

SEXUAL AND REPRODUCTIVE HEALTH: ARE YOU SATISFIED?



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The year 1994 represented a turning point in the way the world thought about population issues. In the *Programme of Action* adopted by the International Conference on Population and Development (ICPD) held in Cairo, Egypt, population growth was firmly placed in a development context and reproductive health, including sexual health, and rights, as well as women's empowerment and gender equality, were recognized as cornerstones of population and development programmes. The following year, the Fourth World Conference on Women, held in Beijing, People's Republic of China, re-affirmed the *ICPD Programme of Action* in its *Beijing Declaration and Platform for Action*.

In the years that followed, many countries and organizations around the world used the *ICPD Programme of Action* and *Beijing Declaration and Platform for Action* as templates for the development of their own sexual and reproductive health (SRH) strategies and action plans. Thus, in the WHO European Region, a regional strategy on SRH was developed in 2001 which has been used by many countries in the Region to formulate their national policies. Similarly, a global reproductive health strategy was approved by the Member States of the WHO at the 57th World Health Assembly in 2004.

The Millennium Development Goals (MDGs) adopted by the United Nations (UN) Member States in 2000 were far less ambitious in the area of SRH and were limited to the (politically less controversial) areas of child health (MDG 4), maternal health (MDG 5) and HIV (as part of MDG 6). MDG 5 ("Improve maternal health") initially called merely for "a three-quarter reduction in the maternal mortality ratio between 1990 and 2015" and, only later, in 2007, was the second target added on "universal access to reproductive health by 2015".

Although progress has been made over the past 15 years, many challenges remain

in fully implementing the Cairo and Beijing action programmes. Also, while there is mostly good news on maternal and child survival, MDGs 4 and 5 in many countries of the WHO European Region have not been achieved. Thus, there is a clear need for having a fresh look at SRH and rights in the countries of the European Region, at the successes and failures, at what worked and did not work and at present needs and realities in order to develop a new action plan. When doing so, a number of recent developments will need to be taken into account.

Foremost among them is the recent adoption, in September 2015, by UN Member States of the action plan *Transforming Our World: the 2030 Agenda for Sustainable Development* and the associated 17 Sustainable Development Goals (SDGs). Among these, Goals 3, 5 and 10 on health and well-being, achieving gender equality and reducing inequalities, respectively, are of particular relevance to SRH and rights. Specifically, UN Member States have confirmed their commitment to "ensure universal access to SRH care services, including for family planning, information and education and the integration of reproductive health into national strategies and programmes by 2030" (Goal 3, Target 7) and to "ensure universal access to SRH and reproductive rights as agreed in accordance with the *Programme of Action* of the International Conference on Population and Development and the *Beijing Platform for Action* and the outcome documents of their review conferences" (Goal 5, Target 6).

Furthermore, *The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030): Survive, Thrive, Transform* launched by the UN Secretary-General in September 2015 supports and provides guidance to accelerate momentum for women's, children's and adolescents' health within the overall framework of the *2030 Agenda for Sustainable Development*. The *Global Strategy* takes a life-course approach, recognizing that a

person's health at each stage of life affects health at other stages and also has cumulative effects for the next generation. The recent Minsk Declaration emphasizes the importance of such an approach to health and its relationship to SRH was eloquently articulated in the most recent issue No. 82 of *Entre Nous*. Also the *Global Strategy* adopts an integrated and multisector approach, realizing that health-enhancing factors including nutrition, education, hygiene and infrastructure, among others, are essential to achieving the SDGs. In the area of SRH the *Global Strategy* calls for, inter alia, "ensure universal access to SRH care services (including for family planning) and rights."

The WHO Regional Committee for Europe, at its 2013 and 2014 sessions, triggered the process of the development of a *European Women's Health Strategy* and a new *European Action Plan for Sexual and Reproductive Health and Rights* that would reflect the strategies and objectives of *Health 2020: a European Policy Framework for Health and Well-being* and those of other recently approved relevant strategies and action plans of the WHO European Region, such as those on child and adolescent health, food and nutrition, HIV/AIDS, mental health and noncommunicable diseases.

It is hoped that the new *European Action Plan for Sexual and Reproductive Health and Rights 2017-2021* will become a major step towards the Region's vision of "[a] Region in which all people are enabled and supported in achieving their full potential for SRH and well-being; their sexual and reproductive rights are respected, protected and fulfilled; and in which countries, individually and jointly, work towards reducing inequities in SRH and rights."

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LINKING SEXUAL AND REPRODUCTIVE HEALTH AND HUMAN RIGHTS

Background

In 1994 the International Conference on Population and Development (ICPD) endorsed a *Programme of Action* that set forth an ambitious population and development strategy (1). The ICPD *Programme of Action* was remarkable in its recognition that gender equality and equity, and the empowerment of women and human rights, are cornerstones of population and development (1). This led to a paradigm shift from earlier policies targeting population control, to one that places the individual at the centre and respects choice, rights and empowerment (see Text Box 1 and 2).

Since this landmark agreement, numerous intergovernmental fora have reaffirmed the ICPD commitment to universal access to sexual and reproductive health (SRH) and to the promotion and protection of reproductive rights (2, 3). The *Beijing Declaration and Platform for Action* (BDPfA) and the *Millennium Declaration* are two key milestones in this process (4). Remarkable achievements have been made over the last 20 years, including gains in women's equality, population health and life expectancy, educational attainment and human rights protection systems (3).

However, inequities in coverage persist, both between and within countries (3, 5). Even among those countries that achieved the Millennium Development Goals (MDGs), progress made on equity varies considerably across countries (5). Socially-determined inequalities and insufficient attention to discrimination and social exclusion in policy development and service provision continue to undermine efforts to ensure and improve both access to and quality of care.

Furthermore, far too often, human rights have been ignored in designing and implementing health and development policies. Gender inequality and violation of women's rights remain a key determinant that produces health inequities and intersect with other forms of health inequities that are produced by age, race, class and ethnicity as other social determinants.

Text Box 1. The link between Human Rights and SRH and Rights as stated in Paragraph 7.3 of the ICPD Programme of Action (1).

Human rights are considered central to sexual and reproductive health because:

- Rights protect against coercion, discrimination, and violence. Women's rights, particularly reproductive rights, include the right of individuals and couples to make decisions concerning their health and reproduction free of discrimination, coercion and violence as expressed in human rights documents.
- Rights require access to necessary information, education and services, as well as mechanisms for redress of abuses and violations of their rights. Human rights recognize that all individuals have equal rights and entitlements to access to sexual and reproductive health education, information and services, irrespective of who they are and where they live.
- Rights require a comprehensive approach. Human rights require comprehensive response to individual's varied and changing needed.

The consequences of this lack of attention and reaffirmation of human rights are very real. This has far too often resulted in siloed funding and vertical interventions rather than the holistic approach, with human rights at the centre (6).

Health is a fundamental, justiciable human right indispensable for the exercise

of other human rights and is, consequently, interdependent with and indivisible from other human rights, including the rights to life, bodily integrity, autonomy, legal capacity, information and privacy. Every preventable death poses a challenge to health, development, and human rights initiatives (7). As we move from MDGs to Sustainable Development Goals

Text Box 2 (1).

"All human beings are born free and equal in dignity and rights. Everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Everyone has the right to life, liberty and security of person."

(ICPD Programme of Action Principle 1)

"Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community."

(ICPD Programme of Action Principle 4)

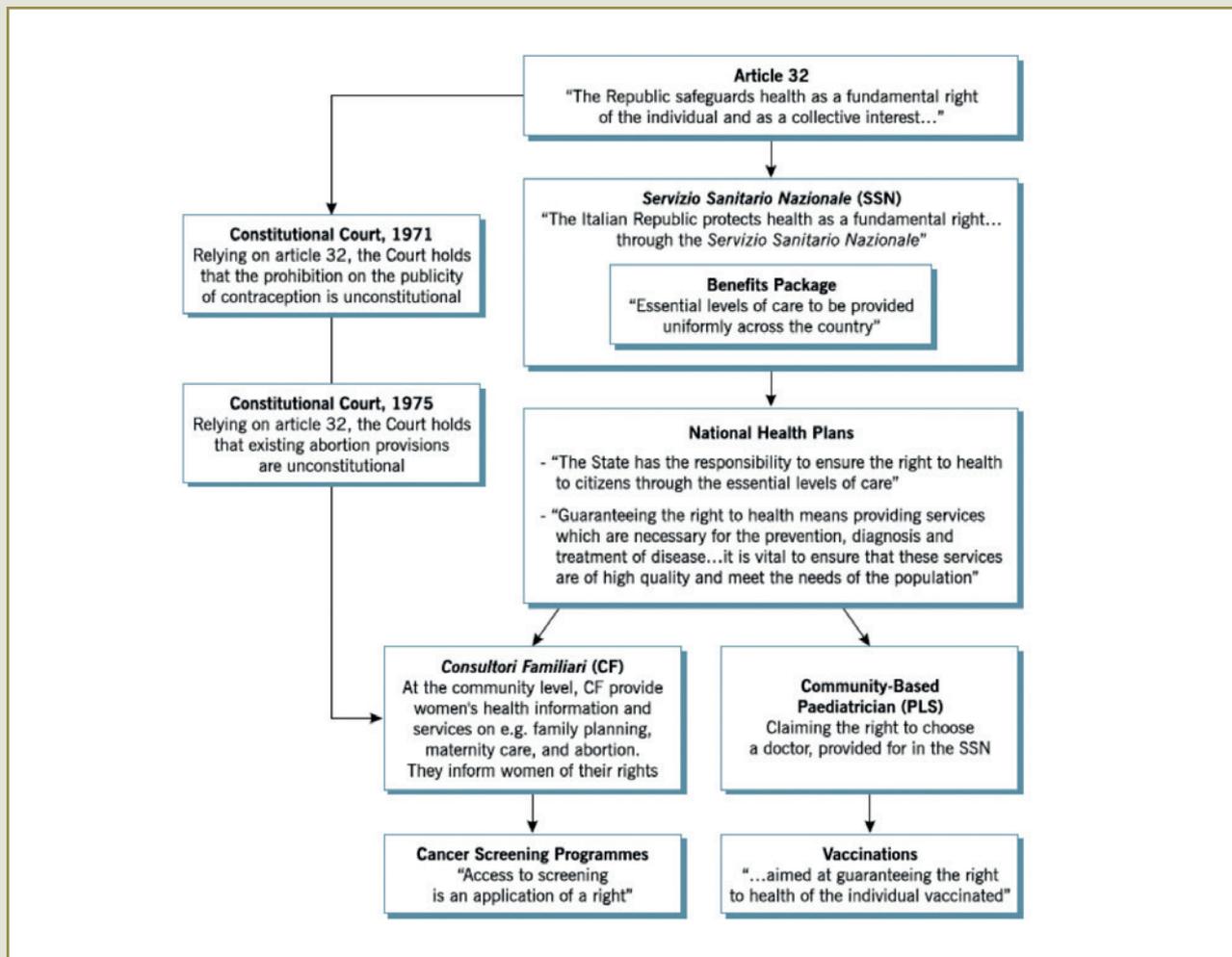


Rajat Khosla



Lale Say

Figure 1. Examples of how a rights based approach implicitly and/or explicitly shaped key government interventions for women and children’s health in Italy since 1948 (8).



(SDGs) these enduring disparities in access and outcomes underscore the need for a closer investigation of these inequities (5). Studies highlight that integrating a human rights based approach in health programming and policy making is likely to result in a positive web of gains across a continuum of processes and outcomes including empowerment of women and improvements in health seeking behaviours (8). Evidence further highlights that a failure of integration of a human rights based approach results in costs of inaction which can undermine the fragile gains that have been made. Inaction or inattention to the fundamental human rights principles of women’s equality has a knock on effect and interacts with other

forms of inequalities such as income, rural/urban status and contributes to skewed availability of and access to critical health services, in many countries (9-11).

Linking SRH and human rights

Increasingly international, regional and national bodies have affirmed the centrality of human rights in the context of SRH and provided guidance on its normative content and application (12). Human rights in relation to SRH: a) protect individuals against coercion, discrimination and violence; b) call for access to necessary information, education and services, including SRH services, to be available, accessible, acceptable and of

good quality; and c) call for accountability of duty bearers and mechanisms for redress of abuses and violations of rights individuals.

Women’s rights, particularly human rights related to SRH, include the right of individuals and couples to make decisions concerning their health and reproduction free of discrimination, coercion, and violence as expressed in human rights documents (1).

Human rights call for a significant shift in how health programming happens by shifting the focus from simply meeting needs to doing so in ways that *fulfill* human rights (see Figure 1) (13). Human rights also put emphasis on addressing inequalities, ensuring participation of

LINKING SEXUAL AND REPRODUCTIVE HEALTH AND HUMAN RIGHTS

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individuals and communities in health planning and decision-making and ensuring accountability. An overall impact of this approach is to achieve the empowerment of individuals to claim their rights to information, education and quality of services (14).

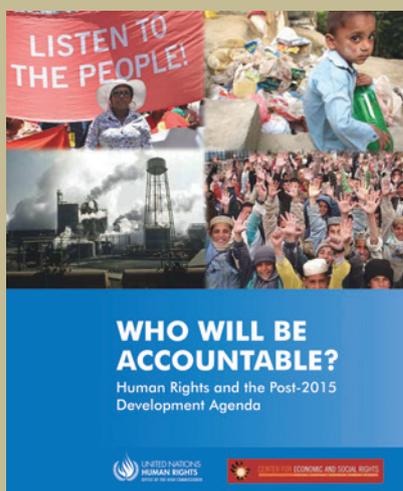
Conclusion

The new international development agenda articulated through the SDGs, offers a key opportunity both to reaf-

firm the centrality of human rights protections, particularly women's and girls' rights, and to prioritize the specific actions required to achieve a comprehensive and integrated approach to women's rights including SRH and rights. Failure to accelerate implementation of women's rights will undermine not only health and human rights but also efforts to reduce poverty, secure equitable social, economic and environmental development and achieve social justice.

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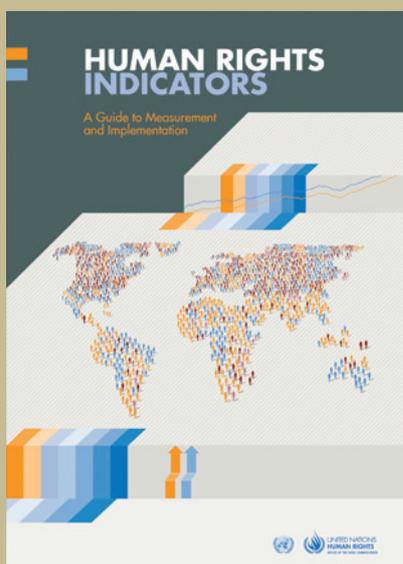


Who will be Accountable? Human Rights and the Post-2015 Development Agenda, UN Human Rights, Centre for Economic and Social Rights, 2013.

Using a human rights framework, this publication addresses the accountability gaps that persist in development and impede attainment of our basic human rights, including those of SRH.

Full document available in English, French and Spanish and summary available in Arabic, Chinese and Russian at:

<http://www.ohchr.org/EN/PublicationsResources/Pages/RecentPublications.aspx>



Human Rights Indicators: A Guide for Measurement and Implementation, UN Human Rights, 2012.

This reference and resource is a valuable tool to help countries develop contextually relevant human rights indicators for implementing and measuring human rights progress in their setting. Available in Arabic, English, French and Spanish at:

<http://www.ohchr.org/EN/PublicationsResources/Pages/RecentPublications.aspx>

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Women's and Children's Health: Evidence of Impact of Human Rights

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Women's and Children's Health: Evidence of Impact of Human Rights, WHO, 2013.

This groundbreaking report documents tangible evidence that a human rights based approach to health contributes to real improvements in the health of women and children globally. A must read for all those working in this domain including policy makers, researchers, public health professionals, health care providers, parliamentarians, governments and civil society. Available in English at:

http://www.who.int/maternal_child_adolescent/documents/women_children_human_rights/en/

SRH AND RIGHTS, WELL-BEING AND EQUITY FOR ALL

Introduction

Since the launch of the first *WHO Regional Strategy on Sexual and Reproductive Health* in 2001 by the WHO Regional Office for Europe much has changed. The Millennium Development Goal deadline of 2015 has arrived and the post 2015 development agenda has brought forward a more comprehensive and holistic approach to development as outlined in the Sustainable Development Goals. *Health 2020, A European Policy Framework and Strategy for the 21st Century* also embraces a comprehensive approach to health and well-being that is rooted in the concepts of equity, gender and human rights and improved governance for health in order to achieve improved health, well-being and health equity for all in the European Region.

In this evolving development landscape it should come as no surprise that the domain of sexual and reproductive health (SRH) has also evolved, shifting from a historical emphasis on reproductive health to a more holistic perspective of SRH throughout the life-course that recognizes the importance of decreasing inequities in SRH and rights in order for all people to achieve their full potential for SRH and well-being (see Figure 1) (1).

Inequities in SRH in the European Region

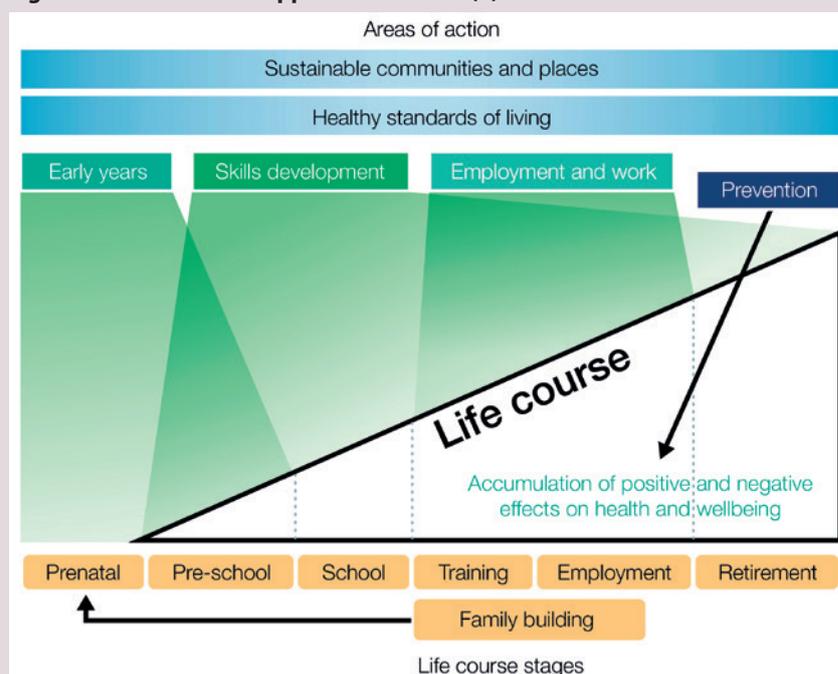
Europe, unlike other WHO Regions, is fortunate in that overall indicators of SRH in the Region are primarily positive. Substantial progress has been made by many countries in improving key SRH indicators since the implementation of the first *WHO Regional Strategy on SRH* nearly 15 years ago. For example, the maternal mortality ratio for the Region was 17.6 per 100 000 live births in 2013 compared to 27.8 in 2000; perinatal mortality decreased from 9.5 deaths per 1000 live births in 2000 to less than 7.4 in 2013; the abortion ratio has nearly halved in this time frame from 431 abortion per 1000 live births in 2000 to 234 in 2013; and the prevalence of modern contraceptive methods has increased from 55.6%

to 61.2% during this time period in the Region (2).

However, this does not mean that challenges do not exist. Relying on Regional indicators only often masks significant inequities that exist within and across countries that are associated with factors commonly linked to disparities such as wealth quintile, ethnicity, level of education, age, gender, vulnerable populations such as adolescents, people with disabilities, sexual minorities, elderly and migrants/refugees, and place of residence (see Figures 2 and 3). In fact these social and economic inequalities are well recognized as underlying factors that drive health inequalities, including in SRH, and allow them to persist. Less advantaged population groups, either as result of social or economic exclusion, are more vulnerable to risk throughout their life-course and much less likely to access SRH services or care, leading to more negative SRH outcomes. Numerous societal, legal and cultural barriers exist for many vulnerable groups, making access to SRH care through existing SRH programmes and services a challenge. In this regard, migrants, adolescents and

ethnic minorities are at particular risk of facing challenges when attempting to access SRH services. Furthermore, many SRH inequities are rooted in gender inequality that place women and young girls at increased risk of adverse SRH outcomes, including gender based violence, as a result of increased vulnerability due to decreased access to education, employment and economic opportunity and less household/decision making ability/power. The environment is also being increasingly recognized as an important determinant of health that can impact on SRH outcomes and contribute to inequities by directly or indirectly influencing susceptibility and biologic exposure, as for example in select working or living conditions. Structural and political factors also contribute, as the policies, strategies and organization of SRH services often result in control and access to SRH resources that is not always equitable for all members of society. This complex relationship of both individual and structural determinants of health drives the cycle of inequities in SRH health present in the European Region today.

Figure 1. The life-course approach to health (1).





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Figure 2. Infant deaths per 1000 live births in the European Region (3).



Health 2020 – improving health, well-being and health equity

The approval in 2012 by the Regional Committee for Europe of *Health 2020* ushered in a new era of policy development for the Region, with health, well-being and equity at the heart of the new innovative and evidence based framework. Recognizing the contribution of the social determinants of health to health and well-being, a whole-of-society and whole-of-government approach is emphasized, with active engagement of all sectors of society and government in order to promote health and well-being and reduce health inequities. It recognizes that good health is essential for development, enhances economic and social stability and sustainability and is central to poverty reduction. It emphasizes that optimizing good health is a basic human right throughout the life-course for all citizens, not only a privileged few. In order to accomplish the goal of improved health for all, *Health 2020* focuses on four common policy priorities: investing in health through a life-course approach and empowering people; tackling the Region’s major health challenges of noncommunicable and communicable

diseases; strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response; and creating resilient and supportive environments.

Within this policy context, SRH becomes an integral element of achieving improved health for all and decreasing health inequities through a life-course approach. A growing body of evidence supports that early investment, starting from pregnancy and in utero, has benefits for health promotion and disease prevention throughout the life-course. Pre-conception, pregnancy and the antenatal period all represent critical times where opportunities to influence health behaviours and outcomes, including future development of noncommunicable disease, are possible. Early action is not the only time to intervene. Interventions that happen later in life can also make a difference. For example, sexuality education and youth friendly health services, that counsel, educate about and provide services for SRH, including positive sexual well-being, also provide important opportunities to influence life long health behaviours and outcomes during critical transitional life stages, such as adoles-

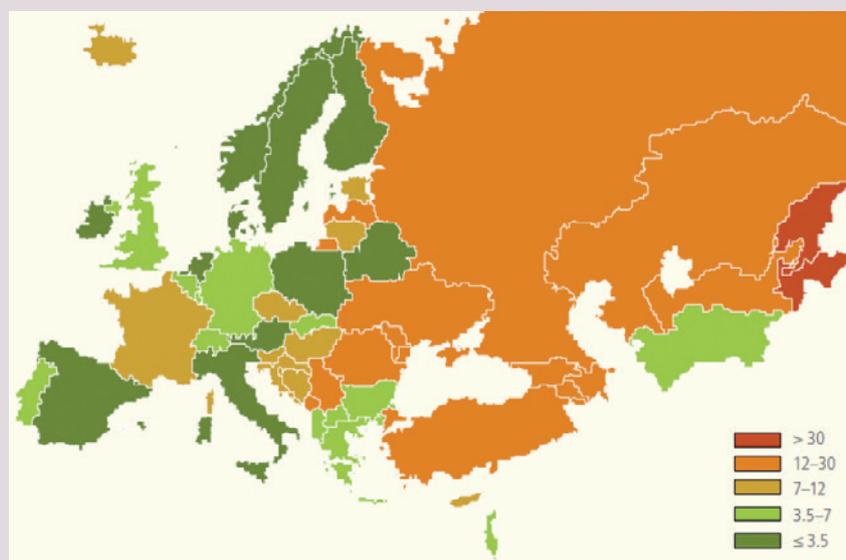
cence. Interventions that promote health and prevent disease at other critical transitional stages, where individuals may be vulnerable, such as adulthood and retirement/ageing, can also be delivered using SRH services as entry points. Ensuring equitable access to these types of SRH services and education for all members of society, but especially vulnerable and marginalized populations, needs to be prioritized, guaranteed and protected by governments and society.

The new WHO European Action Plan for SRH and Rights 2017-2021

In alignment with the vision, policies and priorities of *Health 2020*, promoting health and well-being and reducing health inequities also lies at the heart of the drafted WHO *Action Plan* as stated below:

“We envision a WHO European Region in which all people are enabled and supported in achieving their full potential for sexual and reproductive health and well-being; their sexual and reproductive rights are respected, protected and fulfilled; and in which countries, individually and jointly, work towards reducing inequities in sexual and reproductive health and rights (4)”

Figure 3. Maternal deaths per 100 000 live births in the European Region (3).



Note: the map represents the average value per country based on the three most recent years for which data were available.

SRH AND RIGHTS, WELL-BEING AND EQUITY FOR ALL

(CONTINUED)

In order to attain this vision, the new *Action Plan* proposes 5 strategic directions, meant for the relevant sectors and actors, which will enable the three primary goals of the new *Action Plan* to be met. The three suggested goals and objectives are:

- **Goal A: Promote sexual health and well-being and sexual rights**

- **Objective 1:** Address violations of human rights related to sexuality
- **Objective 2:** Promote people's ability to engage in safe and satisfying sexual relationships
- **Objective 3:** Attend to people's needs or concerns in relation to sexuality

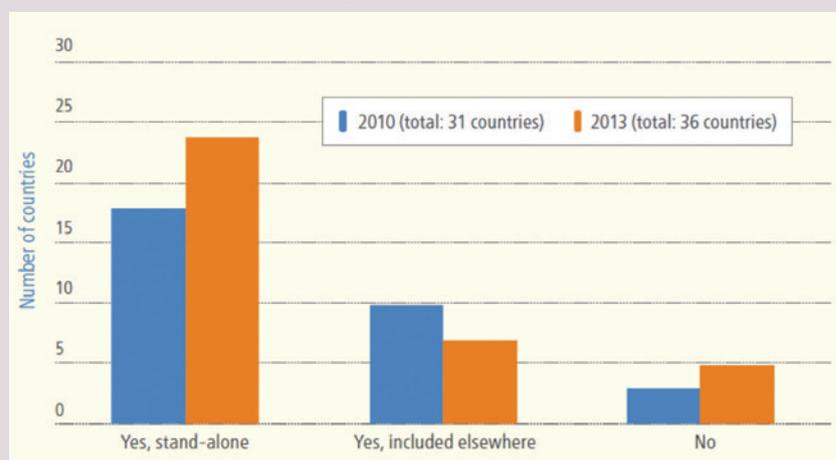
- **Goal B: Promote reproductive health and well-being and reproductive rights**

- **Objective 1:** Foster the exercise of reproductive rights
- **Objective 2:** Reduce unmet need for contraception
- **Objective 3:** Reduce avoidable maternal mortality and morbidity including that due to unsafe abortion
- **Objective 4:** Reduce avoidable perinatal mortality and morbidity
- **Objective 5:** Promote prevention and provide diagnosis and treatment for infertility

- **Goal C: Strive for universal access to sexual and reproductive health and rights and reduce inequities**

- **Objective 1:** Establish/review sexuality education programmes
- **Objective 2:** Expand scope and reach of adolescent sexual and reproductive health services
- **Objective 3:** Establish/strengthen access to sexual and reproductive health services for populations with special needs
- **Objective 4:** Integrate sexual and reproductive health into national strategies and programmes
- **Objective 5:** Develop whole-of-government and whole-of-society approaches for effective and equitable implementation of programmes

Figure 4. Number of countries with policies on health inequities or social determinants of health (3).



and the five strategic directions are:

1. Assess the current situation in order to define priorities,
2. Strengthen health services for effective delivery of high-impact, evidence-based interventions and universal health coverage,
3. Ensure broad cross-sectoral and societal collaboration,
4. Improve leadership and participatory governance for health, and
5. Enhance information and improve evidence.

These five strategic directions have been proposed in recognition of the fact that if we wish to fulfill the ultimate goal of improved SRH health and well-being for all then the approach needs to: be based on an informed understanding of the situation from all perspectives based on both qualitative and quantitative data; be tailored to the priorities and needs of each individual country; include essential evidence-based high-impact interventions for SRH and rights that are delivered through a continuum of care and life-course approach; identify opportunities and methods to ensure universality of equitable access to SRH services; promote and enable broad collaboration and cooperation between and within many different partners and sectors at both the governmental and societal levels; build linkages between

and within government and society to enhance engagement, leadership, advocacy and participatory approaches to achieve improved SRH; strengthen information systems in order to appropriately collect and analyze disaggregated data to identify gaps in programmes and population coverage so that interventions can be improved or newly introduced to ensure universal health coverage.

Taking action to reduce inequities

Progress can be made in addressing the SRH inequities that exist in the Region. The WHO Regional Office for Europe is committed to working with Member States to help reduce SRH inequities and achieve positive health and well-being for all. The new *Action Plan* will serve as an important tool and framework to facilitate this process. It clearly articulates key actions under each objective of the primary goals that are based on principles of equity, fostering community and government commitment and participation and strengthening information and awareness of underlying factors that contribute to SRH disparities. This type of plan is significant as a recent review of Member States conducted by the WHO Regional Office for Europe in response to implementation of *Health 2020* found that many countries are still lacking policies that address health inequities or social determinants of health (see Figure

4). Implemented correctly, the majority of the key actions proposed in the *Action Plan* will have the effect of helping to reduce inequities in SRH throughout the Region, both individually and synergistically. The WHO Regional Office for Europe will further support Member States in achieving this goal by offering and providing:

- technical assistance with the evaluation of the achievements of the current/completed plan of action in SRH and with the situation analysis of the present needs;
- assistance in developing a suitable monitoring framework;
- provision of support to countries for the harmonized and standardized collection of core indicators and the preparation of progress reports;
- dissemination of evidence-based guidelines and tools and assisting countries with their national adaptation;
- facilitation of the exchange of country experiences to highlight barriers and promote best practices;

- close cooperation with partners, including bilateral donor and development agencies and initiatives, funds and foundations, civil society, technical institutions and networks, the commercial private sector and partnership networks in support of national action plans; and

- preparing a mid-term and a final report based on country reports detailing Regional progress in implementing the *Action Plan*.

Together it will be possible to achieve the proposed vision and attain improved SRH and rights for all throughout the European Region. The suggested draft *Action Plan* is one of the first important milestones in working towards this goal.

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The European Health Report 2015. Targets and beyond – reaching new frontiers in evidence, WHO Regional Office for Europe, 2015.

This flagship report presents progress made in the European Region in meeting the targets of *Health 2020* and clearly demonstrates that while the Region is on track opportunities for greater reduction in health inequalities, including SRH, and improved well-being exist. Full text available in English and highlights available in English, French, German and Russian at:

<http://www.euro.who.int/en/data-and-evidence/european-health-report/european-health-report-2015>

ACHIEVEMENTS IN SEXUAL AND REPRODUCTIVE HEALTH: MINISTERIAL STATEMENTS FROM WHO MEMBER STATES



Armen Muradyan



Vjekoslav Mandi

The Republic of Armenia

Based on the strategy developed by the WHO in 2001 and Resolution 57.12 of the 2004 World Health Assembly, in 2006 the *Strategy of reproductive health improvement and 2007-2015 timetable* was adopted by the WHO, UNFPA and approved by the Government protocol decision #29 dated 26 July 2007.

Throughout this period a number of strategies and projects, laws and decrees were adopted and implemented to regulate the sphere of sexual and reproductive health (SRH) and ensure that maternal and infant health services were consistently provided within the framework of state guaranteed free of charge health services. Work was also done to reduce regional disparities. A number of health care facilities were renovated and equipped, access to quality reproductive health care was improved and the capacities of service providers were enhanced through continuous education and the introduction of several evidence-based clinical guidelines. As a result there is: increased modern contraceptive use (20% to 27%); improved antenatal care (90% of pregnant women had 4-6 antenatal visits and 3 ultrasounds); reduction of infant deaths due to perinatal causes by 1/3; and increased inpatient deliveries to 99.7%. During 2006-2014 we also saw significant declines in our maternal, infant and under-five mortality, as well as our abortion and infertility rates.

Despite the achievements, the SRH situation in the country faces many challenges. The level of maternal and perinatal mortality and morbidity still remains high in comparison to other European countries. The accessibility and the affordability of family services are limited, there are high rates of sexually transmitted infections and the increase in the rate of HIV-affected people is alarming, especially among the youth. Abortion is still being used as a method of family planning and recently, a new challenge has emerged, which is that of abortion on the basis of sex-selection. Cancer of reproductive

organs and breast has also become quite widespread.

Continued improvement in SRH remains a priority for the country. Currently the country has committed to elaboration of a new *2016-2020 National Strategy on Reproductive Health, the Programme of Action and the Action Plan*. The strategy aims to improve the SRH of the Armenian population, as well as the accessibility and quality of the services, by giving populations the opportunity to exercise their SRH rights throughout the life-course. The guidance and expertise contained in the new *WHO European Action Plan for Sexual and Reproductive Health and Rights* will be invaluable in helping us achieve this goal.

Mr Armen Muradyan,
Minister of Health,
Republic of Armenia

Bosnia and Herzegovina (BiH)

In BiH health issues are regulated at different levels in the country. At the level of the state, health issues are regulated through the Ministry of Civil Affairs of BiH, which is responsible for defining basic principles, co-ordinating activities, harmonizing plans of the entity authorities and defining a strategy at the international level in health. The Ministry of Health and Social Welfare of the Republic of Srpska and the Ministry of Health for the Federation of BiH are responsible for administering, organizing and funding their own health system. The Council of Ministers adopted the *Policy of Sexual and Reproductive Health and Rights* in BiH in 2012. In relation to sexual and reproductive health (SRH), the two entity ministers described the situation as follows:

Ministry of Health in Federation of BiH (FBiH)

The Ministry of Health together with its partners and in line with the *Strategy for Improvement of Sexual and Reproduc-*

tive Health in Federation BiH 2010-2019 intensively works on the implementation of SRH activities with the goal of advancing the situation in this field. The strength of our strategic framework is its multi-sectoral approach. Besides the health professionals, users of services, the NGO sector as well as educational institutions participate in the development and implementation of the *Strategy*. Some of the most important partners in implementation are UNFPA and IPPF.

Our strategic approach promotes the right to information and education, as well as health services that are customized for individual needs, protection and participation in decision-making. Activities are based on identified priorities in the area of sexual and reproductive health and rights (SRHR) and include family planning, assisted reproductive technology, lowering the abortion rates and strengthening prenatal, antenatal and postnatal care. Activities also target youth, vulnerable groups and marginalized groups with the goal of increasing knowledge on prevention of sexually transmitted infections and promoting SRHR through peer education and the curriculum *Healthy Lifestyles* that was developed in cooperation with education sector.

We plan to evaluate and analyze the implementation of the current *Strategy* in order to accelerate the completion of the set goals and advance SRHR in FBiH. Moving forward we want to give special prominence to advocacy and the changes in the field of promotion, prevention and early detection and treatment of malignant reproductive organs. Our experience to date with our *Strategy* has demonstrated the value and importance of having a clearly defined strategic approach to reach our desired outcomes. Global SRH strategies, such as the current *WHO Global Reproductive Health (RH) Strategy* and the pending *WHO European Action Plan for Sexual and Reproductive Health and Rights* serve as important advocacy tools and references at both the country and



Dragan Bogdani



Nikola Todorov



Nusratullo F. Salimzoda



Maral Ilmamedova



Alexander Kvitashvili

regional level in advancing the SRHR of all people in Europe.

Dr Vjekoslav Mandi,
Ministry of Health in Federation of BiH

**Ministry of Health and Social Welfare
Republika Srpska**

Sexual and reproductive rights are basic human rights. Those rights are recognized in the local as well as international documents on human rights. In order to ensure that individuals develop healthy sexuality, it is necessary to promote and respect these rights, which also serve as the basis for the fight against discrimination. The newly adopted Sustainable Development Goals 2030 further supports this principle by placing access to SRH services as a global goal that secures social justice with the achievement of universal principles of human rights.

The Government of Republika Srpska is committed to this goal. An *Action Plan for BiH (2010-2014)* was signed between the Council of Ministers BiH and the UNFPA Office BiH that allowed specifically for the development of a SRHR policy that would further secure the SRHR (including family planning and universal access to reproductive technology) of our citizens. On 16 August 2012 the Republika Srpska adopted the *Policy for Improvement of SRH in Republika Srpska 2012-2017*. The focus of the *Policy* was guided by recommendations from the WHO and its current *Global RH Strategy*, covering topics such as: sexual and reproductive rights, SRH of youth, SRH of general population, safe and wanted motherhood, control of malignant diseases and research, monitoring and evaluation. A key achievement was when the Ministry of Health and Social Welfare of Republika Srpska in cooperation with the Ministry of Education and Culture Republika Srpska, Institute of Public Health Republika Srpska and Asocijacija XY developed a textbook for the students in high schools, *Healthy Lifestyles* focusing on relevant health,

including SRH, topics. Furthermore, with the development of the *Policy* and with its implementation, we commit to comprehensive improvement in the areas of SRH, which is in line with the goals defined in the *Programme for Health Policy and Strategy for Health in Republika Srpska* until 2010.

In May 2015 UNFPA in cooperation with the Ministry conducted an assessment of the *Policy* with the conclusion that UNFPA and the Ministry continue to partner to evaluate, implement, revise and improve the current *Policy*. As we continue to collaborate on the *Policy* together, the new *WHO European Action Plan for Sexual and Reproductive Health and Rights* will be a welcome addition to inform our ongoing efforts in this field.

Dr Dragan Bogdani,
Ministry of Health and Social Welfare,
Republika Srpska

**The former Yugoslav Republic
of Macedonia**

In 2010 the country officially committed itself to advancing sexual and reproductive health with the development of the *Safe Motherhood Strategy (2010-2015)* and the *Sexual and Reproductive Health Strategy (2010-2020)*. Through the lens of improving maternal and newborn health, a multifaceted approach has allowed for successful initiation of interventions on various fronts, in partnership with the UNFPA, NGOs and other UN Agencies, such as the WHO, OHCHR UNICEF, UN WOMEN and UNDP. To better understand the contributing causes of maternal and newborn morbidity and mortality the change with Ministry of Health has: conducted national assessment of all 30 maternity facilities for provision of emergency obstetric and neonatal care services; strengthened the health system through introduction of over 40 evidence-based policies and guidelines; and introduced the WHO methodology for confidential inquiry for

maternal deaths. In addition, for the first time ever, the foundation of the three main pillars of comprehensive family planning services has been set, addressing both the “demand” and “supply” side. The country is also recognized in the region for speedy and successful introduction of the Minimum Initial Services Package (MISP) for sexual and reproductive health into country policies and services, serving as an example of true collaboration among all stakeholders in the country. Positioning of the health sector in the multi-sectorial approach to gender based violence management has also been strengthened in partnership with the UNFPA.

All these interventions have been guided by human rights principles and international standards. Most of the implemented efforts are part of the national strategies, but not all. Revision of the existing national strategies is required to synchronize and align with these efforts as well as new global and regional initiatives. In this regard new initiatives, strategies and action plans such as the recently adopted Sustainable Development Goals, the *UNFPA Family Planning Strategy* and the draft *WHO European Action Plan for Sexual and Reproductive Health and Rights* are essential aids and tools to ensure that our country SRH initiatives have universality of services, human rights principals and evidence-based medicine at their core. We strongly rely on the UNFPA’s and WHO support; the new cycle of the UNFPA Country Programme provides a five year framework to jointly implement the regional and national strategies, aimed at advanced health and well-being of the population in the country and entire Region. As we go through this process, we count on furthering the existing partnerships aimed at development of effective, people oriented regional strategies and action plans, such as the new *WHO European Action Plan for Sexual and Reproductive Health and Rights*.

Mr Nikola Todorov,
Minister of Health

ACHIEVEMENTS IN SEXUAL AND REPRODUCTIVE HEALTH: MINISTERIAL STATEMENTS FROM WHO MEMBER STATES

(CONTINUED)

The Republic of Tajikistan

H.E. Emomali Rahmon, the President of the Republic of Tajikistan (RoT), declared the year of 2015 as the Year of Family; evidence of a steadily developed governmental policy and strategy on maternal and child health (MCH) protection and reproductive health and rights (RHR).

Special attention of the government to the health of women and children led to passing of the *Law on Reproductive Health (RH) of Population* and a number of strategic documents, including the *National Health Strategy, Safe Motherhood National Plan, RH Strategic Plan and the National Strategy of the RoT on Children and Adolescent Health*. This in turn led to improvements of key health indicators: decreased maternal mortality ratio from 45 per 100 000 live births in 2002 to 29.2 in 2014; increased antenatal care coverage from 58.7% to 98%; increased contraceptive prevalence rate from 15% to 35.3%; decreased number of abortions from 113.9 to 68.6 per 1000 live births; decreased number of home deliveries from 38.7% to 7.4%; and increased rates of cesarean section from 2% to 4.2%.

Achievement of these results became possible thanks to the political will and leadership of the government, as well as joint coordinated actions with development agencies and partners, including UNFPA, WHO, UNICEF, GIZ and USAID. The Ministry of Health and Social Protection of Population (MoHSPP) RH Coordination Council unites all the partners, donor community and NGOs. This mechanism helps us to track attainment of the targets within the mentioned strategic documents and jointly develop plans and programmes meeting the country's needs and requirements. Duplication of actions is avoided. Such collaboration demonstrates effective utilization of available resources from all parties for achievement of common goals.

Despite substantial progress, challenges and opportunities still exist. Currently the new *National Strategy on RH,*

Maternal, Child and Adolescent for the period of 2016-2020 is being developed. In contrast to the previous strategies, it will be complex in nature and cover all the areas of RH, MCH and adolescent health. Flexibility, concordance and coordination of all institutions of maternal, child and adolescent health protection are key elements of the new strategy. The new strategy will help to maintain our progress while responding to new threats, challenges and the changing needs of our population. In addressing these issues the strategy will also build partnership with new actors with widening of their functions and roles, to positively change the traditional roles and public perceptions. We will follow the international principles, standards and approaches, based on human rights and gender sensitivity, as outlined in the draft *WHO European Action Plan for Sexual and Reproductive Health and Rights*, for the benefit of the population of Tajikistan and achievement of the Sustainable Development Goals.

Dr Nusratullo F. Salimzoda,
Minister of Health and
Social Protection of Population,
Republic of Tajikistan

Turkmenistan

The Government of Turkmenistan and the United Nations Populations Fund (UNFPA) have been strategic partners for over two decades. With the contribution of UNFPA, Turkmenistan champions international good practice in maternal and newborn health, emergency obstetric care and reproductive health service delivery, including in humanitarian response preparedness.

The UNFPA country team mobilized Turkmenistan's best medical scientists and practitioners to design and introduce 31 clinical protocols on reproductive health services into clinical practice, as well as develop several key strategic documents, such as: the *National Reproductive Health Strategy 2011-2015; the National*

Breast and Cervical Centre Prevention Strategy 2011-2015; the National Strategy on Response to HIV for 2012-2016; and the National Action Plan on Minimum Initial Service Package endorsed in 2014. In conjunction with UNFPA, UNICEF and WHO our experts were the first in the region to develop a *National Strategy on Maternal, Newborn, Adolescents and Children Health 2015-2019*. This important strategy is based on the life-cycle approach of the *Global Strategy on Maternal, Newborn, Adolescent and Child Health 2016-2030* and is in line with the regional strategic guidance. Currently as a result of these efforts, clinical practice in over 70 percent of maternities across the country complies with clinical protocols and there are over 90 family planning service delivery points in all cities and districts, providing free services to married couples and people individually.

By ensuring qualified and timely technical expertise and advisory support at all levels of planning and implementation, UNFPA has been an essential partner in achieving our national health priorities. Together we have achieved declines in maternal mortality, averted unsafe abortions, provided families with affordable and comprehensive family planning services and piloted innovations both in medical training for professionals and reproductive health education for general population. We have also been working together to develop a comprehensive legal and policy base, build infrastructure, integrate new technologies and methodologies, improve medical education and train practitioners in line with the national data and international standards.

Last year the Government of Turkmenistan and UNFPA signed a Memorandum of Understanding to embark on a new model of partnership due to our new status as an upper middle income country as identified by the World Bank. This new model will enable us to contribute to the next Country Programme cycle to build sustainable health systems and development platforms while placing the needs,

rights and overall well-being of women and girls, young people and adolescents at the heart of our shared mandate. The new *WHO European Action Plan for Sexual and Reproductive Health and Rights* will be an excellent resource to help guide us in this mission.

Dr Maral Ilmammedova,
Chief Obstetrician of the Ministry of
Healthcare and Medical Industry of
Turkmenistan

Ukraine

In the past years, Ukraine has made considerable progress towards national and global health goals, including in the areas supported by our current state programme on “*Reproductive Health of the Nation*” which was designed for the period from 2006 to 2015. National data and an independent assessment confirmed the positive impact of the programme for all indicators on reproductive health, including maternal and newborn health, as well as on increases in the use of modern methods of contraceptives. Despite this progress we are still lagging behind and the ongoing significant economic and social crisis endangers the progress achieved towards the implemen-

tation of the health related Millennium Development Goals.

In light of these new emerging challenges and the adoption of a new global development agenda, the Sustainable Development Goals, Ukraine is currently reforming its national health care system under my leadership. In our efforts, reproductive health, including maternal health, is a key priority as it is at the very heart of the future development of Ukraine and important to national safety and security. The new strategy on reproductive health and reproductive rights will be designed to protect and support the reproductive health of the Ukrainian people and address ways to overcome the pressing economic and social challenges while not losing momentum on progress made on maternal and newborn health.

Together with a strong coalition of partners in the field of reproductive health (including UNFPA, WHO, USAID, UNICEF, SDC and the NGO Women Health and Family Planning) the Ministry of Health will ensure that the new strategy also addresses existing unresolved challenges around: the integration of reproductive health into primary health care; strengthening existing referral systems; reproductive health services in

emergency situations; and access to and quality of care for vulnerable groups. Our efforts will also ensure the systematic coverage of adolescents and young people with healthy lifestyle and prevention activities, in combination with access to youth-friendly services.

Under the overall reform of the health care system, the next *Reproductive Health Strategy* will become the tool for implementing the reforms in the reproductive health sector and lead to tangible, measurable and solid results. We are looking forward to working with partners in developing the new strategy. The *WHO European Action Plan for Sexual and Reproductive Health and Rights 2017-2021* will be an important tool to aid us in this goal.

There can be no development without health and there can be no health development without reproductive health! The Ministry of Health and I personally are committed to the improvement of our health services and the reinforcement of the reproductive health for the people and the future development of Ukraine.

Mr Alexander Kvitashvili,
Minister of Health,
Ukraine



Addressing the Needs of Women and Girls in Humanitarian Emergencies in Eastern Europe and Central Asia, UNFPA, 2015.

This regional supplement to UNFPA's State of World Population 2015 provides an overview of the increased risk women and girls face during humanitarian crisis and how ensuring access to SRH services strengthens the well-being, health and resilience of individuals and communities. Available in English and Russian at: <http://eeca.unfpa.org/publications/addressing-needs-women-and-girls-humanitarian-emergencies-eastern-europe-and-central>

HOW TO MONITOR SEXUAL AND REPRODUCTIVE HEALTH?

The objective of this article is to present the overview of the sexual and reproductive health (SRH) indicators that have been used to monitor changes during the last 20 years in this domain.

Definitions of SRH – understanding what we are trying to measure and monitor

For the last 20 years, the definition of reproductive health (RH) has been formulated on the definition that was published in *the Programme of Action of the International Conference on Population and Development* (ICPD) in Cairo, 1994.

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

According to the WHO working definition sexual health is “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained,

the sexual rights of all persons must be respected, protected and fulfilled” (WHO, 2006).

SRH indicators – an evolving landscape

The *Programme of Action of ICPD* set targets and some of them included indicators. Since the ICPD in Cairo, inter-agency groups, led by the WHO, have been working on the development of indicators to monitor SRH in countries and globally.

In 1997 the Report of an interagency technical meeting “*Reproductive Health Indicators for Global Monitoring*” was published. It included 17 “working” minimal list of RH indicators (see Text Box 1).

Three years later, the Second interagency meeting on RH indicators for global monitoring was organized. Their mandate was to review the existing common set of RH indicators for global monitoring. Following the review the interagency group recommended the addition of HIV/AIDS indicators. The resulting 17 RH indicators published in the report of the Second Interagency meeting included detailed explanation including justification for selection (see Text Box 2).

These indicators were used in the *WHO European Sexual and Reproductive Health Strategy* of 2001 which was used as a framework in the development of many national SRH policy documents (3). However, collection of the SRH health information has been a challenge in many countries. As several indicators can be monitored only using regular surveys, often some data, for example – contraceptive prevalence, are missing. Since then there have been several attempts to prioritize indicators and to improve the methodology of their collection.

The Millennium Development Goal (MDG) 5 targets and indicators have also been used by countries to monitor their achievements (see Text Box 3). However this has also proved challenging as the definition of “skilled health personnel” and “universal access to health care” has not always been clear or easy to specify.

Text Box 1. “Working” minimal list of RH indicators 1997 (1).

1. Total fertility rate
2. Fertility rate of women 15-19 years old
3. Contraceptive prevalence rate (modern contraception)
4. Maternal Mortality Ratio
5. Proportion of women attended at least once during pregnancy for reasons related to pregnancy
6. Proportion of births attended by trained health personnel (excluding trained and untrained traditional birth attendants)
7. Number of health centres per 500 000 population with functioning basic essential obstetric care (basic EOC)
8. Number of hospitals per 500 000 population with functioning comprehensive essential obstetric care (comprehensive EOC)
9. Proportion of babies under four months old who are exclusively breast fed
10. Perinatal mortality rate
11. Proportion of live births of low birth weight
12. Positive syphilis serology prevalence in pregnant women
13. Proportion of pregnant women routinely screened for haemoglobin levels who are anaemic
14. Facility-based fatality rates for post-abortion complications
15. Estimated prevalence of women who have been genitally mutilated
16. Proportion of service delivery points offering PAP smear tests
17. Proportion of women aged 20-44 years who are sexually active, are not using contraception or lactating, who want a pregnancy and have not become pregnant during the last two years

The European Commission has also supported the process of the development and collection of perinatal and reproductive health information through their PERISTAT and REPROSTAT projects. The EURO-PERISTAT indicators are collected in 4 groups (5):

1. Fetal, neonatal and child health that includes data on fetal, neonatal and infant mortality, birth weight, etc.
2. Maternal health includes data on maternal mortality and morbidity.
3. Population characteristics/risk factors – from maternal age to information on education, body mass index before pregnancy, smoking during pregnancy and other indicators.



Gunta Lazdane



Ivo Rakovac

Text Box 2. The 17 RH Indicators 2001 (2).

1. Total fertility rate
2. Contraceptive prevalence
3. Maternal mortality ratio
4. Proportion of women attended, at least once during pregnancy, by skilled health personnel for reasons related to pregnancy
5. Proportion of births attended by skilled health personnel
6. Number of facilities with functioning basic essential obstetric care per 500 000 population
7. Number of facilities with functioning comprehensive essential obstetric care per 500 000 population
8. Perinatal mortality rate
9. Proportion of live births of low birth weight
10. Positive syphilis serology prevalence in pregnant women attending for antenatal care
11. Percentage of women of reproductive age screened for haemoglobin levels who are anaemic
12. Percentage of obstetric and gynaecological admissions owing to abortion
13. Reported prevalence of women with female genital mutilation
14. Percentage of women of reproductive age at risk of pregnancy who report trying for a pregnancy for two years or more
15. Reported incidence of urethritis in men
16. HIV prevalence in pregnant women
17. Knowledge of HIV related prevention practices

4. Health care services – additional information on subfertility, antenatal care, delivery and neonatal intensive care.

The REPROSTAT project, supported by the European Commission, developed and produced the document “*Reproductive Health Indicators in the European Union*” (6) to aid with monitoring RH. It included 13 core indicators as well as one recommended indicator and a number of indicators for future development (see Table 1).

The WHO’s first global strategy on RH was adopted by the 57th World Health Assembly in 2004. It was followed by the publication of “*Accelerating progress towards the attainment of international*

reproductive health goals: a framework for implementing the WHO Global Reproductive Health Strategy” in 2006. This document for the first time included input, process and output indicators as well as the outcome and impact indicators (7).

In 2007 the WHO and UNFPA organized a technical consultation on RH indicators and RH indicators were grouped as follows (8):

- Indicators of policy and social determinants;
- Indicators of access;
- Indicators of service use; and
- Outcome/impact indicators.

The indicators recommended by this consultation were designed to complement and expand upon the 17 RH indicators (2).

While RH indicators have been analyzed and revised by the WHO, UNFPA and other agencies on a regular basis the same is not true for sexual health (SH). One of the first documents “*Measuring sexual health: conceptual and practical considerations and related indicators*” focusing specifically on measuring SH was published in 2010 (9). The source of information for more than 50 proposed indicators was outlined in this document. Interestingly, for 11 of the indicators the recommended data source is law/policy reviews, for 7 – facility surveys and for 15 – national surveys. The challenge with

national surveys is that they require time and funding and as a result the number of countries who are carrying out such representative studies in the WHO European Region is limited. In countries of eastern Europe and central Asia – Demographic Health Surveys (DHS), Reproductive Health Surveys (RHS) and Multiple Indicator Cluster Surveys (MICS) are supported by the aid development partners and provide some information, but much more should be done to ensure even basic sex disaggregated data on SRH.

The Sustainable Development Goals (SDGs)

The recently approved SDGs have several targets related to SRH and within this context the principles for setting SDG indicators are well defined (10). Indicators must be:

1. Limited in number and globally harmonized;
2. Simple, single-variable indicators, with straightforward policy implications;
3. Allow for high frequency monitoring;
4. Consensus based, in line with international standards and system-based information;
5. Constructed from well-established data sources;
6. Disaggregated;

Table 1. REPROSTAT list of indicators (6).

Areas	Core indicator
Sexually transmitted infections/ Sexual behaviour	HIV prevalence (pregnant women)
	Chlamydia prevalence
	Condom use (last high-risk sex contact)
Youth	Median age at first intercourse
	Contraceptive use at first intercourse
	Teenage birth rate
Contraception	Contraceptive Prevalence
Fertility and reproduction	Maternal age at 1st childbirth
	Total fertility rate
	% trying to get pregnant
	% deliveries after Assisted Reproductive Technology
Abortion	Induced abortions
Emergency areas	Hysterectomy rate

HOW TO MONITOR SEXUAL AND REPRODUCTIVE HEALTH?

(CONTINUED)

7. Universal;
8. Mainly outcome-focused;
9. Science-based and forward-looking; and
10. A proxy for broader issues or conditions.

The suggested SDG indicators confirm that SRH and rights is linked with almost all the SDGs, for example (10):

Goal 1. *End poverty in all its forms everywhere* includes “Total fertility rate” as an indicator;

Goal 2. *End hunger, achieve food security and improved nutrition and promote sustainable agriculture* - includes the following SRH indicator “Percentage of infants under 6 months who are exclusively breast fed;”

Goal 3. *Ensure healthy lives and promote well-being for all at all ages* incorporates the following 4 SRH indicators:

- “Maternal mortality ratio (MDG Indicator) and rate,”
- “Neonatal, infant, and under-5 mortality rates,”
- “HIV incidence, treatment rate, and mortality,”
- “Contraceptive prevalence rate;” and

Goals 5. *Achieve gender equality and empower all women and girls* includes the following indicators relevant to SRH:

- “Prevalence of girls and women 15-49 who have experienced physical or sexual violence [by an intimate partner] in the last 12 months;”
- “Percentage of referred cases of sexual and gender-based violence against women and children that are investigated and sentenced;”
- “Percentage of girls and women aged 15-49 years who have undergone Female Genital Mutilation /Cutting” and
- “Met demand for family planning.”

Several indicators are still under development. For monitoring the progress of countries in achieving SDGs com-

Text Box 3. MDG 5 Targets and Indicators (4).

Target 5A: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

- 5.1 Maternal mortality ratio
- 5.2 Proportion of births attended by skilled health personnel

Target 5B: Achieve, by 2015, universal access to reproductive health

- 5.3 Contraceptive prevalence rate
- 5.4 Adolescent birth rate
- 5.5 Antenatal care coverage (at least one visit and at least four visits)
- 5.6 Unmet need for family planning

Text Box 4. Examples of interventions focusing on WOMEN (including pre-pregnancy interventions) (11).

- Information, counselling and services for comprehensive SRH including contraception;
- Prevention, detection and treatment of communicable and noncommunicable diseases and sexually transmitted and reproductive tract infections including HIV, TB and syphilis;
- Iron/folic acid supplementation (pre-pregnancy);
- Screening for and management of cervical and breast cancer;
- Safe abortion (wherever legal) and post-abortion care;
- Prevention of and response to sexual and other forms of gender-based violence; and
- Pre-pregnancy detection and management of risk factors (nutrition, obesity, tobacco, alcohol, mental health, environmental toxins) and genetic conditions.

plementary national indicators are also suggested. Many of them cover SRH and rights areas.

SRH is also one of the implementation packages through the life course in the renewed *UN Strategy on Women’s, Children’s and Adolescents Health 2016-2030*. “Improved monitoring, evaluation and accountability” is one of the principles of the renewed UN Strategy. The Strategy includes the list of evidence-based health interventions that may be used as basis for the data collection and monitoring (see Text Box 4).

Text Box 5. Criteria and principles agreed at the expert meetings used to select the final list of indicators for Health 2020.

- As far as possible, the proposed indicators should be selected on the basis of their routine availability for most countries.
- The final number of indicators should be kept to a minimum.
- While the importance of indicators and targets already the subject of other collections (such as the Millennium Development Goals or Parma Declaration) was recognized, they should not be repeated, in order to keep the list short.
- Some indicators will serve several targets.
- Because of availability and comparability issues (including, for example, mental health, healthy ageing and health system performance), the list of indicators is not able to reflect all relevant policy areas in a balanced way.
- Even if rates at the national level for certain indicators are already favourable, indicators should be used for monitoring (and accountability) where possible.
- Basic demographic information, including age distribution of populations, should be included in addition to the indicator set.
- All rates reported by indicators should be age-standardized.
- Where possible and available, indicator data should be reported disaggregated by age, sex and ethnicity and by socio-economic, vulnerable and subnational groups; this will be subject to data availability and may vary according to the specific indicator.
- There is a need for a set of core (level 1) indicators that all Member States should be monitoring but Member States should also consider additional (level 2) indicators. The core data would be a basic minimum to facilitate regional assessments. Voluntary reporting on the additional indicators should be encouraged as they are useful for informing national target area evaluations.

Core indicators need to be comparable across the WHO European Region as they will be used for regional target monitoring. Other indicators used at the national level require only “internal” comparability.

Health 2020 targets and indicators – process and monitoring framework

Health 2020 is the health policy of the WHO Regional Office for Europe. *Health 2020* aims to support actions across government and society to significantly improve the health and well-being of

populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality. It was adopted by the Regional Committee in the year 2012.

In 2011, one year before the adoption of *Health 2020*, it was agreed at the Regional Committee that a monitoring framework should be developed and that the targets should be SMART: **S**pecific, **M**easurable, **A**chievable, **R**eliable and **T**imely. The 6 overarching targets were agreed, namely:

1. Reduce premature mortality in Europe by 2020,
2. Increase life expectancy in Europe,
3. Reduce inequities in Europe (social determinants target),
4. Enhance the well-being of the European population,
5. Universal coverage and the “right to health” and
6. National targets/ goals set by Member States.

In addition to the conceptual considerations for each of the six overarching targets/areas, attention should also be given to the attributes of the overall package of European targets, balancing for example process and outcomes targets.

Thereafter, two working groups were established, one on development of well-being indicators and one on the indicator development. Criteria and principles used for the selection of indicators agreed in the expert group meetings are given in Box 5.

The establishment of working group on well-being measurement and indicators was necessary because it was felt that a significant amount of basic work on defining and measuring well-being was necessary. Therefore, the group met several times and has adopted the definition of well-being and has agreed on methods to measure different dimensions of well-being in the European context (12, 13).

Among the adopted *Health 2020* indicators, Maternal Mortality Ratio and to some extent life satisfaction is related to SRH. The adopted *Health 2020* monitor-

ing framework is described in detail in the WHO recent publication on *Health 2020* targets and indicators (14).

It is recommended that any potential new monitoring framework for SRH in Europe considers best practices and principles used for the development of *Health 2020* monitoring framework in order to minimize the reporting burden on Member States and ensures the availability and comparability of data.

Conclusion

The focus of SRH information may have changed during the last 20 years globally, as well as in the WHO European Region, however, much more should be done to ensure that each country has at least basic information on the SRH and rights of the people. Without it – it will be difficult to make further strategic actions and improve health and well-being for all.

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THE NEW EUROPEAN STRATEGY FOR SEXUAL AND REPRODUCTIVE HEALTH: WHY IS SEXUAL HEALTH A PRIORITY THIS TIME?

The time was 1993... we were sitting in the office of as it was then called 'SFP' - Sexuality and Family Planning, and discussing with Dr. Daniel Pierotti, the second SFP Adviser since the start of the UNFPA- funded Technical Support Services (TSS) to streamline reproductive health into the agendas of the WHO, Ministries of Health and other organizations dealing with health or development.

It was a young programme for the European Region, as the main focus of TSS had been on those regions of the world with high population growth rates, with subsequently high fertility rates and high maternal mortality rates. The introduction of family planning programmes, there, had two purposes: 1) to contribute to sustainable development and the reduction of poverty by limiting population growth and 2) to contribute to better maternal health and the reduction of maternal mortality by ensuring birth spacing through making good quality contraceptives and counselling services available at affordable prices.

The situation in Europe, in 1993-1994, though, was very different. The growth of the population was not the problem, on the contrary, most countries, both in western and eastern Europe, were struggling with maintaining replacement level fertility rates and were therefore politically not interested in couples using contraception and limiting the number of births per couple to one or two children. In many countries, notably, for example, in the Romania of Ceausescu, a pro-natalist agenda prevailed, partly based on the fear that not enough young people were in the job market to feed the growing number of old-age pensioners and partly also based on the concern that immigrant groups from poorer countries would have higher fertility rates and thus change the ethnic distribution and make-up of a country.

This political agenda however, did not match the personal situations of many families and couples, who found themselves hit by the economic crisis and radical socio-economic transition their countries were going through, with

growing unemployment rates and scarcity of goods and services. Families felt that they could not afford to have more than one or at most two children and limited their birth rates accordingly after the desired family size had been reached. As contraceptives were either unavailable or unaffordable, or people believed that hormonal contraception had many harmful side-effects, this resulted in a high number of repeated abortions used as a method of family planning. Due to the general scarcity of resources in health services at the time the abortion equipment used was often outdated or unsafe. A high proportion of the maternal deaths in the central and eastern European Region and in the former Soviet Union countries were due to abortions performed with such equipment and in an unsafe manner.

On the other hand, planned and desired pregnancies, too, did not always result in safe pregnancies, or safe births, as the scarcity and poor quality of equipment, along with the lack of updated medical expertise resulted in the late recognition of risk factors and respective referral and sometimes risky obstetric practices. The results were unnecessarily high levels of preventable maternal deaths and maternal morbidity, but also preterm births, low birth weight and neonatal and infant deaths at a much higher level than in the western or European Union countries.

Faced with these challenges, the focus of our WHO-UNFPA programmes and projects was to improve reproductive health, to make pregnancy safe, to avoid undesired pregnancies by improving pre-pregnancy, pregnancy, obstetric, neonatal and early paediatric care, as well as increasing the responsibility of men and fathers in the protection of reproductive health (see Image 1).

In the country-wide joint programmes run at the time in Portugal (an exception to the rule in western Europe, where relatively high levels of fertility and maternal mortality still prevailed, particularly in poor regions of the country), in Albania, in Romania and in Turkey, the focus of programmes was on upgrading the

Image 1.



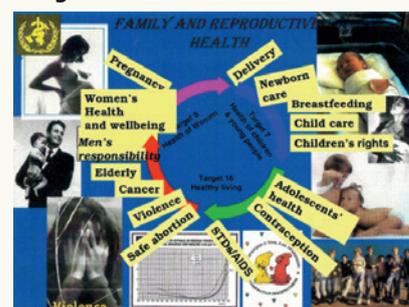
Source: personal collection Dr A Brandrup-Lukanow.

knowledge and skills of health providers, upgrading the equipment of hospitals and maternity wards and providing expendable health supplies, drugs and contraceptives.

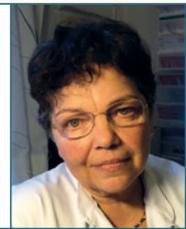
The focus was very much on maintaining safe pregnancies and helping couples to choose the timing and number of their children, as was also later stated in the Action Plan of the International Conference on Population and Development in Cairo in 1994. Part of this included also preventing, and providing treatment for infertility and understanding its causes. Studies were funded looking at the damaging effects of toxic substances used in industry and agriculture, particularly on male fertility, and discussions started on whether in-vitro fertilization services should be provided for with public funds, as that was also included in the right to chose to have children or not.

We looked at what we called the life-cycle approach to sexual and reproductive health, as we called it at the time, but in reality, it was a life-cycle approach to reproductive health more exclusively (see Image 2).

Image 2.



Source: Archival slide from former Family and Community Health Section for a WHO Regional Office for Europe meeting of focal points on Maternal and Child Health in 2002.



We included chronic ill health linked to reproductive functions, such as cancers of the reproductive tract and anaemia caused by multiple pregnancies. We included the needs of special groups, migrants, the elderly, the young, promoted the opening of adolescent counselling clinics and of peer education. It was the time of the beginning of the HIV/AIDS epidemic in Europe, but talking about sexual health was difficult politically. Even in the professional context, the discussion on sexual-venereal diseases were confined to a small and well defined medical specialty, dermato-venereology, outside that, there was no space for the professional public health debate on sexual health.

It was also a cultural challenge, as promoting knowledge on sexual health in schools was seen as spoiling young people and ostracizing parents, as if talking about sex and prevention made young people have more sex without taking preventive precautions. The education system was reluctant to address the issue and preferred to talk about "Healthy Life-styles" rather than "Sex Education".

In several countries of the Region, there were conservative streams opposing the sexual health discussion either on the grounds of religion, or on the grounds of tradition. In some countries, abortion was illegal and the use of contraception discouraged. The purpose of sexual relations was seen to be procreation, beyond that, they were not to exist. These kind of legal restrictions ended up leading to travel across borders for abortions or for procurement of contraceptives, sometimes with the consequence of legal prosecution. It took a long time to recognize that these kind of policies were dangerous and detrimental to women's health and for legal reforms to take place. Another area difficult to speak about in the public health debate was the area of same-sex relations. Human rights movements on the one hand and the imperative of the HIV/AIDS epidemic on the other opened up these previously closed chapters.

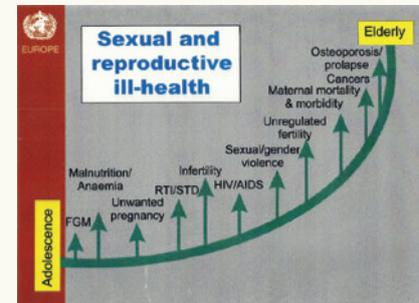
Despite all these constraints, the first European Sexual and Reproductive Health Strategy produced in 2001

became, through repeated pan-European expert consultations, a comprehensive document with a framework of objectives, activities and indicators, used by many countries in the subsequent reviews of their own national frameworks. However, it never became a Regional Committee document, as, at the time, the whole area of sexual and reproductive health was considered less important than topics like health financing, primary health care, chronic diseases or child health, all of which were of course less politically controversial and therefore easier to tackle.

Even without a Regional Committee resolution, the implementation of the Sexual and Reproductive Health Strategy over the past nearly 15 years has led to improved information and public knowledge on sexual and reproductive health, a change of many outdated medical practices, an updating of medical knowledge and an improvement of medical equipment with the help of resources from other organizations, such as the Global Fund for AIDS, TB and Malaria, the World Bank, UNICEF, UNFPA and others. All of this together has resulted in a reduction of maternal mortality and morbidity and of infant and neonatal mortality. Greater attention was also paid to the reproductive health needs of migrants and of young people and to the reproductive health needs of men, and generally, a greater openness in debate, and, at least in some countries, to increased public investments into reproductive health facilities and commodities. The strategy addressed all areas of sexual and reproductive ill health potentially occurring at different stages of life, as represented in the graph (see Image 3).

However, many challenges remain, in particular with regard to the "S" in SRH- sexual health. The first challenge is to demystify sexual health and sexuality to what it is – a part of human nature, human health and human well-being. The need for protection of sexual health starts long before the initiation of sexual activity- it starts with instilling in girls and boys an understanding and acceptance of their bodies and a self-confident

Image 3.



Source: European Regional Strategy on Sexual and Reproductive Health, Copenhagen: WHO Regional Office for Europe, 2001.

approach to sexuality as an integral part of human life and of growing up. That is the responsibility of the education sector and of parents, after which comes the responsibility of the health sector to prevent sexual ill health and to treat it if it occurs. The increasing mobility of society, civil unrest and violence contributing to the HIV/AIDS epidemic and the spread of other sexually transmitted infections, including those leading to the development of cancers of the reproductive tract, as well as the changing of traditions and models of partnership and the generally earlier sexual maturation and sexual debut all call for public health action and increased resources for sexual health and well-being. The development of the new sexual and reproductive health strategy will hopefully provide a new framework and guidance on where investments, be they financial or technical, are most cost-effective and beneficial in the protection of sexual health.

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YOUTH MATTERS! WHY INVEST IN YOUNG PEOPLE'S AND ADOLESCENTS' SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS?

Today, Earth is home to 1.8 billion young people with various needs, aspirations and potentials. If we want to continue to make progress we have to invest in young people's health, to prioritize and involve them in all the processes related to their sexual and reproductive health and rights (SRHR). A new strategy for SRHR must focus on young people when it comes to violence against women and girls, access to SRHR services, including abortion and access to SRHR information and education.

Ending violence against women and girls

The new sustainable development agenda builds on the Millennium Development Goals (MDGs), drafted in 2000, which focused on reducing poverty, hunger, disease, gender inequality and ensuring access to water and sanitation by 2015. The new agenda is an action plan for people, planet, prosperity, peace and partnership. It will foster peaceful, just and inclusive societies and require the participation of all countries, stakeholders and people. The 2030 development agenda is based on 17 goals, including a stand-alone goal on gender equality and the empowerment of women and girls, as well as gender-sensitive targets in other goals.

While much progress has been made towards girls and women's rights over the decades, many gaps remain. For women's rights to become a universal reality it is critical to address the structural causes of gender inequality, such as violence against women, unpaid care work, limited control over assets and property and unequal participation in private and public decision-making.

In order to achieve this ambitious aim, we have to focus our efforts on ending violence against girls and young women. According to UN Women, one in three women is likely to experience physical and sexual violence at some point in her lifetime. Young women in particular are more vulnerable to certain forms of violence, such as coerced sex (1). The most pervasive human rights abuse in the world today, violence against women

and girls (VAWG) is a manifestation of gender-based discrimination and a universal phenomenon that has tremendous financial and psychological costs for individuals and societies.

If we look at the situation in Europe, we will see that many women are subject to various forms of violence: 20 to 25 percent of all women in the region have experienced physical violence at least once during their adult lives and more than one-tenth have suffered sexual violence involving the use of force (2). What are the instruments for greater gender equality and ending VAWG? Firstly, access to education for all young women could foster their personal and professional development. Secondly, access to comprehensive sexuality education (CSE) (in formal and non-formal settings, through peer education and other methods) could help many young people gain the knowledge and skills, which could eventually be an effective instrument to prevent all forms of violence perpetrated against them, as well as to support personal relations and development.

Access to sexual and reproductive health services and supplies for young people

One of the crucial aspects of a sexual and reproductive health package constitutes ensuring access to sexual and reproductive health services and supplies, including the provision of contraceptives; counselling and information; and testing and treatment of sexually transmitted infections. Across Europe, securing this access for young people and adolescents is still not efficiently realized or recognized as a priority, thus affecting their health and general well-being (3).

ASTRA Youth monitors young people's realities regarding the realization of their SRHR in central and eastern Europe. According to their observations, the major barrier leading to the limited access of SRHR services for young people is the sociocultural stigmatization of youth sexuality, rooted in conservative and traditional values. Young people are not perceived as autonomous human beings able

to make their own decisions. They tend to be infantilized and confronted with the negative outcomes of sexual activity, instead of building a positive, affirmative approach towards their own sexuality. Therefore, youth sexuality is controlled through restrictive legislation, such as age limits and parental consent to obtain contraception (4). Economic inequalities also constitute a barrier, as contraceptives are generally not reimbursed and are not affordable for young people. Additionally, healthcare professionals and service providers are not sufficiently trained and disseminate misinformation, thus increasing distrust towards modern contraception methods: only 22 percent of women aged 15-19 report using modern contraception in eastern Europe (4). The Catholic Church and conservative forces' influence is also evident in the conscience clause, which prioritizes doctor's beliefs over the patient's freedom of choice. Youth-friendly, affordable SRHR services are scarce within central and eastern Europe, and even if they are in place, young people feel ashamed to utilize them. All of these contributing factors lead to young people relying on withdrawal as a contraceptive method and leave them vulnerable to sexually transmitted infections (STIs) and unintended pregnancies.

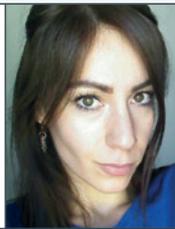
Ensuring young peoples' access to affordable, high quality SRHR services and supplies greatly enhances their general health, their well-being and future opportunities in life. It also realizes their right to choose, gives agency and the capabilities they are entitled to. To enable young people to fulfil their potential, governments must be held accountable to respond to their needs.

Access to abortion services for young women

There are still countries in Europe where access to safe abortion is highly restricted and there is enough evidence to show that this strategy is not preventing women from seeking an abortion. Rather, in countries where access to legal and safe abortion services is restricted, the rate of unsafe abortion and adverse maternal



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outcomes increases (5). Adolescents and young women face even more obstacles than adult women, such as the need for parental consent and other requirements in order to access safe and legal abortion (6). Adults sometimes hold perceptions about young people's capacities and may consider young women to be insufficiently mature or incapable of making informed decisions as a result of their age. Another barrier is the stigma around abortion and the implication of being sexually active as a young woman. The lack of youth-friendly abortion services is yet another obstacle that has the potential to prevent young women from finding the best solution for their particular needs related to unwanted pregnancy (7).

Young women should have the power to be actively involved in and consent to their own care and reproductive life, including access to safe abortion. The reasons why extend well beyond protecting their own health and reproductive rights. They are more likely to reach their full potential and they will have a better chance to follow their plans for the future, which may include education, career and starting a family. Ultimately, men and society in general will benefit if we keep young women healthy and respect their right to bodily integrity and autonomy by ensuring their access to safe and legal abortion services.

Information and education about sexual and reproductive health and rights

Education has come a long way. Unfortunately, in many countries in Europe, it is still not up to the standards and quality one might expect. Sexuality education is often tailored to enhance intelligence and natural sciences skills, but tends to leave cognitive, emotional and psycho-social aspects of everyday life aside. Specifically, it fails to deliver information needed for young people to develop their relationships, stay healthy and plan their families. This is where CSE comes in. In Europe, sexuality education in schools was introduced in some countries more than a century ago. Yet across central and eastern

Europe, the sexuality education curriculum does not address social and psychological aspects of sexuality, being limited to biological aspects and pregnancy or disease prevention (8).

When young people advocate for other young people's access to information and education about sexual and reproductive health and rights, they do so, because they know the needs first hand. One of the loudest requests is that sexuality education should be provided at all educational levels, including in formal and non-formal settings.

If CSE is scientifically accurate, culturally and age-appropriate, gender-sensitive and life skills-based, it can empower young people to make informed decisions about their sexuality and lifestyle (9). This includes better uptake of modern contraceptives leading to a reduction of teenage pregnancies and abortions, a decrease in STIs and HIV infections, as well as sexual abuse and homophobia (10). CSE enables young people to acquire accurate information, including on important issues such as sexual abuse, gender-based violence and harmful practices, but also explore and nurture positive values and attitudes, like self-esteem, respect for human rights and gender equality. Last but not least, CSE empowers young people to develop life skills, including critical thinking, communicating and negotiating (11). CSE must be prioritized as it empowers adolescents and young people to become healthy and responsible individuals, positively developing into adulthood and thereby contributing to their communities and society as a whole.

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SEXUAL VIOLENCE ON THE WHO AGENDA: ADDRESSING MULTIPLE VULNERABILITIES IN AGE, GENDER AND LEGAL STATUS

Sexual violence is a public health problem of global magnitude. A World Health Organization (WHO) report of 2013 stated that 25.4% of women and girls in the WHO European Region have been sexually and/or physically victimized by an intimate partner and 5.2% sexually victimized by non-partners (1). No data were provided on male victimization and female perpetration “due to insufficient data” (1). Yet, more research is revealing male victimization. A recent study in young adults (18-27 years) in 10 European countries (Austria, Belgium, Cyprus, Greece, Lithuania, the Netherlands, Poland, Portugal, Slovakia and Spain) for example, demonstrated that 27.1% of the young men and 32.2% of the young women already had been victimized since the age of consent (2). In addition to women, children, adolescents and young people, research has shown that lesbian, gay, bisexual and transgender people are particularly vulnerable (3). Also migrants, and more specifically young refugees, asylum seekers and undocumented migrants, have been found to be at high risk. Keygnaert et al found up to 28.6% of male and 69.3% of female migrants have been sexually victimized since their arrival in Europe (4). The bulk of the sexual violence consisted of rape with multiple perpetrators, with gang rape appearing to be a common practice. It was often combined with psychological, physical and socio-economic violence. Perpetrators were (ex)partners in a third of the cases, with European professionals and citizens found to be the perpetrators in respectively a fifth and a third of the incidents (4). The pivotal determinant in their vulnerability is their restricted legal status, which hampers their active participation in society, puts them at risk of exploitation and abuse and inhibits their access to health care (4).

Age

Regardless of all the above-mentioned socio-demographic determinants, it has been robustly demonstrated that people who were personally victimized (direct exposure) or who personally

witnessed sexual, physical and psychological violence during childhood, e.g. among their parents (indirect exposure), are not only prone to subsequent (re) victimization but also to perpetration (5). This was also confirmed by the study on young adults in 10 European countries: 16.3% of the young men and 5.0% of the young women had already committed sexual violence to either an (ex)partner, acquaintance or stranger (2). Violence exposure in the young leads thus to more violence in adulthood in both genders. In order to stop this pattern from continuing and given that young people face multiple vulnerabilities in several domains of their life, future sexual violence prevention strategies do need to invest above all in children, adolescents and young adults at all stages of the life course where potential problem development and vulnerabilities may present. In this regard it is crucial that prevention actions stem from a positive view on sexual health and that individual’s sexual health development opportunities are not curtailed as a special argument for preventing them from being put at risk of sexual violence. Taking a life course approach that includes comprehensive sexuality education that focuses on positive sexual relationships and sexuality lies at the heart of preventing coercion and violence.

Gender

So far and by far, women and girls have been found to be the most vulnerable to sexual violence worldwide (1). The lack of knowledge on male victimization has been mostly attributed to underreporting, to less legal redress for male victims and to a lack of appropriate services (6). On the other hand, it has been argued that current prevailing legal, policy and research frameworks on violence stem from a dichotomist paradigm in which a priori men are being considered as sole perpetrators and women as victims, a paradigm that per definition generates gender-biased results. This creates a bias in research by not providing the possibility of identifying real dynamics in violence in females, males and transgenders. Subsequently, it

impacts policy framework development, as these frameworks are based on research data and international action plans. This is problematic, since it ignores a number of victims and perpetrators in all genders who are in need of effective interventions and whom are now left unaddressed (4). Furthermore, this ignorance leads to ill health consequences and enhances the risk of subsequent perpetration and victimization in current and future generations in all genders. In order to be effective and qualitative, it is thus urgently time for a gender-sensitive paradigm on sexual violence victimization and perpetration that reveals and acknowledges the different dynamics of violence in all genders in different societies.

Migration

Currently, the WHO European Region is being challenged in addressing and accommodating an enormous migration influx generated by conflicts and disasters. Refugees, asylum seekers and undocumented migrants have been shown to be at tremendous risk of sexual victimization in their country of origin, during their flight and even upon accommodation in Europe. The first two ones are rather difficult to challenge but could be better incorporated in transnational action plans as for example in the frame of the European Neighbourhood Policy. Yet, the third one could be easily at reach by two fairly new policy frameworks.

The first one is the recast of the *European Directive on minimum standards for reception of asylum seekers (2013/33/EU)* requesting that European Union (EU) Member States take “appropriate measures that prevent gender-based violence including sexual assault and harassment” within reception centres and accommodation facilities and to ensure “access to appropriate medical and psychological treatment or care for vulnerable groups”, which now include victims of a range of sexual violence forms. These requirements remain limited but might be a starting point for more holistic prevention and response policies. Member States had until July 2015 to translate those



provisions into national law. Yet, with the current asylum influx, in many countries the biggest challenge now is to accommodate the asylum seekers and get their asylum claims registered. The ability to provide health checks cannot be guaranteed within the first week(s) let alone that sensitive issues as sexual violence can be addressed. This is a hazardous situation that should immediately be rectified. In international humanitarian crises there are the guidelines from the UNHCR on the “*Minimum Initial Service Package for Reproductive Health in Crisis Situations (MISP)*” that are applied. This is a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence, reduce HIV transmission, prevent excess maternal and newborn morbidity and mortality and plan for comprehensive reproductive health services. As they are what is stated in their name, guaranteeing that both the *MISP* as well as the *Directive for minimum standards of reception* are implemented should thus be the absolute minimum throughout the whole European Region.

The second potentially fruitful instrument is the European “Istanbul” Convention on “*Preventing and combating violence against women and domestic violence*”, which endorses a definition of sexual violence based on the absence of consent. It also proposes that multiple perpetrators or repeated offences are to be considered aggravating circumstances in legislation. Moreover, a full chapter (VII) is dedicated to migration and asylum, broadening opportunities regarding residence status, gender-based asylum claims and non-refoulement. The Convention entered into force in 2014. Several countries of the WHO European Region have already ratified it, which implies that in addition to the abovementioned facts, they should also provide holistic (medical, psychosocial and forensic) care to victims of sexual violence and contribute

in the development of sexual assault referral centres in which this holistic care can be provided. This requires also that protocols on prevention and response to sexual violence are put in place, which is still a challenge for many health systems throughout the Region. Yet, implementing this convention in many European countries would mean a tremendous step forward in the optimal care for victims. The only other challenge, but a necessary step to take from a human rights and public health approach, is to evolve to a system in which all victims are cared for alike, regardless of their gender or sex or legal status.

Indicators

Finally, in order to monitor prevalence, incidence and effectiveness of intervention measures, common indicators are needed. They are currently lacking at levels of age, gender and legal/migration status. Yet, data collection is deemed essential to inform policy-making and monitor the impact of future interventions. The Convention of Istanbul stipulates that the ratifying countries should register cases of sexual victimization. We argue that in order to compare throughout the European Region, that sexual assertiveness, transgressive behaviour and experiences with sexual violence victimization and perpetration, as well as, migration history, age and gender should be routinely incorporated in all sexual health datasets. In that way, we can better assure that sexual violence policies are evidence-based and take multiple vulnerabilities into account, thus reflecting reality.

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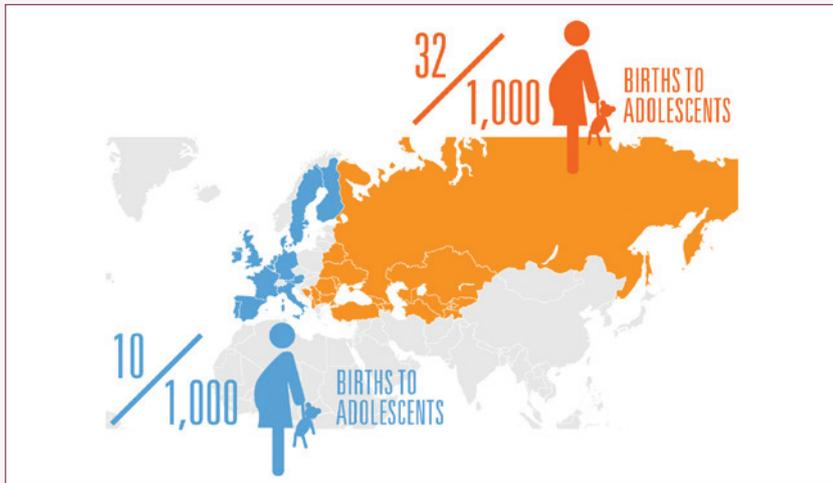


Tahir Mahmood



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Figure 3. Adolescent pregnancy in eastern Europe and central Asia (3).



caused by cervical cancer. The EBCOG supports the Regional strategic vision and key strategies of EECARO to make a positive impact in the quality of care in the Region through the introduction of internationally agreed SRH standards, institutional capacity building and knowledge sharing. The UNFPA is supporting and facilitating the Russian translation of all standards related to SRH, which will be an invaluable measure to make these standards available to clinicians in the countries of eastern Europe and central Asia. The Russian Society of Obstetricians and Gynaecologists is kindly translating the gynaecology standards into Russian to ensure that we can provide the policy makers and professionals of EECARO countries with a complete set of modern standards in the field of SRH. These three sets of standards will be launched at the beginning of 2016.

Together, the UNFPA and the EBCOG are keen to encourage and support young experts and policy makers to visit western Europe and see how high quality SRH services are developed and delivered. We set up an ambitious plan in 2015 to support an Annual Scholarship Award, open to young health professionals who are resident and working in eastern European (excluding those of the European Union) and central Asian Countries (EECA-Region) in the field of sexual and SRH. This scholarship is designed to enable the successful applicants to visit to special-

ized centres offering knowledge and skills in quality improvement in SRH. We are pleased to announce that the first successful recipient of this prestigious award will spend two weeks at the Chalmers Centre of Reproductive Health, Edinburgh to learn how high quality SRH services are being delivered in Scotland. Lessons learnt from this attachment will help young experts to foster links with policy experts in Edinburgh to develop national policies aimed at the improvement of the Quality of Care in SRH.

Both organizations are expanding the collaboration in institutional capacity building, knowledge sharing and the transfer of know-how to EECA countries. The EBCOG would be happy to support and promote SRH at both regional and national levels by supporting the UNFPA's efforts in institutional capacity building of professional associations in EECA countries, providing support of leading European experts to UNFPA meetings and conferences aimed at technical expertise sharing and professional networking. There exists an excellent tradition of joint EBCOG/UNFPA sessions, that started in 2014, with the EBCOG hosted session at the Glasgow 23rd European Congress of Obstetrics and Gynaecology that created a unique forum to bridge the science and policies to advance the SRH in the region. The upcoming 2016 joint session will be a new opportunity to unite the experts from European Union and EECA to

discuss the achievements, challenges and plans for future cooperation. The next step in our collaboration is the development of an interactive Masters Class on SRH. The course will be delivered by the EBCOG's experts to strengthen institutional capacities and to ensure universal access to SRH for all in the EECA Region.

We sincerely hope that the development of the new *European Action Plan for Sexual and Reproductive Health and Rights* will enhance our efforts by mobilizing Member States to synergize efforts and share learnings and experiences in improving the SRH and rights of citizens everywhere. Such joint measures will have a huge and positive effect on the quality of women's SRH and care. We trust that the UNFPA/EBCOG collaboration will support the achievement of the new *European Action Plan for Sexual and Reproductive Health and Rights* objectives, adding to the wider momentum of the implementation of the standards of care and to the increased quality of healthcare provision for women and their babies in EECA countries.

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The Global Strategy for Women's, Children's and Adolescents' Health 2016-2030: Survive, Thrive, Transform, 2015.

This new strategy builds on the success of the 2010 Every Women, Every Child Strategy and serves as a platform to ensure that women, children and adolescents remain a priority focus for the new UN Sustainable Development Goals. It is to be a roadmap for ending all preventable deaths of women, children, and adolescents by 2030, moving beyond reductions in mortality to a vision of healthy life for all through the life-course. Available in English at: <http://www.who.int/life-course/publications/global-strategy-2016-2030/>



Health 2020. A European policy framework and strategy for the 21st century, WHO Regional Office for Europe, 2013.

This new policy framework, approved by the WHO Regional Committee for Europe in 2012, provides European politicians and policy-makers with key strategic advice to support action for health and well-being. It promotes a holistic life course approach that is built around equity, gender, human rights and improved governance for health. Available in English, German, French and Russian at:

<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/health-2020.-a-european-policy-framework-and-strategy-for-the-21st-century-2013>



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Developed in close collaboration with health ministries and other development partners, this key tool provides critical guidance to countries on how to best reform their reproductive health services and systems. Available in English and Russian at:

<http://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health/publications/pre-2007/who-regional-strategy-on-sexual-and-reproductive-health>



Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets. Global strategy adopted by the 57th World Health Assembly, WHO, 2004.

The first global strategy on reproductive health developed by the WHO, this document is meant to guide a wide variety of stakeholders from government to NGOs on how best to achieve reproductive health goals and targets using an international human rights based approach. Available in Arabic, Chinese, English, French, Russian and Spanish at:

http://www.who.int/reproductivehealth/publications/general/RHR_04_8/



Accelerating progress towards the attainment of international reproductive health goals: a framework for implementing the WHO Global Reproductive Health Strategy, WHO, 2006.

Meant to complement the WHO Global Reproductive Health Strategy, this publication outlines a framework for implementation of the Strategy focusing on 7 key areas for action. Available in English, Russian and Spanish at:

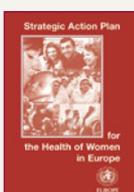
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The WHO Strategic Approach to strengthening sexual and reproductive health policies and programmes, WHO, 2007.

This widely used publication provides a three-stage process for countries to assess, implement and scale up reproductive health needs, priorities and interventions. Available in English, French, Russian and Spanish at:

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Strategic Action Plan for the Health of Women in Europe, WHO Regional Office for Europe, 2001.

This original *Action Plan* clearly articulates the need for a strategic focus on the health of women in the Region, identifying key themes, priorities, policy developments and areas for action. Available in English and Russian at:

<http://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health/key-resources/strategic-action-plan-for-the-health-of-women-in-europe>



Investing in children: the European child and adolescent health strategy 2015–2020, WHO Regional Office for Europe, 2014.

Every child should have every opportunity to live a healthy and meaningful life. To ensure this happens, the Member States in the WHO European Region adopted this new strategy. The strategy recommends adopting a life-course approach that recognizes that adult health and illness are rooted in health and experiences in previous stages of the life-course. Available in English, French, German and Russian at:

<http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2014/investing-in-children-the-european-child-and-adolescent-health-strategy-20152020>



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This framework for programming provides evidence and strategies to help policy makers and programmers deliver services and promote healthy sexuality throughout an individual's lifespan in order to achieve the potential for fulfilled, positive sexual health. Available in English at:

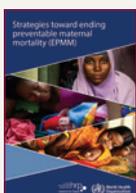
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This document assists policy-makers and health service planners in improving the quality of health-care services for adolescents so they can obtain the health services that they need to promote, protect and improve their health and well-being across the lifecourse. Available in English at:

http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care/en/



Strategies toward ending preventable maternal mortality (EPMM), WHO, 2015.

This excellent report promotes the application of a human rights framework to ensure that high quality RMNCH is available, accessible and acceptable to all, emphasizing the importance of the continuum of care and life-course in its approach. Available in English at:

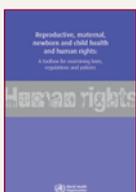
http://www.everywomaneverychild.org/images/EPMM_final_report_2015.pdf



Towards a new Global Strategy for Women's, Children's and Adolescents' Health, BMJ, WHO, 2015.

In this special supplement the evidence and thinking that form the basis of the new global strategy for women, children's and adolescents' health is outlined, including the required priorities and interventions that are needed throughout the lifecourse to improve the health and well-being of women, children and adolescents around the world. Available in English at:

<http://www.bmj.com/content/women's-children's-and-adolescents'-health-0>



Reproductive, maternal, newborn and child health and human rights. A toolbox for examining laws, regulations and policies, WHO, 2014.

Laws and policies play a key role in upholding human rights and promoting sexual and reproductive health throughout the life-course. This toolkit allows countries to use a human rights framework to identify potential barriers and make proposals to overcome or reduce them in order to achieve positive SRH at all life stages. Available in English at:

http://www.who.int/reproductivehealth/publications/gender_rights/rmnch-human-rights/en/



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This document provides a useful framework for implementation of sexuality education, a key effective intervention for improving SRH in the life-course approach to well-being. Available in English at:

http://www.oif.ac.at/fileadmin/OEIF/andere_Publikationen/WHO_BZgA_Standards.pdf



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This global strategy focuses on both advocacy and technical content as a 2 pronged public health approach for programmes and policy makers to sustain and mobilize the commitment required to prevent and control STIs. Available in Arabic, Chinese, English and French at:

<http://www.who.int/reproductivehealth/publications/rtis/9789241563475/>



Global strategy to stop health-care providers from performing female genital mutilation, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, MWIA, WCPA, WMA, 2010.

This important document outlines a global strategy against medicalization of FGM and was developed in collaboration with various key stakeholders such as international bodies, NGOs, civil society and health care providers. Available in Arabic, English and French at:

http://www.who.int/reproductivehealth/publications/fgm/rhr_10_9/



The global elimination of congenital syphilis: rationale and strategy for action, WHO, 2007.

Recognizing the large burden of disease syphilis still causes globally, this strategy outlines a 4 pillar approach to eliminate this global public health problem. Available in Arabic, Chinese, English, French, Portuguese, Russian and Spanish at:

<http://www.who.int/reproductivehealth/publications/rtis/9789241595858/>



Reproductive health indicators. Guidelines for their generation, interpretation and analysis for global monitoring, WHO, 2006.

Intended for use by public health administrators and health programme managers at the national level, this useful document provides an overview of the selection criteria, definition, data sources, collection methods, use and limitations for each of the 17 indicators. Available in English at:

<http://www.who.int/reproductivehealth/publications/monitoring/924156315x/en/>



Indicators and a Monitoring Framework for Sustainable Development Goals: Launching a data revolution for the SDGs, Sustainable Development Solutions Network, 2015.

This comprehensive report, the result of 18 months of collaboration and consultation, outlines how a comprehensive indicator framework might be established to support the goals and targets proposed by the Open Working Group on the SDGs at all levels. Available in English at:

<http://unsdsn.org/resources/publications/indicators/>



National-level monitoring of the achievement of universal access to reproductive health: conceptual and practical. Considerations and related indicators, WHO, UNFPA, 2008.

The product of a technical consultation between the WHO and UNFPA, this report recommends, within a specified framework, a set of indicators to monitor progress towards the goal of universal access to sexual and reproductive health at country level. Available in Arabic, Chinese, English, French, Russian and Spanish at:

<http://www.who.int/reproductivehealth/publications/monitoring/9789241596831/>



Measuring sexual health: conceptual and practical considerations and related indicators, WHO, UNFPA, 2010.

An annex to the report National-level monitoring of the achievement of universal access to reproductive health: conceptual and practical. Considerations and related indicators, this document provides an overview of key indicators for sexual health Available in English at:

http://www.who.int/reproductivehealth/publications/monitoring/who_rhr_10.12/en/



Targets and indicators for Health 2020. Version 2, WHO Regional Office for Europe, 2014.

This document describes the steps taken to develop the Health 2020 targets and indicators, gives an overview of the 20 core and 17 additional indicators and describes the monitoring framework and platform that will be used to track progress with the implementation of Health 2020 across the Region. Available in English and Russian at: <http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2014/targets-and-indicators-for-health-2020.-version-2>



Sexuality Education: What Is It? Policy Brief NO 1. WHO Regional Office for Europe, UNFPA and BZgA, 2015.

This policy brief provides a concise overview of key issues related to sexuality education including benefits, myths and facts. Available in English at: <http://eeca.unfpa.org/publications/sexuality-education-what-it>



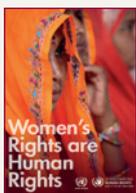
Sexuality Education: What Is Its Impact? Policy Brief NO.2. WHO Regional Office for Europe, UNFPA and BZgA, 2015.

This policy brief outlines how good sexuality education positively impacts the health and well-being of children and young people. Available in English at: <http://eeca.unfpa.org/publications/sexuality-education-what-its-impact>



Combating Violence Against Women and Girls in Eastern Europe and Central Asia, Issue Brief No 6. UNFPA.

A clear overview of the issue of violence against women and girls, including root causes, impact and opportunities for prevention and treatment. Available in English at: <http://eeca.unfpa.org/publications/combating-violence-against-women-and-girls-eastern-europe-and-central-asia>



Women's Rights are Human Rights, UN, 2014.

This informative publication provides an introduction to women's human rights, exploring and explaining international human rights laws, the achievements gained in recent decades and the challenges and gaps that continue to persist. Available in English at: <http://www.ohchr.org/EN/PublicationsResources/Pages/Publications.aspx>



Reproductive Rights are Human Rights: A Handbook for National Human Rights Institutions, UN, UNFPA and the Danish Institute for Human Rights, 2014.

This detailed handbook provides useful tools and guidance to National Human Rights Institutions on how to integrate reproductive rights into their scope of work. Although targeted for these types of institutions, the content is relevant for many other development sector actors. Available in English at: <http://www.ohchr.org/EN/PublicationsResources/Pages/RecentPublications.aspx>

Upcoming events

The 14th European Society of Contraception and Reproductive Health (ESC) Congress and Second Global ESC Conference, 'From molecular biology to social science and politics,' Basel, Switzerland, May 4-7, 2016.

This global event will respond to the multi-dimensional aspects of contraception and reproductive health as well as numerous issues related to SRHR. More information can be found at: <http://www.eschr.eu/events/esc-events/2016>

Women Deliver, Fourth Global Conference, May 16-19, 2016, Copenhagen Denmark.

As the leading global advocate for the well-being, rights and health of women and girls, the 2016 conference will focus on how to make development matter for girls and women. More information can be found at: <http://wd2016.org>

Entre Nous

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