

# TOGETHER FOR A BETTER SEXUAL & REPRODUCTIVE HEALTH



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As the year 2015 approached, so did the deadline for the Millennium Development Goals (MDGs) and the creation of the post-2015 sustainable development agenda. As a result, countries' commitments to improving health for all, including sexual and reproductive health, received heightened scrutiny. This moment gave countries the opportunity to take stock of their accomplishments to date, as well to focus on persistent challenges and opportunities to improving the health of everyone, everywhere.

Much progress had been made: extreme poverty had been more than halved, decreasing from nearly half of the population of the developing world in 1990 to 14% in 2015; the proportion of undernourished people globally declined from 23% in 1990 to 13% in 2015; globally, child mortality fell by more than half (from 90 to 43 deaths per 1000 live births) and global maternal mortality by nearly half (380 deaths to 200 per 100 000 live births) over the past 25 years; the number of new HIV infections globally decreased by nearly 40% between 2000 and 2013; and contraceptive prevalence among women in union aged 15 to 49 increased globally from 55% in 1990 to 64% in 2015.

Despite these significant achievements however, many of the MDGs were unable to meet their original targets and much of the progress was uneven across and within countries and regions. Inconsistencies of service provision, coordination and integration of services, in addition to duplication of efforts, poor communication and utilization of limited resources, as well as the neglect of marginalized and vulnerable populations, continued to represent persistent health system challenges for improving health, including sexual and reproductive health. Moreover, political, legal and social barriers continued to inhibit access for marginalized populations, despite health system improvements.

It became clear that if countries were to realize the “unfinished agenda” of MDG goals, alternative approaches would be required rather than “business as usual.” An integrated, multi-sectoral approach that addresses the underlying structural, social, political and financial determinants of health and well-being must be implemented. This was recognized as crucial to ensure that no one would be left behind and to guarantee that increasing and continuing inequities would be reduced.

Globally, the response to this challenge was the development of the Sustainable Development Goals. Within the WHO European Region, a new roadmap, *Health 2020: A European Policy Framework and Strategy for the 21st Century* recognized and addressed the importance of implementing a new public health approach to improve the health and health equity of Europe's population.

Intersectoral collaboration lies at the heart of these global and regional responses – but what exactly does intersectoral collaboration mean, and how is this different from previous approaches to ensuring people's rights to the highest attainable sexual and reproductive health?

WHO defines intersectoral action for health as “actions undertaken by sectors outside the health sector, possibly, but not necessarily, in collaboration with the health sector, on health or health equity outcomes or on the determinants of health and health equity.”

([http://www.who.int/social\\_determinants/resources/health\\_equity\\_isa\\_2008\\_en.pdf](http://www.who.int/social_determinants/resources/health_equity_isa_2008_en.pdf))

Intersectoral action recognizes that improved health for the whole population, and especially the most marginalized, cannot be attained if governments see it as the sole responsibility of the health sector; health equity is largely determined by policies and socio-economic contexts external to the health system. Unless opportunities for links to be made with

other sectors are found, invested in and acted upon, improvements in the social determinants of health and in national health equity cannot be achieved. Intersectoral action enables us all – health care providers, policy makers, community members, educators, academics, law makers, government officials and the private sector – to engage effectively. It means we can collectively reduce health inequities through shared responsibility and coordinated policies and programming. Intersectoral action can be taken through formal or informal agreements, partnerships, alliances, coalitions or initiatives that operate through different levels within the same sector (vertically) and between different sectors (horizontally).

In recognition of the strengths of such an approach, it is the responsibility of national governments and the global community to jointly provide the required partnerships, relationships, resources, goals, vision and leadership to create conditions of success for intersectoral collaboration. If this collaboration is achieved, the rewards will more than outweigh the efforts.

This issue of *Entre Nous* provides several informative examples and exciting ideas on how collaborative action can improve sexual and reproductive health in the European Region. As we work together towards achieving the Sustainable Development Goals, we can embrace an intersectoral approach to ensure that all of Europe – and indeed the world – can enjoy a future that ensures improved health, health equity and sexual and reproductive health and rights for all.

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# BEYOND SECTORS: NEW METHODS FOR INCLUDING HEALTH IN THE SUSTAINABLE DEVELOPMENT GOALS (SDGs)

Over the past 15 years, there has been important progress in the area of health in Europe and central Asia, thanks to advances in a diverse range of areas, from maternal health to the prevention of sexually transmitted infections (STIs). However, inequalities persist between and within countries (1). Achieving sustainable human development and leaving no one behind will require more than just strong health systems – it will also entail creating stronger systems for achieving health outcomes. For instance, universal health coverage – desirable as it is – will not in itself ensure healthy lives and promote well-being for all generations. Instead, we need decisive action on a much broader front (2). The emphasis should be on tackling the social, economic and environmental determinants (SEEDs) of health and the various dimensions of inequity through policies, programmes and approaches that cut across sectors. In short, health in all policies means health in all SDGs (3).

## Health equity in the 2030 Agenda for Sustainable Development

The implementation of the 2030 Agenda for Sustainable Development began this year. Having committed to expand people's capabilities and opportunities while balancing the social, economic and environmental dimensions of sustainable development, the agenda acknowledges that the 17 SDGs, with their deeply interconnected 169 targets, require integrated approaches (4), greater inter-agency work and collaboration across sectors.

For instance, while SDG 10 focuses on reducing inequality within and across countries, SDG 3 focuses on ensuring healthy lives and promoting well-being for all generations. However, in order to achieve both of these goals, health and inequality need to be tackled across a range of different actions that support all goals.

## SEEDs of health and health equity

SEEDs of health and health inequity tend to intersect and magnify one other, furthering an unequal distribution of health among population groups (5, 6).

In central and eastern Europe, for example, Roma communities experience unfair and avoidable inequities, have less access to healthcare and are disproportionately exposed to the SEEDs of health. They typically have limited access to education and thus achieve lower levels of formal employment and income, while having poorer nutrition (7) and living in sub-standard housing conditions. Health inequities can span entire lives and are even perceptible between Roma and non-Roma communities that live side-by-side\*. Roma across all age groups report more chronic illnesses (including asthma, chronic bronchitis, chronic obstructive pulmonary disease or emphysema; hypertension, rheumatism, arthritis; chronic anxiety or depression; and diabetes) than non-Roma people, and have less access to sexual and reproductive health (SRH) services, including family planning, contraception and maternal healthcare services. As a consequence, Roma women have higher fertility rates and rates of teenage and unwanted pregnancies, often resulting in unsafe abortions and STIs, putting them at higher risk of complications during pregnancy than the general population (8).

While ethnicity is a key dimension of inequity, lifelong inequities linked with gender and educational attainment intersect and reinforce each other. Ethnic inequities in self-reported long-standing illnesses increase with age, reaching 70% among Roma people aged 65 and over, compared with 56% among non-Roma in the same age group. Further, among both Roma and non-Roma communities, long-standing illnesses are more frequent among women than men. There are even disparities among Roma communities themselves. For instance, only 15% of the Roma with secondary level education report chronic disorders, compared to 32% of Roma people without any formal education (9).

## SRH and Agenda 2030

Agenda 2030 acknowledges health and well-being as outcomes, determinants and enablers of the SDGs (10). As such, the

SDG framework provides new momentum for the implementation of *Health 2020* across WHO Member States in the European Region (10). There is a close correspondence between recent solutions identified for improving SRH (1) and the new paradigms for *Health 2020* in the WHO European Region. As we implement the SDGs, collaboration across different sectors will be critical to improve health and SRH, through increasing commitments, focus and investments.

## Collaboration across agencies and sectors

### Leadership and participatory governance for health

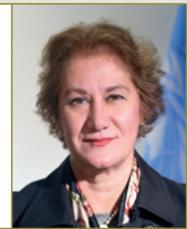
Governments and especially health ministries are important players in leading and managing governance for health. They set norms, provide evidence and “make the healthier choice the easier choice.” Governance for health must be guided by a framework that includes health as a human right, as a global public good, as a component of human well-being and as a matter of social justice (11).

Implementing the new *European Action plan for SRH* will therefore require the cooperation of many national and international partners under the leadership of the health ministries (1). By the same token, governments and international agencies should promote inter-sectoral and inter-agency action to achieve more ambitious outcomes in the realm of health and well-being.

### More focus through partnerships

Joint action across the whole of government and the whole of society must be supported by structures and mechanisms that make it easier to collaborate (11). To that end, the WHO in Europe should seek to better support Member States by strengthening collaboration and coherence among relevant United Nations (UN) agencies at national and regional levels (1).

In Europe and central Asia, the Joint Framework for Action signed by WHO, UNICEF and UNFPA under the auspices



Cihan Sultanoğlu

of the Regional UN Development Group (12); the Issue-based Coalition on Health, which reports to the Regional Coordination Mechanism of the UN Regional Directors; and the UNAIDS Division of Labour provide sound platforms for knowledge exchange, as well as structures and mechanisms that enable collaboration to ensure healthy lives, promote well-being for all at all ages and improve SRH.

### Aligning national development and health priorities can enable investment

Aligning development and health policy in a “one country, one health” development approach can help create policies that lead to coaction. Opportunities for forging alliances reside in non-health sectors or outside government (11).

Capitalizing on both its partnerships with multiple sectors and its access to the Cabinet of Ministers, UNDP is uniquely positioned to facilitate the “one country, one health” development approach in collaboration with WHO. The UN Resident Coordinator function brings together all UN agencies to advocate for UN system-wide mandates and interests, improve operational efficiency and effectiveness and promote more transformative and strategic support for national plans and priorities (13).

### UNDP’s service offering

Pioneering the systematic integration of SEEDs of health and health equity into its development programming, UNDP has been working with WHO and the Institute of Health Equity at University College London (UCL) on a new screening tool for development practitioners, designed to identify, conceptualize and strengthen potential and existing co-benefits for health and development. UNDP’s methodology can now be applied to map multiple health and development benefits from investing in SRH (14).

By accelerating commitments, increasing focus and stimulating investments for health, collaboration across sectors on SEEDs of health and equity is playing a major role in ensuring healthy lives and

well-being for all and in improving SRH in the WHO European Region. As we move forward with the SDGs, collaboration across sectors is critical to improve health outcomes, ensure proper health financing and build stronger systems and institutional arrangements for health. Such an approach encourages us to “do more, do better and leave no one behind.”

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\* The UNDP/WB/EC survey was conducted in May-July 2011 on a random sample of Roma and non-Roma households living in areas with higher density of Roma populations in the EU Member States of Bulgaria, Czech Republic, Hungary, Romania, Slovakia and the non-EU Member States of Albania, Bosnia and Herzegovina, Croatia, FYR of Macedonia, Montenegro, Republic of Moldova and Serbia. In each of the countries, approximately 750 Roma households and approximately 350 non-Roma households living in proximity were interviewed.

### References

1. *Action Plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind.* Copenhagen: WHO Regional Office for Europe, 2016.
2. Sultanoğlu C. *Speech: partnerships for Health in the WHO Region at the 64th Session of WHO Regional Committee for Europe. The road ahead: Good opportunities for partnerships in health and development.* s.l. : UNDP, 2014.
3. Hamelmann C. *Opening speech: WHO European Ministerial Conference on Life-course approach in the Context of Health 2020.* Minsk, Belarus : s.n., 2015.
4. *Transforming Our World: The 2030*

*Agenda for Sustainable Development. A/RES/70/1.* New York: United Nations, 2012.

5. Bell R, Grobicki L, Hamelmann C. *Ensure Healthy Lives and Well-being for All: Addressing Social, Economic and Environmental Determinants of Health and the health Divide in the Context of Sustainable Human Development.* s.l. : UNDP, 2014.
6. Solar O, Irwin A. *A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice).* s.l. Geneva: WHO, 2010.
7. *Review of social determinants and the health divide in the WHO European Region: final report.* Copenhagen: WHO Regional Office for Europe, 2013.
8. Colombini M, Mayhew SH, Rechel B. *Sexual and reproductive health needs and access to services for vulnerable groups in Eastern Europe and Central Asia.* s.l. : UNFPA, 2011.
9. Mihailov D. *The health situation of Roma communities: Analysis of the data from the UNDP/World Bank/EC Regional Roma Survey 2011. Roma Inclusion Working Papers.* s.l. : UNDP, 2012.
10. *Towards a roadmap to implement the 2030 Agenda for Sustainable Development in the WHO European Region.* Copenhagen: WHO Regional Office for Europe, 2016.
11. Kickbusch I, Gleicher D. *Governance for Health in the 21st Century.* s.l. Geneva: WHO, 2012.
12. *Joint Action Framework: WHO Regional Office for Europe, UNFPA Regional Office for Eastern Europe and Central Asia and UNICEF Regional Office for Central and Eastern Europe and the Commonwealth of Independent States.* s.l. : WHO, 2013.
13. *UN Resident Coordinator Generic Job Description.* UNDG, 2014.
14. *Adding it up. The Costs and Benefits of investing in Sexual and Reproductive Health.* New York: Guttmacher Institute, 2014.

# TOWARDS SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS FOR ALL IN EUROPE: AN INTERVIEW WITH THE REGIONAL DIRECTOR OF THE UNITED NATIONS POPULATION FUND EASTERN EUROPE AND CENTRAL ASIAN REGIONAL OFFICE

## **The 20-year review of the International Conference on Population and Development (ICPD) Programme of Action culminated in 2014. What were the key recommendations in the area of sexual and reproductive health and rights (SRH&R) and has there been any progress in their implementation?**

What came out strongly throughout the review process and in the outcome document of the ICPD Beyond 2014 Regional Conference in Geneva (see Figure 1) is the call for a human rights-based approach to sexual and reproductive health. This means that women and girls need to be able to make informed decisions, that their choices be respected and that they must have access to services and information, without discrimination, coercion or violence. We organized a follow-up conference in Sofia last year to develop in more detail what this means in practice for our Region. We have used both the Geneva outcome document and the Sofia Declaration of Commitment (<http://eeca.unfpa.org/news/sofia-declaration-commitment>) as a guide for our work in promoting universal access to sexual and reproductive health in the Region. We are seeing real progress. At the normative level, a new *Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe - leaving no one behind* is being developed by WHO Member States with strong UNFPA involvement (<http://eeca.unfpa.org/news/taking-action-better-sexual-and-reproductive-health-policies>) (see Image 1). This reflects stronger government ownership and support. At the technical level, we are advancing the quality of sexual and reproductive

health care by developing new alliances, supporting institutional capacity building and advancing sexual and reproductive health standards, guidelines and protocols. There is a sharper focus on innovative approaches for improving maternal health and access to contraception and investing in cervical cancer prevention, youth sexual and reproductive health and HIV/AIDS. I believe the notion is gaining traction that realizing the reproductive rights of people is key to unleashing the potential of women and youth and therefore is crucial for development – and for addressing the population dynamics we are facing in this Region.

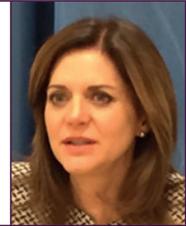
### **As we are entering a new era with the 2030 Agenda for Sustainable Development now having been kicked off, where do you see the main challenges that need to be addressed in our Region when it comes to SRH&R?**

We have made a lot of progress over the past two decades. For example, maternal mortality more than halved since the early 1990s in our Region. But as the ICPD review has clearly shown, we are still facing a lot of challenges. Disparities remain significant, between countries, but also within them. For example, the risk of dying from maternal causes is still almost twice as high in our Region compared to the most developed regions. But if we look at individual countries, we see an enormous spread: from a very high risk of 1 in 390 in Kyrgyzstan to an extremely low risk of 1 in 45 200 in Belarus. We see a similar situation when it comes to the use of modern contraception. Rates are near the world average of 57% in some eastern European and central Asian countries, but extremely low – even below the average of the least developed countries – in several others, mostly in southeastern Europe and the Caucasus. Adolescents and youth still face obstacles in accessing sexual and reproductive health services and information due to a lack of youth-friendly facilities, poor institutional capacities and restrictive policies. Although comprehensive sexual-

ity education is proven to be effective in preventing teenage pregnancy and HIV and other sexually transmitted infections, it is rarely offered in schools. As a result, teenage birth rates are about three times higher than in western Europe. Cervical cancer, though largely preventable, is up to ten times more common in our Region than in western Europe, because of a lack of organized prevention programmes. And nowhere else in the world is the HIV epidemic spreading faster than in our Region, with sexual transmission becoming an increasingly dominant factor. Gender-based violence remains widespread and women and girls who have experienced violence need access to essential services. I believe the new 2030 Agenda provides an excellent opportunity to address these challenges through innovative, holistic approaches and more strategic alliances.

### **What do we need to do differently in this Region to achieve breakthroughs towards the goal of universal access to SRH&R?**

Through delivering the Millennium Development Goals we gained significant experiences and strong evidence that we can now build on. But under the new Agenda 2030 framework we are shifting gears: towards a genuinely issue-based approach that fully reflects the many interlinkages between the challenges we are working on. For example, we cannot find sustainable solutions to population dynamics like ageing or low fertility if we don't make progress on gender equality and SRH&R. We also cannot work on health care reform in isolation, as it can only be successful if it is embedded within supportive social, economic and environmental policies affecting health outcomes. What is needed is a sharper focus on priorities, stronger issue-based intersectoral alliances with civil society and other partners and wider policy frameworks, facilitating the shift from vertical programmes to integrated approaches aimed at reducing the health inequities. We need more knowledge sharing, across regions and within the Region. And we need to reap the potential of public-



private partnerships. Most importantly, we need an even stronger human rights focus. Applying a human rights-based approach to public health is a powerful way to improve health outcomes. For this we need to translate the powerful normative human rights discourse into operational guidance and concrete tools for health planners and service providers, as well as users of health systems. Applying human rights to sexual and reproductive health not only helps governments comply with their binding obligations, but also contributes to improving health outcomes. This is the only way we can build the human capital we need to tackle the challenges we face in this Region.

**What is your vision for this Region for the next 15 years? Where will the Region be in 2030 in terms of sexual and reproductive health?**

There is a tremendous amount of potential in this Region and many lessons to share with the rest of the world. I am convinced that we can achieve breakthroughs in reducing inequalities and making universal access to sexual and reproductive health a reality by ensuring that all individuals can exercise their basic human rights, including those that relate to the most intimate and fundamental aspects of life. Applying the principles enshrined in the 2030 Agenda and the ICPD will help us deliver a Region where every pregnancy is wanted, every child birth is safe and every young person’s potential is fulfilled. It is a tall order, but I believe we are on the right track.

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**Figure 1. Report of the UNECE Regional Conference on ICPD Beyond 2014 “Enabling Choices: Population Priorities for the 21st Century,” United Nations Economic and Social Council, 2013.**

Available at: <http://eeca.unfpa.org/publications/icpd-beyond-2014-unece-regional-conference-report-and-chairs-summary#sthash.bAf0txSL.pdf>

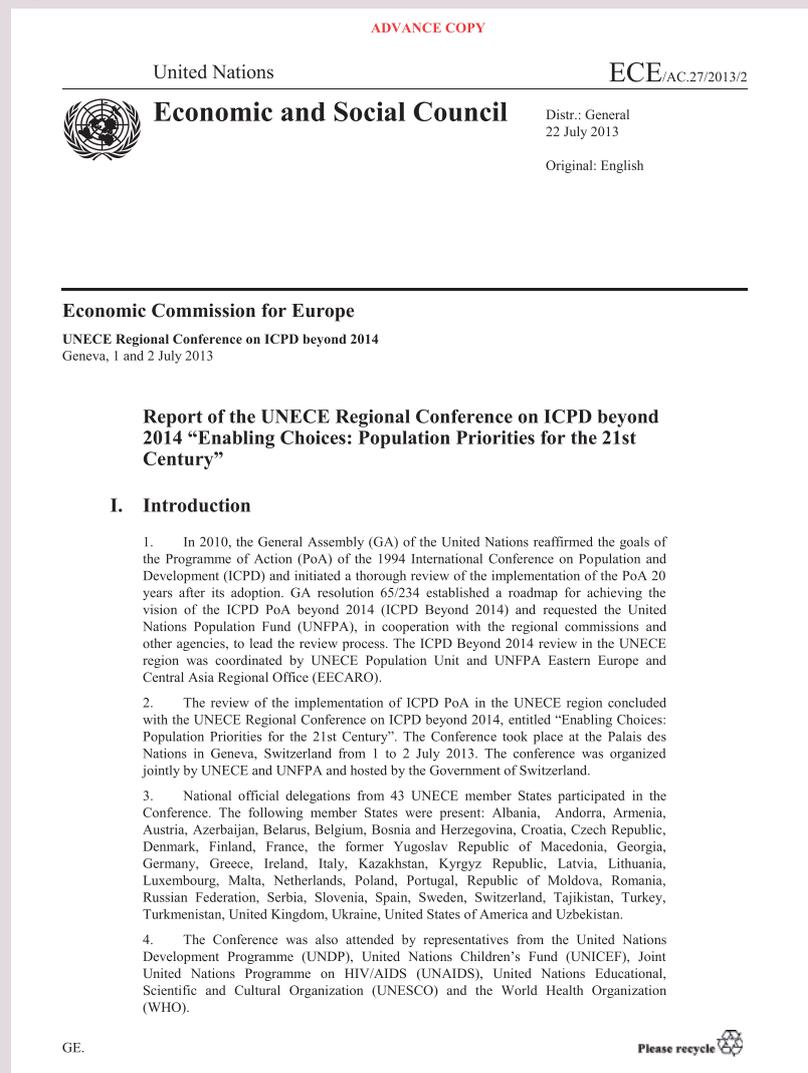


Image1. Nino Berdzuli, Deputy Minister of Labour, Health and Social Affairs of Georgia, speaks at the consultation meeting in Tbilisi.

# TOWARDS A NEW WHO EUROPEAN ACTION PLAN FOR HUMAN RIGHTS-BASED SEXUAL AND REPRODUCTIVE HEALTH (SRH)

In March 2016 a regional consultation of the countries of eastern Europe and central Asia (EECA) took place in Tbilisi, Georgia. The main purpose was to review the latest available draft of the new *WHO European Action Plan (EAP) for Human Rights-based Sexual and Reproductive Health 2017–2021*. The consultation was organized by the UNFPA eastern Europe and central Asian Regional Office (EECARO), in collaboration with the WHO Regional Office for Europe.

This meeting, attended by the representatives of the Ministries of Health of 17 countries of the EECA, was one important step in a longer process of the *European Action Plan* development; it provided an opportunity for discussion, giving comments, consultation on its relevance to the countries' priorities and the new Sustainable Development Agenda. Why is there a need for such a plan? What are the main goals and objectives of it? How does it deal with SRH inequities between and within countries? How will it support the countries to achieve universal access to SRH and accelerate the new Sustainable Development Agenda? These were the questions discussed at the consultation, in addition to the discussion on the content of the *EAP*.

## Common objectives, shared commitments

The consultation brought together the representatives of Ministries of Health involved in policy decisions in the area of SRH, staff from the UNFPA and WHO country offices in eastern Europe and central Asia, as well as international experts in SRH. The main objectives of the meeting were to:

- 1) Review the progress in development and implementation of national SRH policies;
- 2) Review the draft *European Action Plan for Human Rights Based Sexual and Reproductive Health*; and
- 3) Discuss further ways to assist countries in eastern Europe and central Asia to improve SRH outcomes.

The outcomes of the meeting were a consensus on the *EAP* and recommendations on further improvement of SRH in the countries EECA Region. The consultation also resulted in a strong commitment of countries to translate the *EAP*, its approaches and priorities into national SRH strategies and action plans. The urgency of adoption of the plan by the Region was stressed by participants as a key factor for successful implementation of the new SRH agenda in the Region.

## Why a European Action Plan on Sexual and Reproductive Health and Rights (SRH&R)?

The main reason for developing this new plan is that in many of the 53 Member States of the WHO European Region, SRH&R still does not fulfill the various goals and objectives that have been agreed and committed to in international agreements, including the *Programme of Action* agreed at the International Conference on Population and Development (1), the Millennium Development Goals (MDGs, adopted in 2000), the *WHO European Regional Strategy on Sexual and Reproductive Health* (2) adopted in 2001 and the *WHO Reproductive Health Strategy* (3), adopted in 2004. Furthermore, the WHO European Region's vision on health, described in the document "*Health 2020*" (adopted in 2012, available at: <http://www.euro.who.int/en/publications/policy-documents/health-2020.-a-european-policy-framework-and-strategy-for-the-21st-century-2013>), also has not yet been operationalized specifically for the field of SRH&R. In several countries of the Region the above agreements have been used for developing and implementing their national SRH working agendas, but new realities and trends in SRH and rapidly changing environments require new regional and national frameworks to reflect SRH priority issues, as well as their solutions, based on lessons learned and experiences gained during last decade.

The Sustainable Development Goals (SDGs), agreed in 2015, now represent the main international development agenda; it reflects renewed commitment

to advance SRH by addressing challenges and priority issues, applying innovative approaches and forging new partnerships, including intersectoral collaboration.

Regional SRH policy documents require revision based on new evidence and they have to be brought in line with recently approved strategic documents.

## What does the EAP mean in practice for SRH&R in our Region?

The *European Action Plan for Human Rights Based Sexual and Reproductive Health (2017–2021)* provides a framework to guide and inform development of country specific policy responses, action plans and programmes in improving SRH.

The *EAP* reflects an issue-based approach to the priorities in the Region. During the last 15 years of the MDGs implementation, significant progress has been made in the European Region and particularly in the countries of eastern Europe and central Asia in improving maternal and perinatal health, family planning, preventing sexually transmitted infections (STIs) and unsafe abortions, as well as improving sexual health overall. However, although much progress has been made, inequalities remain within, as well as between the EECA Countries; SRH outcomes in the European Union (EU) versus the EECA Countries also reflect serious inequalities.

## What does the data say?

- The EECA Region made significant progress in reducing maternal mortality during the last 15 years, but still the regional average of maternal mortality risk (1 in 1900) is double the one in more developed regions (1 in 3700). The disparities between and among EECA Countries are still significant: the risk of maternal mortality in some central Asian Countries (Kyrgyzstan, Tajikistan and Turkmenistan) are even much higher (1 in 390–500) and closer to the global average of 1 in 190.
- EECA Countries demonstrate diverse trends and dynamics in access to modern contraceptives: the change to mod-



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### GEORGIA

The regional UNFPA/WHO consultations on the European SRH Action Plan in Tbilisi (March 2016) triggered the development process of Georgia's first ever Maternal and Newborn Health Strategy. Consultations were followed by UNFPA EECARO and Country Office joint advocacy. As a result, UNFPA/Georgia currently supports the Ministry of Labour, Health & Social Affairs in the elaboration of a National Strategy (2017–2030) and the three-year Action Plan for Safe Motherhood and Newborn Care, Reproductive Health and Adolescent and Youth SRH. The documents will be finalized by the end September 2016 and will be aligned with the WHO Regional Action Plan.

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### THE FORMER YUGOSLAV REPUBLIC (TFYR) OF MACEDONIA

Following the technical consultations held in Tbilisi on March 14–15, 2016 on the *European Action Plan for Human Rights-Based Sexual and Reproductive Health 2017–2021*, the Ministry of Health convened a multi-stakeholder consultation meeting to provide comments to WHO Regional Office. Participants of this consultative meeting were very grateful for their involvement in the process and noted that “this was the first time that they were consulted for such an important regional document”.

At the national level, the mid-term review of the National SRH Strategy (2010–2020) has been initiated with the support of UNFPA. The process is led by the Ministry of Health and conducted by a multi-stakeholder group, including NGOs. The main purpose of this process is to align the national policies with regional and global initiatives, such as SDGs, the *European Action Plan for Human Rights-Based Sexual and Reproductive Health 2017–2021*, various recommendations of human rights mechanisms, Health 2020 Strategy, etc. The process is expected to be completed by the end of the year, with development of an Action Plan.

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Map of the eastern European and central Asian Region.  
Source: <http://eeca.unfpa.org/sites/default/files/eecamap1.jpg>

### REPUBLIC OF MOLDOVA

Currently the Government of the Republic of Moldova is developing a new strategic document on SRH&R 2016–2020 based on the findings and recommendations of the assessment of the previous National Strategy on Reproductive Health 2005–2015. In this regard a Steering Committee was appointed by the Ministry of Health, which is composed by representatives of different ministries, health institutions, civil society organizations and various relevant stakeholders that met regularly to prioritize and develop the strategic document. The regional UNFPA/WHO consultations on the *European SRH Action Plan* held in Tbilisi in March 2016 has triggered the national process by putting a more prominent focus on rights-based approach and beneficiary-centred interventions in the draft National Programme. In May 2016 the Ministry of Health with the support of WHO and UNFPA has organized a national stakeholders' meeting with the participation of the WHO Regional Office to discuss the draft document. The new strategic document will also draw on newly adopted Sustainable Development Goals, European recommendations and principles on SRH, guided by the principles of universal human rights, non-discrimination, gender equality and equity, evidence-based approach, accountability and sustainability.

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### AZERBAIJAN

Within the frameworks of the joint programme between the UNFPA and WHO Country Offices in Azerbaijan and following the outcomes and recommendations from the UNFPA/WHO consultations on the *European SRH Action Plan* in Tbilisi, March 2016, the Ministry of Health of the Republic of Azerbaijan issued an order on the development and operationalization of the National SRH Strategy 2018–2025 in May 2016. The National Institute of Obstetrics and Gynecology of the Ministry of Health of the Republic of Azerbaijan was delegated a leading role to coordinate the process of the development of the new RH Strategy for Azerbaijan. A National Working Group was established and approved by the Ministry of Health. The situation analysis will be completed by mid-July 2016 and the drafting process for the National SRH Strategy 2018–2025 will start in August 2016, with technical support from the WHO Regional Office for Europe and close cooperation with the National Working Group, representatives from other ministries and committees, including international organizations, UN (WHO, UNFPA, UNICEF) and civil society and private sector organizations. The draft Strategy document will be submitted to the Ministry of Health for the endorsement and, subsequently, approved by the Cabinet of Ministers (November 2016).

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# TOWARDS A NEW WHO EUROPEAN ACTION PLAN FOR HUMAN RIGHTS-BASED SEXUAL AND REPRODUCTIVE HEALTH (SRH)

(CONTINUED)

ern contraceptive prevalence rate varies from 10–13% (in western Balkans) to 26–59% (in central Asia). During the last 10 years the international assistance to EECA Countries decreased by more than 50% per women. Since 2009 the Family Planning Efforts Scores for EECA are decreasing in all 4 parameters (policy, services, access and evaluation). A sizable unmet need for contraception resulting in high unintended pregnancy and abortion rates remain a concern in the Region.

- Cervical cancer is the only preventable cancer of the reproductive system, but due to the lack of the cervical cancer prevention programmes (screening, vaccination) mortality of women of reproductive age, caused by cervical cancer, is 10 times higher in EECA than in the EU; more than 38 000 new cases of the cervical cancer are registered and more than 18 000 women are dying from it annually in EECA Countries.
- Access of adolescents and youth to SRH services and information is limited due to absence of youth oriented services, poor institutional capacities and restrictive policies. The adolescent birth rate (per 1000 women, ages 15–19) is above 40 in half of the countries of EECA, which is high for European standards.
- EECA is the only region with annually growing new cases of HIV and STIs.

## How does the EAP reflect the SDGs and particularly, universal access to SRH services?

In the context of the various 53 countries that comprise the WHO European Region, meeting the new SDGs agenda requires stronger commitments, shared accountabilities and coordinated joint efforts of EU member states and EECA Countries, in order to close the gap in universal access. It also means issue based innovative approaches to SRH priorities and emerging issues. It also means more focus on vulnerable groups, wider partnerships and multi-sectoral cooperation. This is exactly what the new EAP calls for and emphasizes.

## Core characteristics of the EAP

The basis for the EAP has primarily been the documents mentioned above. In particular SDG 3 is important: “Ensure healthy lives and promote well-being for all at all ages” (1). More specifically target 7 under this goal is key for improving SRH. This target states:

*“By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education and the integration of reproductive health into national strategies and programmes” (4).*

The first part of this target had also been included in the MDGs in 2004; the second part is an important new addition. SDG goal 3 also includes targets related to maternal and child health and to HIV/AIDS, that reappear in the proposed EAP.

The Plan starts with nine “guiding principles,” of which the first two are probably most crucial, because those refer to human rights principles that are central to the document. The first principle is “the right of everyone to the enjoyment of the highest attainable standard of health – a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The second part of this principle relates to the WHO definition of health. The second principle is the right to non-discrimination, which is crucial for including various vulnerable and marginalized population groups where SRH is concerned, like unmarried people, sexual minorities or refugees. Another core principle is the “life course approach,” which is a key element now of the WHO’s and its partners’ approach to health in general, but at the same time not always well understood. The life course approach suggests that health outcomes of individuals and communities depend on the interaction of multiple protective and risk factors throughout people’s lives. It also includes the idea that health protection at earlier ages often has a long term impact later in life. This idea is particularly relevant in the case of SRH. For example, prevention

of unwanted pregnancy and subsequent birth during a woman’s teenage years will greatly determine her future life, health and well-being. Other principles of the Plan are, among others: people centred care; action oriented and evidence-based; promotion of gender equity; emphasis on prevention and health promotion; community participation; empowerment; and the need for inter-sectoral collaboration because health is not only determined by interventions within the health care system.

The EAP formulates three goals:

1. *“To enable all people to make informed decisions about their SRH and ensure that their sexual and reproductive rights are respected, protected and fulfilled.”* This goal refers to the need for a rights-based approach and the obligation to inform and educate people on SRH and their rights in this field. The goal is subsequently specified in 4 objectives and for each objectives various key actions are indicated that substantiate the action-oriented character of the Plan. Establishment and strengthening of comprehensive sexuality education is one of these objectives.
2. *“To ensure that all people can enjoy the highest attainable standard of SRH and well-being.”* This goal is particularly relevant for the health care system. Under five concrete objectives the Plan indicates which actions are needed to address women’s and men’s own concerns in the field of SRH&R, to reduce the unmet need for contraception, to eliminate avoidable maternal and perinatal mortality and morbidity, to reduce STIs, to diagnose and treat infertility and to effectively tackle the problem of reproductive cancers.
3. *“To guarantee universal access to SRH and eliminate inequities.”* Under this goal, 4 objectives have been formulated that guarantee that all people have access to SRH information and services, that SRH is sufficiently integrated in public health strategies and that all

relevant stakeholders have a role in reaching those objectives: the so-called “whole government” and “whole society” approach. Adolescents are given specific attention under this goal.

The *EAP* further indicates how the Plan can be transformed into national action plans, and what the respective roles could be of the Ministry of Health, the WHO Regional Office for Europe, as well as NGO’s and other partners. Finally, the document mentions the need for proper monitoring and evaluation of implementation of the Action Plan. A special M&E expert group has been established, that has already advised the WHO on core indicators that should be used to monitor this process and that countries should periodically report on during implementation of the Action Plan in the future.

### **Consultation, reaching agreement and adoption of the *EAP***

Initially, the idea had been to develop a new WHO SRH&R strategy for Europe. For this purpose a meeting was organized in April 2015 in Trieste, Italy, facilitated by the WHO Collaborating Centre in that city. The idea was that the future strategy would become the successor of the one released in 2001, which was meant for the period 2001–2010. However, during that meeting it became clear that there was a need for a more action-oriented document. As a result the title was changed to “Action Plan”, a draft of which was subsequently developed by the WHO Regional Office for Europe. This draft, that has been gradually adapted during the past year, has gone through a process of technical and policy consultations. The above mentioned consultation meeting with country representatives from the WHO and UNFPA EECA has been one important step in this process, that resulted in various recommendations on how to generate more support for adoption and implementation of the Plan. Another milestone has been the high level meeting, with political leaders in Minsk

in October last year, on the WHO European Region’s *Health 2020*. The resulting “Minsk Declaration” includes “actions to promote SRH” (5).

This entire process is expected to come to a conclusion on 12 September this year, when the WHO Regional Committee for Europe will decide on adoption of the Action Plan.

### **The *EAP* is also an advocacy tool**

The new development agenda (SDGs) and other global commitments are currently in the process of regionalization and nationalization. SRH is not only a fundamental human right, but it is also fundamental for the realization of the development agenda in each country and the entire Region. The new era of development requires adoption and operationalization of action oriented sectoral plans and strengthened multi-sectoral cooperation. From this perspective, the *EAP* with its principles, format, content and methodology of development is a good example of an action-oriented multi-country effort that could be replicated by other regions and sectors. However, it requires political, financial and technical support for its endorsement and implementation to make sure that it helps countries, where mothers still die giving birth and where people still suffer from diseases and conditions, which could be prevented if universal access to good quality SRH services was provided. Thousands of deaths could be prevented if the priorities, approaches and actions of the Plan become the agenda of each country in the European Region.

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### **References**

1. ICPD Programme of Action. Cairo, 1994. Available at: [http://www.unfpa.org/sites/default/files/event-pdf/icpd\\_eng\\_2.pdf](http://www.unfpa.org/sites/default/files/event-pdf/icpd_eng_2.pdf)
2. The WHO European Regional Strategy on Sexual and Reproductive Health. Copenhagen: WHO Regional Office for Europe, 2001. Available 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>
3. The WHO Reproductive Health Strategy. Geneva: WHO, 2004. Available at: [https://apps.who.int/iris/bitstream/10665/68754/1/WHO\\_RHR04.8.pdf](https://apps.who.int/iris/bitstream/10665/68754/1/WHO_RHR04.8.pdf)
4. United Nations General Assembly resolution A/RES/70/1. *Transforming our world: the 2030 Agenda for Sustainable Development*. New York: United Nations, 2015. Available at: [http://www.un.org/en/ga/search/view\\_doc.asp?symbol=A/RES/70/1&referer=http://www.un.org/en/ga/70/resolutions.shtml&Lang=E](http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/70/1&referer=http://www.un.org/en/ga/70/resolutions.shtml&Lang=E).
5. *Minsk Declaration; the life-course approach in the context of Health 2020*. Copenhagen: WHO Regional Office for Europe, 2015. Available at: [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0009/289962/The-Minsk-Declaration-EN-rev1.pdf?ua=1](http://www.euro.who.int/__data/assets/pdf_file/0009/289962/The-Minsk-Declaration-EN-rev1.pdf?ua=1).

# AN OPPORTUNE TIME TO IMPROVE SEXUAL AND REPRODUCTIVE HEALTH OF ADOLESCENTS IN THE EUROPEAN REGION THROUGH INTERSECTORAL COLLABORATION

## Introduction

Improving adolescent sexual and reproductive health (SRH) presents an important public health challenge for Europe and central Asia. This has been brought to the forefront by the recently published *Health Behavior in School-aged Children Study (HBSC) 2013/14*, which looks at the status of adolescent health in 42 countries and regions in Europe and emphasizes the urgent need for intersectoral action to improve adolescent health, including SRH (1). The evidence is clear that young people who have access to comprehensive sex and relationship education, confidential reproductive health services and appropriate methods of contraception have better sexual health outcomes (2). The social determinants of health play a key role in SRH, which impacts the development of individuals, their families and communities at large (3). Ensuring access to comprehensive sex and relationship education, reproductive health services, contraception and tackling underlying issues of social determinants requires partnership and collaboration, including strong policy coherence, between the education, social and health sector. Intersectoral approaches with a strong emphasis on public health interventions is crucial to effectively improve the SRH – as well as overall health and well-being – of adolescents in the European Region (1, 2).

It is imperative therefore that Europe continues to scale up the concrete implementation of global, regional, national and subnational strategies to improve SRH amongst adolescents. This includes moving towards greater systematic intersectoral collaboration between the health, social and education sectors. While the importance of intersectoral collaboration and policy coherence has been in key strategy documents for some time (4, 5), the current global policy context marks a renewed opportunity to increase the action needed to address SRH.

The adoption of the global 2030 Agenda for Sustainable Development in September 2015, including its 17 goals for sustainable development (SDGs), provides a unique policy opportunity to

pursue and implement effective intersectoral solutions for all of today's complex public health challenges, including SRH. The health goal – SDG 3 – includes a specific target on SRH, aiming to ensure global universal access to SRH care services by 2030, including family planning, information and education, as well as the integration of reproductive health into national strategies and programmes (6), all of which require stronger and transformative partnerships and support from the education and social sectors.

Agenda 2030 and the SDGs are supported through global and regional strategies and initiatives that echo the call for strengthened intersectoral action. The new *Global Strategy for Women's, Children's and Adolescent's Health 2016–2030* aims to achieve the highest attainable standard of health for all women, children and adolescents, transform the future and ensure that every newborn, mother and child not only survives, but thrives. The education sector is seen as a crucial partner and the strategy specifically recommends multisectoral policies and interventions on the determinants of women's, children's and adolescent's health.

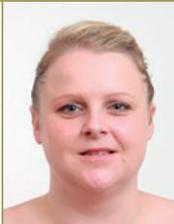
In the European Region, the transformative agenda of the SDGs is supported through the implementation of *Health 2020*, the Regional strategy and policy framework for health and well-being, which highlights the important role of partnerships and intersectoral action. *Health 2020* is supported through the implementation of specific regional strategies and action plans addressing SRH including the *Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe - leaving no one behind*. This Action Plan is linked to the European Women's Health Strategy and will be presented to the 66th session of the WHO Regional Committee for Europe in September 2016. The Action Plan recommends that evidence-based sexuality education be made available to all age groups, including children and adolescents and their parents. It emphasizes the specific

importance of sexuality education for children who are not integrated in regular school systems and other vulnerable groups. This builds on the work undertaken through the strategy on "*Investing in children: child and adolescent health strategy for Europe 2015–2020*" adopted in September 2014 at the WHO Regional Committee, which 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 through working with other sectors.

The current policy context presents a reinvigorated opportunity to invest in effectively strengthening SRH through increased intersectoral action and approaches. The challenge in taking this forward includes identifying evidence-based interventions, as well as strengthening the mechanisms and instruments that facilitate work across sectors. The investment in intersectoral action is a priority for the WHO Regional Office for Europe. As part of the implementation of *Health 2020* it will organize a High Level Conference, *Promoting intersectoral and interagency health and well-being in the European Region: Working together for better health and well-being*, on the 7–8 December 2016, hosted by the Ministry of Social Affairs and Health of France. The meeting will promote strengthening the partnership between health, education and the social context to improve the health and well-being of children in the Region. Lessons from across the Region that demonstrate the transferability and scalability of good practice in addressing this important public health issue will be shared.

## An important public health issue

The 1994 United Nations International Conference on Population and Development defined SRH as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes (7)." It is considered fundamental to human well-being and a basic



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human right and therefore is a significant issue for the 74 million adolescents (10–19 years) living in the European region, representing 8.4% the population (8).

Adolescence is a transitional stage of significant physical and psychological development leading to maturity and independence (9). Adolescents rely on their families, their peers and communities, schools, health services and their workplaces to learn a wide range of important skills that can help them to cope with the pressures they face and make the transition from childhood to adulthood successfully. It is at this stage in life, while young people are still developing emotionally and cognitively, that they start to explore intimate relationships and become sexually active and develop important health behaviours and life skills, including learning how to refuse sex or negotiate safe intercourse. It is a vulnerable time for young people, coinciding with increased peer pressure to engage in other risk taking behaviour, such as alcohol and other drug use, compounding the potential risks to their SRH. This vulnerability when combined with any financial hardship, in some cases may lead to prostitution and increased risk for trafficking and sexual exploitation (1, 8).

Complications linked to pregnancy and childbirth are the second cause of death for 15–19-year-old girls globally (10) and evidence from Latin America shows that girls aged under 16 have a four times higher risk of dying in pregnancy or childbirth than women aged 20–24 years (11). Adolescent pregnancy is also dangerous for the child; deaths in babies during the first month of life are 50–100% more frequent if the mother is an adolescent and the younger the mother the higher the risk. In addition, the rates of preterm birth and low birth weight are higher among the children of adolescents, all of which increase the chance of future health problems for the baby (12).

Longer-term, pregnancies in adolescents can be socially detrimental to the individuals, their families and friends, as well as the communities they live in, as many girls who become pregnant subse-

quently leave school (9). Unsafe sexual intercourse also increases the risk of sexually transmitted diseases (STIs), including HIV. Chlamydia infection, especially if left untreated, may result in infertility later in life (13).

Data from the HBSC 2013/14 study shows that a significant minority of adolescents are sexually active and that many risk STIs or unplanned pregnancy by not using condoms or effective methods of birth control. Over a fifth (21%) of adolescents aged 15 years reported to have had sexual intercourse, with boys reporting more sexual intercourse (24%) than girls (17%) on average. The greatest gender disparities are seen in eastern Europe. A little over a quarter (28%) of those 15 years olds engaging in intercourse reported to have used the contraceptive pill and around two-thirds (65%) reported to have used a condom. The effect of family influence on the likelihood of engaging in sexual intercourse aged 15 years varies by gender. The strongest correlation is observed in boys, where the prevalence is highest in those from the highest-affluence group. Overall use of contraception, however, was not strongly associated with affluence (1).

An indication of the scale of pregnancies in adolescents in the European Region can be gleaned from data of recorded births and abortions to young mothers. In 2013, 5.7% of all live births were recorded in mothers aged under 20 years. This percentage was highest in eastern Europe and central Asia (European Health for All Database, available at: <http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db>). Recent data on abortions in adolescents is not available for many countries in the Region.

STIs in adolescents are difficult to estimate, however the prevalence of the most frequently occurring STIs (Chlamydia and gonorrhoea) has increased in several European countries in the last decade (14).

Importantly, from a policy perspective, data on SRH in adolescents, including in the European Region, is limited; for

example, although data on teenage pregnancy is in general available, very little is known about the circumstance surrounding first intercourse. Moreover, the data does not describe currently the full adolescent population at risk; very little is known about the youngest group of adolescents (aged 10–14), the male adolescent population, migrants and refugees, intravenous drug users and individuals of alternate sexual orientation (8). The SDGs stress the need for inclusiveness and leaving no-one behind, providing an important political opportunity to address this gap in data. Addressing this data gap is an essential component in the development of successful and evidence-based public health interventions to improve SRH, including those that require successful intersectoral approaches.

### **Cross-sectoral interventions between the health and education sectors**

Intersectoral interventions are needed to effectively improve SRH as the adolescent period of the life-course is one that is influenced by various factors; family, peers and school, community and exposure to wider society. Good SRH therefore cannot be seen as an outcome of one sector alone; effective responses and public health interventions to support adolescent health and development require collaboration between a range of actors and sectors. Sustainable and equitable improvements in health, including SRH, are the product of effective policy across all parts of government, including the local level and it is crucial that holistic policy responses reflect the complexity and intersectorality of the challenges.

### **Health education**

The impact of school is crucial for the development of health literacy of adolescents as well as enabling them to engage in health promotion. The WHO strongly recommends health education delivered in a school setting, both to prevent health-compromising behaviours that arise during adolescence and may adversely affect future lifestyle choices and

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to contribute to improved mental health (10). Skills-based health education is an approach to creating and maintaining healthy lifestyles and conditions “through the development of knowledge, attitudes and *especially skills*, using a variety of learning experiences, with an emphasis on participatory methods (15).”

Skills-based health education helps enable adolescents to make informed choices and take effective action regarding their own health. The provision of scientifically accurate and comprehensive sexuality education programmes within schools that include information on contraceptive use and acquisition are a form of skills-based education that can help make sexual activity safer for adolescents and prevent unplanned and unwanted pregnancies, STIs and abortions.

## **Schools as part of the social environment**

Importantly, the school-setting offers more potential benefits for improving adolescents’ SRH beyond offering quality health education. While skills-based health education is important, in isolation it has small effect and will not be enough to significantly address adolescent SRH issues in the Region (10, 16). Schools have a crucial role in the wider community and society and can therefore influence wider societal developments that will contribute to improved adolescent SRH.

## **Healthy school settings**

For several decades, WHO has promoted the notion of “health-promoting schools”, which, through their social and physical environment and the notion of school ethos, or culture, can contribute to the promotion of health throughout wider society. This notion encompasses a safe physical environment, opportunities for physical activity and healthy eating, as well as adequate sanitation including hygiene materials and privacy.

The school-setting also plays an important role in the delivery of health education and SRH services. School-based interventions and interactions experienced by students in the school

setting can also positively influence the common perception of risk in sexual behaviour and other health behavioural choices affecting SRH, including for adolescents at risk of vulnerability or health inequities (10).

Evidence also shows that trusting relationships developed between school staff and students positively effects adolescents’ health-related choices (17). School extra-curricular activity leaders, such as sports coaches and other individuals that students are likely to form a bond with, can act as mentors and promote and guide students to SRH services available in the community.

Schools can work directly with students and other services in the community to provide parents with support and advice on parenting strategies during the later years of childhood. This is particularly relevant to SRH, as research shows that open family communication on sexual issues corresponds with less high-risk sexual behaviours in adolescence (18), and that adolescents who report ease of communication with mothers are less likely to be sexually active (19).

The health and education sectors are therefore key partners in improving and promoting adolescents’ healthy development (10, 20). Not only does the school-setting provide a crucial access point to many adolescents to deliver health education and SRH services, but in addition to this, more years of education are directly associated with improved health outcomes at both the individual and population levels (10).

## **Intersectoral action – working together for health and well-being**

Strengthened intersectoral approaches improve adolescents’ SRH through building accountability and responsibility amongst other sectors that own the drivers or determinants that impact on SRH. The central role of the education sector in adolescents’ lives therefore makes it a crucial sector for partnership.

If strengthened intersectoral action is needed to achieve a successful response to the public health issue of adolescents’

SRH in the European Region, the question that emerges is how to bring sectors together and achieve effective intersectoral collaboration.

Bringing sectors together requires improving policy coherence. While policy coherence must be strengthened across sectors within government (horizontal coherence), it must also be strengthened between different levels of government: international, national, subnational, regional and local (vertical coherence) (21–23). This is highly context-sensitive and specific, but in all instances concrete measures need to be in place to ensure that policy coherence realistically exists – for example: joint impact assessments; setting shared common goals and targets between the sectors involved; shared budgets and joint financing mechanisms; the use of data from both sectors; and joint reporting and monitoring mechanisms.

An effective intersectoral policy response is the product of effective policy across all parts of government, a whole-of-government approach and engaging the whole of the community, a whole-of-society approach. A whole-of-society approach emphasizes the empowerment – of individuals, communities and vulnerable groups – and community resilience, fostered by increased empowerment, as being both consequences and contributors to success factors of the whole-of-society approach (23). This means including communities, populations, and in particular, target groups, in the design, implementation and evaluation of interventions, policies and services impacting on SRH.

Including adolescents and communities in processes not only improves the quality, relevance and ownership of the interventions and services offered, but also empowers adolescents through strengthening their ability to influence and control decisions that affect them and their health.

## **Conclusion**

The ongoing implementation of *Health 2020*, coupled with the recent adoption

of the 2030 agenda, provides a unique opportunity and a sense of urgency for the European Region. There is an opportunity to build upon existing regional and national commitments to health and take forward the implementation of the Region's strategies and action plans addressing SRH by strengthening the work with key sectors and building new transformative partnerships. Improving the health and well-being of adolescents requires action from all involved, including increasing efforts to work together to make sure that all adolescents are able to enjoy good health, including those children who are at greatest risk of falling through gaps.

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## References

- Inchley J et al. eds. *Growing up unequal: gender and socioeconomic differences in young people's health and well-being. Health Behaviour in School-aged Children (HBSC) study: international report from the 2013/2014 survey.* Copenhagen, WHO Regional Office for Europe, 2016.
- Sexuality Education Policy Brief No. 2: Sexuality education: what is its impact?* Cologne: Federal Centre for Health Education (BZgA), 2015.
- WHO Adolescent pregnancy. Available at: [http://www.who.int/maternal\\_child\\_adolescent/topics/maternal/adolescent\\_pregnancy/en/](http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/). Accessed: 26/08/2016.
- Health 2020. A European policy framework and strategy for the 21st century.* Copenhagen: WHO Regional Office for Europe, 2013.
- Promoting intersectoral action for health and well-being in the WHO European Region: Health is a political choice.* Regional Committee for Europe, 65th session, Vilnius, Lithuania, 14–17 September 2015. Copenhagen: WHO Regional Office for Europe, 2015.
- Adolescents: health risks and solutions Fact Sheet. Available at: <http://www.who.int/mediacentre/factsheets/fs345/en/>. Accessed: 30/08/2016.
- International Conference on population and development, Cairo 5–13 September, 1994. Programme of Action.* New York: UN, Dept. for Economic and Social Transformation and Policy Analysis, 1995.
- Avery L, Lazdane G. What do we know about SRH of adolescents in Europe? *Eur J Contracept Reprod Health Care* 2010 ;15(S2):S54–S66.
- WHO. Adolescent Development. Available at: [http://www.who.int/maternal\\_child\\_adolescent/topics/adolescence/dev/en/](http://www.who.int/maternal_child_adolescent/topics/adolescence/dev/en/). Accessed: 30/08/2016.
- Health for the World's Adolescents. A second chance in the second decade.* Geneva: World Health Organization, 2014.
- Conde-Agudelo A, Belizán JM, Lammers C. Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study. *Am J Obstet Gynecol* 2005;192:342e9.
- Ganchimeg T, Ota E, Morisaki N et al. Pregnancy and childbirth outcomes among adolescent mothers: A World Health Organization multi-country study. *BJOG* 2014;121(Supplement s1):40e8.
- Centres for Disease Control and Prevention. Factsheet. Available at: <http://www.cdc.gov/std/chlamydia/stdfact-chlamydia.htm> Accessed: 30/08/2016.
- Laakkonen H. Adolescents' SRH (SRH): empowering young people to realize their full potential. *Entre Nous* 2014;80:3.
- Skills for health, Information series on school health, Document 9.* Geneva: World Health Organization. Available at: [http://www.who.int/school\\_youth\\_health/media/en/sch\\_skills4health\\_03.pdf](http://www.who.int/school_youth_health/media/en/sch_skills4health_03.pdf). Accessed 30/08/2016.
- Oliver S et al. *Health promotion, inequalities and young people's health: a systematic review of research.* London: EPPI Centre, Social Science Research Unit, Institute of Education, University of London, 2008.
- Bonell C et al. Systematic review of the effects of schools and school environment interventions on health: evidence mapping and synthesis. *J Public Health Res* 2013, 1:1.
- Whitaker DJ, Miller KS. Parent-adolescent discussions about sex and condoms: impact on peer influences of sexual risk behavior. *J Adolesc Res* 2000;15(2):251–73.
- Lenciauskiene I, Zaborskis A. The effects of family structure, parent-child relationship and parental monitoring on early sexual behaviour among adolescents in nine European countries. *Scand J Public Health* 2008;36(6):607–18.
- Shared interests in well-being and development. Social Determinants of Health Sectoral Briefing Series, 2.* Geneva: World Health Organization, 2011.
- Elinder, L.S. Obesity, hunger, and agriculture: the damaging role of subsidies. *BMJ* 2005 331:1333-1336.
- Closing the gap in a generation: Health equity through action on the social determinants of health.* Geneva: World Health Organization, 2008.
- Brown C et al. *Governance for health equity: Taking forward the equity values and goals of Health 2020 in the WHO European Region.* Copenhagen: WHO Regional Office for Europe, 2013.

# INTERSECTORAL COLLABORATION BETWEEN EDUCATION AND SEXUAL AND REPRODUCTIVE HEALTH (SRH) – EXPERIENCES FROM SWEDEN AND A FEW OTHER EUROPEAN COUNTRIES

## Guiding documents on SRH and sexuality education

The global community has acknowledged the importance of both positive SRH and access to education for the entire population. Several global and regional documents can be cited. First the Sustainable Development Goals (1):

- 3:7 By 2030, ensure universal access to sexual and reproductive health-care services... (1); and
- 4:7 By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development... (1).

Another key document is the *Global Strategy for Women's and Children's Health* (2), in which the life course and the health system approaches are prominent and integration and collaboration are emphasized.

- *Efforts to improve health must be closely linked to those intended to tackle poverty and malnutrition, improve access to education, ensure gender equity and empowerment... (2).*

The European Union parliament has formulated *Policies for Sexuality Education in the European Union* (3):

- *Sexuality education lessons should be comprehensive whilst dealing with various subjects (3).*

In 2001 the WHO Regional Office for Europe developed the *Regional strategy on sexual and reproductive health* (4) where two of the objectives are:

- *To inform and educate adolescents on all aspects of sexuality and reproduction and assist them in developing the life skills needed to deal with these issues in a satisfactory and responsible manner; and*
- *To ensure easy access to youth friendly SRH services (4).*

Standards for sexuality education in Europe were issued in 2010 (5) and two of the seven characteristics of sexuality education highlight intersectoral collaboration:

- *The continuity of sexuality education over time is complemented by its multisectorial setting. School-based sexuality education is linked to other*

*sectors by establishing cooperation with partners in and out of school, for example health services and counseling centres (5); and*

- *Sexuality education establishes a close cooperation with parents and community in order to build a supportive environment... Cooperation with other stakeholders (public and church-based youth work, youth welfare, health services, counseling centres, faith-based groups) in the field of sexuality education is also beneficial (5).*

## Intersectoral collaboration

Although intersectoral collaboration in SRH involves many stakeholders, the following will mainly focus on the intersection between education and health services, but also mention media, which is increasingly becoming a source of SRH knowledge for adolescents (6–8).

## Sexuality education and SRH services in Sweden

Sweden has mandatory school-based sexuality education. It is included in the national curriculum, under the responsibility of every headmaster. Sexuality education begins early and should be delivered on a regular basis. The content and the methods vary however between schools, since no detailed curriculum is available and teacher training does not include sexuality education. Studies have shown that school based sexuality education is a main source of knowledge about sexuality, together with friends and media (8, 9).

In 2008 a virtual Youth clinic UMO.se, was launched (10). The Swedish Government wanted to strengthen gender equality and access to information and support for all adolescents. The web site contains information about SRH, body development, gender roles, relations, life style and gender based violence. It also has a counseling tool where a panel of counselors respond to questions.

Every school has school health services and the school-nurse regularly invites all students for individual health counseling. Lifestyle and health promotion are important ingredients but the school

nurses do not have any specific education in SRH and therefore rarely include SRH issues. In the recent years, however, they have become responsible for providing Human Papilloma Virus (HPV) vaccine to all 12-year-old girls and thus have the duty to inform students and parents about the purpose of the vaccine. This has been a challenge for some of the nurses but also an opportunity to raise SRH issues with pupils and parents (11, 12).

In the mid 70s youth centres were created in complement to the school-based sexuality education with the aim to prevent sexually transmitted infections and unwanted pregnancies. The centres could be either freestanding or integrated in other health services. Every clinic must have medical and psychosocial competence; for example midwives and social workers or psychologists. Services are free of charge and around 240 youth centres exist in the country. Girls are the main visitors, but boys increasingly attend, for their own reasons or together with a girl friend (13).

Other European countries have similar models. Finland has one of the best sexuality education programmes in Europe and evidence points towards an association with the re-establishment of mandatory sexuality education and an improvement in SRH outcomes (14). In Estonia, similar success has been reported after introduction of sexuality education and youth-friendly SRH services (15, 16).

## Personal experience

Let me share some of my personal experiences. I live in a municipality with around 15 000 inhabitants. I worked in a public Primary Health Care Centre at the antenatal/family planning clinic. We wanted to strengthen access for adolescents to SRH services and therefore set up a youth clinic within the ordinary clinic, but with separate opening hours and drop-in possibility for adolescents. In order to make the clinic attractive to the teenagers we re-decorated the waiting room and the consultation rooms. We contacted the headmaster of the schools, the school nurses and the teachers responsible for sexuality



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education. We developed a collaborative approach with the aim to strengthen sexuality education, open the doors to the SRH services and work better in collaboration with the school nurse. In short the programme was structured as follows:

- All students in grade 6 had the opportunity to discuss puberty, sexual development and gender issues with the female midwife or a male volunteer in sex-separated groups.
- In grade 8 all students came to the clinic for a study visit in small groups. We then discussed sexuality and contraception and what services the clinic could offer.
- In grade 9 we visited the school for education and discussions on sexuality and reproduction. Attitudes, values, communication skills and pornography use were issues on the agenda.
- The school nurse was available for individual counseling and could refer to the youth clinic.

The programme has, with some modifications, run successfully for many years and has contributed to an increased satisfaction among the health and education professionals and the lowest rate of unintended pregnancy in the entire county.

### Challenges and opportunities

Intersectoral collaboration is a win-win situation, but continued efforts are needed to make it a reality in most European countries. Most professionals appreciate working in collaboration with others (17). There are, however, challenges. The high inflow of migrants to many European countries during the last years challenges sexuality educators, but also health service providers since migrants may be more hesitant to seek care. The public-private divide in both sectors means that many actors and stakeholders are involved, with slightly different priorities and resources. School health services could be more equipped to handle SRH issues. Teachers and health care providers need better education and continued support, preferably in multi-professional groups. NGOs active within the SRH

and education field could also be used and media offers a great opportunity. As health care providers and educators we should embrace the opportunity to move intersectoral collaboration forward for the benefit of improved SRH for all in the many countries that comprise Europe.

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### References

1. *Transforming our world: the 2030 agenda for sustainable development.* New York: United Nations, 2015.
2. *The Global Strategy for Women's and Children's Health (2016–2030). Survive, Thrive, Transform.* Every Woman Every Child, 2015. Available at: <http://globalstrategy.everywomaneverychild.org>
3. Beaumont K, Maguire M. *Policies for sexuality education in the European Union.* Brussels: European Parliament, 2013. Available at: <http://www.europarl.europa.eu/studies>
4. *WHO Regional Strategy for Sexual and Reproductive Health.* EUR/01/5022130. Copenhagen: WHO Regional Office for Europe, 2001.
5. *WHO Regional Office for Europe and Federal Centre for Health Education: Standards for Sexuality Education in Europe – a framework for policy makers, educational and health authorities and specialists.* Cologne: BZgA, 2010. Available at: [www.bzga-whocc.de](http://www.bzga-whocc.de).
6. McCarthy O, Carswell K, Murray E et al. What young people want from a sexual health website: design and development of Sexunzipped. *J Med Internet Res* 2012 Oct 12;14(5):e127.
7. Gaugaard C, Nielsen VM, Jensen SØ et al. What Do Danish Youth Want to Know About Sex? Twenty Years of Telephone Counseling on Sexual and Reproductive Issues. *J Sex Marital Ther* 2016 Jan 29:1-10.
8. Mattebo M1, Tydén T, Häggström-Nordin E et al. Pornography and sexual experiences among high school students in Sweden. *J Dev Behav Pediatr* 2014 Apr;35(3):179-88.
9. Häggström-Nordin E1, Borneskog C, Eriksson M et al. Sexual behaviour and contraceptive use among Swedish high school students in two cities: comparisons between genders, study programmes, and over time. *Eur J Contracept Reprod Health Care* 2011 Feb;16(1):36-46.
10. [www.UMO.se](http://www.UMO.se)
11. Gottvall M, Tydén T, Larsson M et al. Challenges and opportunities of a new HPV immunization program perceptions among Swedish school nurses. *Vaccine* 2011 Jun 20;29(28):4576-83.
12. Grandahl M, Tydén T, Rosenblad A et al. School nurses' attitudes and experiences regarding the human papillomavirus vaccination programme in Sweden: a population-based survey. *BMC Public Health* 2014 May 31;14:540.
13. Makenzius M, Gådin KG, Tydén T et al. Male students' behaviour, knowledge, attitudes, and needs in sexual and reproductive health matters. *Eur J Contracept Reprod Health Care* 2009 Aug;14(4):268-76.
14. Apter D, Molina Cartes R. Sexuality education: Finnish and Chilean experiences. *Endocr Dev* 2012;22:332-56. Review.
15. Haldre K, Part K, Ketting E. Youth sexual health improvement in Estonia, 1990–2009: the role of sexuality education and youth-friendly services. *Eur J Contracept Reprod Health Care* 2012 Oct;17(5):351-62.
16. Part K, Rahu K, Rahu M et al. Factors associated with Estonian adolescents' sexuality-related knowledge: Findings from the 1994 and 1999 KISS studies. *Eur J Contracept Reprod Health Care* 2008 Jun;13(2):173-81.
17. Pow J, Elliott L, Raeside R et al. Partnership working and improved service delivery: views of staff providing sexual health services. *J Health Serv Res Policy* 2013 Jul;18(3):132-7.

# NOT WITHOUT US: CIVIL SOCIETY'S ROLE IN IMPLEMENTING THE SUSTAINABLE DEVELOPMENT GOALS

The adoption of the 2030 Agenda for Sustainable Development and its Sustainable Development Goals (SDGs) in September 2015 was preceded by a consultative process that spanned several years. Launched with the UN Conference on Sustainable Development in 2012, it involved various thematic and national consultations, expert group initiatives and intergovernmental stages in the form of an Open Working Group of UN Member States convening in 2013 and 2014 and intergovernmental negotiations during 2015.

Civil society played an active role throughout this process. Civil society stakeholders participated in sessions of the intergovernmental negotiations and the Open Working Group and provided input to governments ahead of and during sessions. Civil society fed into the discussions through participating in consultations organized by UN, government and other stakeholders and engaged in persistent advocacy also outside of formal settings to influence governments' positions. To coordinate their efforts and strengthen the impact of their advocacy, civil society organizations worked in coalitions across sectors and across countries and regions.

Through this engagement, civil society helped shape the 2030 Agenda. Civil society groups strongly advocated for an ambitious and holistic agenda covering a wide set of objectives across social, economic and environmental dimensions of sustainable development. They also firmly called for an agenda grounded in human rights principles and aspiring to improve outcomes for all people, including marginalized population groups, and thus an agenda addressing many of the shortcomings of the Millennium Development Goals (MDGs). Civil society advocacy on these and other asks influenced the aims and ambitions of the Agenda.

## **Sexual and reproductive health and rights cut across the SDGs**

Sexual and reproductive health and rights advocates strongly called for an agenda that, unlike the MDGs, would include

commitment to sexual and reproductive health and rights from the outset. We also advocated for an agenda that would treat sexual and reproductive health and rights as cross-cutting and not just a health issue. We are pleased therefore that two separate targets on sexual and reproductive health and reproductive rights were included under the health and gender equality goals – Goals 3 and 5 – of the 2030 Agenda and that elements of sexual and reproductive health and rights are also touched upon in other targets.

Goal 3 includes targets calling for a significant reduction of maternal and neonatal mortality, an end to the AIDS epidemic and the achievement of universal health coverage, including financial risk protection and access to quality essential health-care services and safe, effective, quality and affordable essential medicines and vaccines for all. Goal 5 targets demand the elimination of discrimination and violence against women and girls and harmful practices, such as child, early and forced marriage and female genital mutilation. Targets under Goal 10 call for the social, economic and political inclusion of all and the elimination of discriminatory laws, policies and practices.

A whole range of targets furthermore address conditions that significantly contribute to an environment in which sexual and reproductive health and rights can be realized. This includes targets under Goals 4 and 8 on education and employment and under Goal 1 on ending poverty. It also includes targets under Goal 16 demanding the development of effective, accountable and transparent institutions at all levels as well as equal access to justice and legal identity, including birth registration, for all. It further includes targets under Goals 9 and 11 which call for the development of quality and reliable infrastructure and safe, affordable and accessible transport systems.

It is also important to bear in mind that sexual and reproductive health and rights are essential to the realization of many of the targets of the Agenda, beyond those under Goals 3 and 5 only.

Achieving targets on education and full and productive employment under Goals 4 and 8 respectively will not be possible if girls and women continue to miss out on education and employment opportunities because of early marriages and pregnancies. The social, economic and political inclusion of all, called for under Goal 10, will not be achieved if restrictive social norms discourage the participation of women and girls or if women's and girls' reproductive rights are denied (see Image 1).

## **SDG implementation – no one size fits all**

The cross-cutting nature of sexual and reproductive health and rights is reflected in the SDGs and must now also guide governments' implementation efforts. There is no one size fits all approach to implementing the 2030 Agenda. Governments will pursue implementation in different ways, depending on their national circumstances and realities. They may choose to incorporate the goals and targets into already existing policies and processes or they may put in place new structures to guide their implementation. They may establish inter-ministerial working groups to coordinate implementation efforts or develop dedicated implementation strategies.

Yet, whatever the approach chosen to implement the SDGs, it will be important for it to be cross-sectoral so as to reflect the interlinkages that exist between the goals and targets. For sexual and reproductive health and rights this will mean that they must not be designated a responsibility of health ministries or ministries of women's affairs only, which would be contrary to the ambitions of the 2030 Agenda, but be understood as a cross-cutting issue to be dealt with across sectors and across ministries.

## **Civil society involvement critical**

Whatever the approach chosen for implementation, it will also be essential that provision be made for meaningful involvement of civil society. Civil society



Image 1. SDGs, SRH and human rights (1).

### Specific targets relating to sexual and reproductive health and rights

There are several targets that relate directly to SRHR, as well as those that have aspects of SRHR, demonstrating the cross-cutting nature and importance of SRHR to achieving sustainable development for all. Given the scope of the Agenda, you may find it most helpful to identify those targets that relate more closely to your work or that are significant gaps in your context.

The specific targets that relate directly to SRHR are:

#### Goal 3. Ensure healthy lives and promote well-being for all at all ages

Targets:

- 3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- 3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
- 3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
- 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

#### Goal 5. Achieve gender equality and empower all women and girls

Targets:

- 5.1 End all forms of discrimination against all women and girls everywhere
- 5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation
- 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

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

However, elements of SRHR can also be found in other goals, demonstrating how SRHR cuts across all areas of sustainable development and is critical to the overall success of the Agenda. Furthermore, many of the targets of the Agenda are essential for creating an environment in which SRHR can be realized.

This includes, for example, the following:

#### Goal 4. Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Targets:

- 4.1 By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes
- 4.5 By 2030, eliminate gender disparities in education and ensure equal access to all levels of education and vocational training for the vulnerable, including persons with disabilities, indigenous peoples and children in vulnerable situations
- 4.7 By 2030, ensure that all learners acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and of culture's contribution to sustainable development

#### Goal 6. Ensure availability and sustainable management of water and sanitation for all

Target:

- 6.2 By 2030, achieve access to adequate and equitable sanitation

and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations

#### Goal 8. Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all

Target:

- 8.5 By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value

#### Goal 10. Reduce inequality within and among countries

Targets:

- 10.2 By 2030, empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status
- 10.3 Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies and action in this regard
- 10.4 Adopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality

#### Goal 16. Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Targets:

- 16.1 Significantly reduce all forms of violence and related death rates everywhere
- 16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children
- 16.3 Promote the rule of law at the national and international levels and ensure equal access to justice for all

# NOT WITHOUT US: CIVIL SOCIETY'S ROLE IN IMPLEMENTING THE SUSTAINABLE DEVELOPMENT GOALS

(CONTINUED)

played a critical role in the lead up to the adoption of the 2030 Agenda, amply demonstrating its ability to work across sectors and engage with a complex and multi-thematic political process and must now also be part of the implementation of the Agenda.

Civil society stakeholders can take on a variety of functions in the implementation process. They can spur government action through persistent advocacy and act as watchdogs holding governments accountable to their commitments. They can advise governments on concrete implementation measures to take, building on their experience on the ground, often working with marginalized communities. Civil society organizations can also directly support implementation through the role they often play in service delivery, including in the area of sexual and reproductive health, and can have an important role in supporting data collection efforts, including on marginalized groups.

To ensure effective civil society engagement in the implementation process, it is important that involvement not be of a merely informal nature. Civil society should have formal roles, such as through formal consultations on government implementation plans and measures, representation on mechanisms that oversee implementation efforts and formal channels for participation in accountability processes (see Image 2).

## Enabling environment for civil society participation

In order for civil society to be able to contribute meaningfully to implementation of the SDGs, it is essential to have an enabling environment in which it can operate freely. This requires respect by governments of rights to freedoms of opinion and expression and of association and peaceful assembly as well as to access to justice. It also requires transparency of government and public access to information. Commitment to these freedoms and entitlements is affirmed in the 2030 Agenda itself. Goal 16 calls for “effective, accountable and transparent institutions” as well as “responsive, inclusive, participa-

tory and representative decision-making” at all levels and also explicitly demands public access to information and protection of fundamental freedoms.

It will be important that governments raise public awareness of the SDGs and implementation measures, including by ensuring availability of information in all relevant languages and in accessible formats. Information on consultations and other opportunities for participation should be made available in good time and through channels accessible to all stakeholders. Particular effort should be invested in outreach to marginalized population groups, which can also be facilitated by civil society organizations.

An enabling environment also requires that civil society actors have access to funding and other resources. Governments should support and encourage civil society capacity-building and engagement through providing for funding for civil society activity and should refrain from unduly restricting civil society organizations’ access to resources. Particular focus should be placed on supporting the capacity-strengthening of organizations representing marginalized population groups and grassroots organizations.

## Not without us

Civil society was a key stakeholder in the development of the 2030 Agenda, contributing its expertise and engaging with decision-makers at different levels and throughout all stages of the process. It must now also have a central role in the implementation of the Agenda.

The 2030 Agenda itself makes multiple references to engagement with civil society in the implementation process. It proclaims the Agenda as “an Agenda of the people, by the people and for the people” and calls for the establishment of a global partnership “with the participation of all countries, all stakeholders and all people” to work on its implementation. Governments must ensure that civil society has a seat at the table as they implement the 2030 Agenda and must provide for an environment in which meaningful civil society engagement is

possible and encouraged. Living up to the promise of the Agenda and the process that preceded its adoption requires no less.

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## References

1. Barclay H, Daettler R, Lau K et al. *Sustainable Development Goals. A SRHR CSO guide for national implementation*. London: IPPF, 2015. Available at: [http://www.ippf.org/sites/default/files/sdg\\_a\\_srhr\\_guide\\_to\\_national\\_implementation\\_english\\_web.pdf](http://www.ippf.org/sites/default/files/sdg_a_srhr_guide_to_national_implementation_english_web.pdf)

**Image 2. Actions for civil society to move forward the SDGs and SRH&R (1).**

This flow chart illustrates some of the steps you can take to turn the 2030 Agenda into action through advocacy, awareness raising and working in coalition.

### **REPORTING AND ACCOUNTABILITY**

- Advocate for your government to report on progress made in a timely and transparent way
- Conduct your own research at national and community level
- Draft shadow reports on progress and track budgets
- Support the establishment of and take part in accountability mechanisms at national, regional and global levels

### **MAKE A PLAN**

- Ask the government where it is with the implementation process
- Volunteer to be on any reference groups or oversight mechanisms
- Identify which team/ministry is responsible for the SRHR targets, and if it links to an existing mechanism or commitment
- Develop a plan to promote and monitor the implementation of the Agenda, especially for goals 3 and 5

### **WORK WITH OTHERS**

- Identify allies at a national level who can support you in your advocacy
- Think beyond your usual partners and reach out to researchers, international human rights institutions, academics, economists and other networks

### **RAISE AWARENESS**

- Identify your priority areas for action on SRHR
- Press your government to start awareness raising in Parliament and the media
- Start a public awareness campaign about the Agenda and how it will help achieve good health outcomes and gender equality

# USING HUMAN RIGHTS INSTRUMENTS TO ADVANCE SEXUAL AND REPRODUCTIVE HEALTH AND IMPLEMENTATION OF THE SUSTAINABLE DEVELOPMENT GOALS IN IRELAND

The Irish Family Planning Association (IFPA) has worked to promote and protect human rights in relation to sexual and reproductive health, relationships and sexuality since 1969. Our work is underpinned by the vision that women have a right to the highest standard of reproductive health. The IFPA has always interpreted this vision as requiring us not only to provide accessible, high quality services, but to advocate for rights-based women-centred policies, programmes and services in Ireland and globally and to challenge laws and policies that act as barriers to access to sexual and reproductive health and rights.

One of the key human rights strategies we use is to provide submissions to the expert bodies that periodically monitor the implementation of the international human rights treaties, covenants and conventions to which Ireland is a signatory. These include the International Covenant on Civil and Political Rights (ICCPR); the International Covenant on Economic, Social and Cultural Rights (CESCR); the UN Convention on the Rights of the Child (UNCRC), which have all examined Ireland's human rights record in the last two years and the UN Committee on the Elimination of Discrimination against Women (CEDAW), which will review Ireland in February 2017. These bodies have well-developed interpretations of the content of sexual and reproductive health and rights and their reviews of national level compliance with human rights norms involve close scrutiny of domestic implementation of international obligations to assess whether and to what extent states are genuinely translating rhetorical human rights obligations into effective implementation measures. They bring the normative power of international human rights law to bear on the domestic policies that determine individuals' experience of sexual and reproductive health and their enjoyment of human rights.

In the context of review of national level implementation of Agenda 2030, these processes provide an already existing

mechanism to ensure that the Sustainable Development Goals (SDGs), targets and indicators relevant to sexual and reproductive health can be monitored according to the norms and in the spirit of the transformative human rights vision that underpins the global agenda. As spaces where engagement by civil society is integral to the work of the expert committees, they also afford opportunities to non-governmental organizations to work through collaborative, inter-sectoral approaches.

In their examination of reports provided by the state, the expert committees rely on submissions provided by national human rights institutions, human rights organizations, service providers and rights holders groups. Organizations like the IFPA, therefore, can use our role as a service provider to submit context-specific and detailed information on government policy. For example, in advance of Ireland's upcoming review by the CEDAW Committee, the IFPA worked within the Women's Human Rights Alliance, an umbrella group of non-governmental organizations, that includes organizations such as the Irish Council for Civil Liberties and the National Women's Council of Ireland, to make a collective submission to the Committee in relation to its preparation of a list of issues (LOI) for consideration by the Government. The LOI asks the state to report on measures to expand access to abortion and to ensure "the accessibility, availability and affordability of modern contraceptive methods and family planning services, as well as to facilitate access by women and girls to health services and, in particular, reproductive health services." We are now preparing a detailed submission on these questions from a health service provider perspective and we will provide more information on these issues. The interactive dialogue with the State in early 2017 will result in a set of observations and recommendations to the State, which we expect to build on the criticisms of lack of implementation of sexual and reproductive health and rights made in other human rights reviews.

In carrying out our work, the IFPA prioritizes cross-sectoral ways of working, such as participation in alliances and coalitions. We support other organizations to engage with human rights processes, for example by contributing to their submissions or by inviting organizations to endorse collective statements. We see this as the most effective way to strengthen the body of evidence on sexual and reproductive health and rights that is brought to the expert monitoring groups. These processes also create a critical space for challenge, dialogue and mutual learning between civil society organizations where we can address the taboo and stigma that has often surrounded sexual and reproductive health and rights. We have seen a significant shift from a time where many organizations considered reproductive health as somehow out of place in human rights advocacy, to the current situation where these issues are more normalized and are discussed with more respect and greater understanding of their centrality to women's human rights and empowerment.

Human rights advocacy gives voice to the experiences of the women and girls who use our services. It ensures that the treaty monitoring bodies are well-informed to engage critically in dialogue with the State about sexual and reproductive health and rights. Since civil society engagement in Ireland has resulted in ever-increasing media coverage of and increased public and political interest in human rights processes, reviews by UN committees also serve to raise the public profile of the right to universal reproductive health, Ireland's poor sexual and reproductive health and rights record and to public debate on these issues.

Human rights monitoring can also provide a bridge between overseas development agencies that have experience of monitoring global development goals and organizations focusing on national level policy that must now be involved in monitoring the SDGs. As an organization that has been actively involved in advo-



**Text Box 1. Sample of recommendations to Ireland on SRH&R by UN Treaty Monitoring Bodies.**

**UN COMMITTEE ON THE RIGHTS OF THE CHILD (CRC) 2016 (1)**

In the light of its general comment No.4 (2003) on adolescent health, the Committee recommends that the State party:

- (a) Decriminalize abortion in all circumstances and review its legislation with a view to ensuring children’s access to safe abortion and post-abortion care services; and ensure that the views of the pregnant girl are always heard and respected in abortion decisions;
- (b) Develop and implement a policy to protect the rights of pregnant teenagers, adolescent mothers and their children and combat discrimination against them;
- (c) Adopt a comprehensive sexual and reproductive health policy for adolescents and ensure that sexual and reproductive health education is part of the mandatory school curriculum and targeted at adolescent girls and boys, with special attention on preventing early pregnancy and sexually transmitted infections; and,
- (d) Take measures to raise awareness of and foster responsible parenthood and sexual behaviour, with particular attention to boys and men.

**UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS 2015 (2)**

The Committee recommends that the State party take all necessary steps, including a referendum on abortion, to revise its legislation on abortion, including the Constitution and the Protection of Life During Pregnancy Act 2013, in line with international human rights standards; adopt guidelines to clarify what constitutes a real substantive risk to the life of a pregnant woman; publicize information on crisis pregnancy options through effective channels of communication; and ensure the accessibility and availability of information on sexual and reproductive health.

**UNITED NATION’S HUMAN RIGHTS COMMITTEE 2014 (3)**

The State party should:

- (a) Revise its legislation on abortion, including its Constitution, to provide for additional exceptions in cases of rape, incest, serious risks to the health of the mother, or fatal foetal abnormality;
- (b) Swiftly adopt the Guidance Document to clarify what constitutes a “real and substantive risk” to the life of the pregnant woman; and
- (c) Consider making more information on crisis pregnancy options available through a variety of channels, and ensure that healthcare providers who provide information on safe abortion services abroad are not subject to criminal sanctions.

**COMMITTEE ON THE ELIMINATION OF DISCRIMINATION AGAINST WOMEN 2005 (4)**

While acknowledging positive developments in the implementation of article 12 of the Convention, in particular the Strategy to Address the Issue of Crisis Pregnancy (2003) that addresses information, education and advice on contraceptive services, the Committee reiterates its concern about the consequences of the very restrictive abortion laws under which abortion is prohibited except where it is established as a matter of probability that there is a real and substantial risk to the life of the mother that can be averted only by the termination of her pregnancy.

The Committee urges the State party to continue to facilitate a national dialogue on women’s right to reproductive health, including on the very restrictive abortion laws. It also urges the State party to further strengthen family planning services, ensuring their availability to all women and men, young adults and teenagers.

cating for the sexual and reproductive health and rights of the Irish population we look forward to working collaboratively with such organizations to ensure that implementation and monitoring of the SDGs in Ireland proceeds in a manner that benefits us all.

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**References**

1. Committee on the Rights of the Child, 71st Session, Concluding Observations: Ireland, UN Doc CRC/C/IRL/CO/3-4, 29 January 2016.
2. Committee on Economic, Social and Cultural Rights, 55th session, 1 – 19 June 2015, Concluding Observations: Ireland, UN Doc E/C.12/IRL/CO/3, 19th June 2015.
3. Human Rights Committee, 111th Session, Concluding Observations: Ireland, UN Doc CCPR/C/IRL/CO/4, 19 August 2014.
4. Committee on the Elimination of Discrimination against Women, 33rd session, Concluding Comments: Ireland, UN Doc CEDAW/C/IRL/CO/4-5, 13 July 2005.

# ADVANCING SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRH&R) IN THE REGION OF VÄSTRA GÖTALAND, SWEDEN

**Intersectoral collaboration for improving sexual and reproductive health (SRH) is easier said than done. The new and revised Sustainable Development Goals help place focus on issues, including those related to SRH, that require a long term commitment on both a strategic level and in everyday situations. This article will highlight the work being carried out by the Swedish region of Västra Götaland as we implement an intersectoral approach to address these issues, as well as provide some insight into future challenges.**

The region of Västra Götaland is, with its 1.6 million inhabitants and 49 municipalities, one of the largest regions in Sweden with health care as its primary responsibility. Organizations of this size demand collaboration, structures and common goals to provide equal care for all its inhabitants. At a first glance the Swedish healthcare system appears to provide extensive access and quality of care for all. However, there are groups falling short.

Sexual health is an important part of general health and Swedish definitions of sexual health, sexual rights, reproductive health and reproductive rights are based on the existing international conventions.

There is a growing consensus that sexual health cannot be achieved and maintained without respect for, and protection of, certain human rights. This is the reason for the region of Västra Götaland's commitment to sexual and



reproductive health and rights (SRH&R) with emphasis on the second R.

## **SRH&R and health equity**

The seventh target under the third Sustainable Development Goal is:

*“By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.”*

Universal access depends on how SRH services are organized; on availability and equal opportunities regardless of sex, transgender identity or expression, ethnicity, religion or other beliefs, disability, sexual orientation or age. Inequities in SRH are known in terms of outcomes, but underlying mechanisms and structures are less explored. Examples of the unjust outcomes as a result of inequity include: the prevalence of sexually transmitted infections (STIs) among select populations; the disproportionate exposure to violence and higher rates of mental health challenges in lesbian, gay, bisexual and transgender populations; and in the lack of SRH care for men, to mention a few.

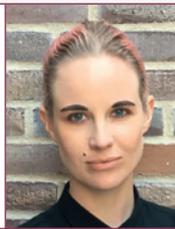
A lack of knowledge about how these underlying mechanisms and structures are maintained and reproduced results in initiatives and measures that tend to be reactive rather than proactive. SRH&R related inequities are especially challenging due to the many taboos inherent within the field. Health care personnel are often reluctant to address sexual issues for reasons that vary from lack of knowledge, to fear of offending the patient and concern about time restraints. This reluctance to openly address SRH&R directly affects the care provided, for example, by assuming heterosexuality, failing to offer testing

and treatment for STIs at relevant sites of care or prescribing physicians failing to mention side effects of medications that may affect sexual function and sexuality. This reluctance also manifests itself in ideas about culture and who is willing to talk about sexuality. Such ideas easily transform into arguments as to why healthcare personnel should avoid questions concerning sexuality. However, in contrast to common beliefs, most people want to be asked about their SRH when it is relevant.

## **An intersectoral approach for SRH&R**

From a SRH perspective, a population is a group of individual rights holders where everyone is entitled to information and service based on their needs and abilities. The healthcare system thus holds the responsibility to promote, protect and fulfill these rights. In the region of Västra Götaland there are five organizational bodies that work with areas linked to SRH&R on a strategic level. Two political committees work with public health and human rights and three centres of excellence are specialized in SRH&R, equal care and intimate partner violence. Each of these organizational bodies have their specific area of expertise and responsibility to suggest changes in the organization of healthcare at large.

Närhälsan Knowledge Centre for Sexual Health (hereafter called the Centre) was established in 2008 with the mission to prevent STIs, including HIV and hepatitis, but soon broadened its work to include the whole area of SRH&R. The Centre works with organizational development, research, education and project management primarily within healthcare, with the aim to make SRH&R available to those with limited access. A key to



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success is the Centre's location within the primary care setting, closely linked to the clinics. This enables a fast track communication between clinical and non-clinical staff, in which the Centre gets input for new projects that ultimately results in developmental work based on the needs expressed by the clinics. One important arena for this communication are the four local networks for SRH&R, with representatives from different areas including, among others, gynaecology, maternity care, youth clinics, school health care and public health. The networks gather four times a year, are coordinated by the Centre and cover the whole region of Västra Götaland. A great example of the efficacy of the networks is the introduction of emergency contraceptives at high schools. At a network meeting the representative for school health care requested the ability to provide emergency contraceptives to students and through participation of the chief physician of maternity care this could be approved immediately.

To make informed decisions about one's SRH people must have enough knowledge and there must be clinics available to provide the services needed. This does not necessarily mean the opening of new clinics, but rather extensive work focused on implementing an SRH&R perspective within the primary health care. The Centre emphasizes this approach in several ways. One of the most successful examples is the Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) clinic certification. To date just under 300 clinics in the Region have undergone the process that leads to certification, including training, group discussions and developmental tasks tailored to the clinic in question. The purpose of the LGBTQ certification is to guarantee a professional and respectful environment for LGBTQ patients and staff members. The work that takes place on a clinical level is a beginning, but other measures must be taken on a structural level. This includes for example how the medical records are structured in terms of gender. Today there is no registration option for non-binary persons, which makes it

impossible for people who have changed their national identification number from female to male to be listed as a patient within maternity care clinics. With regard to this matter the Centre has initiated a pilot project with the aim to make the health care system accessible by all means to transgendered people.

To respect the rights of the individual, clinics must ensure all aspects of accessibility and remove barriers related to language, physical access and socioeconomic status. To identify these barriers it is crucial to involve key populations in the process. One way of doing that is by a close collaboration with local NGOs. The NGOs can also function as a complement to the public health care. One example is the establishment of an anonymous test point for HIV and Syphilis, funded by the Centre. Since it's not possible to be tested anonymously within the healthcare system, this is a way of reaching populations that otherwise wouldn't get tested. In Sweden the utter responsibility for healthcare lies upon Public Service, but this can be seen as a way of making the healthcare more accessible to the population. However, not all key populations are organized and represented in already existing structures, demanding other strategies. Therefore the Centre cooperates and collaborates closely with both actors within the field of social work and the municipality in order to develop projects that reach all of the population. One of the current common projects is SRH&R training for language interpreters. Language has been identified as a barrier when it comes to making SRH&R accessible for newcomers and interpretations within this field can easily become offensive without proper training.

### How to move forward

The Sustainable Development Goals and other international agreements are needed to put pressure on the local authorities but is in itself not enough to move forward. We need both national and regional political will to make a true difference in the regional healthcare. To provide universal access we must under-

stand the underlying mechanisms for inequalities in SRH&R, we must talk with our right holders to understand intersections between groups and how this affects individuals' possibilities to realize their rights and adapt our systems for health-care service.

The next step for the region of Västra Götaland is to develop a regional SRH strategy that provides a mandate to change existing structures and facilitate collaboration between different parts of the organization as well as different medical specialties. The Centre is proud to have been assigned this task by the Regional Council in June 2016. This is an extensive work that ultimately should result in implementation of new approaches in the meeting between patient and healthcare personnel. When each and every patient feel that we can meet their individual needs and rights we have reached our goal.

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**Image1. The region of Västra Götaland Clinic nurses at the annual PRIDE parade, 2016. Photo by Jessica Bentssen**

# SEXUAL VIOLENCE AGAINST REFUGEE WOMEN ON THE MOVE TO AND WITHIN EUROPE

## The refugee crisis

Europe has encountered a refugee crisis in recent years due to continuing conflicts and human rights violations in many countries. This has led to the displacement of millions of people, who seek refuge in Europe (1). The majority of these refugees arrive in Greece or Italy and mainly originate from Syria, Afghanistan and Iraq (2). Since January 2016 women and children account for more than 55% of people travelling on the migration route, attempting to reunite with their families in Europe (2, 3).

**The objective** of this overview is to present the issue of sexual violence (SV) against refugee women and girls and to discuss countermeasures that have been suggested or initiated by the Member States of the WHO European Region and national nongovernmental organizations (NGOs) between January 2015 and May 2016. A literature review was undertaken using Google scholar, the WHO publication database and a cross-search of journal databases.

## The issue of SV for refugee women

The refugee crisis is particularly challenging for women and girls and becomes increasingly difficult as tightened immigration policies and border controls in Europe and along the western Balkan route, overcrowded reception centres, delayed processing times for asylum applications and restricted family reunifications further increase their vulnerability to SV. Men and boys can also be subjected to SV (2-3, 7-8). However, vulnerability differs between men and women due to gender inequality, which usually stems from traditional gender roles and behaviour expectations of men and women in societies, disadvantaging one gender over the other. For instance, women often have a lower status than men in many societies (7). Therefore, a gender-sensitive response by European Member States and NGOs is needed (3).

## Burden of Sexual Violence

Women living and fleeing from conflict areas require targeted intervention

Image 1. The western Balkan Migration Route (18).



measures due to their increased vulnerability. Women are particularly vulnerable in camps, when shelters are not secure and when they have to walk long distances to find basic items like firewood (9). Moreover, economic insecurity and lack of male protection increases the risk for SV (10). A study in 2014 estimated that around 21% of women in 14 conflict countries reported SV (11). Refugee women are affected by SV not only in areas of conflict but also on their journey to and once they arrive in Europe. While various reports call for action to address SV against refugee women, no comprehensive data on prevalence is available as much abuse is not reported by women or recognized by aid workers (12). SV against refugees often occurs in combination with physical, emotional or socio-economic violence. Both men and women seeking refuge in Europe are susceptible to different kinds of violence. Nevertheless, women are more likely to be subjected to SV compared to men (13). According to a study conducted in 2012, 69.3% of female migrants, including refugees, have experienced SV since they have entered Europe and acts were often perpetrated by European professionals or citizens. This is in stark contrast to the 11% lifetime prevalence of SV in European girls and women aged over 15 and indicates the possible magnitude of the issue of SV against refugee women in Europe (14, 15).

## Risks on the journey to Europe

In 2015 and early 2016, most refugees have travelled by sea from Turkey to Greece and then continued overland through the western Balkans into their destination countries, particularly Germany and Sweden (see Image 1). Women and girls, travelling alone or female headed households with children are particularly vulnerable to SV (3, 12).

According to reports, women and girls have been forced to marry to obtain male protection or to engage in 'survival' sex in exchange for documents or transport. However, humanitarian and government interventions often did not adequately focus efforts against SV as it was not perceived as a priority due to lack of data (12). In transit countries like the former Yugoslav Republic (FYR) of Macedonia and Serbia, the registration system for refugees has been found to be inadequate in identifying vulnerable women and girls. Moreover, weak coordination between government and humanitarian actors challenge a comprehensive and gender-sensitive response and referral system (16). Lack of information and unnecessary detention also puts women at increased risk for SV during their entire journey (8).

Since the border closure in March 2016, over 45 000 refugees remain stranded in Greece without adequate accommodation, facilities, medical care and information about their rights. Moreover,



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### Text Box 1. Key Facts about refugees in Europe.

#### KEY FACTS

- 55% of refugees on the move are female.
- Women and girls are at increased risk of SV.
- The border closure of countries along the western Balkan route has further put female refugees at risk of SV.
- Denying female refugees protection against SV is a human rights violation.
- More data and research is needed to estimate SV prevalence.

the identification and referral of vulnerable refugees remains problematic due to a lack of guidelines and operating procedures (17). Consequently, many women and girls are unable to find protection, a safe passage to Europe and cannot reunite with families. This further increases their risk to SV as they become vulnerable to exploitation by traffickers and smugglers as they try to reach Europe by other routes illegally (8, 17) (see Text Box 1).

#### Risks within Europe

Sweden and Germany have been accepting most refugees. However, the incoming refugee population has overwhelmed both countries and accommodation and support services are inadequately equipped to respond to gender-sensitive issues. Moreover, essential European Union Directives for the protection of vulnerable people have been hard to implement in Germany to date. There are also no standardized procedures present to identify and support victims of SV. Therefore, support and help is only provided according to the judgment of the individual aid care worker. Although Sweden and Germany have ratified the Istanbul Convention, which provides details on how to protect refugees, accommodation centres have often failed to provide basic security measures like separate lockable rooms. The large influx of new arrivals has further led to overcrowded reception centres, which challenges the ability to provide safe, private and separate spaces for female refugees, increasing the risk for violence. Perpetration of SV has been reported, not only by fellow refugees but also by security guards and

volunteers, complicating the situation. This has been documented at various accommodation centres. The language barriers also contribute to a lack of information on basic rights, available services and support (3). Therefore, multiple risks are present and increase the likelihood of women and girls to be subjected to SV (13).

#### Consequences

SV can result in unintended pregnancy and sexually transmitted infections (STIs) including HIV. In addition, it can adversely affect the mental health of women and lead to post-traumatic stress disorder, anxiety and depression (4). Moreover, stigma and shame associated with rape in many cultures can lead to underreporting of cases, social rejection, suicide or murder of women and girls by family or community members (9). Women and girls who have been subjected to SV in their lives are also prone to subsequent exposure to SV, which further aggravates health outcomes for women and girls long-term (14).

#### Best Practice and Recommendations

##### Response

##### General guidelines against SV

1. The WHO clinical and policy guidelines: “*Responding to intimate partner violence and sexual violence against women*” recommends (19):

- A comprehensive medical examination;
- First-line support;

- Protection from further harm;
- Timely referral to appropriate services like psychosocial support;
- Provision of emergency contraception and STI prevention e.g. HIV post-exposure prophylaxis;
- Follow-up care and support plan;
- Confidential, supportive and non-judgmental services;
- A gender-sensitive sexual assault care training for health care providers; and
- Sexual assault care service provision integrated with other health care services.

Women subjected to SV require immediate emotional and physical health services and ongoing support in regard to safety and mental health. Health care providers have a vital role in the recognition, treatment and referral of SV victims.

#### SV guidelines specific for refugees

According to the guidelines on prevention and response to SV against refugees provided by the UN Refugee Agency (20), confidentiality, providing safety and protection from further suffering, as well as, acting in the best interest and according to the wishes of the victim are crucial.

Further recommendations include:

- Private consultations with vulnerable refugee women by a social or health workers if SV is suspected;
- Creation and facilitation of women’s groups and associations as an effective and safe channel for women to report SV cases;
- Provision of same gender medical staff;
- Ensuring a gender and cultural sensitive conduct with SV victims; and
- Informing refugee women about their rights.

The WHO document, “*Preventing and addressing intimate partner violence against migrant and ethnic minority women*” (21) also recommends:

- A multi-level and multi-sectoral approach to address the inequities in access to care and services in relation to SV;

# SEXUAL VIOLENCE AGAINST REFUGEE WOMEN ON THE MOVE TO AND WITHIN EUROPE

(CONTINUED)

- Policies affecting refugee women require a gender perspective;
- Involvement of stakeholders, funding and a reduction of barriers to health care and service access;
- Involvement of migrant communities to allow for empowerment;
- Cooperation and network building between health sector, NGOs and the civil society to allow for stronger coordination;
- Targeting the socioeconomic, cultural and environmental determinants of the health of refugees;
- More investment in research due to a limited evidence base; and
- Removal of institutional discrimination and barriers to access of services (21).

## Prevention

To avert SV, health care providers could also play an important part in the coordination and implementation of SV prevention measures against refugee women. Nevertheless, effective prevention will also require the involvement of different stakeholders including legal, social, health organizations and civil society (21). Guidelines for the prevention and response of gender-based violence (GBV) can also be useful for the prevention of SV against refugee women.

## Creating Safe Environments

Current recommendations for the primary prevention of GBV and SV include measures that address the causes and contributing factors of GBV and SV in refugee settings, aim to transform sociocultural norms through the creation of employment opportunities for refugee women and rebuild family and community structures. In addition, provision of safe and effective services and facilities like creating safe and well lit accommodation centres and the cooperation with the legal system to prosecute perpetrators are crucial and mentioned in most guidelines of international organizations. Moreover, monitoring, proper documentation of incidents and education campaigns raising

## Text Box 2. Key actions to prevent SV against refugees.

### KEY ACTIONS

- Implement relevant Directives and apply best practice guidelines.
- The European Member States, NGOs and women's organizations need to cooperate more to protect female refugees as best as possible.
- Create legal passages and safe environments.
- Collect more specific data and invest in research to investigate SV against female refugees.

awareness about GBV and SV have been suggested (22).

The risk of SV increases with large accommodation centres. Therefore, prevention measures need to include smaller accommodation centres with lockable rooms and separate sanitary facilities and a gender balanced staff team, which should be trained in culture and gender-sensitivity and violence prevention and response. Moreover, information sessions to refugees that support integration and the provision of women-only spaces in reception centres have further been recommended (23).

## Legal Passage

Ensuring greater access to legal passage into Europe is a crucial step to prevent refugee women from being exploited by smuggling networks. It also aids to secure the fundamental rights of refugee women. The following options could be used to create legal passage:

- Granting temporary protection;
- Support resettlement or humanitarian aid programmes;
- Find alternative channels to speed up family reunification i.e. humanitarian visa;
- Granting a labour or study visa; and
- Offer medical evacuation programmes (24).

## Refugees' engagement

Last but not least, a greater engagement and participation of refugee women in any decisions or activities that aim to protect them against SV is encouraged to better address concerns and improve protection. Activities, campaigns and programmes against GBV, including SV also

benefit from the engagement of men and boys as gender inequality cannot be addressed without their participation (25).

## Relevant Policy Frameworks

- European parliament resolution calls for a gender-sensitive adoption of asylum policies and procedures (26).
- The draft *Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region 2016–2022* addresses the vulnerability of refugees to violence (27).
- The *Global plan of action to strengthen the role of the health system to address interpersonal violence, in particular against women, girls and children* advocates for a multi-sectoral, evidence-based and comprehensive response and prevention strategy (28).
- The draft *Action Plan for Sexual and Reproductive Health for the fulfillment of the 2030 Agenda for Sustainable Development in Europe* will protect against SV with a rights-based and life-course approach (29).

Several NGOs are also committed to providing appropriate response measures. Medica Mondiale for example, has established vast partnerships with other grassroots organizations in several countries and provides protective services in response to SV victims across the Syrian-Turkish border. Women in Exile, another NGO in Germany, supports asylum seeking women, living in social housing by engaging and empowering them in the struggle against SV. Consequently, a stronger cooperation with NGOs has been suggested to respond to the needs of

vulnerable female refugees more comprehensively (8).

### Conclusion

Refugee women and girls are always at risk of SV on the entire journey to find refuge. Many European countries have been overwhelmed by the refugee influx. Furthermore, prevention and response measures for SV against refugee women have been insufficiently implemented. Additionally, the closure of the western Balkan migration route has further increased the risk of SV for female refugees. Greater efforts are still needed to ensure that the human right to safety and protection is provided to female refugees. This requires political will, a shared responsibility as well as a stronger cooperation of the European countries and other stakeholders, and the implementation of essential Directives and guidelines of best practice. Greater attention to surveillance of SV in refugees, to research and evaluation of services is also required (see Text Box 2).

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### References

1. Purvis C. *Europes Refugee Crisis Policy Brief*. London: IRC, 2015.
2. Bonewit A. *Reception of female refugees and asylum seekers in the EU case study Germany*. Brussels: Policy Department C Citizens Rights and Constitutional Affairs European Parliament, 2016.
3. *Falling Through the Cracks: Refugee Women and Girls in Germany and Sweden*. New York: Women's Refugee Commission, 2016.
4. Krug EG, Dahlberg LL, Mercy JA. *World report on violence and health*. Geneva: WHO, 2002.
5. <http://www.unhcr.org/55df0e556.html>
6. <http://www.un.org/womenwatch/osagi/conceptsanddefinitions.htm>
7. *Violence prevention, the evidence*. Geneva: WHO, 2009.
8. *Women Refugees at Risk in Europe*. Nobel Women's Initiative, 2016.
9. Hynes M, Lopes Cardozo B. Observations from the CDC: Sexual Violence against Refugee Women. *J Womens Health Gender Based Med* 2000; 9(8): 819-823.
10. Chynoweth SK. The Need for Priority Reproductive Health Services for Displaced Iraqi Women and Girls. *Reprod Health Matters* 2008; 16(3): 93-102.
11. Hossain M, Zimmerman C, Watts C. Preventing violence against women and girls in conflict. *Lancet*. 2014; 383: 2021-2022.
12. Eapen R, Falcione F, Hersh M et al. *Initial assessment report: Protection Risks for Women and Girls in the European Refugee and Migrant Crisis Greece and the former Yugoslav Republic of Macedonia*. UNHCR, UNFPA, WRC, UNFPA, 2015.
13. Keynaert I, Dias SF, Degomme O et al. Sexual and gender-based violence in the European asylum and reception sector: a perpetuum mobile? *Eur Journal Public Health* 2014; 25(1): 90-96.
14. Keynaert I, Vettenburg N, Temmerman M. Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. *Cult Health Sex* 2012; 14(5): 505-520.
15. Keynaert I, Guieu A. What the eye does not see: a critical interpretative synthesis of European Union policies addressing sexual violence in vulnerable migrants. *Reprod Health Matters* 2015; 23(46): 45-55.
16. Wolfensohn G. *Gender assessment of the refugee and Migration Crisis in Serbia and FYR of Macedonia*. Istanbul: UN Women, 2016.
17. *Trapped in Greece an avoidable refugee crisis*. London: Amnesty International Publications, 2016.
18. Lilyanova, Velina. *Briefing January 2016, The Western Balkans: Frontline of the migrant crisis*. PE 573.949. European Parliamentary Research Service (EPRS), 2016.
19. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva:WHO, 2013.
20. *Sexual Violence against refugees. Guidelines on Prevention and Response Geneva 1995*. Geneva: UNHCR, 1995.
21. Vives-Cases C, La Parra D, Goicolea I et al. *Preventing and addressing intimate partner violence against migrant and ethnic minority women: the role of the health sector*. Policy Brief. Copenhagen: WHO, 2014.
22. Asgary RE, Wong M. Systematic review of prevention and management strategies for the consequences of gender-based violence in refugee settings. *Int Health* 2013; 5: 85-91.

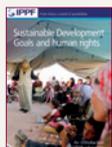


**Sustainable Development Goals. A SRHR CSO guide for national implementation, IPPF, 2015.**

This excellent publication clearly outlines the new 2030 Development agenda and articulates specific actions civil society organizations can take to ensure that progress in sexual and reproductive health and rights continues at the national level.

Available in English at:

[http://www.ippf.org/sites/default/files/sdg\\_a\\_srhr\\_guide\\_to\\_national\\_implementation\\_english\\_web.pdf](http://www.ippf.org/sites/default/files/sdg_a_srhr_guide_to_national_implementation_english_web.pdf)



**Sustainable Development Goals and human rights. An introduction for SRHR advocates, IPPF, 2016.**

A follow up to the publication above, this factsheet provides clear examples of the linkages between the SDG agenda and human rights, highlighting how advocates in the field of SRH can utilize these linkages to move forward the SRH and rights agenda.

Available in English at:

[http://www.ippf.org/sites/default/files/2016-06/SDGs\\_Human\\_Rights.pdf](http://www.ippf.org/sites/default/files/2016-06/SDGs_Human_Rights.pdf)



**Ensure Healthy Lives and Well-being for All: Addressing Social, Economic and Environmental Determinants of Health and the Health Divide in the Context of Sustainable Human Development, UNDP, 2014.**

Through a review of UNDP's programmes and activities on the ground, this publication provides key insights as to how best to integrate health and development through an intersectoral approach in order to achieve well-being and health equity for all.

Available in English at:

<http://www.eurasia.undp.org/content/dam/rbec/docs/UNDP-RBEC-HIV-SEEDS.pdf>



**UNDP Policy and Programme Brief. UNDP support to the implementation of the 2030 agenda for sustainable development, UNDP, 2016.**

Focusing on the cross cutting elements of partnerships, data and accountability this document outlines the principle of MAPS (Mainstreaming, Acceleration and Policy Support) that can be used intersectorally to reduce health inequities and promote well-being and sustainable development globally. Available in English at: [http://www.undp.org/content/dam/undp/library/SDGs/SDG%20Implementation%20and%20UNDP\\_Policy\\_and\\_Programme\\_Brief.pdf](http://www.undp.org/content/dam/undp/library/SDGs/SDG%20Implementation%20and%20UNDP_Policy_and_Programme_Brief.pdf)



**The sustainable development goals are coming to life. Stories of country implementation and UN support, UNDG, 2016.**

This publication provides key insights into the range of actions and partnerships, including increased levels of coherence across policy areas and between levels of government, taken at country level, including countries of Europe, to implement the SDG agenda, including SRHR. Available in English at:

[https://undg.org/main/undg\\_document/the-sustainable-development-goals-are-coming-to-life/](https://undg.org/main/undg_document/the-sustainable-development-goals-are-coming-to-life/)



**Regional Committee for Europe 66th Session: Towards a roadmap to implement the 2030 Agenda for Sustainable Development in the WHO European Region, Working Document, WHO Regional Office for Europe, 2016.**

This working document for the upcoming 66th Regional Committee to be held in Copenhagen, Denmark summarizes the links between health, economic growth, social development, environmental protection, poverty and inequality reduction. It emphasizes the need for a whole of government and whole of society approach in order to promote health and well-being for the population of Europe. Available in English, German, French and Russian at: <http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/66th-session/documentation/working-documents/eurrc6617-towards-a-roadmap-to-implement-the-2030-agenda-for-sustainable-development-in-the-who-european-region>



**Transforming our world: the 2030 agenda for sustainable development, UN, 2012.**

The new development agenda post 2015 is presented in this report, highlighting the need for an intersectoral approach in order to attain the goals set out in the agenda for the global world, including those related to health and SRH. Available in English at:

<https://sustainabledevelopment.un.org/post2015/transformingourworld/publication>



**Noncommunicable diseases prevention and control in the South-eastern Europe Health Network. An analysis of intersectoral collaboration, WHO Regional Office for Europe, 2012.**

The evidence demonstrating the linkages between NCDs and SRH are well recognized, This document highlights how an intersectoral approach enabled the successful prevention and control of NCDs in Europe. Available in English at:

<http://www.euro.who.int/en/publications/abstracts/noncommunicable-diseases-prevention-and-control-in-the-south-eastern-europe-health-network.-an-analysis-of-intersectoral-collaboration-2012>



**Health in All Policies. Seizing opportunities, implementing policies, European Observatory on Health Systems and Policies, National Institute for Health and Welfare and Ministry of Social Affairs and Health, Finland, 2013.**

Although not specific to SRH, this document presents the challenges and benefits associated with incorporating an intersectoral health in all policy approach to improve population health and health equity. Available in English and Russian at:

<http://www.euro.who.int/en/about-us/partners/observatory/publications/studies/health-in-all-policies-seizing-opportunities,-implementing-policies>



**Promoting intersectoral and interagency action for health and wellbeing in the WHO European Region: synergy among the health, education and social sectors. Meeting Report, Paris, France, 24 April 2015, WHO Regional Office for Europe, 2015.**

This easily readable report provides a concise summary of the approaches, preconditions and common challenges to implementation of intersectoral action for health and well-being with the education and social sectors. Available in English at:

[http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0007/286504/Promoting-intersectoral-and-interagency-action-for-health-and-well-being-in-the-WHO-European-Region\\_Paris.pdf](http://www.euro.who.int/__data/assets/pdf_file/0007/286504/Promoting-intersectoral-and-interagency-action-for-health-and-well-being-in-the-WHO-European-Region_Paris.pdf)



**Beyond the mortality advantage. Investigating women's health in Europe, WHO Regional Office for Europe, 2015.**

This brief report presents the underlying characteristics and factors associated with poor or positive health for women across the lifespan in Europe, highlighting the need for intersectoral action in order to address the broader determinants affecting health to achieve positive SRH and rights for the women of Europe. Available in English and Russian at:

<http://www.euro.who.int/en/health-topics/health-determinants/gender/publications/2015/beyond-the-mortality-advantage.-investigating-womens-health-in-europe>



**Young people's health as a whole-of-society response – series, WHO Regional Office for Europe, 2011.**

This series of publications summarizes current knowledge and policies, actions/interventions on what works in promoting the well-being of adolescents, including social and emotional well-being, chronic conditions and disabilities, adolescent pregnancy, HIV/STIs, overweight and obesity, violence, injuries and substance abuse. It is a useful tool to facilitate and strengthen innovative ways of working across sectors to achieve this goal. Available in English at: <http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2012/young-peoples-health-as-a-whole-of-society-response-series>



**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/rmncch-human-rights/en/](http://www.who.int/reproductivehealth/publications/gender_rights/rmncch-human-rights/en/)



**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, promotes a holistic life course approach that is built around equity, gender, human rights, improved governance for health and collaboration across sectors. It provides European politicians and policy-makers with key strategic advice to support action for health and well-being. Available in English, German, French and Russian at:

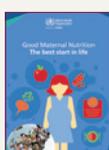
<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/health-2020.-a-european-policy-framework-and-strategy-for-the-21st-century-2013>



**Health 2020 Sector Briefs: intersectoral action for better health and well-being, WHO Regional Office For Europe, 2015.**

Developed as part of the implementation package for Member States for Health 2020, these sector briefs present evidence of the relationships between education, foreign policy, social protection, transport and health and the need for coherent and effective intersectoral action for the promotion of health and well-being for all. Available in English, French, German and Russian at:

<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/implementation-package/1.-introducing-health-2020-to-different-stakeholders-across-sectors/sector-briefs-intersectoral-action-for-better-health-and-well-being>



**Good Maternal Nutrition. The best start in life, WHO Regional Office for Europe, 2016.**

Summarizing the results of a survey in which 51 of the 53 Member States in the WHO European Region took part, this publication presents opportunities for action and collaboration between health providers, civil society, policy makers and governments to promote nutrition and health throughout the life-course. Available in English and Russian at:

<http://www.euro.who.int/en/health-topics/disease-prevention/nutrition/publications/2016/good-maternal-nutrition.-the-best-start-in-life-2016>

## Upcoming events

**66th session of the WHO Regional Committee for Europe, 12–15 September 2016, Copenhagen, Denmark, WHO Regional Office for Europe.**

Further information available at: <http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/66th-session>

**Meeting of working group on the technical preparation of the 2017 international conference on sexuality education (29–30 May in Berlin), 30 September 2016, 10am–5 pm. Cologne, Germany, BZgA.**

Further information available at: [Laura.Brockschmidt@bzga.de](mailto:Laura.Brockschmidt@bzga.de)

**High-level conference on working together for better health and well-being, 7–8 December 2016, Paris, France. WHO Regional Office for Europe and the Ministry of Social Affairs and Health of France.**

Further information available at: <http://www.euro.who.int/en/media-centre/events/events/2016/12/high-level-conference-on-working-together-for-better-health-and-well-being>

## *Entre Nous*

*The European Magazine  
for Sexual and Reproductive Health*

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