FROM SEXUAL AND REPRODUCTIVE ILL-HEALTH TO CHOICES AND WELL-BEING
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I would like to begin this editorial by thanking everyone for their support and active involvement in the development of the “Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind”. Despite the diverse beliefs and attitudes towards sexual and reproductive health (SRH) and rights in the WHO European Region, the Action plan and its resolution were adopted by the 66th session of the WHO Regional Committee for Europe in September 2016. Three countries - Hungary, Poland and Turkey - disassociated themselves from the Action plan. Full consensus was not achieved, however the core message that in the 21st century the European Region is ready to discuss the positive aspects of SRH using a life-course approach remained intact. This was in large part due to the hard work and dedication of many people and organizations involved in drafting the document. The adopted document is not a “must” to all but is based on available evidence meant to inspire countries and people to acknowledge that achieving full potential for SRH and well-being is not possible without: 1) respecting the human rights related to SRH; and 2) implementing suggested actions to decrease the SRH inequities and inequalities between and within countries.

Thus it seems fitting that this shifting awareness and recognition of what is required to promote and achieve positive SRH and well-being for all be the main theme of this last issue of the European Magazine for Sexual and Reproductive Health “Entre Nous”.

During its 35 years of existence, Entre Nous presented readers with the existing challenges and successes in SRH within the Region. The magazine changed from the only source of information on SRH in the early 1980’s to a magazine that provides the trends in and overviews of different aspects of SRH through the life-course. From its initial beginnings prior to the International Conference on Population and Development in Cairo in 1994 to its conclusion during the era of the Sustainable Development Goals, magazine topics have been varied and relevant, ranging from preconception to pregnancy and safe motherhood; adolescent and youth SRH and rights; linkages between SRH and noncommunicable disease; child marriage; and the sexual health of older people. While not an exhaustive list of the topical issues that were covered, each issue of Entre Nous was designed to reflect the important and changing discourse and actions that were occurring over time with regards to the field of SRH and rights in the European Region.

The world has changed during the last 30-40 years. In 1991 the geography of Europe changed and the ability to question and discuss issues in SRH and rights became possible for countries that had not previously enjoyed this opportunity. Evidence based medicine in SRH lead to a transition away from a medical and narrow perspective of SRH to broader concepts of SRH that included health promotion, public health and human rights. During this period many substantial achievements in SRH, including maternal and newborn health, occurred. Yet, it is important for us all to acknowledge that these achievements have not been universal across our Region. We must not forget that much work and effort remains to achieve universal SRH and well-being for all.

What has been the role of Entre Nous in this process? It is not easily quantifiable. External and internal evaluations conducted by the Advisory Editorial Board Members, the UNFPA Regional Office for Eastern Europe and Central Asia and the WHO Regional Office for Europe have all documented overwhelming positive feedback and support for the magazine by readers and end users. One of our greatest achievements has been the breadth of end users who find the magazine pertinent - from policy makers to programme managers to service providers to civil society.

The digital age has transformed the way we learn and interact; webinars, e-learning and other modern methods of sharing knowledge and experience have replaced expensive congresses and conferences. With this new technical reality, bidding “farewell” to Entre Nous seemed appropriate.

I would like to extend a heartfelt thanks to everyone who has helped keep Entre Nous alive for so many years, who believe in better SRH for all and who have helped to make this goal a reality: our readers; our authors and our editors; members of our Editorial Advisory Board and of the European Regional Advisory Board in Research and Training in Reproductive Health; our sister agency UNFPA; and the WHO staff in Geneva and in the Regional Office for Europe. Although we are saying “adieu”, we will not be forgotten: a digital archive of all issues of Entre Nous will be available and downloadable at: http://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health/publications/entre-nous/entre-nous archive of all issues of Entre Nous will be available and downloadable at: http://www.euro.who.int/en/health-topics/Life-stages/sexual-and-reproductive-health/publications/entre-nous/entre-nous

This final issue of Entre Nous links the past with the future. It very much reflects the recently adopted vision from the Action Plan for Sexual and Reproductive Health that “The WHO European Region is a region in which all people, regardless of sex, age, gender, sexual orientation, gender identity, socioeconomic condition, ethnicity, cultural background and legal status, are enabled and supported in achieving their full potential for SRH and well-being; a region where their human rights related to SRH are respected, protected and fulfilled; and a region in which countries, individually and jointly, work towards reducing inequities in sexual and reproductive health and rights.” I hope that you will enjoy reading it.

Gunta Lazdane, MD, PhD, Programme Manager, Sexual and Reproductive Health, Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for Europe, lazdaneg@who.int
Eras are usually characterized by the fact that they have a beginning, an end and that significant things have happened while they lasted.

Today, we have come to the end of the era of Entre Nous, the European Magazine for Sexual and Reproductive Health. During its era it has existed as a printed media distributed in eight languages throughout Europe, the two-block Europe, the post cold war Europe, the post-soviet Europe and finally, today’s Europe with a more unified understanding of political, social, public health and rights issues.

This last issue of Entre Nous can therefore not be only about numbers and statistics. It is also about how communication and the sharing of up-to-date knowledge has, beside, or sometimes independently of improvement of socio-economic conditions, health policies and health services, changed knowledge, attitude and practice in the individual approach to reproductive health, as well as in the approach of society as a whole to sexual and reproductive health (SRH) issues.

What has changed in the SRH debate and in the SRH status of populations since 1983? How has Entre Nous contributed to this change, if at all?

These are two questions that are not easy to answer. Looking back at the newsletter–style 1983 issue, we can see clearly that some of the issues dealt with then still present challenges today, though their extent is perhaps different. In the Entre Nous issue of January 1983, Waddad Haddad, the Regional Adviser for Sexuality and Family Planning at the time, wrote: “a few basic problems are common to most countries of the Region...” as she went on to cite examples of these common problems:

- “Family Planning services are not fully integrated into general health services and receive inadequate legislative support.”;
- “Health personnel lack adequate training in family planning and sexuality, especially in how to manage family planning services and how to handle their psychosocial aspects.”;
- “Workers in family planning do not benefit from an adequate international exchange of information on their counterparts’ experience with family planning services and on the results of their studies.”;
- “Two high risk groups, migrants and adolescents, receive less attention than they should.”; and
- “In both developed and developing countries, the traditional role of men and women is changing but the consequences of this change for contraceptive practice have not yet been fully assessed...”

Following the tracks laid by Waddad Haddad in the late seventies and early eighties, we have, in many issues of Entre Nous, as well as in many other WHO or UNFPA publications and in numerous conferences, workshops and training programmes, tried to improve and contribute to the international exchange between health workers and planners of health services. The hope was that this would lead to mutual inspiration and a healthy competition with new ideas to try and resolve at least the first two issues mentioned above.

Our hopes and investments, both in terms of time and finances, were rewarded: the health statistics collected by ministries of Health over the decades and collated in the Health for All Database of WHO, show statistical curves reflecting the extreme health divides in Europe in the eighties, and their gradual alignment from the early nineties onwards (see Graphs 1 and 2) (1). We saw accelerated progress in the development of SRH policies at regional and national levels and the improvement of the quality of SRH services, in line with international evidence based standards, guidelines and protocols. Significant progress was made in the reduction of maternal and infant mortality (see Graphs 1 and 2) (1) and in mortality caused by unsafe abortion through more knowledge about and increased access to modern contraception. Of course, this achievement was due...
Significant progress has also been made in the knowledge adults and young people have about their bodies, their sexuality, their rights, protecting themselves against unwanted pregnancy and sexually transmitted infections (see Image 1) (2). Very significant progress has been made, in many countries, with regard to addressing issues of health and sexuality education in schools. We have also seen significant progress with respect to medical staff knowledge and attitude on how to address issues previously considered very private and impossible to speak about, especially with young people. Staff at the primary health care level have learned to address sexuality and family planning as part of a history-taking and counseling routine. Patients – or clients – have, on the other hand, by and large, learned that they can address these issues with their doctor or nurse without having to feel ashamed. This cultural change of attitude and practice has perhaps required the biggest input and much more advocacy effort than raising funds to buy essential drugs or family planning commodities to improve SRH. Raising funds for drugs is seen as “neutral” and “objectively necessary”, whereas speaking about sex in a professional, counseling or educational context, did and still does meet a lot of resistance. Paradoxically, it was not only a gradual liberalization of values, but also really the explosive growth of the HIV/AIDS epidemic that made the change of culture not only necessary, but also urgent.

The role of civil society organizations and youth and students’ organizations in particular has been pivotal in the move towards mainstreaming SRH. Initially, their work was nearly hidden and they had to tread carefully. In the 1980’s, there was a network of family planning clinics belonging to volunteer family planning associations, tucked away in little corners of town – this was where you could go to get advice and commodities, and if you did, it was considered better not to be seen. Today, general practitioners (GPs) in most countries of the European Region will provide the same advice and no one has to worry about being seen.
on the way in and out because you could be consulting a GP for a broken leg or common cold. That is progress, because it makes it possible for many more to use the services.

Significant progress has been made thanks to another field of advocacy: the work with politicians and parliamentarians. The turning point was the International Conference on Population and Development (ICPD) in 1994, spearheaded by Dr Nafis Sadik of the UNFPA and Professor Dr Fred Sai, where SRH was, perhaps for the first time, addressed so openly and explicitly at a high-level global political meeting.

Following ICPD, it became possible and accepted for politicians to speak openly about SRH as an integral part of a country’s national agenda to improve the health of its population. This included recognizing the facts and the challenges and addressing the necessary financial and human resource investments. It included speaking about SRH in news programmes and talking to those who needed the services, including young people. As a result, over the years and decades to come, global, regional and national strategies were developed to respond to the needs and guide health systems investments towards SRH. In recognition of the fact that in 1994 there were many countries that could not cover all health and reproductive health commodities themselves, or fund all the necessary training and re-training of health staff, donor countries and development agencies established multiyear commitments and cooperation frameworks for investments to work towards reducing reproductive ill-health and preventing unnecessary and premature deaths.

The agreement on the Millennium Development Goals in the year 2000 initiated by the former UN Secretary General Kofi Annan and the commitment of the global community to achieve these Goals represented a major stepping stone: for the first time, quantitative, measurable goals were set which made planning, investment and accountability processes more transparent. As a result, some of the already existing joint programmes, such as the mutual support of WHO and UNFPA, became more clearly structured and formalized. Since 2014 UNFPA/WHO Regional cooperation has been framed by the Regional Joint Programme on SRH to accelerate the interagency efforts in response to priority issues in the area of SRH, and this year, in September 2016, the 66th European Regional Committee of the WHO adopted the “Action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in Europe – leaving no one behind”, which draws the way forward, linking the ICPD Programme of Action and the 2030 global health and development agenda priorities.

The financial investments made in SRH received a further boost with the interagency and multicountry commitment to strengthen health systems overall, in recognition of the fact that individual diseases or health problems cannot be tackled successfully if health systems are weak.

However, the investments made still focus largely on the provisions of goods, services and training, and only in a minor way on supporting research that is badly needed, especially operational research regarding the development of cost-effective and user friendly models of SRH services. It was only relatively late that the internationally funded inter-agency Programme of Research, Development and Research Training in Human Reproduction (HRP) began allocating funds to this area of research aiming to improve implementation.

Today, it is accepted that research is an essential component of strategies at the national and global level if progress is to be made. Entre Nous has, in many issues over the past decades, helped to share and to shape the research agenda and in this way helped researchers to exchange their scientific results and experiences (see Image 2) (3). As a result of this work, many Reproductive Health and Research Collaborating Centres of the WHO could initiate research on such different areas of importance such as: standardization of RH indicators; abortion and its complications in different parts of the Region; contraceptive prevalence; and knowledge, attitude and practice studies among adolescents.

Despite the significant results achieved by countries, universal access to SRH remains one of the priorities of the new 2030 agenda, which renewed the commitment of the countries and the global community and expanded the opportunities to invest in SRH through effective policies, innovative approaches, and strengthened interagency and intersectoral cooperation (see Image 3) (4).

Now, let’s go back to what Waddad Haddad wrote in 1983 and see where the agenda is still unfinished: migrants and adolescents, she said, were two groups who required more attention than they were receiving. Today, more than ever, with the unhaltable stream of migrants and refugees arriving from resource depleted conflict zones into areas which sometimes do not have the additional resources needed to cope with the needs of such large population groups, largely consisting of people of reproductive age, this statement still holds true. Over the years, Entre Nous has, in several issues, described the challenges and provided a
platform for examples of good practice – from the setting up of migrant clinics for patients not registered in the respective national health care system, to the provision of standard reproductive health kits as integral parts of kits provided by the UN Refugee Agency (UNHCR) and other organizations to refugee camps, to addressing issues of gender-based violence in conflict zones and refugee settings. We cannot be sure of, but can hope, that some of the experiences published help those health workers and policy makers who have to confront these issues today. 

*Entre Nous* has also played an important role with regards to the SRH of youth. Many issues of *Entre Nous* have dealt with adolescents’ needs, counseling approaches, rights issues, risks and strengths, peer education, school programmes and the like. The publications went hand in hand with an increased training and sensitization of health workers, a general empowerment of young people to take decisions regarding their own life at an earlier age and the establishment of clinics catering for their needs. *Entre Nous* provided a small building block in the overall developments, but in many cases an important building block, as experiences with youth clinics were carried from one country to another, through sharing of experiences in the magazine, and the concept expanded.

To respond to varying needs of readers and end users, the format and contents of *Entre Nous*, have been modified over the years of its existence, taking into account that in the era of rapid development of technologies, new mechanisms and instruments are needed for communication, advocacy and knowledge-sharing. Thus, the web based format of the magazine reached a wider audience and provided the opportunity for the further sharing of articles through social media, with the printed version fading into the background. Each issue continued to highlight upcoming events in the Region and presented new publications, reports and research findings in the area of SRH, focusing on a particular topic, sharing knowledge, experiences and evidence from the Region and advocating for advanced SRH policies, services and strengthened cooperation.

The ideas, evidences and values, shared by the different issues of *Entre Nous* during many years will remain available in the electronic archive as evidence of the progress in the area of SRH in the Region for over 30 years. *Entre Nous* itself as a publication will not continue, but in the future, the priority issues, policy papers and research reports on SRH will be integrated and shared by various other communication channels and existing platforms in the European Region.

We can be sad, but perhaps, in reality, that is a good thing; there was a time when SRH was a more private matter and that was why it had to be discussed. In fact, “Entre Nous” - French for “between us” implied a private matter between two people, or in fact only those professionals concerned who dealt with gynaecology, sexology, sexually transmitted infections, HIV and SRH as their main occupation. Today, thanks to publications like *Entre Nous* and all those who contributed to it, SRH is rightly considered everybody’s business and everyone’s responsibility and there is no longer a need to keep it “between us”.

So all is as it should be and we can therefore, with a light heart say goodbye and thank you to *Entre Nous* and to all those who made it happen. It was hard work, it was sometimes difficult and diplomatic work, but it was inspirational and moving – and sometimes it was, yes, we can say it: it was also fun, and an honour to have been part of the process!

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**References**

In 2004 I visited central Asia for the first time. I was speaking at a WHO Making Pregnancy Safer workshop in Kyrgyzstan attended by delegations from the newly independent central Asian republics. Seven years later I was guest editor of Entre Nous No. 74, which described how the work that started there beside Lake Issyk-Kul was beginning to change childbirth in Kazakhstan. During the intervening years I made many visits to former Soviet countries and learned a lot. I discovered how the old system had perpetuated dangerously out-of-date maternity care. More importantly, I began to understand what it takes to bring about change.

Change requires action at all levels, from government ministries to local communities. My job was to convince doctors about the usefulness of confidential enquiries. These audits, which have been running in the United Kingdom for 60 years, involve honest appraisal of the problems revealed by maternal deaths and, more recently, “near misses”. I soon discovered that the idea of telling the truth to an official enquiry is alien to people brought up in the Soviet era. At our workshops several days of discussion were needed before sceptical clinicians became enthusiastic about this method of improving care.

Looking again at Entre Nous No. 74, I am reminded of just how many people were involved in that project. There they all are – the Minister of Health, the staff of the WHO Country Office and many local clinicians. The visiting team included doctors and midwives who spoke Russian. Their experience was essential for winning hearts and minds up and down the country. I had to work through interpreters, as did our leader, Dr Alberta Bacci, whose enthusiasm and charisma transcended the language barrier.

What part did Entre Nous No. 74 play in all this? It had two roles, internal and external, and so was published in both Russian and English (the versions were identical: articles submitted in Russian were translated into English for editing and then back again). The internal role was to recognize the work of everyone involved and encourage further progress within Kazakhstan. In any project a report is essential but all too often these are dull and destined to gather dust. Entre Nous No. 74 was attractively designed and, I thought, stood a good chance of stimulating its diverse readership to continue their efforts.

Its external role was to tell others about our work. There are various ways of doing this and we also prepared a manuscript for a peer-reviewed specialist journal. After a lifetime of editing such papers, however, I have a realistic view of their impact. They are read by researchers working in the same field and are unlikely to influence practitioners, let alone politicians, unless attention is drawn to them. Achieving change needs emotional input, which was provided by the midwives’ perceptions at the end of Issue 74. I doubt if that important article would have been accepted by a scientific journal.

Increasingly we are all relying on the Internet to disseminate information and some people believe it will make journals redundant. I disagree. The Internet helps like-minded professionals to interact but is poor at promoting engagement between disciplines. Many authors need the discreet help of an editor to make their writing clear and a designer to make their articles attractive. For 35 years Entre Nous has been fulfilling these functions in sexual and reproductive health, a field which continues to produce unexpected challenges. I’m disappointed that Entre Nous is to cease publication and I believe it will be missed. How long will it be, I wonder, before it is reborn?

James Drife
Guest Editor Issue No. 74

Like everybody else who has been involved in the production of, or contributed to, Entre Nous over the years, I am saddened by the passing of what has developed into an iconic publication on sexual and reproductive health (SRH) in Europe – and by extension, the world.

My appointment as editor in 1994 was unusual, as I don’t have a public health background and was then editor of a few international magazines. The department, led by Dr Mark Tschechkowski, wanted to respond to the increasing demand for quality information in the SRH field, especially from the newly independent states and felt it was time for Entre Nous to transform from a newsletter to a free standing magazine. I was brought in as a professional to help make this transition and also to provide a fresh perspective on issues that were becoming increasingly contentious worldwide.

I had a desk in the maws of the ‘chocolate box’, working under the direct supervision of Dr Assia Brandrup-Lukanow, then the WHO EURO Regional Adviser...
knowledge and passion for the subject was infectious and I soon found myself immersed in the highways and byways of this fascinating issue.

Looking back, it was a different world then. Those were still very early days of the Internet and most people relied on information from publications and the media. Although some of us did not realize it then, we were on the cusp of some revolutionary and highly controversial changes of attitude towards sexuality, gender equality and family planning. Old, established concepts were about to be given a rude shaking up. Change on this scale invited the inevitable clash of ideas and cultures.

My time at Entre Nous coincided with two seminal events – one was the ICPD conference in Cairo and the other was the invention of RU 486, which revolutionized abortion care and had the potential to turn what had generally been a dangerous, often illegal operation into a safer procedure.

The implications were enormous and went well beyond abortion per se. Implicit in this was a massive cultural change in terms of gender equality and the rights of women. It went against the grain of some established religious, cultural and social norms. ICPD, in turn ruffled feathers further by placing human sexuality beyond the realm primarily of reproduction.

We covered both issues in the editions I edited. As part of a UN organization, we had to tread warily but with some staunch support from the top management, including from Regional Director Dr Jo Asvall, who was not averse to pushing through politically difficult public health issues, we pulled it off.

I left soon after to return to my main occupation covering development matters, but was gratified to learn that Entre Nous, translated into several European languages, had gone from strength to strength and was eagerly received even in many countries beyond the European Region including the Spanish, Portuguese and French speaking countries of Africa and Latin America.

In conclusion, I found my brief time at Entre Nous both exhilarating and fulfilling and was convinced that in some way at least, it had helped bring about the vast cultural change in gender relations we now take for granted.

Anver Versi
– Editor 1994

In early 1998 just as I was leaving for Mexico to work as a volunteer for 6 months, I got a call: I was accepted to be the new editor of Entre Nous magazine. With an agreement that I was initially able to work from abroad, I set out to learn everything I could about the topic of the then upcoming issue: emergency contraception. During my tenure, the field of sexual and reproductive health would go on to change greatly. We revisited the Programme of Action of the International Conference on Population and Development in a special issue in 1999 and again in 2004, a decade after it was signed. We saw a massive focus on HIV treatment from 2004 as part of the 3 by 5 Initiative and ultimately that scale up, and the systemic problems that the field of HIV still faced, is what led me to concentrate fully on HIV and AIDS during my remaining five years at the WHO Regional Office for Europe.

In the race to combat stigma and discrimination and empower key populations, like people who inject drugs and men who have sex with men, sexual and reproductive health (SRH) became overshadowed, in both global interest and in terms of allotted funding. Recently, it has been with great excitement and fascination that I see the issue returning to the forefront of European health research in my current work. With a majority of people living with HIV in Europe soon to be virally suppressed, new questions have emerged. What about their quality of life? Shouldn’t they be supported in having sero-discordant relationships and even having children, given the negligible risk of HIV transmission among those adhering to antiretroviral therapy? This new quality of life frontier is in fact anchored in SRH and is now being revived thanks to the success of interventions to prevent and treat HIV.

Another issue that emerged while I was at the WHO Regional Office for Europe was co-infection with HIV, in particular hepatitis C. While people living with HIV could be saved from dying from AIDS itself, their livers were suffering and event-
10 years after leaving *Entre Nous*. From before I joined as editor, right up to this last issue, *Entre Nous* has been the voice of cutting-edge viewpoints and original research on SRH and rights. It will be sorely missed, which is something that I fear will not be well recognized until the next time we are searching article databases looking for a European perspective on one of the many issues encompassed by SRH and rights.

In closing, I have to warmly thank the two chief editors I served under: Dr Gunta Lazdane and Dr Assia Brandrup-Lukanow for their leadership and support, as well as Thomas Warming, who colourfully illustrated many issues of *Entre Nous*.

**Jeffrey Lazarus**
– Editor 1998-2005

It was both a pleasure and an eye-opener for me becoming the Editor of *Entre Nous*. It was with awe that I took over from Jeffrey Lazarus in 2005.

During my time, I dealt with topics of violence against women, the importance of working in partnerships, low fertility and cervical cancer in the European Region. Although I was well aware that the Region faced sexual and reproductive health and rights challenges, working as an editor for *Entre Nous* made me realize that despite the large public health challenges developing countries face, the European Region has lots to tackle in its own backyard.

Ensuring sexual and reproductive health and rights for the world’s population has for many years proven to be a minefield. Access to contraception, comprehensive sexuality education and safe abortion are by many countries seen as highly controversial issues. Unholy alliances have been formed over the years to systematically prevent progress in the implementation of the 1994 ICPD Plan of Action. The more progressive countries outside of the European Region have always looked to the European Union (EU) Member States to take the lead in international UN negotiations to secure that the sexual and reproductive health and rights agenda was moved forward.

This expectation remains true until this day and to a large extent rightly so however, with the enlargement of the EU in 2004 this became more challenging, as more conservative and Catholic states entered the Union.

Dealing with European issues as an editor of *Entre Nous*, made me very conscious that working with governments in progressive countries and the EU-system at large, to promote sexual and reproductive health and rights, is critical in holding fort against more conservative voices in our own Region. Without strong political support and EU consensus on issues related to sexual and reproductive health, not only do our own fellow European citizens – both women and men – suffer from rights violations in relation to e.g. right to safe abortion or same sex relationships, but it also weakens the EU position in key negotiations internationally.

The European sexual and reproductive health community therefore must continue to work hard to hold our governments to account on key sexual and reproductive health and rights commitments and particularly support colleagues in the Region that are faced with stronger political opposition. As the very recent situation in Poland has shown us, there are strong forces that vigilantly oppose the idea of women’s access to safe abortions but it has also shown that when our community stands strong and when we raise our voices, damage can be avoided. Despite the ICPD being more than 20 years old, the battle continues. There is no time for complacency – not in Europe, not anywhere.

*Entre Nous* has made important contributions to the European sexual and reproductive health debate over the years. Hopefully, despite this being the last issue of *Entre Nous*, other good platforms for sharing of European perspectives on sexual and reproductive health and rights will remain active – this is clearly needed!

**Jacqueline Bryld**
– Editor 2005-2007
I remember vividly both the excitement and anxiety I felt as I assumed the role of editor of Entre Nous from Jacqueline Bryld in 2007; excitement over the opportunity to be part of Entre Nous and anxiety about ensuring that the issues would continue to be of the same high calibre and relevance as previous editions. Thankfully, the anxiety resolved after my first issue as editor and what remained was the pleasure and, yes, continued excitement of being able to work with a remarkable team of individuals who were dedicated to championing sexual and reproductive health (SRH) and rights in the European Region, as well as globally.

My time at Entre Nous also coincided with a renewed commitment to and focus on SRH, particularly maternal, newborn and child health, by global development bodies, UN agencies, civil society and governments. This was an exciting time to be editor. Events such as the countdown to the completion of the implementation of the Millennium Development Goals allowed us to critically assess and evaluate what progress had been made in the area of SRH and rights and, more importantly, what challenges remained. The Post-2015 Development Agenda and the Sustainable Development Goals emphasized that in order to attain the highest attainable standard of health for all, including SRH, we needed to do things differently from previous approaches. This was reflected in later issues of the magazine that moved beyond specific topics in the field of SRH to a broader, more holistic development agenda and public health approach to SRH that focused on overarching principles such as human rights, equality and equity, sustainability and intersectionality.

Now, as I write these words for the final issue of Entre Nous I do so with both a sadness and fondness present. Sadness to say farewell to a magazine that has, over its lifetime, made a remarkable contribution to the field of SRH and rights in the European Region, and fondness for precisely the same reason. It has truly been a remarkable experience to have been the editor of a publication that has always been willing to prioritize and advocate for the pressing issues in SRH and rights, recognizing the importance of ensuring that vulnerable and marginalized populations, controversial subjects, sharing of successes and challenges and focusing on equity are essential to decreasing existing SRH inequities and the attainment of positive SRH, rights and well-being for all in the Region. It has not always been easy for the magazine to be the voice that brings awareness and attention to these critical issues; doing so has required diplomacy, commitment, flexibility and courage from all involved. I applaud all of the authors, editorial assistants, readers, publishers, colleagues and Editorial Advisory Board and WHO European Regional Advisory Panel on Research and Training in Reproductive Health members for supporting us with this task and allowing our work to remain relevant for so long.

Finally, my reflections on being editor of Entre Nous would not be complete without a few well deserved words of appreciation: to Dominique Gundelach, Jane Persson and Nathalie Germain Julskov, your dedication, attention to detail, sense of humour and professionalism were integral to the success of Entre Nous; to Tamar Khomasuridze and Rita Columbia, your thoughtful perspectives on SRH and suggestions for topics and authors kept the magazine fresh and current; to Maria Lundahl Assov, your creativity with layout and design meant each publication was easily readable and visually appealing; and to Gunta Lazdane, your mentorship, support and friendship inspired us all to ensure that every issue of Entre Nous was the very best it could be for the community of readers and contributors in Europe and beyond.

Lisa Avery
– Editor 2007-2016
A FAREWELL TO ENTRE NOUS

As we now hold the last issue of Entre Nous in our hands, it is fair to say that a formidable era is coming to an end. For more than 30 years, Entre Nous has been the go-to magazine for the sexual and reproductive health community in Europe, central Asia and beyond. It has provided a platform for policy dialogue, advocacy and information-sharing and contributed to strengthening the regional network of policy-makers and experts.

For me personally, Entre Nous has been an extremely valuable companion during my years working on population and sexual and reproductive health and rights issues. I joined UNFPA roughly at the same time as the first edition of Entre Nous went to print. Since then, I have had the privilege to contribute articles myself and I have actively used in my own work the state-of-the-art expertise, good advice and lessons learned published in the magazine. Entre Nous has helped me with doing my work for the women, men and young people we serve and I know this is the case for many of my colleagues at UNFPA and in the broader sexual and reproductive health community.

Over the years, the magazine’s format, focus and content changed. Its outlook broadened. Additional language versions widened the audience. Most recently it underwent a redesign to make it more compatible with social media platforms.

Yet what remained constant was Entre Nous’ ability to take up newly emerging issues and serve as a platform for experts and policy-makers to debate them, at times long before these issues were recognized as priorities by the wider development community. The magazine thus contributed to putting new priorities on the agenda, shaping the policy dialogue and, ultimately, new responses.

For example, back in 2006 Entre Nous No. 63, titled “Low-fertility – The future of Europe”, drew attention to a demographic trend now on many people’s mind in the Region and Entre Nous No. 77 (2013) broke new ground discussing sexual health in ageing societies (see Image 2). Entre Nous No. 78 (2013) charted the way “From ICPD to post-2015” and helped shape the transition in our Region from the Millennium Development Goals to the Sustainable Development Goals (see Image 3). Entre Nous No. 84 (2016) provided strong evidence and served as an advocacy platform for the adoption of the European SRH Action Plan by Member States in 2016 (see Image 4). Entre Nous No. 82 (2015), with its focus on the life-course approach, preceded the adoption by the 2015 WHO European Ministerial Conference of the Minsk Declaration on the life-course approach (see Image 5).

Going through Entre Nous’ electronic archive and looking at the topics covered is like a journey through this Region’s trajectory over the past quarter of a century. It tells the story of the many opportunities that have opened up, the new challenges that have emerged for people to realize their rights and what can be done to empower people to fulfill their potential. With its Russian and Spanish language versions, Entre Nous reached audiences that have had very limited access to a variety of ideas and experiences at the international level.

UNFPA, in partnership with WHO, has been a proud supporter of Entre Nous over the years, most recently as part of
the joint UNFPA-WHO Regional Programme with a renewed concept and format, wider coverage and stronger inputs to interagency cooperation at the regional and national levels.

I would like to thank all those who have supported and engaged with Entre Nous over the years – as readers and as contributors. We are also grateful to the current and former members of the editorial board and the editors, in particular Gunta Lazdane, the WHO Regional Office for Europe’s Regional Adviser on Sexual and Reproductive Health, who is retiring this year after having championed sexual and reproductive health in our Region, including through Entre Nous, for many years.

The new Agenda 2030 brought a new stimulus for tackling the persistent sexual and reproductive health challenges in our Region. While we have made a lot of progress over the past 25 years, much more remains to be done to ensure universal access to sexual and reproductive health and ensuring that no one is left behind. It is therefore of utmost importance that the policy dialogue, debates and information-sharing so far facilitated by Entre Nous will continue on other platforms and that we secure Entre Nous’ legacy of bringing together the thinkers and doers in a powerful sexual reproductive health community equipped to bring about the change we need for the people we serve.

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Over the past 30 years, across a wide range of European jurisdictions, significant progress has been made in the adoption of laws and policies that support women’s and girls’ exercise of reproductive autonomy and safeguard their sexual and reproductive health (SRH). Alongside this evolution at the national level we have seen considerable critical developments in the recognition of sexual and reproductive rights as human rights by international and European human rights bodies. Five illustrations of significant legal and policy advancements are highlighted below, ranging from the legalization of abortion to increased protection against gender-based violence.

At the same time, while celebrating these advancements is important, it is equally critical to recall that many women and girls across the European Region continue to face violations of their sexual and reproductive rights. Serious challenges persist and in some contexts the prospect of regression is real. In the coming years European policy makers and advocates must redouble their efforts to guarantee sexual and reproductive rights. They must step up efforts to improve and reform relevant laws and policies, taking them to the next level so all women and girls in the Region can fully enjoy these rights.

1. Legalization of abortion and recognition of women’s access to safe and legal abortion as a human rights issue

Over the past 30 years, the trend towards the liberalization of abortion laws continued in Europe. For example since 1986 Albania, Belgium, Luxembourg, Portugal, Spain and Switzerland all introduced legislation allowing women’s access to abortion upon request (1).

Now abortion is legal in the vast majority of countries in the Region. Highly restrictive laws remain in place only in Andorra, Ireland, Liechtenstein, Malta and Poland and these countries’ laws have attracted considerable criticism from international and European human rights bodies for their failure to guarantee women’s human rights.

In fact there has been very significant progress in the last three decades in advancing the recognition by international and European human rights bodies of women’s access to abortion services as a human rights issue. This was spurred by global political commitments at the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women in Beijing and propelled forward by a strong body of jurisprudence developed by the UN human rights treaty monitoring bodies, the European Court of Human Rights and the European Committee of Social Rights.

In this time the UN treaty monitoring bodies have robustly articulated States’ obligations with regard to women’s access to abortion. They have called on States to liberalize restrictive abortion laws, decriminalize abortion and adopt measures to guarantee women and girls access to safe abortion services. Furthermore, they have urged States to ensure that their laws and policies respect women’s right to make decisions about their SRH and to remove barriers that undermine women’s autonomy. This year the UN Human Rights Committee held for the first time, in dealing with an individual complaint, that criminalizing and prohibiting abortion violates international human rights law (2).

Furthermore, in the last decade a number of important judgments from the European Court of Human Rights have recognized that denying women access to legal abortion services violates their fundamental human rights (3). It has held that when States obstruct, delay or otherwise hinder women’s access to legal abortion services or to necessary SRH health information they violate women’s rights. The European Court, and treaty monitoring bodies, have clearly affirmed that when abortion is legal it must be accessible in practice. In addition, the European Committee of Social Rights has ruled that abortion services must be organized in a manner that ensures that the needs of women are met (4).

2. Legalization of emergency contraception over the counter and international recognition of women’s rights to affordable contraception

At the national level, important progress has been achieved over the past 30 years in making modern contraceptive services more widely available to women across Europe. In terms of legal and policy progress the sale of emergency contraception without prescription has become the norm, rather than the exception. France led the way in 1999 and today at least one brand of emergency contraception pills is available over the counter without prescription in most European countries (5).

At the international level, human rights bodies have also affirmed that in order to guarantee the right to health and other human rights, States must ensure that a comprehensive range of contraceptives, including emergency contraception, is available and affordable for women and adolescents.

3. Recognition of access to comprehensive sexuality education as a human rights concern

Over the past 30 years international human rights bodies have recognized that the rights to health, education and equality and non-discrimination require States to provide children with comprehensive evidence-based sexuality education. They have recommended that sexuality education be made compulsory and provided throughout primary and secondary education.

At the regional level, the European Committee of Social Rights has held that sexuality education must be provided on a scientific and non-discriminatory basis without censoring, withholding or intentionally misrepresenting information about SRH (6).

4. Recognition of forced sterilization of Roma women as an acute human rights violation

Across Europe Roma women have faced some of the most concerning violations of their sexual and reproductive rights.
Forced sterilizations of Roma women was widespread in some central and eastern European countries up until the 1990s with devastating consequences.

In the past 15 years both the European Court of Human Rights and the UN Committee on the Elimination of Discrimination Against Women have recognized that sterilizing a woman without her free and informed consent violates her fundamental human rights (7). They have affirmed that forced sterilizations can cause women severe suffering and distress amounting to inhuman and degrading treatment. Furthermore, the CEDAW Committee has held that forced sterilization of Roma women constitutes intersectional discrimination. Human rights bodies have called for effective remedies to be provided to victims and for adoption of effective measures to prevent future violations of Roma women’s rights.

At the national level, accountability for abuses has been established in some places through investigations and prosecutions. Furthermore, some countries have adopted laws and policies to safeguard against these types of violations through strengthened procedures for women to give their free and informed consent to sterilization.

5. Increased efforts to prevent and redress violence against women and recognition that such violence is a human rights issue

The past 30 years has seen a fundamental shift in the recognition that violence against women by non-state actors engages the State’s human rights obligations. At the same time the gravity and scale of these abuses have mobilized State action to better prevent and redress violence against women.

As a result, relevant national legal frameworks have been significantly improved and most countries in the Region now have specific laws and policies in place. For example, all members of the Council of Europe have adopted national strategies or action plans addressing violence against women.

Over the last decade, the European Court of Human Rights in a number of landmark judgments has held States responsible for failures to take effective steps to protect women from violence and threats to their lives from private actors, including intimate partners. It has established that such failures violate a number of human rights, including the rights to life, to privacy and to be free from inhuman or degrading treatment (8).

Importantly the European Court has begun to also recognize that domestic violence is often caused by deeply entrenched gender discrimination. It has affirmed that domestic violence disproportionately and distinctly affects women and that it is a form of discrimination against women (9). The European Court has found that inaction by the authorities in the face of reports of violence against women condones such acts and reflects discriminatory attitudes.

Finally it is worth noting the adoption by the Council of Europe of the Convention on Preventing and Combating Violence Against Women and Domestic Violence (also known as the Istanbul Convention), which entered into force on 1 August 2014. This important new instrument reflects a strong commitment to ending violence against women and addressing its root causes.

Conclusion

These are just five examples of positive achievements in the legal and policy protection and recognition of women’s sexual and reproductive rights over the past three decades in Europe. Obviously, many more examples of progress exist both at the national and regional level.

However, we must not forget that many challenges also persist in the Region. In particular, we must not neglect the significant inequalities and disparities in the enjoyment of sexual and reproductive rights that continue to affect many women and girls in Europe. Marginalized groups of women and girls, including those belonging to ethnic minorities, undocumented migrants and asylum seekers and those who are economically disadvantaged, face entrenched discrimination and denial of these rights.

We have a responsibility over the coming years to make further advancements to ensure that all women and girls in Europe can fully and equally enjoy their sexual and reproductive rights.

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ATTAINING AND MAINTAINING POSITIVE SEXUAL AND REPRODUCTIVE HEALTH IN EUROPE: HIGHLIGHTING YOUNG PEOPLE’S INVOLVEMENT

Over the last 25–30 years there has been noticeable progress made by young people, which has resulted in enormous achievements, in particular on sexual and reproductive health and rights (SRHR), which is without doubt a contentious topic. The new 2030 agenda lays the path for us young people to continue to safeguard the realization of SRHR for all, and to become united on burning issues, such as access to safe and legal abortion. The new agenda enables us to produce better results and ensure young people are at the heart of the new Sustainable Development Agenda, both in terms of involvement and decision-making processes.

January 1st 2017 marks the one-year anniversary of the implementation of the United Nations Sustainable Development Goals (SDGs). Together the international community, alongside civil society, academia and most importantly youth participated in negotiations on the new Sustainable Development Agenda, which ultimately guides the world’s priorities over the next 15 years.

Despite ambitious commitments, the SDGs did not manage to meet the needs of everyone. Young people’s SRHR were not fully represented. In the following article, young SRHR advocates demonstrate the unfulfilled needs and gaps with specific examples and reflections.

Youth friendly abortion care: the issue of parental consent

In keeping with youth-friendly sexual and reproductive health (SRH) services, addressing the importance of youth-friendly abortion care is of utmost importance. Statistics on unsafe abortions show that young women are at a greater risk. According to the latest available data from The Guttmacher Institute, around 22 million unsafe abortions are estimated to take place worldwide each year (1). Consequently, complications from unsafe abortions cause high-rates of morbidity and mortality, causing the death of approximately 47,000 women a year, where nearly half are young women (2).

Every year there are approximately 85 million unplanned pregnancies (3). Women who seek to terminate an unplanned pregnancy are often stigmatized (even within a less restricted national legal framework). Young women are often stigmatized, not only for seeking to terminate an unplanned pregnancy, but also for being sexually active in the first place.

The vast majority of countries in the European Region have no restrictions with regards to reasons for wanting to terminate a pregnancy (4). However, a lack of regulation on the reason for terminating a pregnancy does not mean that there is equal access to abortion for all women in a country. One often mentioned issue is cost, while another key barrier is parental consent. In the majority of countries within the European Region without restrictions on the reason for seeking abortion, adolescents and young women are required to obtain parental consent when seeking an abortion (5). This occurs even though the United Nations Committee on the Rights of the Child has determined that in accordance with their evolving capacities, girls aged between 16 and 17 should be able to access SRH services without parental consent (6).

As a result all of the above leaves a large group of adolescents and young women greatly exposed. Their bodily autonomy is challenged by a combination of legal restrictions and the absence of regulations on their right to access safe and legal abortion.

Comprehensive Sexuality Education (CSE) as an instrument to empower young people

CSE “enables young people to protect their health, well-being and dignity. It is based on human rights principles and advances gender equality and the rights and empowerment of young people” - as reflected in the most recent Global Review of UNESCO (7).

High demand for access to CSE by young people was evidenced by the 2012 Bali Global Youth Forum Declaration, the 2014 Colombo Declaration on Youth, youth delegates’ inputs to the post-2015 Sustainable Development Agenda and the AIDS Conference 2016 Youth Call.

Ideally, one day every young person will have the ability to make life-changing decisions regarding their SRH. Yet research suggests that the majority of adolescents lack the knowledge required to make these decisions responsibly, leaving them vulnerable to coercion, sexually transmitted infections (STIs) and unintended pregnancy (8). Furthermore, CSE goes beyond information, helping young people to explore their SRH in a positive way.

According to the data provided by the “All in” initiative, young people account for almost 50% of new HIV infections. According to UNFPA, only 21% of young people have adequate access to information on HIV/AIDS, while data from eastern Europe and central Asia indicates that the highest cases of teenage pregnancy are among adolescents and young girls up to the age of 18 (8). This data presents only a partial indication of how knowledge on youth and CSE could be used to change attitudes and behaviour leading to better SRH for young people worldwide.

An innovative example of providing free access to CSE is the newly developed social media platform “Global Hub for CSE Advocacy” (http://www.advocates4cse.com). It aims to empower experts and activists working in the field with adequate information and serves as a platform for exchanging good practices and relevant country data.

Understanding, nourishing and supporting youth leadership and participation

According to the European Charter on the Participation of Young People in Local and Regional Life, “participation and active citizenship is about having the right, the means, the space and the opportunity and where necessary the support to participate in and influence decisions and engage in actions and activities so as to contribute to building a better society (9).” Although this is how the concept is
defined in the preamble of the revised Charter, there is a considerable difference in how youth participation is perceived and practiced across and within countries in Europe.

Looking back, one of the milestones in recognizing the value of youth participation was at the International Conference on Population and Development (ICPD) Programme of Action adopted in Cairo in 1994. This included a reference on the need for “Countries to meet the needs and aspirations of youth, particularly in the areas of formal and non-formal education (…) and health, thereby ensuring their integration and participation in all spheres of society, including participation in the political process and preparation for leadership roles (10).” It is considered to be one of the stepping stones that led to a shift in viewing young people not only as beneficiaries of health and education programmes, but as rights holders and capable actors that should have a say on issues that affect their lives, including their SRHR.

Since then, youth participation has been understood, nourished and practiced in several ways. The ICPD Review survey from 2014 revealed that most countries reported instituting concrete procedures and mechanisms for adolescents and youth to participate in the planning, implementation and evaluation of development activities that have a direct impact on their lives (11). The examples provided range from the existence of Youth Councils to mechanisms for involving young people in the drafting of youth laws (Georgia), the development of annual plans of action (Azerbaijan) and the organizing of Youth Governance Days (Republic of Moldova).

Although progress and achievements have been made, realizing and incorporating the values and principles that define meaningful youth participation is still a work in progress in many countries in Europe. One of the reasons could be linked to the general lack of strong evidence of the effect of youth participation on the impact of SRHR interventions (12). Therefore, while we should invest more in gathering data and evidence, we must continue our work to ensure that young people have the skills, the platforms and the support to contribute to the decisions and actions that immediately affect their lives.

Our involvement as today’s youth is highly crucial in terms of the administration and execution of positive achievements and changes within the WHO European Region. Youth are clearly the foremost driving force to attain and maintain positive SRH in Europe.

Despite a substantial amount of work undertaken by young people on SRHR over the last 25-30 years, we must continue to ensure that young people are actively involved in decision-making processes and that governments are held accountable for their commitments to young people’s SRHR.

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References
**Introduction**

Women globally migrate at a rate similar to men (1), but migration affects them differently (2). As the Committee on the Elimination of Discrimination against women (CEDAW Committee) has noted: “To understand the specific ways in which women are impacted, traditional female roles, a gendered labour market, the universal prevalence of gender-based violence and the worldwide feminization of poverty and labour migration (3)” All of this has an impact on the health of migrant women, whose physical, economic and social well-being is also undermined by intersecting forms of discrimination linked to ethnicity, race and poverty.

This is especially true for undocumented women – that is women who, for a variety of reasons, do not have a valid permit to remain in the country in which they live. Many undocumented migrants enter the European Union (EU) with a valid permit to study or work, to seek family reunification or asylum and later lose that status, often because of job loss, administrative delays in processing their immigration application, expired documents, having been born to undocumented parents, or having left an exploitative employer or abusive partner on whose status they depended. For women without residence status, or whose residence status is precarious or uncertain, the insecurity of their situation and legal barriers to obtaining health services are themselves drivers of poorer health outcomes.

**Barriers to accessing health care in Europe for undocumented women**

In the majority of EU countries, undocumented migrants’ right to access health services is severely limited. In just 10 of the 28 EU Member States do undocumented migrants have the right under national law to access primary care; in 6 their access is limited to emergency care (and in some countries, like Bulgaria, they may even be expected to pay for it). The remaining 12 EU countries are in between, entitling undocumented migrants to something more than emergency care, but often far less than the full complement of primary and secondary health care services. Indeed, in many cases, any entitlement to non-emergency care in these countries is limited to specific categories of people, such as undocumented pregnant women or undocumented children, or to certain communicable diseases like HIV – and is disconnected from any broader right to primary care, limiting their effectiveness. Even when they are legally entitled to care, undocumented women face practical barriers. These can be due to complex administrative requirements, cost, or the risk (sometimes imposed by law) of being denounced by hospital administrators to immigration authorities.

**The impact of undocumented women’s restricted access to health services**

Exclusion from health services means that undocumented women face delayed access to screening, treatment and care (4), limited access to contraception and pregnancy termination and heightened levels of discrimination and gender-based violence, all of which damages women’s health and perpetuates health inequities. Difficult pregnancies and poor pregnancy outcomes are disproportionately experienced by migrants throughout Europe including: low birth weight; infant and maternal mortality; and the increased likelihood of migrant women delivering their babies without professional assistance (5). Of 310 pregnant women in situations of vulnerability from whom data was collected by Doctors of the World in Europe in 2014, 54.2% had no access to antenatal care (4). At the country level, a 2015 report found that the rate of maternal death in the United Kingdom was significantly higher for foreign-born mothers compared to United Kingdom-born residents (6).

Pregnant women and adolescents arriving at the EU’s borders are acutely affected by inadequate access to medical care and are also at increased risk of sexual violence. Migrant women in detention face a double blow to their health, as detention is both a cause of diminished physical and mental health (7), as well as a place where access to adequate care is generally limited. Detention has corrosive and well-documented effects on the health of all migrants. The situation of girls (and children more generally) and of pregnant women has been given particular attention, with frequent calls to end their detention (8).

The central role of women as care givers and bread winners in many migrant households also means that poor health – linked to their exclusion from health services – has a profound impact on their families.

**RECOMMENDATION**

The European Commission, in collaboration with the WHO and other relevant partners, including professional partners such as EBCOG, should establish a working group to develop a European wide human rights and evidence-based policy on ensuring access to health care for all migrant women and their families, regardless of their migration status.

This work should be undertaken in the framework of the EU’s commitments under the Sustainable Development Goals (SDGs) to women’s equality, universal access to health care, including SRH services, and facilitating orderly, regular and safe migration. It should build on: the recommendations of the European Commission’s Expert Panel on Effective Ways of Investing in Health; the resolutions adopted at the 66th session of the WHO Regional Committee for Europe on creating a roadmap to implement the SDGs; and action plans for refugee and migrant health. SRH and women’s health. EBCOG has the expertise to offer support in developing European wide standards of care for these vulnerable women.
homing, the labour market and basic services - has a heavy impact on entire families and communities. For undocumented women, an unplanned pregnancy can result in significant emotional and economic hardship. Over-represented in low-wage jobs, pregnancy and the responsibilities of childcare can mean reduced hours or job loss at a time of increased expenses. At the same time, undocumented women and girls often have more limited access to contraception and limited mobility so travelling outside their country of residence to access services (especially in countries where abortion itself is prohibited by law) is not an option. Restrictive access to contraception and to termination of pregnancy therefore has a particularly negative impact on undocumented women and girls.

Limiting undocumented migrant women’s entitlement to maternity care fails to recognize their broader health needs, including those linked to prevention and health promotion, and that restricting access to care also means restricting access to information. It means that, in the majority of EU countries, undocumented women and girls do not have access to mammograms and cervical cancer screening, to family planning, or to regular check-ups that would help to prevent, detect and treat conditions like heart disease, cancer and diabetes. Shutting women and girls out from primary care services fails to recognize that it is often health professionals who are the first to recognize and provide assistance to those who have experienced violence and to connect them to other support and services.

Excluding a portion of the population from health services is also bad policy: it contradicts public health goals by undermining efforts to prevent, treat and manage communicable diseases and drives up costs in the long run. Indeed, recent research shows that providing access to preventive health care for migrants in an irregular situation, including prenatal care, would be cost-saving for health care systems (9).

Sexual and reproductive health (SRH): human rights and medical ethics
Restricting access to health care for a segment of the population because of their administrative status is also a violation of international human rights norms. The right to health, protected under international human rights law, is a core right, essential to the realization of all other rights. States have a duty to respect and guarantee this right without discrimination to everyone within their borders (10). The use of health services to “fight” irregular migration by creating intolerable conditions in the name of deterrence, is not only ineffective, but institutionalizes discrimination, is incompatible with states’ obligations and is an erosion of the entire framework of rights that underpins women and girls’ democracy.

The EU Fundamental Rights Agency, the Council of Europe, the UN Secretary General and the UN Special Rapporteur on the Rights of Migrants have all called for governments to establish a ‘firewall’ separating the provision of basic services from immigration control (11). In practice, this requires limiting the sharing of personal data between health care providers and immigration enforcement authorities so that undocumented migrants can go to health care facilities without fear of being arrested.

Human rights not only create obligations for states: they also underlie health professionals’ duties towards those to whom they provide care. Traditional medical ethics is dominated by a concern for the doctor-patient relationship. Human rights provide a complementary perspective that focuses on issues of equity, of discrimination and social exclusion that often drive abuses against patients (12). It also provides clarity about the duty of health professionals when laws and policies violate the rights of their patients (13). The World Medical Association has underscored the duty of physicians to provide appropriate care to all, whatever their status, and to speak out against laws that would compel them to violate patients’ rights, including by turning them away (14). Other associations of health professionals have taken a public stand against laws and policies contrary to medical ethics and their patients’ fundamental rights.

CASE STUDY
In July 2016 a woman arrived at a general hospital, in Cyprus’ largest city, bleeding and suffering from exhaustion. Before coming to hospital, the woman had given birth to a stillborn baby. Health professionals reported her to the police and she was later detained and charged with “concealment of child birth”, “participating in a conspiracy for the concealment of child birth” and “overstaying” her visa.

She had not sought medical attention during her pregnancy because her work permit had expired, leaving her undocumented and without any right to health care under Cypriot law. News media picked up the story, portraying her as a villain. Left out of the narrative was the situation of migrant women in Cyprus who face extremely limited access to health services and frequently precarious status, dependent on the whim of their employers. Lost was the individual tragedy of a stillborn child, delivered without access to support or assistance, or any discussion of the role of health professionals, charged with her care, in denouncing the woman to the immigration authorities.

This is not an isolated case. Cyprus is one of 7 EU countries where undocumented women have no specific entitlement to maternity care. Limited or no entitlements to maternity care, as well as fear of being reported or arrested, have prevented undocumented women across Europe from accessing essential, timely information and care.
Addressing issues around service delivery

It is well recognized that migrants who do not speak the native language and those from less affluent parts of the world are at increased risk of higher maternal morbidities, mortality and poor perinatal outcomes. It is important that all stakeholders involved in the care of pregnant women and babies (clinicians, researchers, healthcare planners, policy makers and users of healthcare systems) work together to streamline the provision of care for these vulnerable women.

In order to improve perinatal outcomes, concerted efforts by all Member States are required in order to implement high quality overarching standards of care for maternity and gynaecological services. The European Board and College of Obstetrics and Gynaecology (EBCOG), an umbrella representative body of the specialists in obstetrics and gynaecology in 37 countries across Europe have developed standards of care for women's health in Europe. These standards focus on the safety, care, dignity and treatment of patients. They reflect the care that a health service and prudent healthcare professional should provide in order to be effective and safe for the patient. These standards define a roadmap of quality service underpinned by clinical governance, safety and patient experience. They cover all aspects of a woman's journey through her life: from preconception, pregnancy, delivery and post delivery care to her post reproductive stage of life. These standards were launched at the European Parliament in November 2014. Now these standards have also been translated into Russian (accessible at: www.ebcog.eu). Highlights from the EBOG standards are presented in Table 1.

Table 1. EBCOG European Standards of Care.

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<td>1.</td>
<td>All pregnant women should be offered information on the full range of options available to them throughout pregnancy, birth and early parenthood, including locally available services, screening tests, types of antenatal and postnatal care and place of birth.</td>
</tr>
<tr>
<td>2.</td>
<td>Maternity services should ensure that there are comprehensive, culturally sensitive, multidisciplinary policies, standard operating procedures, services and facilities for the management and support of families who have experienced a maternal loss, early or mid pregnancy loss, stillbirth or neonatal death.</td>
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<tr>
<td>3.</td>
<td>There should be effective systems of communication between all team members in each discipline as well as with women and their families. The team members should be trained to recognize signs of domestic abuse and serious psychiatric illness.</td>
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<tr>
<td>4.</td>
<td>Interpreting services should be provided for women where the local language is not their first language. Relatives should not act as interpreters. Arrangements should be in place for interpreting services in the community, especially in emergency or acute situations.</td>
</tr>
<tr>
<td>5.</td>
<td>Services should be flexible enough to meet the needs of all women including pregnant teenagers, those with learning and physical disabilities, women from ethnic minorities, vulnerable women, hard to reach groups, asylum seekers and refugees.</td>
</tr>
<tr>
<td>6.</td>
<td>Migrant women may be at increased risk from previously undiagnosed existing medical conditions. Clinicians should ensure that a comprehensive medical history has been taken at booking and, where appropriate, a full clinical assessment of their overall health is undertaken as soon as possible.</td>
</tr>
<tr>
<td>7.</td>
<td>Local protocols should be developed to support equal access to healthcare needs for all vulnerable groups, including the migrant population and those who do not speak the host country's language. They should respect cultural differences relating to women's health and modesty.</td>
</tr>
<tr>
<td>8.</td>
<td>Clinics need to be aware that in some cultures women are reluctant to share information relating to women's health with males. Where possible clinics should be sensitive to this issue and identify a way to communicate that builds trust.</td>
</tr>
<tr>
<td>9.</td>
<td>Migrants in an irregular situation seeking medical assistance should not be apprehended at or next to medical facilities.</td>
</tr>
<tr>
<td>10.</td>
<td>Clinics should ensure regular training of their front line staff in communication skills, cultural/gender awareness, equality and diversity and safeguarding vulnerable individuals.</td>
</tr>
</tbody>
</table>
Conclusion

Migrant women are women, with the need – and the right – to access basic services, including health care, that ensure their physical and mental well-being, whatever their residence status. Yet they are systematically excluded from health systems on the basis of their migration status alone, deepening inequities across Europe at the expense of the most marginalized. Policies that prioritize migration enforcement over human health and human rights damage migrant women’s health and are incompatible with broader societal goals relating to the empowerment and equality of women. International human rights law, well-established principles of public health and sensible financial planning require that no segment of the population be limited to emergency care. Health care professionals have an important role, not only in filling the gap in service created by restrictive laws, but also in speaking out against them as inconsistent with medical ethics and their commitment to do no harm – recognizing that patients’ interests, dignity and health are undercut not only by improper action, but also by failing to act, to treat and to speak up.

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3. CEDAW Committee, General Recommendation No. 26 about women migrant workers, para. 5.

Significance / Epidemiology

Pregnancy implies emotional, physical and social changes for the mother, her partner and the rest of the family, but while many mothers greatly enjoy these changes and adapt well to them, others react with severe distress. Women’s socio-economic and cultural context modulates the adaptive responses to the pregnancy and unfavorable economic conditions or specific social circumstances make adjustment more difficult.

Generally, psychological morbidity is considerably high in women of reproductive age (1). In particular, mood and anxiety disorders are a common, even if often unrecognized and still tabooed problem in pregnant women, and at least as frequent during pregnancy as in the postpartum period (2). The prevalence of mental disorders generally increases between the first and the third trimester of pregnancy (3). The stress related to the physiological changes that occur during pregnancy can also exacerbate the symptoms.

Perinatal depression

Depression has an impact on both the pregnant woman and the child. Depressed pregnant women may experience loss of appetite and weight, they are more prone to nicotine, drug and alcohol consumption and they often do not attend for the recommended antenatal care. Low birth weight is more prevalent in children of depressed women; there is a higher risk for prematurity and for complications during delivery as well as for caesarean section (3). Untreated depression may result in dysfunction in the mother-child relationship, impairment of the child’s neuro-behavioural development and negative long-term socioemotional consequences (4). Although it is well established that good mental health care in the perinatal period may be crucial for the mental health of future generations, such care provision remains fragmented and often difficult to access in many geographical settings including Europe.

Early detection and screening for perinatal depression

In order to prevent a negative impact on the course of the pregnancy and the development of the child, early detection of mental health problems during pregnancy is crucial. Health care professionals should be alert to the possibility of depression among pregnant and postpartum women and should attend to symptoms that may suggest depression.

With the Whooley questions in combination with the Edinburgh Postnatal Depression Scale (EPDS) there exists a valid strategy to screen for perinatal depression, even if there is currently no evidence from high-quality clinical trials that screening improves health outcome (5). Attention should also be paid to experience of intimate partner violence and symptoms of posttraumatic stress disorder (PTSD). Many women are reluctant to disclose psychological distress to others, including caregivers, because of the stigma of mental illness. This is particularly problematic at this life stage because of concerns about being regarded as a ‘bad mother’. Attention should therefore be paid to providing a safe environment and access to non-stigmatizing support that is regard by women as appropriate to their needs. The availability and acceptability of appropriate referral pathways are also necessary components of ethical screening programmes.

Perinatal care

Considering the consequences of untreated mental health problems during pregnancy, routine antenatal care should include optimization of the woman’s psychological well-being and the provision of psychosocial support. Interdisciplinary care is necessary in cases of depression and appropriate antidepressant medication should be started, if psychosocial support and/or psychotherapy are not sufficient and the severity of the depressive symptoms affords it. No consistent association between use of antidepressant medication during pregnancy and negative long-term effects on the child has been demonstrated and the potential impact of maternal psychiatric illness on the child should be taken into account when considering drug use during pregnancy (6).

In women with known depressive disorder or at risk for developing perinatal depression, care should start when a pregnancy is intended, be maintained throughout pregnancy and extend beyond delivery. Continuity of care and support should be provided beyond the early postpartum period.

Best Practice Advice

The National Institute for Health and Care Excellence (NICE) guideline “Antenatal and postnatal mental health: clinical management and service guidance” provides excellent pathways and defined quality standards for the care of women with mental health problems from preconception counseling through pregnancy to the postpartum period (available at https://www.nice.org.uk/guidance/cg192). Furthermore the International Marcé Society for Perinatal Mental Health, an organization of mainly psychiatrists and psychologists dedicated to supporting research and assistance surrounding prenatal and postpartum mental health for mothers, fathers and their babies (http://marcesociety.com/), promotes and disseminates knowledge which could inform health care policy. Its Position Statement 2013 provides guidance for clinicians, policy makers and health services for undertaking universal psychosocial assessment of women during the perinatal period.

Implications for Training

There is a need for health professionals to be adequately trained in the recognition and management of mental health disorders in pregnancy. This need is largely unmet, and many doctors, midwives and allied professionals lack the confidence and knowledge required for effective, woman-centred care. The National Health System of Scotland Perinatal Mental Health Curricular Framework provides the content and learning outcomes for a comprehensive training programme in the prevention, identification and
management of perinatal mental health disorders and the pertinent professional, ethical and legal issues. It is an exemplar template that can be adapted to suit local training needs at various levels.

**European Board and College of Obstetrics and Gynaecology (EBCOG) Standards of Care**

EBCOG has also developed standards of care for pregnant women with mental health disorders (available at http://www.ebcog.eu/index.php?view=list&slug=standard-of-care&option=com_docman&an=181). These standards are meant to provide health care providers and the women they care for with up to date evidence based strategies to minimize risk and optimize outcomes during and after pregnancy for both mother and newborn.

**The Way Forward**

Health policy makers should make appropriate specialist services accessible to pregnant women with mental health disorders. Training and education on preventing, identifying and managing perinatal mental health disorders should be provided as part of national specialist training curricula and all the health professionals involved should be trained to be aware of risk factors and of the impact of mental health disorders. There is a need for policy makers to ensure that clear protocols and standards of care are in place, are rigorously applied and are updated as appropriate. Multi-disciplinary care must be coordinated and clear referral pathways should be in place. The roles and responsibilities of all the staff concerned should be explicit. Women with mental health disorders should be treated sensitively and with respect. Governments and policy makers should actively strive to educate and raise the awareness of society in general about mental illness and thus reduce the stigma, paying attention to the way that women face the different stages of the pregnancy, including maternal or fetal medical complications that may arise. Health care policies should identify and address barriers and facilitators to both service provision and service uptake. These aspects have been considered in various national and regional policy papers in the United States, Canada, Australia and the United Kingdom but to the best of our knowledge, no national or supra-national policies have been articulated in mainland Europe. This gap needs to be bridged as soon as possible. We urge governments to ensure that health policy on perinatal mental health is backed up by implementation strategies and guidelines for the commissioning of services and ensure that the policy is fully supported by dedicated and adequate funding. Together with other UN agencies, such as WHO and UNFPA, the International Society of Psychosomatic Obstetrics and Gynaecology (ISPOG) and EBCOG would be pleased to set up a joint working group to develop European wide guidance for the care of these vulnerable women.

**Implications for health care policies**

Health care policies should consider these strategies, providing health professionals all the appropriate means to assure assessment of women’s mental status during pregnancy. Also, health professionals should be aware of maternal mental health, paying attention to the way that women face the different stages of the pregnancy, including maternal or fetal medical complications that may arise. Health care policies should identify and address barriers and facilitators to both service provision and service uptake. These aspects have been considered in various national and regional policy papers in the United States, Canada, Australia and the United Kingdom but to the best of our knowledge, no national or supra-national policies have been articulated in mainland Europe. This gap needs to be bridged as soon as possible. We urge governments to ensure that health policy on perinatal mental health is backed up by implementation strategies and guidelines for the commissioning of services and ensure that the policy is fully supported by dedicated and adequate funding. Together with other UN agencies, such as WHO and UNFPA, the International Society of Psychosomatic Obstetrics and Gynaecology (ISPOG) and EBCOG would be pleased to set up a joint working group to develop European wide guidance for the care of these vulnerable women.

**References**

S
RHR is a broad concept, including and taking account of the whole population throughout the life-course. It is an area with importance for self-esteem, well-being and intimate relations, regardless of sex, gender identity/expression, sexual orientation, age, ethnicity, financial status and disability. The aim of the national response to SRHR in Sweden is to create societal and social preconditions to secure and improve SRHR. The starting point is the overall public health target to create societal prerequisites for good health on equal terms for the entire population (1) as well as the main principle of non-discrimination (2).

Globally the problem and consequences of inequalities between men and women are vast and even worse with regards to transgender people. The problem of inequalities is multifaceted; women die and suffer from sexual and reproductive ill-health as a consequence of: rising HIV and sexually transmitted infection (STI) cases; little or no sexuality education; lack of self-power over one’s own body or mind; high exposure to discrimination; and in many countries, lack of capacity or opportunities for women to have their own representation.

Sweden has a long tradition of addressing SRHR, partly based on the Swedish welfare model that promotes equal opportunities for all. Publicly funded universal health and childcare, as well as subsidized university education are part of its founding principles. This welfare model has generated a range of reforms and policies that have also been of importance for improved equity and gender equality and hence also affected SRHR in Sweden in a positive way.

Historically, SRHR has focused on the prevention of ill-health, including sexual ill-health, unwanted pregnancies, HIV and STIs and sexual violence. At the same time, there has been an awareness of the importance of the health promotional aspects of healthcare, for example, focusing on sexual health for young people by implementing youth friendly health services via youth clinics. A vital contribution in reducing the taboo of sexuality at large is that Sweden, since 1956 has an age appropriate compulsory sex and relationship education, starting from pre-school and throughout secondary school.

However, the perspective has changed during the years. It has progressed from being a narrow population-based development issue to a broader public health agenda, where sexual health is seen as a determinant for health and sexual health a prerequisite for reproductive health. Today’s SRHR efforts have a clear focus on equity, gender equality and human rights, including sexual rights (3). Ever since the world faced the HIV epidemic, the response to HIV raised awareness of the SRHR inequalities and its negative impact on sustainable and successful prevention.

In Sweden there has been and is a broad political consensus and continued support for HIV prevention. A state grant of 15 million Euro has been allocated to HIV prevention annually, a national strategy has been in place since the year 2006 and there has been a clear focus on co-operation between all national, regional and local levels of government. The HIV prevention strategy includes the perspectives of SRHR, for example, by advocating for minority groups, especially men who have sex with men, migrant groups and youths and young adults (4). Equally important as the link between HIV and SRHR is the link to Lesbian Gay Bisexual Transgender (LGBT) rights. In Sweden, a national strategy for equal rights and opportunities regardless of sexual orientation, gender identity or gender expression has been present since 2014. The continuous efforts for prevention of HIV and treatment to prevent progression to AIDS has led to an increased awareness of the living conditions of people living with HIV and the stigma and discrimination that comes with ignorance. The focus today must be on “leaving no-one behind”.

Sweden has a long tradition of a strong rights based civil society. There are many organizations promoting and supporting SRHR. Two of them are the Swedish Association for Sexuality Education (RFSU: http://www.rfsu.se/en/Engelska/) and the Swedish Federation for Lesbian, Gay, Bisexual and Transgender and Queer Rights (RFSL: http://www.rfsl.se/en/).

Under the umbrella of the International Planned Parenthood Federation, the Swedish organization RFSU, founded in 1933, works both nationally and internationally, especially with SRHR. RFSL fought from the beginning for the right to legal and safe abortion and contraception, sex education in schools and to end the decriminalization of homosexuality. It remains a strong voice for SRHR. RFSL is a non-profit organization founded in 1950. RFSL’s goal is that the same rights, opportunities and obligations shall apply to LGBT people as they do for everyone else in society.

Since 2014 the government of Sweden has developed a focused, feminist political approach promoting equality policies and strategies such as the national gender mainstreaming of governmental agencies and universities (JIM), a national strategy for preventing men’s violence against women and other measures to integrate the wide governmental gender equality goals into the political agenda. This is in line with the ongoing work with Agenda 2030 that is currently being rolled out.

Interestingly enough, in Sweden, the government’s intention and priorities regarding SRHR have mainly been presented in official documents regarding Sweden’s foreign policy on the subject (3, 5, 6). In 2014 the government commissioned three governmental agencies to explore the need for and propose a national SRHR strategy, but it was not further investigated. However, in 2016 the Public Health Agency of Sweden became the national coordinator of SRHR. The agency is responsible for knowledge-building as well as for any monitoring and evaluation processes. In this role, the
agency will carry out the first population-based SRHR survey in Sweden during 2016-2019. Two earlier studies (1967 and 1996) have been carried out in Sweden, encompassing some parts of the SRHR arena, but focusing mainly on sexual behaviour (7, 8). The coming study will provide a baseline and a scientific basis for future prevention initiatives and work.

Current challenges to strengthening and assuring SRHR in Sweden are increasing socio-economic inequalities, segregation of groups and rural versus urban areas which increasingly affects availability and access to public services as well as information. With information today being largely available but also largely filtered through social networks, the challenge for governmental agencies, institutions, healthcare and civil society is to get through – and raise – the questions of sexual health, reproductive health and the rights to health. This is essential for a society where equity and equality are cornerstones, both in terms of monitoring and evaluation (to obtain information on and from risk groups) as well as in terms of promotion and prevention (delivering interventions and information to segments of society). Having this in mind, the Public Health Agency will within the next 5 years have built new knowledge and evidence for SRHR in Sweden, focusing on the structural and societal determinants of SRHR.

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ACHIEVEMENTS IN SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS: IMPROVED ACCESS AND QUALITY OF ABORTION SERVICES FOR WOMEN IN THE REPUBLIC OF MOLDOVA

Introduction
Each year, 47,000 women die worldwide due to complications of unsafe abortions, with even more suffering major health complications (1). Evidence indicates that access to legal abortion determines the level of unsafe abortions, as well as the incidence of death caused by unsafe abortions. It also confirms that women will obtain abortions regardless of the legal status of the procedure and/or availability of safe services and that restricting access to abortion simply leads women to resort to clandestine and/or unsafe abortion (2). The provision of safe and quality abortion services can reduce maternal mortality. It is recognized that almost all the deaths and complications from unsafe abortion are preventable. Procedures and techniques for early-induced abortion are simple and safe. When performed by trained health care providers with proper equipment, correct technique and sanitary standards, abortion is one of the safest medical procedures (3). International and regional human rights bodies have specifically stated that where abortion is legal, it should be safe and available, a principle to which States originally agreed to at the International Conference on Population and Development Programme of Action (ICPD) in 1994 and its five year follow-up conference.

The situation in the Republic of Moldova
Abortion was legalized in Moldova in 1955. Today, very little has been modified from the original law, which allows women to have a pregnancy termination up to 12 weeks upon request. After 12 weeks gestation abortion is regulated by the Ministry of Health (MoH). It is permitted only after 12 weeks and up to 21 weeks based on a large list of medical indications and nine social indications (age under 18 and more than 40; divorce or death of the spouse during pregnancy; pregnancy as a result of rape, incest or human trafficking; pregnant women, with 5 and more children, or if she is taking care of a child that is less than 2 years old; poverty; and homeless women). There was an attempt to restrict access to abortion in 2011 by a member of parliament, but, due to the mobilization of civil society and the negative reaction of the MoH and UN Human Rights representatives in the country, the proposal was rejected. The 2012 approved Reproductive Health Law clearly states, “In Moldova women have the right to safe abortion” (4).

During the time between the 1960s and 1990s, abortion was the primary means to regulate fertility, due to the lack of family planning knowledge among the population and poor access to services. Abortion rates were high (up to 20 per 1000 reproductive age women), reflecting the continuing unmet need for contraception, especially for vulnerable groups, for women from rural areas and adolescents. The quality of abortion services was poor and relied on outdated methods. Precarious equipment, lack of consistent training of abortion providers and of evidence-based guidelines and protocols contributed to a high level of post-abortion complications. The percentage of maternal deaths caused by abortion in the general context of maternal mortality was very high accounting for 30.3% of all deaths during the period of 1996-2005 (5).

Recognizing the importance of the issue, abortion was included among 11 priority areas in the National Strategy for Reproductive Health 2005-2015 approved by the government. The Strategy aimed to reduce the use of abortion as a method of birth control and ensure its provision in safe conditions. The expected results of the Strategy were: the rate of abortions will not exceed 15 per 1000 women of reproductive age; over 70% of women will have a chosen method of contraception post-abortion when leaving the facility; and there will be a decrease in the post-abortion complication rate and the maternal deaths caused by post-abortion complications.

In order to comply with the provisions of the Strategy, the MoH adopted the WHO Strategic Approach to strengthening sexual and reproductive health policies and programmes, with the goal to strengthen national abortion policies and improve the quality of service delivery.

The first step taken was the Strategic Assessment of quality and access to contraception and pregnancy termination services, conducted in 2005. The MoH delegated the NGO the Reproductive Health Training Centre (RHTC) the coordination of the assessment and the implementation of other related activities within the Reproductive Health Strategy.

The strategic assessment resulted in recommendations for interventions related to abortion policies and service delivery including: development of national standards and guidelines for comprehensive abortion care (CAC); revision of the national training curriculum; development and introduction of the CAC model for outpatient services; upgrading of the health management information system for abortion; and registration of Medabor® (a combipack of mifepristone and misoprostol for pregnancy termination).

With the support provided by the WHO and other international organizations, between 2007 and 2011 the RHTC team developed the National Safe Abortion Standards, based on WHO recommendations and approved by the MoH in 2011. They also reviewed and approved the abortion training curriculum and upgraded and institutionalized the system for statistical data collection to reflect not only the quantity but also the quality of pregnancy termination services.

The model of outpatient CAC was developed and tested in six model-centres and scaled-up nationally. According to the National Centre for Health Statistics, about one third of all terminations of pregnancy in the country are performed in outpatient settings within these 6 facilities using WHO recommended methods such as vacuum aspiration and medical abortion. The registration of Medabor® in 2014 has also contributed to better access to medical abortion drugs for all women.

In 2012 an assessment of the quality of pregnancy termination services in model-centres showed a very low proportion of abortion complications, higher user
Maia, economic and social well-being of the elderly population.

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Figure 1: Abortion methods used in the Republic of Moldova from 2005-2015 in number of cases (6).

EVA = electrical vacuum aspiration, MVA = manual vacuum aspiration, D&C = dilation and curettage, MA = medical abortion

satisfaction (both patients and providers) with service setup and a greater proportion of women adopting a post-abortion contraceptive method. Given the extremely positive experience of model-centres, the MoH recommended that CAC be implemented in other relevant healthcare facilities in the country as per the national regulations and standards in effect. As a result, several healthcare facilities reorganized their abortion care services to align with MoH recommendations and national standards by using vacuum aspiration and medical abortion instead of dilation and curettage.

The abortion rate dropped down to 15 per 1000 reproductive age women in 2015 (6). Today, three quarters of all abortions in the country are performed with WHO recommended methods: manual or electrical vacuum aspiration (70%) or medical abortion with mifepristone and misoprostol (15.4%), compared to three quarters of procedures performed with dilation and sharp curettage when programme strengthening efforts began in 2005 (see Figure 1).

Other quality of care indicators, collected as part of national abortion statistics, also show positive results: local paracervical anaesthesia is replacing general anaesthesia and is used in 70% of aspiration abortions; misoprostol is used for cervical priming in 20% of women prior to surgical abortion; post abortion contraception is offered up to 66.7% of women before leaving the facilities; and the rate of post-abortion complications is very low at 0.6% (6). The level of maternal mortality has also declined and the last case of abortion-related death was registered in 2010.

What the future holds

The MoH is keen to see all abortions performed in outpatient services with WHO recommended methods in the near future. Future plans also include expanding medical abortion services in the country’s network of youth-friendly services clinics and expansion of CAC in strategically selected Reproductive Health Offices. The RHTC team is also committed to working with the MoH to develop and implement a national CAC facility accreditation system and a system for monitoring the quality of abortion services. This should further encourage all centres currently providing abortion care to strengthen their services, in line with national standards, resulting in higher standards of care nationwide. Finally, the project team will support the MoH in updating the national standards to ensure that they continue to reflect the latest WHO recommendations for clinical care and provision of rights-based services. Based on achievements to date, continued positive improvements in access to and quality of abortion services for all women in the Republic of Moldova will be possible and attainable.

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MEANS TO FACILITATE IMPLEMENTATION OF SAFE ABORTION TECHNOLOGIES IN THE FIRST TRimestER

Background
Despite significant progress in reduction of absolute number of abortions over the past 10 years, abortion as a means of contraception by women remains high in the Russian Federation. In 2014 the abortion rate was 22.8 per 1000 women aged 15-49 years (1).

Abortions have been legal in the Russian Federation since 1995. However, dilatation and curettage (D&C) remains the most common method (59.1%)(1), primarily due to a lack of knowledge and skills of reproductive health professionals on alternative methods for performing abortion. Following the Ministry of Health’s “Strategic assessment of policies, programmes and services in the area of unwanted pregnancies, abortions and contraception in the Russian Federation”, one of the main recommendations was prompt replacement of obsolete methods of pregnancy termination in the first and the second trimesters.

We hypothesized that education and training of health care providers would result in more widespread adoption of manual vacuum aspiration (MVA) procedures for abortions between 6 and 12 weeks of gestation in both outpatient and inpatient settings compared to administrative directives alone for the same procedure. To check this hypothesis we used a comparative assessment of the two options to facilitate introduction of MVA into practice in the Sverdlovsk region of Russia was conducted. The administrative directives (Directive of the Ministry of Healthcare of the Sverdlovsk region 1229p) empowered health care providers to use MVA both in outpatient and inpatient facilities for termination of pregnancies diagnosed not later than 10 weeks of gestation. The strategic assessment and this study was supported by the WHO Regional Office for Europe and implemented in 2013-2014.

Methodology
The participating health care facilities were divided into 2 groups. The intervention group consisted of 6 health care facilities (3 inpatient clinics, 3 outpatient antenatal clinics and 12 physicians) that received training from May 28-29, 2013. Participants in this group were educated and trained with a special course that focused on both the theoretical and practical aspects of MVA, which included training on models and in the operating room. The control group included 6 health care facilities: 3 inpatient and 3 outpatient clinics, with a total number of 12 doctors. The participants in the control group did not attend the educational training course.

Assessment of the knowledge of obstetricians and gynaecologists in the intervention group was carried out before and 6 months after training. The knowledge of the control group was initially assessed together with the intervention group and 1 year afterwards. Evaluation of statistical indicators of participating facilities and settings was carried out using data collected from health systems reports submitted 6 and 12 months after termination of the training course. To facilitate comparative analysis statistical indicators for the year 2012 were also retrieved.

Criteria used to evaluate the effectiveness of the intervention included:
- the quality of theoretical knowledge (academic evaluation by 5-point Likert scale);
- total number of abortions and the MVA/D&C ratio; methods of anaesthesia; post-abortion complications; and methods used for re-evacuation of the uterine cavity.

The results and discussion
Analysis showed that 70% of abortions were carried out in hospitals during the study period. This is an unjustifiably high rate, as the safety of abortion up to 12 weeks by MVA under combined anaesthesia in an outpatient setting has been proven by numerous studies (2). The reported incidence of early complications is 0.1% to 3.4% and serious complications requiring hospital admission do not exceed 0.1 to 0.25% (2). This is most likely a consequence of implementation of the major directive regulating abortion services in the Russian Federation. The Directive of the Ministry of Healthcare 572n “On approval of the Order of medical care provision in obstetrics and gynaecology (excluding assisted reproductive technologies)”, reads: “Pregnancy termination in terms of up to 12 weeks by surgical method is performed in the daytime inpatient units of medical facilities or in the hospitals”, while antenatal outpatient clinics, according to the same Directive, are allowed to perform abortions only in “early terms” of pregnancy (less than 6 weeks gestation). This regulation reflects what was happening 30 years ago, when MVA started to replace sharp curettage. It was not allowed to be performed on an outpatient basis in pregnancies greater than 6 weeks due to concern of severe complications which could require the use of general anaesthesia and respiratory support. Evidence now proves this is no longer a valid concern.

It does, however, remain problematic. Even the new regional regulating document, the Directive of the Ministry of Healthcare of the Sverdlovsk region 1229p, which enables abortions between 6-12 weeks gestation to be performed in antenatal outpatients clinics, failed to overcome the above mentioned restriction of the directive of a “higher” (state government) level. New directives will need to take this “contradiction” into consideration if we wish to see a decrease in the number of first trimester abortions performed in the hospital setting and an increase in the outpatient setting.

As for the knowledge of healthcare providers, those who completed the educational training course demonstrated an 80% increase, with the overall estimate of knowledge changing from 3.1 points (satisfactory) to 4.6 points (excellent) and the number of correct answers from 59% to 92%. This improvement was observed immediately after training and was also demonstrated during repeat testing 6 months later. In contrast, the group of healthcare providers who did not attend the educational training course did not show significant knowledge improvements. The quality of knowledge increased only by 11% from 3.1 points (satisfactory) to 3.3 points (satisfactory).
The number of correct answers increased slightly – from 59% to 67%, with one third of the answers remaining incorrect at 33.4%.

Application of safe abortion technologies (MVA and medical abortion) in outpatient facilities increased by 44.5% in both groups and reached 100% coverage by the end of the study period (D&C was no longer used in the outpatient setting for first trimester terminations). The ratio of D&C/MVA in the first half of the study year was 0/1 in all antenatal clinics (regardless of whether the health workers had been trained or not) in contrast to 2012, when it was 1/1, i.e. D&C and MVA were used equally as often. This may be attributed to implementation of both the national and regional directives. For in-patient facilities the use of MVA increased by 23% and reached 100% in the intervention group, while in the control group the increase was only 7.5%. However, in 2014, by the end of the second half of the study year, the method of MVA was the predominant method used, regardless of whether the study site had taken the training course or not. This would imply that the directive alone also worked, though not as quickly as together with education/training of the providers.

In our study, the initial (pre-study) number of post abortion complications for abortions performed in outpatient clinics, did not exceed average world statistics (6%) (2) and consisted mostly of incomplete abortions (5.1%). All women who experienced this complication were referred to hospitals, although repeated MVA or completion of abortion with the use of prostaglandins could be performed in an outpatient setting.

One year after the end of the educational training course the number of early post abortion complications following abortion in antenatal clinics decreased 20 and 15 times in the intervention and control groups compared with the year prior to training (from 6% to 0.3% and 0.4%). The number of complications requiring hospital admissions due to early post abortion complications in the outpatient setting in the intervention group decreased 5 times and in the control group 3.75 times (from 1.5% to 0.3% and 0.4% respectively). In the hospital setting a decrease was also seen in early post abortion complications, although much smaller in magnitude (4.6 times, from 5.6% to 1.2%, in the intervention group and 3.2 times, from 5.6% to 1.7%, in the control group). The number of re-admissions due to post abortion complications performed in hospitals decreased 6.9 times (from 5.5 to 0.8%) in the intervention group and 5 times (from 5.5% to 1.1%) in the control group. If re-evacuation of the uterine cavity was necessary, 99.8% of providers who had received training used MVA instead of sharp curettage, while the doctors who were not trained still used the more invasive method of D&C in 33% of cases. The increased use of MVA both for abortion and for re-evacuation of the uterine cavity in incomplete abortion instead of sharp curettage should be considered a positive change. Another significant positive change was the application of the combined pain control protocol including verbal support, analgesics and cervical block with local anaesthetic preparation in 100% of abortions performed in outpatient settings.

**Conclusion**

Our study demonstrated that provision of education and training to healthcare providers on safe practices of MVA lead to a rapid introduction of MVA into clinical practice for termination of first trimester pregnancies in the outpatient and inpatient settings. While increase in uptake of MVA was also seen with administrative directives, this improvement was slower and of smaller magnitude. Where training had been completed MVA usage reached maximum saturation 6 months earlier than where training had not been completed. Furthermore, provision of the educational training course for health care providers contributed to an improvement of the quality of care by means of a significant reduction of early complications, hospital admissions and sharp curettage for re-evacuation of the uterus. Thus, the directive methods of introduction of modern methods of abortion, while important, should be accompanied by targeted education and training of health care providers.

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**References**

For this final issue of *Entre Nous* we take a look back at our most popular and requested publications from the magazine.


Given the groundbreaking influence the 1994 International Conference on Population and Development, held in Cairo, had on sexual and reproductive health and rights to the development agenda, it is not surprising that we revisited the commitments made in the Programme of Action not once, but twice. Taking a critical look at progress to date, accomplishments and persistent or widening gaps and inequities in SRH and rights, both issues were favourites, especially with policy makers and programme implementers. Willing to bring attention to unfinished agendas, both issues played a crucial role in raising awareness of neglected issues in SRH and rights to inform both the Millennium Development Goals and the Post-2015 Development Agenda.

**Abortion in Europe, *Entre Nous* No. 59, 2005.**

Co-published with the International Planned Parenthood Federation European Network (IPPFEN), this is perhaps our most popular issue. Not a single copy remains in either English or Russian and numerous requests are received on a regular basis for original copies. Published shortly after the WHO guidelines on safe abortion, this issue brought attention to the continued neglect of sexual and reproductive health and rights for women and the persistent barriers faced by women in Europe in terms of unmet need for contraception and restrictive policies for safe abortion. Rates of abortion that were some of the highest in the world, combined with poor quality of care meant that Europe faced high rates of mortality and morbidity associated with legal abortion. The message was clear – Europe was not spared from the consequences of unsafe abortion – and the articles in Issue No. 59 ensured that the European community was made aware of this dire situation.

**Low Fertility: The Future of Europe, *Entre Nous* No. 63, 2006.**

As the focus of development goals shifted from reducing global population growth to ensuring sexual and reproductive health and rights for all, this issue of *Entre Nous* was brave enough to bring attention to the low fertility rates and negative population growth that was the new reality for Europe. Planned to assist policy makers, the issue brought together a diverse group of authors from academic institutions, professional associations and UN agencies to share experiences with and discuss the importance of family friendly policies, informed choice, social factors and proactive migration policies from across the Region. Its thought-provoking articles provided an opportunity for reflection for the *Entre Nous* community on the parallels and contrasts between international agreements and demographic trends in the European Region.

**Can We Prevent Cervical Cancer? *Entre Nous* No. 64, 2007.**

In 2006 the first human papillomavirus (HPV) vaccines for the prevention of cervical cancer were approved. With this approval came new implementation challenges, applied research questions, questions of funding sustainability and of course controversy. At the heart of the controversy was the proposal that the vaccine – which would prevent both a sexually transmitted infection and a reproductive health cancer – be delivered to an adolescent or pre-adolescent population. *Entre Nous* rose to the challenge and through its articles provided evidence based, up to date information on the burden of cervical cancer in Europe, including prevention, screening and treatment strategies from diverse European countries.

Faced with the alarming increase in noncommunicable diseases (NCDs) within the European Region and globally, the 75th issue of *Entre Nous* brought attention to the linkages between NCDs and sexual and reproductive health (SRH) and the importance of addressing them in partnership. Despite the similarities in terms of vulnerability and risks to ill health between the two, there had been a public health failure to explore and understand the relationship between the two for men and women across the life-course. While bringing attention to these 2 linked public health priorities, *Entre Nous* also provided guidance on what was required by governments, civil society, private sectors, policy makers and individuals to tackle the complex interaction between NCDs, SRH and sustainable development.

Young and Healthy? *Entre Nous* No. 69, 2009.

Co-published with the National Health System Scotland and the International Planned Parenthood Federation European Network (IPPFEN), this issue would not be the first or last time *Entre Nous* explored the importance of ensuring sexual and reproductive health and rights for young people. The diversity of voices, from both youth and non youth and the exchange of information and experiences between varied countries on topics that ranged from quality services, to sexuality education, to sexual and reproductive health and rights and inclusive policies all contributed to its popularity.


Once again the magazine decided to be forwarding thinking by focusing on the topic of sexuality within the ageing population – a topic that for far too long had remained taboo. The ground breaking articles addressed a broad spectrum of aspects of ageing and sexual health and brought attention to the reality that sexuality and sexual health are an intrinsic part of health and well-being in older age. A sensation at the office, colleagues, of all ages, were known to drop into the office to pick up a copy for themselves or family members. The cover remains a favourite of all who worked on the magazine.


The vastly different cultures, religions and economic backgrounds across Europe contribute to its diversity and are part of what makes the Region so unique. However, these same aspects also present unique challenges with regards to sexual and reproductive health and rights. Published during the period where many countries of eastern and central Europe were emerging from or still going through transition, this issue of *Entre Nous* celebrated Europe’s multiculturalism while also critically examining the challenges diversity presents to policy makers, service providers and programmers. It was a refreshing look at the varied contextual and political factors that influence sexual and reproductive health and rights in the Region, many of which are still relevant today.