGs and in Cairo at the International Conference on Population and Development. With the right commitment and the right instruments to map and address the social determinants of health and SRH, we will quickly get closer to a society with reduced inequalities and more accessible and affordable care.

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UNFPA REGIONAL TECHNICAL MEETING ON REDUCING HEALTH INEQUALITIES IN EASTERN EUROPE AND CENTRAL ASIA

Background

For many people in eastern Europe and central Asia, health has improved over the past decade; however, significant inequities in sexual and reproductive health (SRH) indicators across the Region persist. For example, throughout the Region, Roma, other ethnic minorities, people living in poverty, migrants and internally displaced people appear to be systematically disadvantaged in accessing maternal and SRH care.

To address these issues of inequities in health the UNFPA Regional Office for eastern Europe and central Asia conducted a technical meeting focusing on underlying determinants of health inequalities. This meeting focused on select vulnerable populations (Roma, disadvantaged youth, migrants and refugees/internally displaced persons (IDPs)) and the required approaches to meet the needs of such populations with an emphasis on SRH, including maternal and child health.

Specifically, the primary objectives of the meeting were: (1) to review existing information on underlying factors contributing to health inequalities/inequities, and to collect expert opinions on achievements and critical gaps where accelerated actions are needed; and (2) to develop technical and evidence-based recommendations to enhance the effectiveness and coherence of country policies and programmatic interventions.

More than 60 experts from western and eastern Europe as well as central Asia attended the meeting. UN agencies and international civil society organizations participated and contributed to achieving the meeting's outcomes.

Social Determinants of Health

During the meeting various frameworks (i.e. the social determinants of health framework as well as the social exclusion framework) and relevant studies conducted by World Bank, UNICEF and UNDP were presented and discussed by the experts to help foster a broader understanding of key concepts related to health inequities.

In 2005, the WHO established the Commission on Social Determinants of Health in order to address concerns about persistent and widening health inequities (1). The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices.

The conceptual framework of social determinants of health portrays the significance of socioeconomic, political and cultural contexts, an individual's social position and health systems and health behaviour in shaping the distribution of health and well-being. Within this framework, interventions to reduce health inequities should target the improvement of daily living conditions and tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life.

Social exclusion, protection and vulnerability

Social exclusion refers to processes that push certain individuals to the social margins and prevent their full participation in relevant social, economic, cultural, and political processes (2). The more a group is marginalized, the more vulnerable it is. Nevertheless, being a migrant, from a certain ethnic group or a person with a disability does not make a person inherently more vulnerable or at increased risk. Rather, it is the interaction between several factors that creates increased vulnerability. These factors include poverty, a lack of basic competencies and lifelong learning opportunities, discrimination that can distance these individuals from employment, income generation and education opportunities, as well as from social and community networks and activities. Since they typically have little or no access to power and decision-making bodies, victims of social exclusion often feel powerless and unable to take control over the decisions that affect their daily lives.

Another way of thinking of exclusion and vulnerability is from the view of a relational concept. One group of people's disadvantage is partly shaped by their relationship with the social system. This approach focuses on exclusion as consisting of dynamic multi-dimensional processes embedded in unequal power relationships, interacting across cultural, economic, political and social dimensions and operating at the level of individuals, communities, nation states and global regions.

The UNDP Regional Human Development Report analyses social exclusion as the result of multiple and mutually reinforcing deprivation in central and south-eastern Europe, the Russian Federation, the Caucasus and central Asia across three dimensions – economic exclusion, exclusion from social services and civic exclusion (3). The report indicates that inequities in access to health care have widened during transition, with less access for the poor, elderly and minorities (particularly Roma) and between urban and rural areas. A major reason for the rising inequality appears to have been significant growth in private expenditure, in out-of-pocket or informal payments and in fees for medicines and services (3). The report also argues that besides these financial barriers to health care, absence of community-based and tailored services, as well as attitudes and discrimination in the health sector, are similarly important in explaining exclusion from health care services.

Another issue affecting vulnerable groups is that of the gaps in social protection and in particular social health protection. A recent report by the International Labour Organization examining inequities in access to health care for vulnerable groups notes that despite the fact that the overall objective of providing universal coverage ranges high on the agenda of countries in the European Region, and is stipulated in most national legislations, substantial inequalities in accessing health services persist for these groups (4). These inequalities in access to health care originate from issues



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related to social health protection and the broader health system, particularly with regard to gaps in legislation, fair financing, and allocation of funds, and the broader contextual environment in which vulnerable groups live and work, including income and poverty, lack of access to employment and social protection and status in society. It is in this broader contextual environment that the poor, women, Roma and migrants are found to be particularly disadvantaged.

Reducing health inequities in the Region

Following the debates on presented frameworks and study results, the experts had discussions in working groups to review the challenges with regard to accessing SRH care among the Roma, migrants, refugees/IDPs and most at risk youth and how these challenges could be addressed. The results revealed that there were commonalities across all four groups in terms of challenges, gaps and lessons learned, including:

- The need for more data in order to produce policies and to convince governments and funding agencies of the need for sustained interventions/programming;
- The need for financial resources;
- The need for enactment and enforcement of policies and strategies that are directly linked to legislation. While laws and policies addressing these vulnerable groups exist questions pertaining to proper implementation and the benefits that may arise for these vulnerable populations are largely unanswered;
- The involvement of the target population in the planning process so that cultural sensitivities are taken into account; and
- The need for a comprehensive, holistic approach in addressing health inequities. This approach would encompass the social sector including education and labour market sectors.

These commonalities, lessons learned and challenges for the four vulnerable groups

then formed the basis for the recommendations issued from the meeting. The recommendations fall within the WHO Commission on Social Determinants of Health principles for action.

Overall recommendations

1. Improve the conditions of daily life:

- Comprehensive social protection is needed, especially for those persons in precarious work situations, including informal work and household or care work.
- Availability of universal health coverage: A minimum package of health services, with a focus on primary healthcare, for these particular vulnerable groups is needed.
- Access to health systems: SRH care services should be responsive to the needs of its clients including the provision of SRH information and taking into account gender, cultural sensitivities and language barriers.

2. Tackle the inequitable distribution of power, resources and money:

- Governments should adopt the WHO social determinants framework in order to address health inequities.
- Governance: coherent legislation and policies that promote health equity need to be in place and monitored.
- Improve legislation to address issues related to discriminatory practices and especially gender inequalities.

3. Measure, understand and assess the impact of action

- Basic data on the social determinants of health is required to develop more effective policies, systems and programmes. It is important that countries agree on process and outcome indicators in order to have comparable information and common monitoring mechanisms.
- Partnerships/networking: governments, non-governmental organizations and civil society need to be aware of who is doing what and where both nationally and regionally.
- Training/capacity building: This

underlies of importance of having competent personnel within the various facets of healthcare – i.e. policy development, service provision and monitoring.

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SEXUAL AND REPRODUCTIVE HEALTH IN EASTERN EUROPE AND CENTRAL ASIA: EXPLORING VULNERABLE GROUPS' NEEDS AND ACCESS TO SERVICES

Introduction

The eastern Europe and central Asia (EECA) Region has made progress in improving access to sexual and reproductive health (SRH) services, but there remain great disparities within and across countries and universal access has still not been achieved. Throughout the Region, Roma, other ethnic minorities, people living in poverty, migrants, and internally displaced persons (IDPs) are facing particular challenges in accessing SRH services.

This article reports findings of a study prepared for the UNFPA technical meeting on *Reducing Health Inequalities: Focus on Vulnerable People and SRH*, which took place in Istanbul in March 2011 (1). The study aimed to explore the SRH needs of and policies for three vulnerable groups in seven eastern European and central Asian countries:

- Roma (in Albania, Bulgaria and the former Yugoslav Republic of Macedonia);
- Internally displaced persons (in Bosnia and Herzegovina and Georgia); and
- Adolescents (in Kyrgyzstan and Tajikistan).

Our study was based on a review of the (published and grey) literature and a series of focus group discussions with members of vulnerable groups.

Why are they vulnerable?

Roma women

Roma women in south eastern Europe do not only tend to have less access to SRH services, but are also generally confronted with poor living conditions, inadequate nutrition, low levels of education, unhealthy lifestyles, high birth and abortion rates, and a high number of teenage pregnancies. Due to this plethora of factors, Roma women are at a higher risk of complications during pregnancy than the general population (2, 3).

Roma women are also affected by the unmet need for modern contraception that can be found across eastern Europe (4). For example in Bulgaria, 59 percent

of Roma women interviewed in a survey in 2008 did not use any contraceptive method. Abortion is consequently still a widespread method of family planning. In the Bulgarian survey, 52 per cent of Roma women stated they had an abortion, with the highest percentage among the 18- to 23-year-olds (5).

IDPs

Internally displaced women in general tend to have poorer SRH, including unwanted and poorly spaced pregnancies (6). Maternal mortality and morbidity are a major issue for displaced women in south eastern Europe and the Caucasus, as they are more likely to receive poorer quality of care, due to a breakdown of infrastructure and the shortage of qualified personnel. In Turkey, for instance, 52 percent of all births by displaced women were not attended by health professionals, resulting in a much higher risk of infant and maternal death (7).

Anecdotal evidence also seems to indicate higher rates of sexually transmitted infections for internally displaced women in Bosnia and Herzegovina and Georgia, which coincide with lower awareness of SRH issues, substantial unmet need for modern contraceptives, and high reliance on abortion.

Adolescents

Young people under 25 years of age in central Asia are particularly vulnerable to poor SRH, due to several factors. First, early marriages and pregnancies are quite common in central Asia, putting young women at risk of maternal mortality and morbidity. In Tajikistan, for instance, 15 percent of young people are married by the age of 18, with higher rates among the poorer or less educated (8).

Contraceptive use is low among young people in central Asia, despite increased awareness in recent years. For instance, in Tajikistan, only about 9 percent of young married or in-union girls aged 15-19 used any form of modern contraception in 2005, compared to 50 per cent of women aged 35-49 (9). Due to the low use of family planning methods, high abortion

rates among teenage girls are a rising problem (10, 11).

SRH policies and legal framework for vulnerable groups

Specific policies and strategies for vulnerable groups are sparse. Although Albania, Bosnia and Herzegovina, The Former Yugoslav Republic of Macedonia and Bulgaria have all signed up to the Decade on Roma Inclusion (2005-2015) and the National Action Plans for Albania and Bulgaria envisage improvements in SRH services and awareness, the integration of Roma-specific issues into national policy and practice continues to be weak in these and other countries of the Region with large Roma minorities.

Georgia has legislation in place to protect health services for IDPs through guaranteed health funding. However, apart from some formal health financing safeguards, neither Georgia nor Bosnia and Herzegovina appear to have much in the way of explicit policies safeguarding the SRH and rights of IDPs.

Tajikistan and Kyrgyzstan, which both have large youthful populations with multiple SRH needs, do not seem to have specific health policies for adolescents' SRH (beyond some general provisions for the protection of child health).

What are the main barriers for these vulnerable people?

Our study revealed a number of barriers to accessing SRH services for each of the vulnerable groups studied. Barriers deemed most important by our Roma respondents were high levels of poverty and the lack of appropriate mechanisms of financial protection, exacerbated by requests from health care providers for informal payments. In fact, reliance on out-of-pocket payments (both formal and informal) in eastern Europe has led to a disproportionate exclusion of many Roma from accessing health systems, as many are unemployed or do not have a regular income (12). Discrimination against Roma, including explicit racial discrimination, contributed to their reported unwillingness to utilize services. Geographical



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barriers, gender inequities and poor knowledge of SRH were other common challenges.

For IDPs in south eastern Europe and the Caucasus, their absolute poverty levels emerged most strongly as a barrier to accessing SRH services, linked to the distance they needed to travel to reach facilities, especially in IDP camps or settlements with no or few clinics and medical supplies. Lack of emergency transport was also highlighted as a problem, given the distance to hospitals. The lack of health insurance was another reported problem in accessing health services, particularly in relation to pregnancy and delivery care, which is supposed to be free. Gender inequities play a part in poor knowledge of SRH, especially in Georgia, with the dominance of men in SRH decision-making, as well as the stigma associated with men seeking SRH services.

For adolescents in central Asia, stigma of accessing SRH services, poor knowledge of SRH and SRH services and financial barriers were all important. Social norms in Kyrgyzstan and Tajikistan place a high value on virginity, and early sexuality is taboo, making it difficult for young people to talk to adults or access information and services. Fear of gender-based violence against young women, such as forced early marriages, rape and bride-kidnapping (in Kyrgyzstan) seemed to impede their ability to discuss SRH issues or seek services for fear of assumptions about their lack of virginity.

Conclusion

Our study findings suggest that health systems in the Region have failed to respond to the SRH needs of some of the most vulnerable groups of society. There seems to be an urgent need to improve access to high-quality SRH services to vulnerable groups. This includes improved access to information about SRH issues and services, contraception and pregnancy-related services and commodities.

Improved financial protection seems to be a key issue. The limited scope of health services covered by insurance schemes, the exclusion of many vulnerable groups

from these schemes, and the continued existence of informal payments are among the most pressing challenges for improving access to SRH services in this part of Europe. There is also a clear need for overcoming racial discrimination against Roma, improving awareness and information among all vulnerable groups, and addressing gender inequalities, particularly with regard to youth sexuality.

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SEXUAL AND REPRODUCTIVE HEALTH INEQUITIES AMONG ROMA IN THE EUROPEAN REGION: LESSONS LEARNED FROM THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA

Sexual and reproductive health inequities and Roma women

Overall health, including sexual and reproductive health (SRH), of the Roma population is an alarming issue that warrants urgent attention. The health status of Roma cannot be viewed in isolation from their social situation. Poverty, stigmatization, discrimination and social exclusion are key social determinants that have contributed to inequitable access to health services and poor health outcomes within this vulnerable group. The inter-relationship between these factors are complex: low level of education, unemployment and poverty form a continuous cycle that feeds social exclusion, limits access to health service and negatively affects health status. Yet despite recognition of the vulnerability of the Roma population, data on their health status is limited, they are often overlooked when it comes to health related research and Romani women in the global context are often not mentioned as individual subjects, but grouped as part of broader vulnerable groups (1).

This lack of data does not correlate with absence of problems. In 2008 the survey “Prosperity and health of Romani women, path towards challenges,” conducted by the National Roma Centrum of Kumanovo and funded by the Open Society Institute Roma Health Project, was carried out in four cities (representing 23.02% of the total Roma population) in the former Yugoslav Republic (TFYR) of Macedonia (2). The overall objective of the study was to identify the main barriers faced by Romani women in accessing health services in order to develop interventions to improve the accessibility to quality health care. The study involved 2756 Romani women and girls. The key results and their implications form the basis for this article.

RESULTS

Contraception use, abortion and antenatal care

Consistent with other studies (3,4), the survey found low rates of contraception, high rates of abortion and low utilization of SRH services, especially antenatal care. Just under half (48%) of the women interviewed had had one or more abortions, 357 (12.9%) had 3 or more abortions and approximately two thirds of the women did not attend regular antenatal care (64.9%). Factors that were consistently found to represent significant barriers to access to SRH services were: 1) lack of appropriate identification documents limiting access to health insurance and 2) lack of financial resources.

Policies, identification papers and SRH

According to the Constitution of TFYR of Macedonia all people have the right to work, to free choice of profession, to a safe working environment and material security while being temporarily unemployed (5). These rights, along with those of health and educational rights often require personal identification documents and citizenship as a condition to exercise them. This requirement complicates acquisition of health insurance and access to SRH services for those who do not have such documentation. Of the women and girls in our study 2107 (76.5%) did not have passports, 1332 (48%) did not have marriage certificates, 400 (14.5%) did not have identification cards and 281 (10%) did not have citizenship. The lack of such crucial official documentation enables exclusion of Romani women from SRH services and facilitates human rights violations in the provision of SRH care.

Financial barriers and equitable access to SRH services

The collapse of the former Soviet Union, followed by the period of transition and current economic crisis has meant that many former communist countries have had to deal with weakened health systems. Development and adoption of policies

that provide health insurance to cover health services partially, with the rest paid out of pocket by the user, have become more common in such countries, including TFYR of Macedonia. Unfortunately this system disproportionately affects the most economically vulnerable, such as the Roma population. Unemployment and illiteracy are major problems among Roma women, continuing to generate poverty, reliance on social welfare and social exclusion from society. The high representation of women completely illiterate or with low level of education is an important determinant of low SRH health status. Of the total number of 2756 women surveyed, 1779 or 69.1% stated that they were beneficiaries of social assistance and two thirds of the women listed lack of finances as the reason for not seeking SRH services, especially antenatal care. Reliance on social and other state aid indicates “asymmetric” participation in society and these women are accused that they spend more than they contribute. Given the daily discrimination and marginalization faced by Roma families that helps drive the social exclusion which contributes to lack of access to employment and continued poverty, lack of access to SRH services secondary to financial barriers seems likely to be a continued reality for this population.

Current situation

While the importance of this issue was finally recognized with the launch of the Decade of Roma Inclusion 2005-2015, the disparities faced by Roma continues to be a topic that many governments are not appropriately sensitized towards. Acceptance of strategies proposed to improve the overall situation of Roma by the countries involved in the decade of Roma inclusion did not place enough attention on SRH. It was often missed as a topic in the frameworks of action that each country prepared and many of the policies that attempt to address SRH health issues do not accurately fulfill the true needs of Romani women, have very limited budget to attempt to do so or have not been adequately implemented.



One example is that of the Reproductive Health Strategy of TFYR of Macedonia, developed in 2010. An innovative strategy, in an attempt to decrease inequities in SRH, it introduced laws on the rights of the patient, free antenatal care, free annual pap smears for cervical cancer screening and free mammography for women over 40 for breast cancer screening. However while the government adopted the strategy and should be commended on its efforts, challenges on the ground have not seen these good policies rapidly rolled out into good practice. Limited awareness by the beneficiaries of the strategy, the presence of small user fees, uncertainty about roles and duties with regards to patient's rights and weak monitoring systems have hampered the overall implementation reminding us that translation of policy to action is a complex event.

Way forward

Addressing the challenge of decreasing the SRH inequities among the Roma in Europe will require understanding at all levels (policy, programming, research) of the relationship between social determinants of health and SRH outcomes. Actions will not only require better research and data on why this group has worse health outcomes or what contributes to these disparities, but, most importantly, the participation of Roma individual and civil society in this discussion. Only when the Roma are actively engaged as participants in the processes that shapes their access to SRH services will society begin to see progress being made in this field and true improvements in their SRH outcomes.

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DECREASING INEQUALITY IN HEALTH – MOVING TOWARDS HEALTH 2020

The following is an excerpt from an interview by Dr Gunta Lazdane, Chief Editor of *Entre Nous*, with Dr Agis D. Tsourus, Head, Policy and Cross-cutting Programmes and Regional Director's Special Projects of the WHO Regional Office for Europe.

Q: In many high level meetings Zsuzsanna Jakab, WHO Regional Director for Europe has mentioned the new European policy for health “Health 2020”. Could you, please, inform our readers about this new WHO European policy?

A: The new European policy for health, “Health 2020,” brings knowledge about the determinants of health, the best interventions to tackle the public health challenges of our time, and the major drivers of and trends that influence our health, both in European countries and globally, into focus through one coherent policy framework. It is based on the knowledge that decisions need to be made based on evidence, best practices, sound governance and existing opportunities. We hope that the new framework will make it easier to attain improved health and well-being in our Region.

Q: At the beginning of the millennium several health policies and development strategies were developed. Is there a need for a new health strategy?

A: Yes, you are right. Countries in the European Region have a shared history of working together for public health. Europe was the only WHO region to set its own Health for All targets back in the 1980s. It has initiated and pioneered new concepts and accumulated extensive experience working with other sectors.

This Region has a legacy of health policy development for more than 30 years. The world is changing every day and we are to face new challenges and learn new ways of thinking. We need a policy that meets the needs of the 21st century. The language may seem similar, but the context is different.

For a long time we have been talking about effective ways to tackle some of the significant public health challenges, for example non-communicable diseases and maternal and child health. While overall population health has improved, serious inequities still exist, with the social determinants of health playing an important role in these persistent disparities. As an example I would like to mention outdated, old fashion ways in addressing chronic diseases. We are usually trying to convince the individual to make the right choice and change behaviour, however, we often fail. Analysis of the social determinants of health helps us to understand all the various influences on an individual that can determine his or her choices.

Inequities are deeply rooted in the policies of almost every sector of our society. Some people say “we are to provide equal opportunities to everybody”. The question is, “Is it enough?” We know that there continues to be uneven progress in achieving health goals to date. Both globally and within Europe countries are faced with an increasing complexity of factors that shape health, as well as, continuing and new challenges to health as a human right, a public good and an asset for development. If we truly want to address these issues we need to identify the “causes of the causes” of health inequalities.

Q: Readers of our magazine have special interest in the area of sexual and reproductive health. Is this area included in “Health 2020”?

A: Yes, of course. Early stages of life are of huge importance. Our recommendation is to invest in maternal and child health – the main dividend to pay off.

Q: Many readers are familiar with the recently published WHO European review on social determinants and the health divide (more in RESOURCES, pp.30-31). How is this document linked with “Health 2020”?

A: The European review of the social determinants and the health divide was commissioned to inform Health 2020 to support our work in a vastly diverse Region. Determinants of health are truly crosscutting and the equity lens is included in every area of work of the Health 2020 framework – from the newborn to aging population. We have designed the development process of the Health 2020 strategy in a way that all WHO programmes have the opportunity to ensure that the findings of the review will be related to all technical areas of work.

Q: Is there any possibility to define which social determinant is of the most importance for health?

A: The European Region is very diverse. The evidence of the social determinants of health provides the basis to build awareness and to identify priority areas of intervention to address the health divide. For example, what may be a given standard in western Europe with regard to support in the early stages of life may not be the case in the countries of central Asia, thus relative prioritization matters.

I would like to mention some key sectors that have an essential influence on health:

- Environmental sector – we have a long shared working experience that is well documented;
- Education – it is important throughout the life course but especially in early years;
- Financing sector, for example close collaboration when it comes to taxation (tobacco, alcohol, etc.) is essential; and
- Social welfare and support sector - joint strategies to ensure health and quality of life are also very important.

All of the Health 2020 social determinants of health work that is carried out



Agis D. Tsourus

are linked with social changes in the 21st century. Take for example, the global and regional financial crisis. We know that it may have a significant impact on the health of the population, but we need to find ways of “doing more and better for less”. Good policy choices across sectors should be made in times of financial crisis in order to protect and promote the health of the people.

Q: You mentioned the diversity of our Region. How will countries use the Health 2020 document?

A: Health 2020 is planned as an umbrella document for the work of the WHO in the entire Region. It is not a prescription for countries, but rather an evidence-based framework that may be helpful for them and it is up to them how they will use it. This European Health policy will include information not only on WHAT? should be done, but also on HOW? to do it. We hope that Health 2020 will help put health higher on the political agenda and that it can be a goal of the whole government, not only of the Ministry of Health.

Q: In the area of sexual and reproductive health we often discuss human rights to health, including sexual and reproductive health. Are human rights aspects discussed in Health 2020?

A: The human right to health is enshrined in the WHO constitution. It is governments’ responsibility for their health and the health of their population, however, countries are at different starting points. Health 2020 identifies common principles, values and targets, but recognizes that decision-makers will use multiple pathways to achieve their goals.

Q: You mentioned that active involvement of all parties is crucial for development of the Health 2020 strategy. Could you, please, tell our readers; how they can assist in ensuring that this policy and action document meets the goals of all countries of the European Region?

A: Development of “Health 2020 - the New European Health policy for better health in Europe” is a two-year process

that started a year ago. It is fully participatory in every sense. One of the main principles of the development of this policy document is reaching our different sectors, levels of government, civil society and non-governmental organizations. It is very important to listen and create ownership to ensure that there is an added value to all involved parties.

In fact, from the end of January until March there will be a written consultation with all our Member States. They could use this opportunity to generate debates on health priorities and engage the public health community, stakeholders across sectors, local municipalities and other partners.

We hope to create a movement. The final document is important, but “the journey” is as important. We hope that civil society organizations will see this as an important opportunity to improve health in their countries and beyond. An interactive website will be established and all additional information will be available on www.euro.who.int early in 2012. I would also like to encourage all interested parties to explore ways to enrich the process using existing networks.

The world is changing. Community participation in the early 80’s was so different from nowadays with Internet and social media in place. Health is understood as an integral part of socio-economic development. It is much higher on the political agenda of governments. Readers of “Entre Nous” are welcome to engage in this debate to ensure that the most important facts, strategies and interventions are chosen, analysed and ways forward agreed upon.



VISION FOR HEALTH 2020

“A WHO European Region where all peoples are enabled and supported in achieving their full health potential and well-being, and in which countries, individually and jointly, work towards reducing inequalities in health within the Region and beyond”.

DOMESTIC VIOLENCE IN ROMANIA: THE RELATIONSHIP BETWEEN SOCIAL DETERMINANTS OF HEALTH AND ABUSE

Introduction

Domestic violence is a devastating public health issue that continues to be frighteningly common and to be accepted as “normal” within too many societies (1-4). As part of the WHO initiated a multi-country study on Women’s Health and Domestic Violence (1), between 2003-2004, the Romanian Academy Institute of Anthropology “Francisc I Rainer,” conducted the research “Domestic violence - an anthropological view”.

This paper presents only one aspect of the research: that of the relationship between select social determinants of health (socioeconomic status, types of violence and religious beliefs of victims and aggressors) and domestic violence in Romania. Four centres in Romania that offer shelter and counseling against sexual abuse and violence were chosen as study sites. A structured questionnaire was then administered to 140 women who had been victims of violence and in-depth interviews were conducted with 84 women. The data collected was then analysed using SPSS and chi square tests.

Findings

The socio-economical level of the victims (Table 1)

Training level. A greater proportion of women (65.5%) with minimal educational training were found to be victims of domestic violence than women with higher levels of education (medium = 33%, university and more = 1.2%). These findings are in line with other international studies, which report that a lower educational level is associated with increased risk of violence (2, 3). Women with more education tend to have partners who are also more educated; these women have a greater range of choice in partners, have more freedom to choose whether to marry or not and were able to negotiate greater autonomy and control of resources within the marriage.

Occupational status. Our study found that unemployed women (63.1%) or women who have non-professional occupa-

tions (26.2%) represent the majority of victims of domestic violence. Fifty-six percent of the unemployed subjects were housewives. Preserving the same trend seen with education levels, women with higher occupational status represented a much smaller proportion in the abused population.

Income level. There were four income levels defined in our questionnaire, based on official figures. As with education and occupation, our research pattern again emphasized the relationship between income inequity (minimum salary/wage) and abuse; a high number of victims had no income (34.5%) or low income (56%) compared to a high-income level (0%).

Further analysis revealed a significant correlation ($p < 0.05$) between occupational status of the victim, personal incomes and post-violence reaction of the victim. In our study, while the majority of women who are victims of domestic violence are aware of their situation and wish to leave, their limited financial status limits their ability to change their situation and increases their feeling of being trapped. Higher occupational status brings greater financial rewards, so women are in a better position to react after an episode of violence, providing them with the power to leave if desired. Unfortunately, in-depth interviews conducted during our study revealed that often the acts of violence coming from the partner have been generated by the woman’s desire to have a personal income, which is perceived by men as a method of undermining their authority.

Types of violence and their frequency

As shown in table 2, the most frequent type of violence that victims are submitted to is that of verbal abuse with all women in our study reporting this type of violence. Moderate physical violence (57.14%) and psychological violence (50%) represent the next most common types of abuse among our study population.

The religious beliefs of both victims and aggressors

According to our data the respondents (victims and aggressors) are 100% orthodox. Overall frequency of church attendance is low for both victims and aggressors; just over half (victims = 58.4% and aggressors = 53.5%) attend church only on the occasion of great religious celebrations or family anniversary events. However of those who do attend church more regularly, victims do so with a higher frequency than aggressors, both weekly and monthly ($p < 0.05$). Therefore, only 2.4% of the victims never go to church or other similar places, as compared to 40.8% in case of the aggressors.

Among our study population, when we examined attendance habits as a couple we found that 43% of the cases indicate an accordance between partners in frequency of church attendance. Meanwhile, 56.8% of the couples demonstrated differences in church attendance frequency between victims and aggressors. The most evident difference between partners was noticed in 6 couples where the victim goes to church weekly and the aggressor never goes to church.

These differences may be the cause of family controversies that could generate aggressions. It is possible that the aggressors may not see the church as a means of support for their daily problems. Victims on the other hand may see the church as a form of support and/or even as a shelter.

Conclusions

Domestic violence is a public health problem that needs constant legislative and civil preventive measures. We appreciate that victims of domestic violence need special places where they could benefit from: emergency financial assistance, social assistance, judicial support (informed about rights and legal proceedings they could institute against the aggressors), support in securing employment and a place to live, and psychological counselling.

The family – as a socializing force, responsible for handing down values – also needs to be educated in order to change



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Table 1. Level of training, occupational status, and personal income of victims of gender based violence in Romania.

Level of training	% (n=84)	Occupational status	% (n=84)	Level of personal incomes	% (n=84)
Superior: Tertiary education >12 licensed years (university degree, PhD, etc.)	1.2	High: Professionals (intellectual and scientific areas), managers	1.2	High income: More than 350 EUR	0
Medium: Secondary education 10-12 years (secondary school, post high school, foreman school)	33.3	Medium: Technician, foreman	9.5	Medium income: 150-350 EUR	4.8
Minimum: Primary education <10 years (elementary, vocational, apprentice school)	65.5	Low: Unskilled workers, day-labourers	26.2	Low income: up to 150 EUR	56
No education	0	Inactive population: Unemployed, pensioners, housewives	36.1	No income	34.5
No response	0	No response	0	No response	4.7
Total	100	Total	100	Total	100

Table 2. The frequency of select types of violence among victims of gender based violence, Romania (n = 84).

Types of violence	Never (%)	Occasionally (%)	Frequently (5)	Total (%)
Verbal violence (threats, vulgar language)	0	7.15	92.85	100
Psychological violence (blackmail, humiliation, isolation, interdicting the contact with children, relatives, friends, etc.)	25	25	50	100
Sexual violence	65.47	21.42	13.11	100
Moderated physical violence (clouting, hustling)	3.57	39.29	57.14	100
Serious physical violence (wounds and corporal injuries)	35.71	25	39.29	100
Economic violence (taking with force the money earned, and not contributing as regards to livelihood)	29.76	36.91	33.33	100

the mentality regarding violence. Each family member should possess the skill that Daniel Goleman named “emotional intelligence”: solving familial and extra familial problems through dialogue (4). Additional measures to help diminish the trans-generational passing of violence should include facilitating the awareness of family relational models; emphasizing and improving types of communication between mother and child; improved awareness of violence and its effects on children as direct or indirect participants to family violence.

Legislative and policy measures need to focus not only on providing support for these women but also on the direct connection between abuse and social determinants of health that place women in vulnerable positions. The costs of prevention programmes are much smaller than the economical (medical and justice) and social costs of this phenomenon.

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MIGRANTS' HEALTH NEEDS AND PUBLIC HEALTH ASPECTS ASSOCIATED WITH THE NORTH AFRICA CRISIS

With the European population becoming increasingly diverse, health systems need to find ways to respond adequately to this diversity. This is particularly relevant with regard to migrants and their growing contribution to the European populations. In 2009, 4.0% of the European Union's (EU) total population were "extra-community" EU citizens with an estimated additional 4% unregistered migrants (1).

Migration has been shown to be a global phenomenon with sudden "enlargement" of the migration movements resulting in a critical influx of migrants. This has occurred on several occasions over the last years in the WHO European Region. In Europe, these sudden migration movements have been triggered by political instability or conflicts. The 1990s were marked by major migrations from countries of the Balkan region during the conflict affecting that area. More recently (2011), a large influx of migrants from north Africa to southern European countries has taken place associated with the political upheavals in Egypt and Tunisia, the conflict in Libya and the instability in Syria. In these situations, the health system and public health services, including sexual and reproductive health (SRH) services, of receiving countries are challenged by the needs of a large influx of people over a short period of time. For example in 1998, 100 000 Albanians moved in a few days to Italy and from January to September 2011 approximately 52 000 people moved to Lampedusa from Tunisia, Libya and other sub-Saharan countries.

All of these situations posed significant challenges to the health systems of EU recipient countries. Scaling up of basic services, including those of SRH, were required in order to adequately respond to the essential needs of the migrants and fulfil their fundamental human rights. Yet, providing health care to undocumented migrants in Europe is a challenge as this group generally falls outside the system. Data on the basic epidemiological characteristics of the migrant populations

are fragmented and often not comparable over time and among countries. This makes it impossible to establish public health responses based on the effective needs of the migrants and contributes to diffuse misconceptions that may decrease the effectiveness of the health system response and its adequacy.

Many migrants lack knowledge of their basic human rights, making it challenging for the authorities to reach out to undocumented migrants, trafficked persons and asylum-seekers. In many countries of the European Region (including several EU countries), laws and regulations often act as obstacles to undocumented migrants when seeking access to health and other basic services. Cultural, religious and languages differences represent yet another challenge for cooperation between health care providers and migrants. Lack of cultural sensitivity or racist attitudes within health services may contribute to poor communication between patients and health care providers, by creating a hostile environment or by disregarding specific needs of the patients.

WHO Support

Assistance from the WHO Regional Office for Europe focuses on addressing the challenges faced by European countries in coping with a large influx of migrants. This entails support to strengthen national and local capacities in order to address

public health, including SRH, and health system aspects related to migrants' health needs. The recent experience arising from the northern Africa crisis underlines the need to identify best practices, share experiences, and undertake an efficient policy dialogue among relevant stakeholders. It also suggests the need for a long-term programme in the WHO European Region that addresses migrants and health. Such a programme should support the implementation of WHA resolution 61.17 of 2008 (2) and be consistent with the overall development of public health strategies in the Region, with attention to the social determinants of health.

Despite the stereotypes and stigma often associated to "migrants and diseases", migrants are basically a healthy population. Rather, the travel and the social exclusion in the arrival countries makes them vulnerable to a number of threats to their physical and mental health, induced by limited access to basic services in the hosting country. Too often the specific health needs of migrants are poorly understood and health systems are not prepared to adequately respond to them.

In April 2011, a Ministerial Conference was held in Rome, Italy, by the Ministry of Health of Italy, the EC Directorate-General for Health and Consumers, and the WHO Regional Office for Europe to review the situation on migration and health. Participants included Ministers



Migrants' tented camp in Lampedusa, Italy.



of Health, high-level health officials from Cyprus, France, Greece, Malta and Spain and representatives of the United Nations and EU agencies (including ECDC). The objectives of the conference were: to review the public health preparedness in those countries; to agree upon coordinated health actions and necessary technical measures to protect the public health of affected populations; and to provide essential health services to displaced populations and migrants. Following the conference a WHO Regional Office for Europe "Rome Action Plan" has been developed.

SRH and migration

When migration health issues are addressed, particular attention should be given to gender disparities and to gender/power relationships that frequently govern women's access to information and health care. Migrant women and children may have lower health status, including poorer pregnancy outcomes, when compared to non-migrant women in host societies. This is true even after the link between poverty and lower health for both groups is taken into account. The reasons for the poorer pregnancy outcome of migrant women are still not well understood, however, initially, the blame was on immigrant mothers having large families, late antenatal care, and being generally unable to adjust to a western lifestyle. More recently, social determinants of health and causes outside the control of immigrant mothers have been identified:

- the stress of migration,
- the rupture of previous social networks,
- religious and cultural factors, including culturally insensitive SRH services, and
- poor access to SRH care services and discrimination within the health system.

Migrant mothers from different ethnic groups may have different expectations and perceptions of health and health services than the majority of mothers in

the host country. This is especially true for recent migrants who do not have the support of well-integrated communities.

The complexity of SRH and migration needs specific attention in the cases of forced migration. The health of refugees and displaced persons encompasses a wide range of SRH issues including: family planning; safe motherhood; sexually transmitted infections, particularly HIV/AIDS; and gender-based violence. Yet it is important to remind ourselves that SRH remains a relatively new area of attention within the humanitarian sector.

Literature shows that preventive services, such as cancer screening programmes and prenatal/maternity services, are poorly utilized by migrant women compared to non-migrants. High rates of induced abortions for non-western migrants indicate difficulties in accessing preventive measures related to SRH (3). Migrant women from various geographical origins have less contact with maternity care compared to non-migrants. With regard to vaccination, a Spanish study showed lower coverage of migrant compared to non-migrant children (4).

Health differentials during pregnancy, birth, the neonatal period and the first year of life are sensitive indicators of social inequalities. If a group such as migrants experiences higher rates of maternal and child morbidity or mortality, it is usually an indication that they are socially disadvantaged. In a recent systematic literature review by Gissler et al. (5) on the topic of stillbirth, neonatal mortality and infant mortality among migrants in Europe, over half of the 55 studies reviewed reported worse mortality outcomes for migrants compared to the respective majority population.

Conclusion

Migration poses significant challenges both to the recipient countries and to the migrants themselves. While meeting the overall health needs of migrants requires immediate, sustained action, SRH remains an area of particular difficulty. Perinatal and infant mortality risks vary by migrant groups and may differ from

one generation to the next. Possible determinants of differences in perinatal risk suggest that each migrant group faces different barriers and problems when accessing SRH services. Despite policy efforts by several Member States of the European Region that promote improved access to SRH service by migrants, there remain differences in perinatal outcomes between migrant and non-migrant woman. This may be explained by inequities in access to quality of SRH services, including antenatal care. At the service level several actions could help to address these inequities such as: improved knowledge of barriers and needs of migrant populations by medical staff; migrant-sensitive guidelines for antenatal, postpartum and neonatal care; and SRH promotion and prevention for women with a migration background.

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CONTRACEPTIVE BEHAVIOUR CHANGE: BEYOND CONTRACEPTIVE PRESCRIPTION

Background

Utilization of contraception depends on more than just a medical prescription. Motivation for contraceptive behaviour is complex and dependent on multiple factors, including those which are linked to social determinants of health: age, economic and gender power dynamics that influence the ability to access sexual and reproductive health (SRH) services and assume responsibility for sexual activity; perceived risk of pregnancy and other sexually transmitted infections (STIs); as well as individual or societal beliefs

that reflect personal, religious, cultural and social representations of fertility, femininity, masculinity, motherhood and romantic-erotic relationships. In order to improve access to and uptake of contraceptive methods, these factors must be considered and appropriately integrated into contraceptive counseling.

With this in mind, in Portugal, the Department of Reproductive Health of the Directorate General of Health, developed a specific project to help improve the counseling around contraception focusing on both users and providers of these

services at primary health centres around Lisbon. Two key themes were central to the development of the project:

- 1) that behavioural change is a key element to improved contraception usage, and
- 2) that such change should not only target users; cultural, social or religious representations “lived by” health professionals may also interfere with full access to SRH services and information and should, therefore, also be addressed in training.

Table 1. Behavioural change stages, practical examples of interactions and possible focused interventions.

Stage	Examples of provider client interactions: what women may say	Possible Intervention
Pre-contemplation	<p>“I am not really fertile,” “I don’t have regular menses,” “I just have sex on week-ends,” “My partner is away,” “Someone/ a doctor once told me that I have polycystic ovaries so I can’t get pregnant easily.”</p>	<p>Intervention should be centered on risk, i.e. it is possible to get pregnant even if you: don’t have regular menses; have sex only a few times a month, etc.</p> <p>Discuss benefits and positive outcomes related to change: be able to study or work without the pressure of having a baby to take care of; having regular and predictable menses, especially if living away from a partner, etc.</p>
Contemplation	<p>“I want to have a baby but this may not be the best time,” “I should have a baby, my biological clock is ticking.”</p> <p>“I’ve no time for attending consultation,” “My parents can’t know that I need contraceptives.”</p> <p>“I am not really sexually active, I just do it once in a while,” “Using contraception for a long time reduces fertility,” “All my friends became fatter after beginning the pill.”</p>	<p>Address ambivalence, discussing benefits versus risks.</p> <p>Identify barriers to change: access to SRH services or select methods, family or partner influences.</p> <p>Identify misconceptions about sexuality, fertility, maternity, contraceptives, menses etc. Do not underestimate “urban myths” about contraception, especially the oral contraceptive pill.</p>
Preparation	<p>“I would like to do something,” “I’ve tried many times to take the pill, but I always forgot it.”</p>	<p>Build trust: positive reinforcement.</p> <p>Define goals, reschedule new consultation.</p>
Action	<p>“I would like to know which options suite me better,” “I would like to do “X” for contraception.”</p>	<p>Discuss methods, advantages, possible side effects. If the client shows a clear preference for a method, respect the preference (work with her to know if she knows it well, has realistic expectations and what are the reasons for that).</p> <p>Reschedule consultation: always admit that this a process, it needs follow-up.</p>
Maintenance	<p>Positive: More relaxed with sexual encounters, not afraid of being pregnant, cycle control, less pain with menses.</p> <p>Negative: Irregular menses, amenorrhea, spotting.</p>	<p>Discuss negative and positive aspects of changing methods.</p> <p>Be free to give: positive reinforcement on positive gains; review contraceptive choice if negative aspects are significant and not associated with misinformation.</p>
Relapse	<p>“My colleagues/friends say its not natural not to have menses,” “Doctor X assured me that amenorrhea was not good,” “My husband went to work abroad, he just comes home on week-ends,” “I’m tired of spotting.”</p>	<p>Find the reason for relapse : why, what or whom was the reason for giving up.</p> <p>Explain misconceptions – when applicable.</p> <p>Identify, together with the client, different solutions.</p>



Intervention

Three hour sessions with primary healthcare professionals (doctors, nurses, psychologists, social workers) were conducted around Lisbon. The main objectives of this intervention were to encourage health professionals to:

- a) recognize that attempts to improve contraceptive behaviour should involve utilization of a conceptual model of behavioural change, consisting of several stages, where intervention is tailored to the distinct stage that individual women represent; and
- b) recognize and identify how as health care professionals their perceptions, beliefs and emotions may play a crucial role in women and men's access to SRH services and information.

During these sessions, Prochaska and DiClemente's model of behavioural change (1) was presented, with identification of the various stages and appropriate interventions at each step. Emphasis was placed on behavioural change as a process, with various stages. Thus, changing a behaviour can be a linear process, or it can be subject to steps of variable duration or even relapse. As a result, a stage-specific intervention allows identification of what stage each person (in this case a woman) is at, and how the health professional may need to act differently in different phases.

Case studies were then used to facilitate small group discussion, with recognition by participants of the appropriate behaviour change stage linked to each case and correct problem solving responses for each individual scenario. The results were then reviewed and discussed together. Special attention was paid to working out types of interventions tailored to the different stages, as well as to perceptions and emotions raised by the professionals during the discussion. Table 1 outlines various stages, possible solutions and practical examples utilized during these sessions. For example, women in the preparation and/or action phases are often willing to start contraception and are motivated to utilize the best method that

suits her lifestyle compared to women in the precontemplation phase, who despite being sexually active, may have misconceptions about fertility or risk of pregnancy and STIs and thus does not consider herself at risk of these events. While the former situation requires that the provider provides information on available methods and reinforces the importance of individual self-confidence and decision making, the latter situation requires that the provider centres the discussion not on methods but on the benefits gained with the change of behaviour (use of contraception and avoidance of unplanned STIs and pregnancy).

During these sessions extra attention was also spent on the maintenance stage, to which sufficient importance is not often given. Health professional were reminded of the fact that motivation can be difficult to sustain for long times and that the decision to use contraception by an individual should not be viewed as a single unchangeable act. Follow-up consultations should address the positive aspects (internal rewards) and obstacles in maintaining behaviour. In the process of relapse it is important to understand what factors influenced the individual's decision to stop using contraception, including the role of and feelings towards side effects. It is not uncommon that side effects such as amenorrhea or spotting can cause women to feel less feminine or fertile and lead to discontinuation of contraception.

Conclusion: contraceptive counseling – the importance of the role of the health professional

Studies have shown that personal experience and socio-cultural beliefs of the counselor play an important role in determining contraceptive user behaviour (2-4). Often, contraceptive counseling by providers neglects select important SRH issues, such as STIs, emergency contraception and sexual health (3). Furthermore, professionals' gender also influences contraceptive counseling; the choice of counseling topics and attitudes toward the patient differ between genders (3,4).

Given the importance of these findings it is crucial to work with professionals to improve communication skills regarding sexuality, sexual orientation and practices, contraception and personal and social perceptions towards SRH. Our project, through the use of a behavioural change model and group discussion of case-studies, enables disclosure of ideas and preconceptions among professionals, with the ultimate goal of creating improved interactions between providers and users of SRH services and increased utilization of contraception. While it is too early to demonstrate any increased uptake in contraceptive methods, the positive feedback from both clients and providers at the primary health centres highlight those interventions that address select social determinants of health can and do help to improve quality of contraception services.

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DISPLACED POPULATIONS IN GEORGIA: UNFPA SUPPORTED SEXUAL AND REPRODUCTIVE HEALTH PROGRAMMES

Background

After gaining independence in 1991, economic crisis, armed conflicts, poverty, unemployment, and collapse of the system led the country of Georgia to face severe economic constraints (1). This difficult transition period negatively affected the social determinants of health and the health status of the population. High abortion rates, maternal mortality and infant mortality rates were evidence of the deterioration in the sexual and reproductive health (SRH) status of the population.

Armed conflicts have continued to exacerbate the situation. In the early nineties armed conflicts caused the displacement of an estimated 300 000 people, mostly from the regions of Abkhazia and South Ossetia. In August 2008 conflict with the Russian Federation caused additional forced displacement of 132 000 people. Since then, approximately 110 000 people have returned to their homes, whereas the remaining people are still displaced and continue living in collective centers and new settlements (2).

UNFPA and SRH programmes for internally displaced persons (IDPs)

Based on its mandate and role for implementing the ICPD Programme of Action, since the mid-nineties UNFPA has been supporting the Government of Georgia (GoG) to improve the SRH status of population, and particularly, the IDPs through provision of quality SRH services and information. The social determinants of health are considered in planning, implementation and monitoring and evaluation of these programmes. Analyzing the strategies deployed by UNFPA and GoG and the results achieved, it is evident, that consideration of the implications of forced displacement as a social determinant of SRH outcomes is a critical aspect of effective response to crisis and post-crisis.

In 1999, UNFPA with support of partners (The Ministry of Health, Labour and Social Affairs (MoLHSA), USAID, UNHCR, USAID, CDC) integrated women displaced from two breakaway

regions in the beginning of the 90's in the first nationwide Reproductive Health Survey (RHS) (3). The survey provided the data on both social aspects and SRH status of the general population and displaced groups. It has served as a main reference for donors and government to assess the relevance and effectiveness of programmes implemented before 1999, and to integrate the lessons learned in the planning process.

The 1999 RHS (3) reports lower total induced abortion rate among IDP women compared to non-IDP woman (3.1 vs. 3.7) and a contraceptive prevalence rate among IDP women that was very similar to non-IDPs (40.4 vs. 38.6). This suggests that the strong focus of donors on filling the gap in access to SRH services for the IDP population yielded results.

Since 2000, specifically created SRH Mobile Teams have been reaching out to all regions of Georgia, providing free of charge high-quality SRH services to vulnerable populations with a special focus on displaced women. The SRH services include family planning (counseling and distribution of modern contraceptives), antenatal care, testing and prevention of HIV and sexually transmitted infections (STIs), and provision of information, education and counseling (IEC) materials. Furthermore, UNFPA has been providing the SRH supplies and equipment to the "IDP Polyclinics" serving this group while also providing intensive capacity building training to SRH providers, thus contributing to improved quality of SRH services.

New Crisis

The 2008 armed conflict with the Russian Federation caused new crisis in the country affecting the whole population; this conflict resulted in the second wave of displacement of almost 132 000 people. Women and girls were particularly vulnerable among the conflict-affected population, as the destruction of infrastructure, lack of access to SRH services and poverty led to an increased risk of complications during pregnancy and delivery (4). Meeting the needs of this

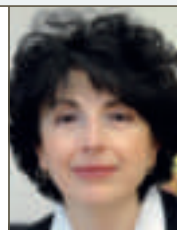
newly displaced population and sustaining the results achieved before the crisis was the main challenge for Government, civil society and donors, including UNFPA. However, strong coordination and existing capacity to respond to crisis was a real asset for deployment of an effective response. The Reproductive Health National Council, functioning in Georgia since 2006 under the leadership of the First Lady of Georgia, Sandra E. Roelofs, and support of UNFPA, ensured strong coordination and resource mobilization for SRH programmes targeting the IDPs.

The Government of Georgia provided a very quick and effective response to the crisis. The MoLHSA ensured a coordinated nationwide health system response during the crisis. GoG ensured free access to primary healthcare and referral for IDPs residing in two tent cities and more than 100 collective centres throughout the country. Medical staff from polyclinics regularly visited collective centres, providing ambulatory medical care and basic medications free of charge at local polyclinics. These efforts were complemented by UNFPA SRH services. The Fund, as the reliable partner of the MoLHSA in the field of SRH, immediately reacted on the humanitarian crisis through involvement in the cluster coordination mechanism unifying more than 35 organizations including UN agencies, international NGOs, Georgian government and civil society. UNFPA, as the member of the Health, WASH and Protection Clusters regularly shared and coordinated the plans with partners to ensure timely and comprehensive response to the conflict-affected population.

Based on the rapid needs assessment carried out in places of immediate displacement, UNFPA started multifaceted interventions to address the emergency needs by providing life-saving SRH services to IDP and conflict-affected women and girls through operation of five Reproductive Health Mobile Teams. These teams were equipped with trained SRH service providers and social workers to prevent and respond to sexual and gender based violence (SGBV) in post-



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Table 1: Selected SRH Indicators, Georgia, 1999-2010 (3, 6, 7).

	1999	2005	2010
Fertility Rate (births per woman)	1.7	1.6	2.0
Total Induced Abortion Rate (per 1000 women per year)	3.7	3.1	1.6
Contraceptive Prevalence Rate	41%	47%	53%

conflict situations. These mobile teams targeted specific sites such as IDP camps and new settlements, as well as villages and towns in the conflict-affected regions. As the risk of unwanted pregnancies, unsafe deliveries and abortions and STIs was high, UNFPA, in addition to directly providing services to conflict-affected populations, ensured availability of SRH commodities, supplies and equipment in the SRH Service Delivery Points in these regions. At the same time UNFPA initiated provision of “family dignity kits” to IDPs and returnees containing the most demanded hygiene and personal items for youth, male and female populations. A high literacy rate and education level of the IDPs allowed the implementation of a wide-scope IEC campaign on SRH and rights and SGBV issues.

Current situation

After 3 years as the armed conflict ended, in conflict affected areas where health infrastructure was destroyed during the conflict, availability of quality SRH services remains the challenge.

UNFPA/Georgia continues to tailor its interventions to meet the needs of this most vulnerable segment of the population.

Presently, all IDPs residing in the collective centres are eligible for state insurance. State provided health insurance covers the IDPs and conflict-affected population, as well as the rest of the population, under the grouping of social vulnerability (5). In the context of the UNFPA-Government Country Programme, UNFPA assists Georgia by supplying SRH commodities, includ-

ing contraceptives, to be distributed by SRH services free of charge. Partnership with USAID in this area has provided the opportunity to mobilize limited financial resources and to expand the coverage of insurance; at present 1.4 million people are insured in Georgia. This assistance is vital to help safeguard access to SRH services. Furthermore, in partnership with the MoLHSA and coordination of the RH National Council, UNFPA supports integration of the Minimum Integrated Service Package in the MoLHSA Contingency Plans and National Emergency Response Plan.

The focus of SRH programmes on the most vulnerable and particularly, the displaced population, has built a strong basis for maintaining and improving the SRH status of the population despite the 2008 crisis and massive displacement. The effectiveness of these SRH programmes was demonstrated by the results of the 2010 RHS, showing decreasing trends in infant mortality rates and total induced abortion rate vis-à-vis increased contraceptive prevalence and total fertility rate (table 1).

Conclusions

UNFPA’s involvement in delivery of SRH programmes to IDPS has resulted in the following lessons learned:

1. Forced displacement is an important social determinant and has enormous impact on health, particularly SRH.
2. The negative impact of crisis situations can be prevented, if social determinants and their impact on SRH are analysed and integrated in contingency plans and humanitarian programmes.

3. Integration of the social determinants in the rapid needs assessment allows identification of the most vulnerable groups and tailoring of interventions to meet the most pressing health concerns and needs.
4. As access to free quality SRH services still remains a challenge in conflict affected areas, donor assistance is vital to sustain and improve the SRH status of the population.

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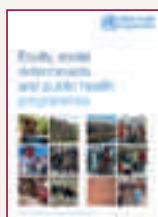
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This book provides an analysis of the social determinants of health that impact on specific health conditions, including maternal and child health, and select promising interventions to improve health equity in these areas. Available in English at:

www.who.int/publications

Relevant websites

WHO Social Determinants of Health: http://www.who.int/social_determinants/en

Action: SDH (WHO created electronic discussion platform regarding social determinants of health): www.actionsdh.org

WHO Regional Office for Europe Health Determinants: <http://www.euro.who.int/en/what-we-do/health-topics/health-determinants>

CDC: <http://www.cdc.gov/socialdeterminants/>

Upcoming events

13th World Congress on Public Health. Moving Towards Global Health Equity: Opportunities and Threats. April 23-27, 2012 Addis Ababa, Ethiopia . Information available at: <http://www.etpha.org/2012/>

12th Congress of the European Society of Contraception and Reproductive Health. June 20-23, 2012, Athens, Greece. <http://www.esrh.eu>

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