ARE WE ON TRACK?
PROGRESS TOWARDS
MDG 3, 4 AND 5 IN EUROPE
Entre Nous
The European Magazine for Sexual and Reproductive Health

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A decade ago 189 countries from around the world pledged their support for the launch of the Millennium Development Goals (MDGs), with the aim of working together to eliminate inequities and ensure the highest possible attainment of health for all people. Women and children featured predominantly; of the 8 development goals 3 were directly related to women and children (MDG 3, 4 and 5) and the other 5 goals were indirectly connected. As the countdown to 2015 approaches, activities such as the global review of progress towards the development goals, the G8 Muskoka Initiative and the renewed commitment to maternal and child health with the launch of the UN Global Strategy for Women’s and Children’s Health at the MDG Summit in September 2010, have caused 2010 to be considered a milestone year on the development agenda – a turning point for maternal and child health.

Globally there is much to be excited about as we review progress towards the development goals. For the first time, new data have revealed significant progress in the reduction of maternal and child deaths, with several low income countries on track to meet MDG 4 and 5. Innovative approaches, including private public partnerships and the use of new technology, are providing exciting opportunities to address health system challenges faced in many low resource countries. This momentum needs to be continued, for despite positive changes there is still much that needs to be addressed if we wish to have all countries attain the MDGs – inequities persist both across and within regions and countries, including within the WHO European Region.

In the recent overview of progress towards the MDGs in the WHO European Region there is a clear indication that MDG efforts are falling short in some areas, particularly MDG 4 and MDG 5. Although available data reflect a steady decline for under-five and infant mortality rates as well as for the average maternal mortality ratio, striking inequities persist between and within countries. For example, there is a 25-fold difference in infant mortality rate and a 30-40-fold difference in maternal mortality rate between countries with the lowest and the highest rates. Evidence suggests that there are also substantial within country inequities in terms of access to skilled health workers at delivery and antenatal care by socioeconomic status (education, wealth), ethnicity and residence (urban-rural). In Armenia for example, there is a graded relationship between women’s educational level and access to antenatal care. Composite measures of gender equality indicate huge differences between countries in the European Region, with wide discrepancies in gender power relations and gender bias across all development sectors; more women work part time and earn lower wages than their male counterparts and overall numbers of women in the highest levels of government remain low. More importantly it has become increasingly clear that progress in MDGs 4 and 5 is hampered by poor progress in the determinants of health related MDGs, such as gender, education and poverty. Thus accelerated progress towards the MDGs requires collaborations and coordinated, simultaneous action across multiple sectors and systems.

Recognizing that scaling up progress towards the MDG targets presents a challenge for the European Region, the WHO Regional Office for Europe is leading the way in coordinating efforts and working to accelerate progress towards achieving MDGs 3, 4 and 5 by: helping countries deliver integrated reproductive and child health care guided by comprehensive gender responsive and equity based policies, strengthening health systems through training and capacity building materials and technical guidance to enhance quality of care, applying a human rights based framework to advance sexual and reproductive health through legislation and policy formulation and strengthening stewardship through improved health information systems, data collection and accountability.

Each article in this issue of Entre Nous provides a unique perspective on the challenges and successes present throughout the Region in the attempt to achieve the targets for MDGs 3, 4 and 5. As you read them I encourage you to think about the words of the Secretary-General of the United Nations, Ban Ki-moon: “As we seek to usher in a new era for the health of women and children, let us be flexible in our approaches; let us learn from what works and what doesn’t; and let us challenge ourselves and others to deliver.”

We need to ensure that the health of women and children remains high on the international agenda, accelerating delivery of results at country and regional level through committed, accountable partnerships. To do this requires the engagement not only of governments, aid organizations, non-governmental organizations, community and faith based organizations, academic institutions and private enterprise, but also every woman, man and child. Historic leaps in development are possible if we take the time to learn from each other, collaborate and focus on what each of us can do best.

Zsuzsanna Jakab
Regional Director, WHO Regional Office for Europe
The Millennium Development Goals (MDGs) are a series of globally agreed social and economic targets with a 2015 deadline. While the health of women and children is critical to the achievement of all MDGs, the goals related to women’s and children’s health are the ones lagging most behind. Worldwide every year more than 8 million children die before reaching their 5th birthday, 215 million women who would prefer to delay or avoid pregnancy lack access to safe and effective contraception and an estimated 358 000 women per year die during pregnancy or childbirth.

The Global Strategy for Women’s and Children’s Health (1), launched at the UN summit on the MDGs in New York in September 2010, identifies the finance and policy changes needed, along with vital interventions to help improve women’s and children’s health and save lives. Between 2011 and 2015 it is expected to prevent, in the world’s 49 poorest countries, the deaths of more than 15 million children under five, as well as 33 million unwanted pregnancies and the deaths of 570 000 women from complications related to pregnancy and childbirth.

To help ensure that the Global Strategy is successful, several agencies, including the WHO, UNICEF, UNFPA, UNAIDS and the World Bank are collaborating to mobilize ongoing political and operational support, including fighting for universal access to care for all women and children. This team will identify and connect resources to the people who need them based on the priorities set by countries in their national health plans. In addition, the Bill & Melinda Gates Foundation, the GAVI Alliance, and the Global Fund to fight HIV/AIDS, TB, and Malaria are working with this team to ensure integration of services and efforts across a broad range of health needs.

So far governments, the private sector, foundations, international organizations, civil society and research groups have committed US$ 40 billion in resources to scale up health services worldwide during the next five years. The detailed list of commitments includes for example the announcement of France and Norway to increase by 20% their contributions to the Global Fund to fight AIDS, TB and Malaria over the period 2011-2013 and the pledge of the United Kingdom to double its annual support for maternal, newborn and child health by 2012, and sustain that level to 2015 (2). All funding will be measured and tracked to ensure accountability for commitments, actions and results. The WHO has been asked by the Secretary General of the UN to be the responsible agency to develop a monitoring framework to track the progress made by countries and by relevant stakeholders in implementing their commitments. The pledges made until now represent more money for health but are also expected to ensure more health for the money, through better and more focused use of available resources.

Why women’s and children’s health?

With just five years left to achieve the MDGs, it has become obvious that the efforts to improve the health of women and children have to be intensified: while MDGs 4 and 5 are key to all development goals, they stand as the slowest-moving of all MDGs.

Most of the deaths that affect women and children can be avoided by ensuring that all women and children get the prevention, treatment and care they need. This includes access to good quality care before, during and after pregnancy and childbirth, family planning, vaccines and proper nutrition, as well as treatment of pneumonia, diarrhoea, HIV/AIDS, malaria tuberculosis and noncommunicable diseases. Effective and affordable interventions are available to save women’s and children’s lives.

Investing in both women’s and children’s health leads to high economic returns, including greater national productivity and higher economic growth for countries. The global economic impact of maternal and newborn mortality is estimated at US$15 billion in lost productivity every year. Investing in women’s and children’s health creates the foundation for a more productive present and future workforce.

How does the Global Strategy work?

For the Global Strategy to be successful, all partners have to work together: governments, donor countries, international organizations, the private sector, foundations, research groups and civil society. Innovative policies, products and processes are expected to help achieve the ambitious targets set by MDGs 4 and 5. The goal is to support country-led health plans, strengthen health systems and address existing gaps in the delivery of basic health care. Integrated health care services and coordinated research and innovation will accelerate progress. The partners are also expected to address other issues that affect the health of women and children such as water and sanitation, infrastructure, nutrition, human rights, gender equality and women’s empowerment.

While the Global Strategy aims to reduce countries’ current reporting burden it also emphasizes the need for clear accountability and calls for a tracking of all commitments, actions and results based on national leadership and country ownership. To achieve measurable results for women and children national monitoring and evaluation as well as community-based monitoring must be improved and supported.

What are the implications of the Global Strategy for the WHO Regional Office for Europe?

In the past 15 years, the WHO Regional Office for Europe’s regional activities in the area of maternal and child health mainly focused on improving the quality of health care, strengthening health systems and improving monitoring of
maternal, perinatal and child mortality in countries in eastern Europe and central Asia. The political commitment of governments to achieving the MDGs is high within the Region, but some countries are still developing comprehensive national plans to achieve the targets set by these goals. In addition not all governments allocate sufficient funds to maternal and child health services and fail to adjust their budgets to reflect MDGs 4 and 5 as priority health issues.

Evidence shows that civil society is playing a prominent role in efforts to improve maternal and child health. European governments need to fully recognize the specific contribution of non-governmental organizations and leverage their potential to access individuals, families and communities and support change at the grass root level.

A broad range of tools on improving maternal and child health care has been developed by WHO and its partners to meet the specific Regional needs (i.e. Making Pregnancy Safer – Assessment tool for the quality of hospital care for mothers and newborn babies, the training package for MPS/Promoting effective perinatal care). While these tools are available throughout the Region, urgent action is required to scale-up their use and accelerate their application.

Progress has also been made in the European Region in increasing the quality of service delivery. For example, many outdated practices in perinatal care have been abandoned, and several recommended approaches have been adopted in pilot facilities; familiarity with the concept of evidence-based medicine has increased among providers, national confidential enquiries into maternal deaths are being prepared and facility-based near-miss case reviews piloted (3). Moreover, many countries in the Region are still struggling with over-medicalization of maternal and child care, updating obsolete practices, a lack of skilled staff and problems retaining trained health personnel. Therefore, urgent action is needed to develop comprehensive implementation plans and human resource strategies that will forecast future workforce needs and plan for necessary recruitment and training in focus countries.

**Conclusion**

Not every country and every population group within countries has fully benefited from progress in recent years. Issues of equity are paramount: even countries that are doing very well face challenges in providing quality health services to every woman and every child. Existing negative gender norms and other values that impact on health, such as gender-based violence and early marriage, are barriers to receiving adequate maternal and child health care. Therefore, more action is required to promote the use of services, improve their quality and remove barriers to access to care.

The Global Strategy for Women’s and Children’s health offers the opportunity to reinforce the ongoing activities but is also a powerful instrument to bring governments, donors, civil society and other stakeholders together to harmonize their efforts in improve the lives of all women and children in the Region.

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**References**


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Reproductive health commodities are just as important to sexual and reproductive health as vaccines are to child survival. We need to focus not on what individuals should or should not need, but on what they request and demand. For those who may not always enjoy the freedom to exercise their human rights in this area, access to the broad range of commodities can literally be the difference between life and death.

19 October 2006 Reproductive Health Commodity Security – Challenges, Statement by Thoraya Ahmed Obaid, Executive Director, UNFPA

Achieving RHCS is critical for improving maternal health and access to sexual and reproductive health (SRH) services. Doubling investment in health would yield staggering results: a 70% reduction in maternal deaths and a 44% reduction in the deaths of newborns (1). Delaying first pregnancy and enabling birth spacing are also important elements in reducing not only maternal mortality but also morbidity (which is harder to measure) which has a major impact on women's lives and economic status.

RHCS is also essential for addressing the problem of HIV/AIDS, given that condoms are the only product able to prevent sexually transmitted HIV. In addition the risk of contracting HIV is 2 – 9 times greater when other sexually transmitted infections (STIs) are present which makes the case for ensuring the supply of drugs and equipment for testing and treating STIs (2). All these necessitate a regular and reliable source of commodities which are affordable by everyone.

Rational selection of commodities is a vital component to ensure improved access to these medicines, followed by efficient procurement, logistic systems and rational use, which are equally important. Essential commodities for reproductive health include contraceptives, medicines for prevention, diagnosis and treatment of reproductive tract infections, STIs and HIV/AIDS, and medicines to ensure healthy pregnancy and delivery, and to manage complications of unsafe abortions and for comprehensive abortion services where the law permits.

Governments can educate, inform and motivate individuals to choose healthier behaviours, but fail to sustain the results if the basic supplies of SRH commodities are not made consistently available to the population.

RHCs situation in eastern Europe and central Asia (EECA)

In 2009, UNFPA conducted a desk review of existing RHCS, budgeting and national capacities and progress achieved in family planning service provision throughout the EECA Region (3). Data was gathered through literature review and a survey administered to each of the 20 UNFPA Country Offices in the Region. The report provides an overview and analysis of RHCS across the Region, looking at the policy environment and at systems which support RHCS including procurement, distribution and coordination.

1. Policy, law and enabling environment

Ultimately the security of reproductive health commodities in a country depends on its government. A donor may be able to provide and distribute supplies where a government lacks commitment but this is a less than ideal situation. Preferably a national government should have a clearly stated policy on RHCS which is seen to contribute to wider development needs.

According to the desk review only four countries in eastern Europe (Albania, Republic of Moldova, Turkey and The former Yugoslav Republic of Macedonia) have national action plans in place to address RHCS. In central Asia only Tajikistan completed its strategy and action plan complementing the National Plan on Reproductive Health 2005-2014.

Of the fourteen countries in Europe and the Caucasus, six of them have national development strategies which directly or indirectly addressed needs to improve RHCS. Three of them are of fairly recent origin (The former Yugoslav Republic of Macedonia 2008, Bulgaria 2008, Armenia 2009). The Russian Federation includes strategies to improve RHCS in the 2008 document Concept of Long Term Socio-Economic Development of the Russian Federation to 2020, which outlines strategies for the improvement of the quality of medical help for women during pregnancy and delivery; development of perinatal technologies, treatment of infertility, abortion...
prevention and decline in the number of abortions.

In central Asia only one (Tajikistan) out of the five countries includes strategies to improve RHCS in national development plans, in this case the PRSP (2007 – 2009). Tajikistan also has a National Strategic Plan on reproductive health for the period until 2014.

2. Mechanisms to support RHCS

A number of systems play a key role in ensuring the secure supply of SRH commodities. They include essential service packages and essential drug lists (EDL), funding, procurement, service packages and essential drug commodities. They include essential in ensuring the secure supply of SRH commodities.

Distribution systems are a major influence on commodity security. There is no point in having enough funding for contraceptives and obstetric drugs if the commodities are not then sent out to the right facilities in adequate quantities and in time to be of use. In many countries UNFPA is taking the lead among development partners to improve those systems.

Without state support it is either up to either health insurance schemes to include them in their reimbursement package, or donors or the individual to buy contraceptives. The report shows a lack of funding for contraceptives provided by governments, while provision of obstetric drugs is covered largely by governments or health insurance funds. Only 7 out of the 20 countries in eastern Europe and central Asia have national budgets covering a portion of contraceptives supply. In most countries contraceptives are provided through private sector that increases inequities in health.

Distribution systems are a major influence on commodity security. There is no point in having enough funding for contraceptives and obstetric drugs if the commodities are not then sent out to the right facilities in adequate quantities and in time to be of use. In many countries UNFPA is taking the lead among development partners to improve those systems.

Recommendations

During the desk review the following key challenges were identified for the further improvement of RHCS in the Region:

1. Support to national financing, planning and systems;
2. Support to the finalization of national strategies and action plans for RHCS;
3. Support to resource mobilization;
4. Policy and reform challenges: orientation towards pronatalism presents a challenge to family planning programmes which can appear to counteract policies that promote population growth;
5. Access (availability, affordability and acceptability); and
6. Private sector involvement.

Further improvement of RHCS in the Region will require commitment and support from all key players (donors, governments, UN agencies, non-governmental organizations, civil society) in order to ensure that all individuals have universal access to SRH services and that the Region continues its progress towards achieving MDG 5.

Ezizgeldi Hellenov

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References

The following text is an excerpt from the document: “Millennium Development Goals in the WHO European Region: A situational analysis at the eve of the 5-year countdown.” WHO Regional Office for Europe, 2010

The MDG 4 target is to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. The under-five mortality rate is the probability that a newborn will die before reaching the age of five, expressed as a rate per 1000 live births. Indicators for monitoring progress include the:

- under-five mortality rate;
- infant mortality rate;
- proportion of 1 year-old children immunized against measles (1).

Monitoring progress towards MDG 4 in the European Region has faced significant challenges, in light of weak health information systems and significant differences between official data and estimates of international agencies in many Newly Independent State (NIS) countries. The countries in the Region that in 2007 had achieved the target of a two-thirds reduction against 1990 rates were Iceland, San Marino and Sweden, all of which had an estimated rate of 2 (5). In the European Region, neonatal deaths constitute almost half of under-five deaths. Prematurity and low birth weight, birth asphyxia and birth trauma, and neonatal infections are among the leading causes of neonatal deaths (4).

Acute respiratory infections, diarrhoeal diseases, and non-communicable diseases are among the lead causes of post-neonatal deaths. Malnutrition leaves children more vulnerable to illness and early death (4). As evidenced in the World Health Statistics 2009 report (5), there has been a steady decline in estimated under-five mortality rates across the Region, from an average of 32 in 1990 to 15 in 2007. However, there are striking variations in current rates across the Region. The countries with the highest estimated under-five mortality rates in 2007 were Tajikistan (67), Turkmenistan (50), and Uzbekistan (41) (5). The countries with the lowest were San Marino (2) followed by Finland, Iceland, and Sweden, the three of which had an estimated rate of 3 (5).

The countries in the Region that in 2007 had achieved the target of a two-thirds reduction against 1990 rates were Albania, Cyprus, Czech Republic, Portugal, San Marino, Serbia, and Turkey (5).

For the Region as a whole, infant mortality rates, defined as the deaths of children before reaching the age of one per 1000 live births, have steadily declined since 1990. The estimated Regional average went from 27 in 1990 to 13 in 2007 (5). The five countries with the highest estimated rates in 2007, as stated in the World Health Statistics 2009 report, were: Tajikistan (57), Turkmenistan (45), Uzbekistan (36), Azerbaijan (34), and Kyrgyzstan (33). In contrast, the countries with the lowest estimated rate in 2007 were Iceland, San Marino and Sweden, all of which had an estimated rate of 2 (5).

The effect of the current financial crisis and economic downturn on progress towards MDG 4 in the European Region is not yet known. However, at a global level, countries that suffered economic contractions of 10 percent or more between 1980 and 2004 experienced more than 1 million additional infant deaths (6). It is estimated that slowed economic growth resulting from the current crisis may cause as many as 200 000 to 400 000 more infant deaths per year on average globally between 2009 and 2015. This translates into 1.4 million to 2.8 million additional infant deaths during the period (6).

Research from the African Region suggests that the majority of excess deaths in Africa will be of female infants, as available data indicates that the mortality of girls is substantially more sensitive to income shocks than the mortality of boys (7). How this could develop in the European Region from a gender and socioeconomic perspective requires further research, also with regards to selective abortion.

Globally, in half of the 90 countries that have the necessary data, under-five child mortality rates are at least 1.4 times higher in rural areas compared with urban areas and at least 1.9 times higher among the poorest 20% of households compared to the richest 20% of households (5). In the European Region, available evidence shows a similar picture; children in rural areas, of lower wealth quintiles and born to mothers with lower levels of education—or from ethnic minority, migrant and internally displaced populations—seem to be systematically disadvantaged in terms of benefiting from progress made towards MDG 4 (8). Table 1 shows recent data of inequities in under-five mortality in select countries of the European Region. Action on socioeconomic and environmental
Tables

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Note: Ratios cover rural–urban, lowest–highest wealth quintile. Data for Albania, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, the former Yugoslav Republic of Macedonia and Uzbekistan are derived from Multiple Indicator Cluster Surveys (MICS, round 3) that were extracted from country reports available on the UNICEF web site (http://www.childinfo.org/mics_available.html, accessed 7 December 2009).
environment concerns such as climate change that can disproportionately impact children. MDG 1 tackles poverty and hunger as determinants of child health, with the latter being particularly important as malnutrition accounts for a substantial proportion of all deaths of children aged under five worldwide. MDGs 2 & 3 address women’s education levels, which correlate with significant differences in under-five mortality and immunization coverage for measles, with the children of less educated mothers being generally more vulnerable (13).

MDG 3 further focuses on gender-linked inequities and inequalities that influence child survival and well-being. The mortality of girl children is a good indicator of gender equality and women’s rights. Gender differences affecting boys are also important to account for with regards to MDG 4. In the European Region the overall proportion of DALYs due to injuries is nearly twice as high for males as for females, although there are differences by type of injury. This difference emerges early-on and is related to different gender roles and risk-taking behaviors starting in early childhood (11). As such, gender differences need to be taken into account in the design of health services and prevention programmes.

The WHO Regional Office for Europe contributes to efforts to attain MDG 4 (and MDG 5) by helping countries to develop comprehensive equity- and gender-sensitive policies to deliver integrated, effective care in a continuum—starting with family planning and healthy pregnancy and going through birth and care up to five years of age and beyond. There are multiple initiatives working towards this end, some of which are outlined below:

- The European strategic approach to making pregnancy safer - Improving maternal and perinatal health (14) supports continuum of care during pregnancy, childbirth and postpartum period for mothers and newborn babies including universal access to cost-effective interventions and a functioning referral system and regionalization of perinatal care.
- The WHO European strategy for child and adolescent health and development provides guidance for developing a framework for an evidence-based review and improvement of national child and adolescent health and development policies, programmes and action plans. It also promotes multisectoral action and identifies the role of the health sector in the development and coordination of policies and the delivery of services (15). WHO is now working with 14 countries to implement national strategies based on the European strategy for child and adolescent health and development.
- A Gender Tool was developed to assist countries in making child and adolescents health programmes gender responsive.
- Using human rights to advance sexual and reproductive health of youth and adolescents: a tool for examining laws, regulations and policies. The tool assists countries in using a human rights framework to identify and address legal, regulatory and policy barriers to population access to, and use of, sexual and reproductive health care information and services, and to the provision of quality services. An "adolescent sensitive" version of the tool is looking at the policy issues that need to be addressed, pertinent to this age group.
- The WHO Regional Office for Europe support for increased immunization coverage aims to build Member States’ capacities to achieve current and future target levels of immunization performance in terms of access, utilization, quality, safety and equity.
- The Regional Office provides support for the global WHO/UNICEF strategy on Integrated Management of Childhood Illness (IMCI) adopted by 15 countries in the region. IMCI aims to reduce death, illness and disability, and to promote improved growth and development among children under 5 years of age. Integration of IMCI into national primary care improves quality of services for young children, reduces unnecessary hospital admissions and rationalizes use of drugs and resources.
- The Regional Office provides technical guidance and capacity-building materials and activities for the quality assessment of pediatric hospitals.
- The WHO-supported Children’s Environment and Health Action Plan for Europe (CEHAPE), adopted by the 4th Ministerial Conference on Environment and Health in 2004, provides a policy framework and tools to help identify risks to children's health through environmental exposures and address them through evidence-based policies and interventions (16).

References

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Box 1. Aspects of the unfinished health systems agenda – examples of activities to reduce under-five and infant mortality and improve measles immunization coverage

Stewardship:
For health systems in many countries, there is a need for national assessments on gaps and overlaps in policies concerning maternal, newborn and child health within the health sector, as well as increased analysis of the impact of other sectors’ policies on the health of these groups. Many health systems require improved data on newborn and child health, related to mortality, morbidity, access to services, risk/protective factors and inequities. Health system stewardship also entails a proactive stance by national authorities, including through liaising with other sectors and stakeholders, towards issues relevant to child health such as breastfeeding and nutrition.

Resource generation:
Progress towards MDG 4 requires an appropriate mix of adequately skilled professionals including family doctors, obstetricians, pediatricians, nurses, midwives, and immunization staff; in a number of countries, this mix is not yet in place. A balanced distribution of skilled staff in rural and urban areas is also still needed in many countries. The introduction of evidence-based guidelines in both pre-service and in-service education is essential.

Service delivery:
Service delivery to reduce under-five mortality can be further enhanced through the introduction and implementation of evidence-based medicine, IMCI as an integrated programme, and the improved equitable access to and use of basic effective interventions. Related to the immunization coverage target, equitable service delivery can be facilitated through the provision of an optimized combination of immunization service delivery strategies.

Financing:
Services for children and newborn are often, and should be, an integral part of basic financing. A needs-based allocation of financial resources to child and maternal health is therefore important. Efforts are required to address out-of-pocket payments that disproportionately impact poorer households and present financial barriers to accessing services.

Gender equality and multi-sectoral action as pre-requisites for maternal and child health

In the recent overview of progress towards the Millennium Development Goals (MDGs) in the WHO European Region (1) there is a clear indication that MDG efforts are falling short in select areas, particularly MDG 4 and 5. Although available data reflect a steady decline for under-five and infant mortality rates as well as for the average maternal mortality ratio, striking inequities persist between and within countries. For example, in the Region there is a 25-fold difference in infant mortality rate and a 30-40-fold difference in maternal mortality rate between countries with the lowest and the highest rates. There are also substantial within country inequities in the Region in access to skilled health workers for delivery and antenatal care by socio-economic status, ethnicity and residence.

There is mounting evidence to show that gender equality and empowerment of women (a development goal itself - MDG 3) synergizes development efforts and is important to achieving all other MDGs, especially MDG 4 and 5. Composite measures of gender equality indicate huge differences between countries in the Region which includes countries with the highest rank of gender equality (in terms of e.g. education, gainful employment, decision making power, life expectancy), but also countries where the majority of women cannot even visit health care facilities without permission from their husbands.

Gender equality interventions protect and promote girls’ and women’s human rights through education including sexuality education, access to fertility control and safe abortion, better nutrition, protection against violence, as well as by removing discrimination in work and access to and control over household resources. These not only improve the likelihood of wanted, healthy pregnancies and normal births, but also help to promote child survival and development. The most extreme expression of unequal gender power relations is violence against women — violence during pregnancy has serious repercussions for both infant and maternal health outcomes.

Some of the efforts towards gender equality, improved maternal health and reduced under-five mortality need to be within the health sector but many are outside. Policies in sectors such as labour market, transportation, social services or education are crucial for addressing gender inequalities, because of their direct and indirect impacts on health risks and women’s ability to access and utilize health care services.

Recommendations by the Women and Gender Equity Knowledge Network (WGEKN)

The (WGEKN) of the WHO Commission on Social Determinants of Health was set up in 2006 to draw together the evidence base on health disparities and inequity due to gender and on the policies and actions that can address them. Based on the available evidence, the final report of the WGEKN (2) recommends seven approaches for action both within and outside the health sector that are essential for forward movement towards gender equity in health and thus towards the achievement of MDG 3, 4 and 5.

1) Address the essential structural dimensions of gender inequality

Deepening the normative framework of human rights has been important in altering values, beliefs and knowledge about gender power relations and their implications for health. The first action priority is therefore to protect and promote women’s human rights that are key parts of the normative framework for health. This in turn requires the empowerment of women so that they can actually claim and realize their human rights, including sexual and reproductive rights. This points to the next two action priorities, namely structural reforms including gender-sensitive infrastructure, and expanding women’s opportunities and capabilities through e.g. education and participation in decision-making processes.

2) Challenge gender stereotypes and adopt multi-level strategies to change the norms and practices that directly harm women’s health

Challenging gender norms, especially in the areas of sexuality and reproduction touch the most intimate personal relationships. No single or simple action or policy intervention can therefore be expected to provide a panacea for the problem. Multi-level interventions are needed. The WGEKN identified three sets of actions: (a) creating formal agreements, codes and laws to change norms that violate women’s human rights, and then implementing them; (b) adopting multi-level strategies to change norms including supporting women’s organizations; and (c) working with boys and men to transform masculinist values and behaviour that harm women’s health and their own.

3) Reduce the health risks of being women and men by tackling gendered exposures and vulnerabilities

Many health conditions reflect a combination of biological sex differences and gendered social determinants. Where biological sex differences interact with social determinants to define different needs for women and men in health, policy efforts must address these different needs. Significant advocacy is required to raise attention and sustain support for other services that address the specific health needs of poor women, thereby reducing their exposure and vulnerability to unfavourable health outcomes. Not only must neglected sex-specific health conditions be addressed, but sex-specific needs in health conditions that affect both women and men must be considered, so that treatment can be accessed by both women and men without bias. Two intertwined strategies to address social
bias are: tackling the social context of individual behaviour, and empowering individuals and communities for positive change.

4) Transform the gendered politics of health systems

Although many of the underpinnings of women’s health need to be tackled within the broader social and economic arena, the role of the health sector remains critical, especially for maternal and child health. In the short term, the health sector may be a promising entry point for gender equity-oriented policies and interventions, and for preventing impoverishment due to health care expenses. Action priorities include supporting improvements in women’s access to services, especially to sexual and reproductive health care of good quality, recognition of women’s role as health care providers, building accountability for gender equality and equity into health systems, and especially in ongoing health reform programmes and mechanisms. Minimizing gender bias in health systems also requires systematic approaches to building awareness and transforming values among service providers.

5) Take action to improve the evidence base for policies by changing gender imbalances in health research

Gender discrimination and bias also permeate health research. Gender imbalances in research content include the following dimensions: slow recognition of health problems that particularly affect women; misdirected or partial approaches to women’s and men’s health needs; and lack of recognition of the interaction between gender and other social factors. Gender imbalances in the research process include: non-collection of sex-disaggregated data in individual research projects or larger data systems; research methodologies are not sensitive to the different dimensions of disparity; methods used in medical research and clinical trials for new drugs that lack a gender perspective and exclude female subjects from study populations; gender imbalance in ethical committees, research funding and advisory bodies; and differential treatment of women scientists. Mechanisms and policies need to be developed to ensure that gender imbalances in both the content and processes of health research are avoided and corrected.

6) Take action to make organizations at all levels function more effectively to mainstream gender equality and equity and empower women for health by creating supportive structures, incentives, and accountability mechanisms

Working towards gender equality challenges long-standing male dominated power structures within organizations. Tackling this requires effective political leadership, well designed organizational mandates, structures, incentives and accountability mechanisms. Gender mainstreaming in government and non-government organizations has to be owned institutionally, funded adequately, and implemented effectively. It needs to be supported by an action-oriented gender unit with strong positioning and authority, and civil society linkages to ensure effectiveness and accountability.

7) Support women’s organizations which are critical to ensuring that women have voice and agency

Such organizations are often at the forefront of identifying problems, experimenting with innovative solutions and prioritizing demands for accountability from all actors, both public and private.

Conclusion

These seven approaches encompass a set of priority actions that need to be taken both within and outside the health sector, and need the engagement and accountability from all actors – international and regional agencies, governments, the for-profit sector, civil society organizations and people’s movements. While health ministries nationally and the WHO and its regional organizations internationally, have a critical leadership role in mobilizing political will and energizing coalitions and alliances, no person or organization can be exempt from action to challenge the barriers of gender inequity. Only thus can progress towards the MDGs be made.

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Gender shapes all aspects of SRH but gender norms and values often promote inequities and inequalities on:
- How men and women make decisions about their SRH;
- What risks they take;
- What type of contraceptives men and women use;
- What access men and women have to services;
- Which services may be acceptable for men and women;
- What they can openly discuss with the provider;
- What access men and women have to services;
- How partners, families, services and society deal with wanted and unwanted pregnancy.

Concern for gender disparities and enhanced gender equity/equality also contributes to specific SRH outcomes, such as:
- Improved contraceptive prevalence;
- Reduced HIV transmission;
- Increasing quality of services and access to services;
- Reduced violence against women; and
- Decreased maternal and perinatal mortality.

Thus, promoting gender equity—fairness and justice in distribution of responsibilities and access to resources to women, men, girls, and boys—is a major goal for SRH policies and programmes. But how can gender perspectives be addressed in implementation of SRH policies?

### How engendered are SRH policies?

The WHO training programme on gender mainstreaming for health managers (1) has developed a framework that allows classification of policies from a gender perspective. A successful gender responsive (level 3 to 5 in Box 1) SRH policy promotes the empowerment of women, the involvement of men and supports gender equity/equality goals to enhance SRH outcomes for all. An equitable approach to SRH services and programmes focuses on the different needs of women, men, adolescents, and communities. In order to eliminate gender disparities women and men must actively participate in reproductive and sexual decision making. Moreover, it is critical that adolescent boys and girls be involved and their concerns addressed if sustainable and equitable SRH outcomes are to be achieved.

Many of the SRH policies in the Region are gender sensitive and acknowledge the impact of gender norms and inequalities on SRH. However, few take this into account when designing interventions and even fewer promote gender equity in their actions. With this in mind the WHO Regional Office for Europe developed a checklist to assess the gender responsiveness of SRH policies. This checklist assists countries to integrate gender equity/equality objectives into SRH policies and is also meant to assist in identifying gaps and strengths.

### Guiding principles

The checklist is based on the following WHO guiding principles for promoting the integration of gender considerations into health policies:

**Gender is a social determinant of health**

Gender interacts with culture, religion, ethnicity, education and social and economic background. The interaction between these determinants of health may increase vulnerability and exposure to risk. Gender responsive policies acknowledge and address these determinants in its actions.

**Promotion and use of sex disaggregated data and gender analysis**

Policies should promote and be based in the use of quantitative and qualitative data disaggregated by sex, age and relevant social stratifications. Gender differences and inequities deserve an analysis that looks at the root causes of these and facilitate the design of actions to address them.

**Building capacity**

Stakeholders involved in the design and implementation of policies should have a basic understanding of gender issues and

### BOX 1

Classification framework for gender responsiveness of policies and programmes (1)

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>CHARACTERISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unequal</td>
<td>Privileges men over women (or vice versa). Inequalities are clear and undisguised. Deny women's rights or give men rights and opportunities that women do not have (or vice versa).</td>
</tr>
<tr>
<td>2. Blind</td>
<td>Ignores gender norms; blind to differences in allocation of roles and resources; not intentionally discriminatory but reinforces gender-based discrimination. Often ignores the lack of opportunities /discrimination which underpin what appears to be fair practice.</td>
</tr>
<tr>
<td>3. Sensitive</td>
<td>Gender norms, roles and inequalities have been considered and acknowledged but no action is taken to address them. Similar to being &quot;gender aware&quot;: awareness of the issues – but does not necessarily mean that something is then done about it</td>
</tr>
<tr>
<td>4. Specific</td>
<td>Recognizes differences in gender roles, responsibilities and access to resources, and takes account of these when designing interventions. Gender specific policies or programmes do not try and change the underlying causes of these gender differences.</td>
</tr>
<tr>
<td>5. Transformative</td>
<td>Recognizes differences in gender roles, norms and access to resources. Actively tries to change these, so as to promote gender equality.</td>
</tr>
</tbody>
</table>
the interrelations between gender and other social determinants of health.

**Establishing accountability**

Programmes that achieve sustainable and equitable SRH outcomes hold those involved accountable for the achievement of gender equity/equality goals throughout implementation. Successful implementation requires leadership and staff with gender expertise. Regular appraisal and monitoring of activities should include information on progress in integrating gender into actions. Budgets should reflect the integration of gender analysis and gender sensitive indicators should be included in performance monitoring and assessment.

**Promoting respect for the rights of individuals and groups**

Addressing gender based discrimination is a prerequisite for achieving health equity. Gender responsive programmes support the right to adequate health care and the right to reproductive self-determination in the face of unequal power relations that form the basis for the denial of women’s reproductive rights. Equitable SRH programmes promote, monitor, implement, and enforce human rights norms relevant to SRH.

**Piloting the checklist: The Republic of Moldova and Tajikistan**

In 2009 and 2010, Tajikistan and the Republic of Moldova adapted the checklist and used it to assess the integration of gender in their SRH policies. In the Republic of Moldova, this assessment was part of the mid term evaluation of the National Strategy on Reproductive Health (2005 – 2015).

The following methods of data collection were used in both countries: review of strategic plans, interview with key stakeholders, field visits to observe provision of relevant services and focus group discussions with healthcare providers and service users. The results of the assessment reinforce the fact that even when policies express a clear commitment towards gender equality and equity, this gets lost at implementation level. Below are some examples extracted from the assessments which illustrate the gaps in implementation of the strategies.

Social, economic and traditional factors create gender differences, which affects women and men’s unequal access to SRH services. In the Republic of Moldova, acknowledging the low level of information and responsibility of men in SRH, addressing their needs is one of the priority areas of the strategy. However, this has not been translated into action and information and services continue to target mostly women. In Tajikistan, socioeconomic factors change men and women’s child bearing planning. While women and men of young age (20-28 years) prefer to have no more than 3 children and have no sex preferences, married couples of elder age group (in average 40 years) prefer to have four children, but “they will give birth till a boy will be born”. When it comes to unpaid household labour, women form the majority of this population, especially in rural areas – in the Republic of Moldova, 73% of women in comparison with 27% of men. In Tajikistan, the fact that older women began to appear at SRH centres is considered as a positive change achieved by the centres. Traditionally older women have been considered as “potential ideologists” of the SRH values in Tajik families.

As mentioned before, one of the basics of mainstreaming gender is the systematic use of sex disaggregated data and a gender analysis of the differences and inequities. In the Republic of Moldova, male HIV incidence doubled between 2003 and 2007 from 6.5 to 13.9 new cases per 100 000 inhabitants, while among women it tripled from 3.3 in 2003 to 9.6 cases per 100 000 inhabitants in 2007 (2). This may be explained by the fact that over the last years HIV/AIDS has been transmitted mainly through sexual intercourse but it could also be because women undergo medical examination more often, as part of prenatal services, while testing of men is undertaken usually at their request. A gender analysis will allow us to understand the reasons and act upon those.

One of the weakest areas in implementation is the accountability mechanisms. None of the strategies established gender specific indicators to monitor progress or allocated budget for gender specific actions. Gender budgeting is one of the important tools to advancing gender equity in health policy implementation. It usually entails disaggregating government expenditure taking into consideration the different impact on different categories of women, men girls and boys.

Both strategies recognize gender equality as key principles in improving the SRH of the population. The assessments are a first attempt to unpack the gender issues in the development and implementation of policies and are being used to feed the ongoing discussions and recommendations for revisiting the strategies. The checklist is under revisions with the results of the experiences from the two countries and will soon be posted in the WHO web site.

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Working with Parliamentarians towards Achieving Health MDGs – European Parliamentary Forum on Population and Development

Parliamentarians have the opportunity and responsibility to promote sexual and reproductive health and rights, maternal health and gender equality, which are core elements of human dignity and are central to human development.

The European Parliamentary Forum (EPF) on Population and Development is a Brussels-based Parliamentary network that serves as a platform for cooperation and coordination for the 28 all-party groups in Parliaments throughout Europe that focus on improving sexual and reproductive health and rights (SRHR) at home and abroad through national and regional health and foreign aid budgets. Because Europe is home to 32 of the world’s 43 governmental donors of development assistance, Parliamentarians in Europe play a crucial role in making sure international funding commitments are met and programmes are available where they are needed the most. Domestically these Parliamentarians work to improve the health and rights of their countries’ most vulnerable populations.

In adopting the UN Millennium Declaration, the international community committed itself to an ambitious goal: cutting in half the number of people living in absolute poverty by 2015. The Millennium Development Goals (MDGs), which are based on the declaration, set out specific targets for life expectancy, education, housing, reproductive health, gender equality, openness of trade and environmental protection.

Ensuring universal access to SRHR is instrumentally important for achieving the MDGs and achieving health goals – improving maternal health, reducing child mortality, promoting gender equality and combating HIV/AIDS - depends directly on making access to these services widespread. Working with Parliamentarians as directly elected bodies is crucial for ensuring the MDGs attainment is on track locally and globally.

The methodology of parliamentary advocacy

Altogether, EPF has worked in 83% of European countries and at the European and international levels there are four main types of activities that have been used to generate support for SRHR among Parliamentarians. They are: study tours to developing countries; thematic meetings, seminars and trainings; large-scale conferences; and participation in regional and international meetings (such as UN meetings). A crucial element is the role of partnering with and supporting the civil society organizations on the local and international level, as well as UN agencies and inter-governmental organizations, that have interest in working with Parliamentarians.

Engaging in Parliamentary advocacy is a highly efficient means to advance SRHR, because a single programme of advocacy activities focused on Members of Parliament (MPs) will yield multiple results as the impact ripples out in different directions. Once MPs are made aware of SRHR issues and gain knowledge and experience through a programme of activities (particularly study tours), they can use their influence to advance SRHR in a number of ways:

- **Leverage high level support** for SRHR issues by offering the opportunity for higher officials to express their views before a Parliamentary audience;
- **Advocate among peers** by communicating their understanding of SRHR to their fellow-Parliamentarians;
- **Educate party members** by sending updates to the list-serves of their party members, which can reach up to tens of thousands;
- **Inform the public** by using their own or party’s websites to address SRHR issues or by working with media to get their information out; and
- **Advance the issue in other fora**, such as Parliamentary Assembly of the Organisation for Security and Cooperation in Europe (OSCE), Assemble Parlementaire de la francophonie, Parliamentary Assembly of the Council of Europe, etc.

Awareness raising for resource mobilization

In 2009 alone, through involvement in six study tours to developing countries, EPF reached out to 62 Parliamentarians and young decision makers. At the same time, EPF involved a record number of over 200 Parliamentarians from Europe in various international and regional events around SRHR, which empowered them in their efforts in working on SRHR on their return home. Their participation has been vital in later on mobilizing resources for SRHR: for example in the Netherlands, while official development aid has been slashed for 2010, the funding for SRHR has increased by 12.5 million; in Portugal in 2009, the Portuguese Parliamentary Group on Population and Development, that works closely with the Portuguese Family Planning Association (AFP), advocated for an increase to the UNFPA contribution that resulted in an 80% increase of Portugal’s core funding to UNFPA for 2010 over 2009.

Central and eastern Europe

Working with Parliamentarians from eastern Europe, south-east Europe and the south Caucasus is central in overcoming the Region’s challenges in terms of achieving health MDGs after a decade and a half of years of transition. The latest Regional consultation on the MDGs conducted in March 2010 by UNECE (1) revealed that while well-on-track towards achieving MDG 4 – reducing child mortality, with child mortality falling by 50%, the Region faces an alarmingly high number of adolescent pregnancies and lack of progress for providing antenatal care from skilled health providers, especially to rural women. While somewhat on track to reach the target of MDG 5 - improve maternal health, a large number...
of maternal deaths are still related to mostly preventable diseases. There has also been low progress towards MDG 6 - combat HIV/AIDS, malaria and other diseases, with HIV prevalence being on the rise in eastern Europe and none of the countries providing adequate anti-retroviral treatment coverage for the infected.

In terms of reproductive health commodity security in eastern Europe, one of the challenges is to get funding of contraceptives onto the government’s agenda. Currently 64% of countries in the eastern European region (9 out of 14) have 0% of governmental funding on reproductive health services and rely heavily on donors support (2).

The main constrains that Parliamentarians and advocates face are similar in many countries of the Region and can be summarized as the following (3):

• Lack of basic information and understanding about the issue,
• Lack of political will,
• Active religious or cultural opposition,
• Lack of interest, and
• Lack of resources.

Since 2005, the EPF has established All-Party Parliamentary Groups (APPG) in 8 countries in the Region: Armenia, Azerbaijan, Bosnia and Herzegovina, Georgia, Romania, the Russian Federation and Turkey. One of the successful examples of working with Parliamentarians has been the 3 year EC/UNFPA Reproductive Health Initiative for Youth in south Caucasus, where EPF, partnering with UNFPA Country Offices in Armenia, Azerbaijan and Georgia worked on an enabling legislative environment to improve the situation of young people’s reproductive health. Between 2006 and 2009 the EPF together with UNFPA Country Offices in Armenia, Azerbaijan and Georgia conducted a series of regional and local meetings for Parliamentarians as well as involved them in more than 15 European and international activities, such as conferences, study tours and trainings on the topic. As a result, currently all three countries have a solid All-Party Parliamentary Working Groups on Population and Development with permanent Secretariats. Parliamentarians have become members of the international community striving to improve SRHR. These Parliamentarians have introduced a number of legislative proposals, such as the integration of youth friendly services into the general health system in Armenia, the Draft Law on SRHR with a youth component in Azerbaijan, and creation of the Committee on MDGs in the Georgian Parliament. At the international level, 15 various statements and recommendations of the European Parliament and Council of Europe Parliamentary Assembly called for the improvement of gender equality, reproductive health, and the fight against HIV/AIDS in the Region, thus generating international pressure on the Region’s legislators.

Conclusion
The development of Parliamentary leaders who can successfully mobilize resources for programmes on reproductive health, gender equality and child health is the primary purpose of the EPF and its member groups. The process of cultivating Parliamentary leadership is summarized in figure 1.

Since the EPF’s creation the Parliamentarians’ involvement and visibility in international decision-making settings has increased significantly. Each time that the funding or policies for reproductive health programmes have been threatened, the Parliamentarians have proved to be successful advocates; overall, where an All-Party Parliamentary Groups exists, the funding for reproductive health has never decreased.

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Figure 1. Cultivating Parliamentary Leadership

| Interest ⇒ | Awareness ⇒ | Commitment ⇒ | Leadership ⇒ |
| MP has interest in SRHR | EPF / APPG provides evidence-based policy ideas through briefings, conferences, written materials, study tours, etc. | EPF / APPG creates chances to act, via speeches, declarations, media visibility, international meetings, etc. | MP becomes SRHR leader in Parliament, initiating changes in policy and mobilizing resources for SRHR programmes |
A s the global community evaluates overall progress towards the Millennium Development Goals (MDGs), Romania is an interesting case to ponder. As a new European Union (EU) member since 2007, the country boasts remarkable progress in its relatively short post-communist transition. Indeed, by MDG standards, Romania is poised to be on track for meeting all goals but, by the government’s own admission (1), it is lagging behind in one key area: Goal 3!

This is a paradox for a European country, since gender empowerment has been both an important cause, as well as a consequence of sustained economic development, and EU membership was possible for Romania precisely due to its communist times to more substantive development, and EU membership was possible for Romania precisely due to its gender balance quickly moved from the forced formal equality during communist times to more substantive empowerment, resulting in many improvements over the years, the changes seem not yet sufficient to see the country in a position to meet all self-imposed targets in this critical review year.

This article will address Romania’s progress to date, identify key remaining challenges and outline some of the UN System’s assistance in helping the country enjoy all the social and economic benefits that come from fully meeting MDG 3 by 2015.

Progress to date

MDG 3, adopted following the September 2000 UN General Assembly’s Millennium Declaration, states: “Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015”, and sets three indicators:

3.1 Ratios of girls to boys in primary, secondary and tertiary education,
3.2 Share of women in wage employment in the non-agricultural sectors, and
3.3 Proportion of seats held by women in national parliament.

Romania, owing to its egalitarian communist past, has long since met the challenge of equal school enrolment for boys and girls alike. Therefore the government tailored the goal, adding country-specific targets. Thus, as adopted in 2003, “national” MDG 3 reads: “Promote gender equality and support employment by women and youth” and the revised indicators/targets are:

3.1 Increase the employment of women up to 60% until 2015,
3.2 Increase the employment of youth between the ages of 15 and 24, and
3.3 Halving, by year 2015 the incidents of domestic violence.

Romania is on track for meeting the first target, since the wage-employment of women in the non-agricultural sectors has increased steadily in the country, although the share of women aged 15-64 who are employed has plunged slightly, most likely due to the overall economic crisis (see figure 1).

The second target however, related to youth, fares less well: the unemployment of 15-24 year-olds is still high, at an average of 21%, and likely to increase, due both to the overall economic downturn but also to Romania’s particular economic predicament. Indeed, owing to the economic crisis, the government cancelled some of the special employment programmes that targeted 15-24 years-olds, and folded the former stand-alone Youth Ministry into the Ministry of Education.

However, the third target, regarding domestic violence, has evolved quite positively in the last few years. Although following the passage of the law (Law no. 217/2003 Regarding the prevention and fight against domestic violence regulating the redress of violence victims and the punishment of perpetrators) the number of cases appeared initially to increase (due to additional reporting), after the initial increase the cases tapered off and progressively declined. Moreover, the integrated approach in monitoring and reporting domestic violence cases (made possible with the help of UNFPA), has allowed dramatically improved services to victims and rehabilitation opportunities for perpetrators in one part of the country.

Furthermore, there are other areas where relative “gender equality” was achieved, albeit in indirect ways, through the large gains made by women in exercising the right to abortion and to contraception. Since the fall of communism, when Ceausescu’s pro-natalist policies deprived women of the ability to exercise free choice, positive changes to exercise free choice, positive changes in access to family planning have been significant. This improved access to family planning, has contributed significantly to the improvement of another MDG Goal in Romania—Goal 5, regarding maternal health, where the number of maternal deaths due to abortion has substantially diminished (2).
Continued challenges
Several challenges need to be overcome before Romania can enjoy the benefits of a society without gender gaps; but there is one area in particular where policies and mindsets need to be brought in line with current European standards: namely in women’s ability to enjoy fair political representation.

If one of the benefits of living in a democracy is people’s capacity to be represented and have a say in the decisions that affect their lives, then indeed women’s voices are extremely weak in Romania. Fewer than 10% (9.67% to be precise) of the parliamentarians are women, compared with the UNECE recommendation of 30% and the EU average of 24%. The Romanian Executive boasts of only one woman minister, after having none in the former government, when, out of 19 ministries, 12 did not have any women in decision-making positions. Lamenting this situation, a recent report states that, alarmingly, the “Percentage of women increases [only] as the decision-making power positions decrease” (3). At the local level the situation is even more dire: only 3.5% of Romania’s mayors and 4.7% of Romania’s prefects (central government’s representatives in the territory) are female.

This extremely weak political representation contrasts markedly with the very high educational attainment of women in all fields. Specifically, when it comes to governance and legislative competencies, one is surprised to see that a whopping 71% of graduates in public policy fields (political science, law, economics, public administration, sociology, etc.) are women.

The determinants of such a discrepancy are still an open question but perhaps Romanian women’s inability to integrate the public sphere and partake in governance decisions needs also to be viewed in light of the absence of a specific impetus given by the MDGs. Indeed one cannot fail noticing that indicator 3.3 of Global MDG 3 (about “the proportion of seats held by women in national parliaments”), is the only one that the Romanian government failed to endorse—perhaps owing to a much healthier gender balance earlier in the decade and to the expectation that there would be an ascending trend.

In a counterfactual way, this may bode well for MDG advocates everywhere, as it shows how inclusion of specific targets and indicators, supported by committed monitoring by government and civil society alike, encourages change and yields many visible achievements in the process. The absence of these ingredients has put Romanian women at a considerable disadvantage in terms of political representation.

The UN legacy
As a European country, Romania technically no longer needs UN assistance. Yet the government seeks it, designing innovative ways in which the relevant developmental experience of the UN in Romania can be harnessed and transferred to other countries undertaking similar transitions.

Clearly in the remaining 5 years gender equality will need considerable advocacy if Romania is to fully attain all the MDGs. Given that in the rest of Europe the gender gap is quickly vanishing in public sphere and business alike, Romania will need to follow suit. The key is finding the right champions and agents of change.

The UN in Romania has already embraced stronger advocacy for female representation as a key step in empowering women. Further developments, such as gender mainstreaming in education and the curricula and gender sensitive budgeting, will follow, hopefully, as a direct result of increased female representation. In addition, UNFPA, is breaking new ground by having completed its programming cycle and looking at ways to leave a lasting legacy by transferring its knowledge and know how to various public institutions and NGOs. The plans include working with men and women alike to monitor and analyze the gender situation, generate public debate and create a platform on the basis of which informed decisions can be taken. As women empowerment has been such a harbinger for sustainable prosperity, forceful advocacy for gender equality is a key component of the UN legacy.

Conclusion
When looking at the world at large, one cannot help it but notice the importance of gender parity in allowing citizens to enjoy key governance benefits such as the absence of corruption or high standards of living for men and women alike. A cursory look, for instance, at the Human Development Report or the Global Corruption Index, shows that those countries at the top of the list as having a high Human Development Index and being perceived as “less corrupt”, are also most likely to be those countries that rank highest in the presence of women in decision-making positions in the public sphere.

This critical MDG review year seems the right catalyst to help boost the self-confidence of Romanian women and empower them to move their country forward by establishing a more equitable gender balance, to the clear benefit of both the men and the women of Romania.

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References
2. www.unfpa.ro
Regional profile
The health of women and children in Volgograd, a region in the Russian Federation, is similar to that seen throughout the Russian Federation. Since the year 2000 there has been a trend towards population growth, reversing the negative population growth picture that had persisted since 1992. A general decline in population based mortality has also been seen since 2003. However, these gains have not necessarily translated into improved health indices for women and children. Over the last 16 years the proportion of normal uncomplicated deliveries has declined from 39.25% to 17.1%, with a resultant high number of ill infants (see figure 1) (1). High levels of infant morbidity and mortality were complicated by poor levels of breastfeeding; in 1998 less than half of all the infants in the Region were breastfed (1). In 2009 83.3% of pregnant women developed either an obstetrical complication or non-obstetrical related illness (1). Hence, just 27% of pregnant women can be classified as healthy. Hypertensive disorders of pregnancy (14.5%), including eclampsia (0.5%) and obstetric haemorrhage (11.6%) remain the leading causes of complications (1). Family planning also remains a challenge. Despite easy access to modern contraceptives, surgical termination of pregnancy still remains the main method of fertility control in the Region, with 48.6% of all conceptions ending in induced abortion (1). This paper will focus on 2 sexual and reproductive issues that have been priorities for improvement in the Region: induced abortion and breastfeeding of infants.

Induced abortion
Preventing unplanned and unwanted pregnancies and decreasing reliance on induced abortion as a primary means of contraception has been a key focus in Volgograd. Both governmental and non-governmental organizations have worked together closely in an effort to change the existing situation. During the last 5 years these organizations have lead advocacy efforts and information education and communication activities targeting the issue. Health care providers have also undergone extensive training on how to properly provide information, counseling and services. These efforts have demonstrated positive results. Over the past 14 years a decline in the total number of abortions occurred: from 45,404 cases (116.2 per 1000 births) in 1995 to 27,203 (92.3 per 1000 births) in 2009 (1). Examining categories of abortions has shown specific changes: over the last three years in the group aged 15-19 it has declined from 3089 (10.1%) to 2209 (8.1%) and for criminal abortions from 17 (0.05%) to 3 (0.01%), correspondingly (1). However, among adolescent girls under 14 the number of abortions has increased from 14 (0.04%) to 20 (0.07%) (1). This may be as a result of poor education and information on prevention of unwanted and unplanned pregnancy among adolescents of this age group. Advocacy groups are working with both the Ministry of Health and Ministry of Education in order to design appropriate education material that will target this age group. Advocacy groups are working with both the Ministry of Health and Ministry of Education in order to design appropriate education material that will target this age group.

Implementation of WHO/UNICEF Baby-friendly Hospital Initiative (BFHI)
One of the effective technologies for the promotion of mother’s and children’s health is the WHO/UNICEF/BFHI. It aims at improving the care of mothers and newborns and protecting, promoting and supporting breastfeeding. Breastfeeding is an unequalled way of providing a child with the ideal food for healthy growth and development; it is also an integral part of the reproductive process with important implications for the health of mothers and family planning initiatives.

Before 1996, all maternities in the Volgograd Region used technologies promoting an early transition to bottle feeding; the mother and child were kept in separate wards after birth. In 1998 only one half of all the infants in the Region were breastfed, an important determinant of high levels of infant morbidity and mortality. Thus, in 1996 about 96% of infants who died in the post neonatal period were bottle-fed (3). In this respect, Misoprostol) remains rather limited: 956 (4.1%) in 2008 and 1393 (5.1%) in 2009 (2). Unfortunately this procedure is most-ly available to the residents of the city of Volgograd (1). Thus to further decrease the number of unwanted pregnancies, the population must have better access to modern family planning services with young people and adolescent girls under 14 selected as very specific target group.

Fig. 1. Proportion of physiological deliveries and sick infants in the Volgograd Region (in %) (1)

![Graph showing proportion of physiological deliveries and sick infants in the Volgograd Region over the years.](image)

<table>
<thead>
<tr>
<th>Year</th>
<th>Proportion of Physiological Deliveries (%)</th>
<th>Proportion of Sick Infants (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>44.8</td>
<td>15.3</td>
</tr>
<tr>
<td>1998</td>
<td>43.0</td>
<td>14.9</td>
</tr>
<tr>
<td>1999</td>
<td>41.5</td>
<td>14.5</td>
</tr>
<tr>
<td>2000</td>
<td>40.2</td>
<td>13.8</td>
</tr>
<tr>
<td>2001</td>
<td>39.2</td>
<td>13.2</td>
</tr>
<tr>
<td>2002</td>
<td>38.5</td>
<td>12.7</td>
</tr>
<tr>
<td>2003</td>
<td>37.5</td>
<td>12.4</td>
</tr>
<tr>
<td>2004</td>
<td>36.5</td>
<td>12.3</td>
</tr>
<tr>
<td>2005</td>
<td>35.7</td>
<td>12.0</td>
</tr>
<tr>
<td>2006</td>
<td>34.8</td>
<td>11.9</td>
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<tr>
<td>2007</td>
<td>33.7</td>
<td>11.9</td>
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<tr>
<td>2008</td>
<td>32.8</td>
<td>11.9</td>
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<tr>
<td>2009</td>
<td>32.4</td>
<td>11.9</td>
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implementation of the BFHI represented a promising strategy among the various complex measures undertaken in the Region aimed at decreasing infant morbidity and mortality (4). The strategies promoted by the BFHI belong to the type of resource-saving technologies; they do not require a lot of financing but rather are determined only by the commitment and professionalism of the personnel. When maternity’s started the policy of rooming in baby and mother, early initiation of breastfeeding and providing exclusive breastfeeding, the overall breastfeeding rate increased dramatically. Between 1998 and 2009 the proportion of infants receiving breast milk after six months increased from 49.4% to 72.7%, which is twice as high as the average for all the Russian Federation (1). In addition, as a result of implementing the BFHI, during the period of 1995–2009, the rate of infectious diseases among infants in maternity’s decreased from 14.9 per 1000 to 0.53 per 1000; for pneumonia the rate dropped from 30.1 to 13.8 per 1000 (1). There has also been a reduction in mortality rates: perinatal mortality decreased from 9.2 to 7.5 per 1000 births and infant death rates decreased twofold, from 19.2 to 9.8 per 1000 live births (1).

Implementation of the BFHI also appeared to improve maternal health, contributing to the stable drop in postpartum hemorrhage rates seen in the obstetric hospitals of the Region during the time of implementation (see Figure 2). This is most likely secondary to the activation of the oxytocin reflex which promotes effective contraction of the uterus.

Our calculations of the cost-effectiveness of implementing BFHI in the Region demonstrated that the cost of buying bottles, pacifiers, formula, and energy dropped to 200 rubles per each delivery. Factoring in all the maternity’s in the Region, this saving amounts to 3 million rubles a year (1). Thus, evaluation of the BFHI implementation demonstrates significant clinical and economic effectiveness and benefit towards improving maternal and infant health. To date, over 170 health care institutions have been rated as Baby-Friendly.

Conclusions:
Over the last 15 years through the hard work of the government and numerous national and international agencies, Volgograd has demonstrated its commitment to promote and improve mother’s and children’s health. Use of WHO based tools, strategies and guidelines have been key resources in addressing the priority topics of induced abortion and breastfeeding. The BFHI has been especially successful and the Volgograd experience should be recommended for implementation in other regions of the Russian Federation.

References
Maternal health: the legal and programme frameworks

Maternal mortality is one of the most sensitive and integral indicators of health care services. The maternal mortality rate reflects the economic and social status of women, their access to social care and health care and the competence of the health system to respond to each case. During the last 10 years the Republic of Moldova has achieved certain results in improving maternal and child health. This progress is connected with the Republic of Moldova’s selection as a pilot country for the WHO’s respective programmes’ implementation. The commitment of the Republic of Moldova to make efforts towards sustainable improvement of women’s and children’s health and health care services is provided for by a range of laws and decisions:

1. Millennium Development Goals: The Republic of Moldova aims to reduce the maternal mortality rate by three quarters - from 28.0 in 2002 to 13.3 per 100 000 live births in 2015. This document provides an analysis of the social and economic (unemployment, poor working conditions for women, gender based violence), as well as medical factors (unsafe abortions, medical complications of prengancy) that contribute to the relatively high level of the maternal mortality in country (1);

2. National Concept “Making Pregnancy Safer” developed from the evidence based interventions of the WHO “Making Pregnancy Safer” Initiative from 2002 (2);

3. The National Health Policy of the Republic of Moldova for 2007-2021:
   a) Ensuring a healthy beginning of life;
   b) Preserving the health of the young generation (3);

4. Health System Development Strategy for the period 2008 – 2017. This Strategy was established to synergize the development of the various health system components towards the achievement of one common goal – continuous improvement of population health, with one of the basic objectives being “Improvement of mother and child health”(4);

5. National Reproductive Health Strategy 2005-2015 (5); and

6. The Family Friendly Maternity Concept (order no.327 of 04.10.2005): The new technologies applied in maternities support the development of friendly centres of care where intimacy, confidentiality, participation of women in decision making and taking care of healthy and sick children, rooming-in for mothers and babies, child friendly technologies and family members’ visits to maternity centres are encouraged and considered best practice (6).

The maternal health improvement is also inextricably linked to the achievements attained in perinatology. The National Perinatal Programmes (National Programme on improvement of the Perinatal Healthcare services (1998-2002); Programme on the provision of quality perinatal healthcare services (2003-2007); Programme on Modernizing the Perinatal System (2008-2011) – introduction of the high-tech interventions) were developed and implemented for the purpose of making pregnancy and delivery safer and reducing maternal mortality. The key objectives of these programmes were:

- Inclusion of cost-efficient technologies;
- Creation of necessary sanitary conditions in maternities;
- Provision of necessary medical equipment to perinatal centres;
- Establishment of regionalization and division of the perinatal and maternal healthcare and delivery system into three levels (Level I - physiologic delivery and low-risk delivery, Level II - medium risk, Level III - severe obstetric and neonatal morbidity);
- Training healthcare staff, emphasizing provision of individual care,
- Reduction of polypragmyas,
- Reduction of the use of medications in childbirth, and
- Promotion of the partner’s participation in childbirth.

The maternal mortality analyses and new approaches in achieving the Millennium Development Goals

During the last 10 years the Republic of Moldova has achieved certain successes in improving essential health indicators, including reducing the maternal mortality ratio. Though maternal mortality indicators recorded a positive trend in 2001 – 2007, reaching the level of 15.8 per 100 000 live births in 2007, in 2008 it increased to 38.4 per 100 000 live births (7). Of all maternal mortality cases in 2008 just under half (47%) of the deaths were complicated by social factors, such as: migratory lifestyle (13%), women working abroad in the Republic of Moldova without medical care (27%), rural residency (73%) and failure to seek professional health care (7%) (8). Despite the fact that during 2009, maternal mortality has decreased (17.2 per 100 000 live births) the target set in the Millennium Development Goals- reducing maternal mortality rate from 16.0 per 100 000 live births in 2006 to 15.5 in 2010 - has not been achieved (19 cases by November 2010). Maternal mortality is a thus a complex issue, that

In addition to these laws, strategic documents have also been developed which also emphasize the Republic of Moldova’s commitment to maternal and child health. These include:

- The Law on health care No. 411-XIII of 28.03.1995,
- The law on children’s rights protection No. 338-XIII of 15.12.1994, and

The maternal mortality analyses and new approaches in achieving the Millennium Development Goals
can be very difficult to solve, but which can achieve continuous positive gains by reducing poverty, increasing the responsibility and the knowledge of women about health and health seeking behaviour, and by reaching an adequate level of protocol implementation in the supervision, behavior and treatment of pregnant women by health care providers.

In compliance with WHO recommendations, in 2005 the “Beyond the numbers” programme was implemented in the Republic of Moldova, with a focus on two main methods to improve maternal mortality:

- Near-miss case reviews (NMCR), and
- Confidential enquiries into maternal death (CEMD).

CEMD are carried out on all maternal deaths that occur in the country and the NMCR are implemented within all third and second referral level Perinatal Centres.

The first national CEMD report for 2006-2008 was prepared and presented information on:

- The main obstacles in overcoming the problem of maternal mortality;
- Package of possible actions to prevent maternal mortality;
- Possible solutions within the Health System and the identification of further strategic actions;
- Necessary information for development of the clinical protocols; and
- Identification of key areas requiring recommendations for the public health sector, and for the actions at community level.

While the implementation of the CEMD did not replace the formal procedure of the Ministry of Health to review each case of maternal mortality, it has, at the national level allowed the identification of the contributing causes of maternal mortality, development and utilization of clinical protocols, and taking of decisions and proposals for improvement (Table 1).

### Priorities for the future actions

Based on the Republic of Moldova’s experience working to achieve MDG 5 the following priorities have been recognized as essential steps for future action:

1. Implementation of NMCR at the national level, including first referral Perinatal Centres;
2. Strengthening of health systems, especially primary care services;
3. Development and implementation of clinical protocols and standards of care at national level;
4. Development and implementation of monitoring and evaluation mechanisms for these national standards and clinical protocols;
5. Development of a medico-social protection mechanism to ensure vulnerable groups have equitable access to quality medical care; and
6. Development of a private – public partnership to deliver quality reproductive health services to reproductive aged women.

### Table 1. Maternal Mortality Indicators: National statistics, Millennium Development Goals and National Reproductive Health Strategy targets 2006-2015

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<tbody>
<tr>
<td>Maternal mortality per 100 000 live births</td>
<td>23.5</td>
<td>18.6</td>
<td>16</td>
<td>15.8</td>
<td>38.4</td>
<td>17.2</td>
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<tr>
<td>MDG target</td>
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<td></td>
<td>16</td>
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<tr>
<td>NRHS target</td>
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<td>under 20.0</td>
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### References

ALBANIA:
THE MATERNAL, NEWBORN AND CHILD HEALTH CARE REFORM PROJECT

Background
In Albania, women and children enjoy special rights to protection by the state and improving their health is a high priority on the agenda of the country. Important legislative and policy progress related to women and children’s health and gender equality has been made in Albania including: “Pregnancy Interruption” Law, Reproductive Health Law, HIV/AIDS Law; Law on Protection of Minors from Alcohol Consumption, Anti Smoking Law, Health Care Law, Law for Protection and promotion of breast feeding, Universal Salt Iodization Law, Public Health Law, all of which have affected and influenced the health of the overall population of Albania, but especially the health of women and children.

The first National Law against Domestic Violence, the National Strategy and Plan of Action against Gender-based Violence and the Strategy Promoting Gender Equality are important mechanisms and policy documents aimed at encouraging a safer and equal environment for women and girls in Albanian society. The “National Reproductive Health Strategy 2010-2015” currently being finalized pays particular attention to child and maternal health, strategically investing in building a sustainable health system.

The “Maternal, Newborn and Child Health Care Reform” Project
The Ministry of Health, in September 2008, launched the new national project “Maternal, Newborn and Child Health Care Reform” with the financial support of the Spanish Agency for Cooperation for Development and the technical assistance of the WHO. The project is implemented in 3 pilot regions of the country.

The main objective of the project is to contribute to the improvement of the health status of mothers, infants and children of Albania, especially of the poorest segments of the population, and therefore to the attainment of the Millennium Development Goals (MDGs) 3, 4 and 5.

The expected outcomes are:
1) Improved capacity to efficiently deliver quality MNCH services at hospital level,
2) Increased equitable access to effective MNCH health services, and
3) Strengthened Ministry of Health stewardship role in relation to MNCH services.

This project aims to contribute to improving access to quality maternal, neonatal and child health (MNCH) services by (i) articulating a network of services able to ensure the continuity of care; (ii) strengthening family and community involvement in MNCH as well as developing gender-sensitive health promotion activities to improve maternal, child and adolescent health, and (iii) providing free essential public health services with a special focus on school health services.

Beneficiaries of the project
The joint partner and main beneficiary of this project is the Ministry of Health, both at central and at regional level. The direct beneficiaries and co-implementers of the project are the health workers working in the regional hospitals and in the district hospitals of the selected pilot regions. The ultimate beneficiaries are the Albanian women, newborns and children of the three pilot regions and to a minor extent of the rest of the regions of the country.

Outcome 1: Improve the quality of hospital care for mothers and children
Main activities are (a) assessing hospitals (maternity and paediatrics wards) safety and quality of services using a WHO updated assessment tool, and (b) building capacity and updating technical skills in the selected hospitals on effective perinatal, child and maternal care.

Use of the WHO quality assessment tool allowed the Ministry of Health, key stakeholders and partners to carry out assessments of health care provided at facility level in a homogeneous and valid way, and contributed to the identification of key areas of MNCH care that needed to be improved. The assessment tools used in the first year of the project to assess and monitor the baseline quality of care situations were also used during the second and the third year of the project to monitor subsequent improvements, thus providing key information before and after interventions to improve quality of care, as well as for incentives and accreditation schemes. The assessment tool also was useful for introducing the concept and the contents of internationally recommended guidelines and standards.

Hospital assessment identified that the care provided in the maternity and pediatric wards in the hospitals was offered in the absence of national clinical guidelines and in the absence of local protocols. This resulted in over medicalization, unnecessary procedures and interventions and substandard quality of care. The main areas for improvement identified included: clinical guideline development, organization of health services, financing of health services and human resource concerns.

The second main activity developed for improving the quality of care was building capacity in hospitals on effective perinatal, child and maternal care. An Effective Perinatal Care (EPC) training programme was delivered in pilot sites of the project using translated WHO materials. Participation was multi-disciplinary with participants from all three pilot sites. Evidence based clinical practice was introduced to all participants and stressed as a priority for ensuring quality of patient care. After the training, individual hospital action plans were developed including plans for dissemination of material to staff in each site.

Paediatric, obstetric and neonatology clinical practice guideline development was performed under the Ministry of Health policy, through collaboration between interested parties including leading professional associations and the Faculty of Medicine. Through the development, implementation and monitoring of clinical practice guidelines, or the
standards for diagnostic and therapeutic interventions, the project aims to promote consistent and high quality care for mothers, newborns and children.

**Outcome 2: Equitable access to effective MNCH care services**

The situation analyses done before the project revealed that in Albania the burden of MNCH mortality occurs disproportionately among poor people and those living in rural remote areas. One reason for this is that they are less likely to access essential MNCH services due to the substantial cultural and gender barriers that are borne by women and financial costs that are borne by the household. It is therefore necessary to address these barriers to care in order to achieve the MDGs. A second reason for inequities in MNCH mortality is that when addressing the health needs of vulnerable groups, lifestyle and behavior change programmes have limited impact unless they tackle the social and economic determinants of health. It is thus necessary to develop health promotion activities that go beyond the health sector and involve other socioeconomic actors.

The current project aims to strengthening family and community involvement in MNCH services in order to increase equitable access to treatment and care. The aim of working at the family and community level is to contribute to the empowerment of women, families and communities to improve and increase control over MNCH, as well as to increase access and utilization of quality health services, provided by front-line health workers and skilled attendants. Pilot activities, including gender sensitive health promotion activities with the community on improving MNCH have been implemented in the pilot commune of one region where the project is implemented.

**Outcome 3: Strengthening the stewardship role in the field of MNCH**

In the context of health systems, stewardship involves influencing policies and actions in all sectors that may affect the health of the population. The stewardship function therefore implies the ability to formulate strategic policy direction, to ensure good regulation and the tools for implementing it, and to provide the necessary intelligence on health system performance in order to ensure accountability and transparency. Albania faces big challenges when providing equitable and sustainable health services.

The share of public spending in total health spending is relatively low, resulting in high out-of-pocket spending, reaching approximately 100 percent of private health spending. Albania spends approximately 6 percent of GDP on healthcare commensurate with its income level, but the share of public sector spending on health is below that of other countries with similar income levels. At 2.5 percent of GDP in 2005, it remains below that of most European and transition countries. It is the project’s aim that the health system governance in relation to MNCH services will be improved through strengthening MoH capacity to develop effective MNCH policies, strategies and planning. With this in mind the project has supported several activities:

1. The implementation of the Demographic Health Survey in the country. Using data from these large survey the project will further support the MoH and the Institute of Public Health in developing performance indicators for MNCH, as well as, set up a monitoring and evaluation system for MNCH. Using the data obtained by the survey, and developing the performance indicators will improve transparency and accountability.

2. Improving the continuum of care by revisiting and strengthening the referral system. There is a considerable need for revising the services delivered at each level of care, ensuring quality, and thereby increasing the effectiveness and performance of the system. This project aims at increasing the monitoring capacity of the Ministry of Health by facilitating access to reliable updated health care delivery and utilization data and analysis. Such data is crucial to enable the MoH to develop effective policies.

3. Assisting the Ministry of Health in addressing health inequities by mitigating the impact of socioeconomic and gender determinants of MNCH in coordination with other projects and programmes that are working on these issues, such as UNFPA, UNIFEM and UNDP.

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Around 100 participants representing 22 countries and a range of partner agencies convened in Durres, Albania from 28–30 September 2010 to review Member States’ progress in achieving the MDGs 3, 4 and 5 (Box 1).

The meeting was organized by WHO Regional Office for Europe in partnership with agencies in the field of maternal and child health and sexual and reproductive health. It came hard on the heels of the Special General Assembly of the United Nations, at which a global strategy on maternal and child health that lays out plans to accelerate action to achieve MDGs 4 and 5 over the next five years was launched.

Specific aims of the meeting were to:
• identify factors and health system actions that contribute to the achievement of MDGs 3, 4 and 5;
• identify actions to exploit best synergies between MDGs 3, 4 and 5 and other health-related MDGs; and
• agree on specific steps to be taken at regional, subregional and national levels to accelerate progress towards MDGs 3, 4 and 5.

**Key findings from the meeting**

Presentations confirmed strong political commitment to achieving the MDGs at country level. Member States have enacted policies, strategies and, in some cases, legislation in pursuit of the targets.

Despite a reduction in under-five mortality, with several countries on target to reach the MDG goal of a two thirds reduction by 2015, neonatal mortality remains a challenge, particularly in central and eastern Europe and the Commonwealth of Independent States. A number of the issues around neonatal mortality — adolescent pregnancy, preterm birth and access to reproductive health services, antenatal care and skilled care at childbirth — also relate directly to maternal health. Accelerated action to improve maternal health would be likely to result in improvements in neonatal mortality, participants believed.

The importance of health services being free at the point of delivery was stressed, particularly in relation to reducing inequities in access for women and disadvantaged groups. It was felt that health insurance schemes within countries should be sufficiently sensitive to allow for free access at the point of delivery. Ongoing issues around informal payments, with their potential to increase inequities, were also raised and discussed, with full recognition of the need to remunerate health professionals fairly for their work.

Issues around equity were very prominent throughout the meeting, particularly in relation to vulnerable groups. It was recognized that even those countries that are doing very well on the MDG targets have specific groups who are particularly vulnerable: a presentation from Spain, for instance, highlighted challenges around increasing the empowerment of women from minority communities in relation to achieving better reproductive and sexual health.

Better education for women leads to increased demands for health services and antenatal care from women and higher levels of childhood immunization. The meeting conveyed a strong message that providing educational opportunities for women would result in better health not just for women, but also for their children, especially when supported by measures to ensure women’s economic empowerment through employment opportunities and direct receipt of benefits. Member States were urged to address this issue alongside actions to overcome outmoded ways of thinking about gender roles and measures to challenge attitudes that encourage acceptance of gender-based violence and women’s disempowerment. The importance of the involvement of men and boys in this area was highlighted.

The need for better data collection and analysis systems that allow for disaggregation of data by key criteria such as gender was a recurrent theme. Investment in agreed data collection and monitoring systems, with mechanisms to ensure their use, was considered essential in pursuing MDG targets. Protocols and guidelines were highlighted as useful tools in promoting and measuring the quality of care, which in itself was highlighted as a key factor.

Presentations and discussion on these issues led to the development of a series of suggested actions that participants believed would support Member States in meeting their MDG commitments. The actions, which are reproduced in Box 2, focus on general considerations, equity, quality and multisectoral action.

**Conclusion**

MDGs 3, 4 and 5 cannot be seen in isolation from the other MDGs. The United Nations summit affirmed this by recognizing that all the MDGs are “inter-
Participants accepted that they were advocates for promoting the MDGs within their countries. It was suggested that health was often seen as a deficit model – a drain on resources – within governments. But participants stood ready to challenge this and to advocate for health as an assets model that contributes to the economic and social growth of countries.

The meeting agreed that it is time to stop apologizing for spending money on maternal and child health. Such spending, it was claimed, is vital not only in securing the health and well-being of women and children today, but also that of future generations.

Alex Mathieson
Rapporteur of the meeting,
alex.mathieson@blueyonder.co.uk

Box 2. Meeting suggested action areas

<table>
<thead>
<tr>
<th>Overarching suggestions for action</th>
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<tbody>
<tr>
<td>• Advocates for health can be effective in persuading ministers (not just health ministers) in their countries that health is not a deficit model, but is an asset model that contributes enormously to the economic and social prosperity of countries.</td>
</tr>
<tr>
<td>• Integrating the interactions between gender and other social determinants of health, such as income, education, ethnicity and migration status, in policies and interventions is likely to have positive outcomes in terms of improving the health of vulnerable groups.</td>
</tr>
<tr>
<td>• Under-five mortality reductions are on target in most countries, but neonatal mortality remains a challenge – this has direct links to maternal health.</td>
</tr>
<tr>
<td>• Maternal mortality is decreasing throughout the Region: the acceleration of actions to ensure that appropriate interventions reach vulnerable women will further support this positive trend.</td>
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<tr>
<td>• Free reproductive, maternal and child health services at point of access are important in pursuing further improvements in maternal and child mortality.</td>
</tr>
<tr>
<td>• Countries and international partners will be supported in achieving “universal access to reproductive health” (MDG target 5b) by giving the issue their urgent, focused attention.</td>
</tr>
<tr>
<td>• Investment in agreed data collection and monitoring systems, with mechanisms being put in place to ensure their use, is essential in pursuing MDG targets.</td>
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<th>Suggestions for action on policy</th>
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<tr>
<td>• Political commitment to achieving MDGs is high within countries, but that does not guarantee action.</td>
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<tr>
<td>• The specific contribution of civil society in addressing inequities and reaching vulnerable groups is recognised – further support for this from governments will be beneficial.</td>
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<tr>
<th>Suggestions for action on quality</th>
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<tr>
<td>• Progress has been made in establishing quality assurance mechanisms, but much still remains to be done on this issue across the Region.</td>
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<tr>
<td>• Urgent action to develop comprehensive human resource plans that will forecast future workforce needs will produce benefits.</td>
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<tr>
<td>• A broad range of tools on improving maternal and child health is available throughout the Region, but they would benefit from urgent action to scale up and accelerate their application.</td>
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<td>• Progress has been made in increasing the quality of service delivery, but more action is required to promote use of services, particularly by vulnerable groups.</td>
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<th>Suggestions for action on equity</th>
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<tr>
<td>• Issues of equity are paramount: even countries that are doing very well face equity issues with particular groups.</td>
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<td>• The education of girls and women is one of the key determinants of maternal and child health.</td>
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<td>• Education and access to economic resources allow women to make informed choices regarding their health and the health of their children.</td>
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<td>• Existing negative gender norms and values that impact on health, such as gender-based violence and early marriage, need to be challenged by the health sector.</td>
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<td>• Economic security issues for women are linked to education, employment and social protection.</td>
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<td>• There are benefits to be gained from ensuring maternal and child health services are equitably represented in decision-making processes on how health budgets are set and priorities identified.</td>
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<th>Suggestions for multisectoral action</th>
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<tr>
<td>• Multisectoral action is required to tackle inequities. The meeting encourages ministries of health to support and facilitate multisectoral collaboration as a means to improving health and well-being.</td>
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<tr>
<td>• The planning, delivery and monitoring of services is more effective when individuals and communities are involved.</td>
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Background
Access to reproductive health in Ireland has improved considerably since the 1994 Conference on Population and Development. Women now have access to a full range of contraceptive methods from primary health care providers and family planning clinics, women on low-incomes can obtain contraceptives services and supplies free of charge under the public health scheme, relationship and sexuality education is compulsory in all post-primary schools and a free, organized national cervical screening programme was rolled out in 2008. However, significant barriers to universal access to reproductive health in Ireland persist. Emergency contraceptive pills are not available without a doctor’s prescription, abortion is criminalized in almost all circumstances, the cost of condoms and contraception services remains high and laws governing young people’s rights to access sexual and reproductive health (SRH) services are inconsistent.

Youth and socially marginalized groups are the most negatively impacted by these obstacles and are more likely to suffer poor SRH as a result. As a specialist SRH care service provider, the Irish Family Planning Association (IFPA) advocates for the rights of all people to access high quality services and supplies without discrimination. IFPA doctors, nurses, counsellors, receptionists, trainers and advocacy staff have extensive knowledge and experience of addressing and overcoming barriers related to SRH services, particularly among vulnerable and marginalized populations. The IFPA monitors and identifies emerging obstacles to SRH as expressed by our clients and seeks to work in coalition with other stakeholders to find practical and rights-based strategies that best meet clients’ needs. This approach has proved successful with a variety of socially marginalized communities including: people with physical and intellectual disabilities, women from disadvantaged areas, migrant women, single parents, young people, early school leavers and women from ethnic minority communities.

Addressing SRH for asylum seekers through innovative partnerships
In recent years, women seeking asylum in Ireland are increasingly presenting to IFPA services and reporting significant difficulties in accessing appropriate, confidential and sensitive SRH care. These difficulties can largely be ascribed to restrictive integration policies for people seeking asylum that are not gender sensitive and the fragmented nature of SRH services in Ireland. In response to this emerging trend, the IFPA teamed up with a minority ethnic-led national network of African and migrant women living in Ireland, AkiDwA, to develop a strategy to improve access to SRH services for women seeking asylum in Ireland.
Utilising their respective areas of expertise and with support from the European Refugee Fund, the IFPA and AkiDwA implemented an innovative programme from February 2009 to February 2010 that sought to empower women seeking asylum to assert their rights to SRH and also to support service providers in providing high quality SRH care for their asylum seeking clients.

The first phase of the project involved a needs analysis with members of AkiDwA to determine what kind of information, training and health services would be most relevant and useful for women seeking asylum. Armed with this information, the IFPA and AkiDwA designed a specific training course on SRH for women seeking asylum, compiled a leaflet of all free SRH services in Ireland that are available to women irrespective of their immigration status, translated the leaflet into the seven most common languages of migrants in Ireland and organized free SRH checks at IFPA medical clinics.

The training was delivered to 29 women seeking asylum in Ireland over 10 weeks. The participants were from 13 different countries, mostly in Africa, and had an average age of 33. Modules in the course included: puberty, menstruation, pregnancy, contraception, crisis pregnancy, HIV/AIDS, sexually transmitted infections, negotiating safer sex, gender based violence, health checks, breast checks, cervical cancer screening, female genital mutilation and public speaking.

Twelve of the participants also completed a peer education component of the training which has enabled them to deliver the course to their peers in State accommodation centres where people seeking asylum are required to live.

In addition to the training, four information sessions on SRH were held in State accommodation centres, reaching 33 women. Eight thousand multilingual leaflets were distributed to over 95 locations including health and migrant focused NGOs, direct provision reception and accommodation centres, ‘drop in’ support services for migrants and citizen information centres. As well, 51 women availed of the free SRH checks from IFPA clinics.

The project activities were intended to have a cumulative effect so that the obstacles to achieving good SRH as articulated by the programme participants themselves would inform discussions with service providers and contribute to practical steps in improving quality of care. As such, a consultative forum was set up mid way through the programme to provide advice on the production of a good practice handbook on SRH for people working with women seeking asylum in Ireland. Members of the consultative forum included women seeking asylum who participated in the training course, doctors, nurses, social workers, receptionists, crisis pregnancy counsellors, representatives from non-governmental organizations that specialize in women’s health, migrant health, migrant rights and sexual health and also representatives from statutory bodies.

The forum was very helpful in terms of identifying priority areas to be addressed in the handbook but also as a space to discuss and brainstorm on practical ways to reduce the women’s barriers to SRH. The completed handbook entitled “Sexual Health & Asylum: A handbook for people working with Women Seeking Asylum in Ireland” can be downloaded from www.ifpa.ie.

Impact

The entire programme was hugely successful in creating a dialogue between service providers and women seeking asylum, improving participants knowledge of SRH, empowering women to assert their rights and entitlements, educating service providers on the particular barriers experienced by women seeking asylum and working with women seeking asylum to explore the impact of gender on their SRH.

Through coordinating this programme and documenting the experiences of women, the IFPA is able to demonstrate to policy makers that there are huge gaps in the availability and delivery of SRH care in Ireland. For example, the criminalization of abortion in Ireland has a disproportionate negative impact on women seeking asylum seeking to terminate a pregnancy. Women must apply for visas, re entry visas and raise the necessary funds in order to travel abroad to access safe and legal abortion services. Often these obstacles are insurmountable and women are forced to parent against their will or seek out illegal and often unsafe methods of terminating their pregnancy. Another example relates to the high cost of condoms and the unavailability of free condoms. Most people seeking asylum are living at poverty line and cannot afford to buy condoms from a commercial outlet and condoms are not freely available from any source in Ireland. This creates increased risks of contracting sexually transmitted infections including HIV and unwanted pregnancy, particularly for women involved in prostitution and women experiencing gender based violence. These gaps need to be addressed as a matter of priority in order to fulfil Ireland’s international human rights obligations and to realize the Irish Government’s policy to provide equal access to health care without discrimination.

The programme also provides an evidence-base for the success of participatory, multi-disciplinary and rights-based approach to SRH care. For example, the IFPA initially offered free health checks for women living in accommodation centres but the uptake was low. However, when the IFPA and the local community group collaborated to introduce the services to women seeking asylum together, the uptake increased significantly. The IFPA will continue to work with marginalized groups to improve access on the ground and also work with policy makers to ensure the experiences and needs of different groups are reflected in strategies designed to achieve universal access to SRH.

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This report reviews progress made over the past decade in achieving MDGs 4 and 5, summarizing coverage levels of effective interventions, knowledge gaps and need for accountability by governments and development partners. An excellent review of where we are and what remains to be done. Available in English and select sections in French and Spanish at: http://www.countdown2015mnch.org


Based on data from national country surveys and global databases, this report focuses on the ability of health systems to deliver equitable maternal, neonatal and child health services, including a review of policies that support or hinder achievement of this goal. Available in English and select sections in French and Spanish at: http://www.countdown2015mnch.org


Dedicated towards monitoring the progress of coverage of effective child survival interventions, this report identified barriers to rapid scaling-up of interventions, shared new knowledge on effective interventions and delivery strategies, and agreed on indicators to monitor progress. Available in English and select sections in French and Spanish at: http://www.countdown2015mnch.org

The Lancet Articles 2010.

In collaboration with the Countdown to 2015 and the Women Deliver Conference, a series of special maternal, neonatal and child health articles have been published focusing on progress, challenges and new interventions. Available in English at: http://www.thelancet.com/


Based on a review of 50 country studies, this document finds that the resources and know-how necessary to achieve the MDGs exist. It highlights the important synergies that exist among the MDGs - with acceleration in one goal often speeding up progress in others. Available in English at: http://www.undp.org/mdg/basics.shtml


Published annually by the Statistics Division of the United Nations Department of Economic and Social Affairs, this report presents the most comprehensive global assessment of progress to date, based on data provided by a large number of international organizations within and outside the United Nations system. Available in English at: http://www.un.org/millenniumgoals/reports.shtml

Addressing violence against women and achieving the Millennium Development Goals, WHO Department of Gender, Women and Health, 2005.

Violence against women hinders progress in achieving the Millennium Development Goals (MDGs). This document highlights the connections between the MDGs and the prevention of violence against women and provides recommendations to address violence against women and promote progress towards the 8 MDGs. Available in English at: http://www.who.int/gender/documents/violence/who_fch_gwh_05_1/en/index.html
This document describes the critical role of the national health policy and strategy in strengthening health systems and delivering effective interventions in an integrated approach to accelerate progress towards the health Millennium Development Goals, with a special focus on the health of women and children.
Available in English at:

This report, WHO’s annual compilation of data from its 193 Member States, includes a summary of progress towards the health related MDGs. Available in Arabic, Chinese, English, French, Russian and Spanish at:

Millennium Development Goals in the WHO European Region. A situation analysis at the eve of the five-year countdown, WHO Regional Office for Europe, 2010.
This report highlights the advances made, continued challenges faced and inequities in progress within and between the 53 Member States of the WHO European Region as they work towards achieving the MDGs. Available in English at:

Useful websites
United Nations Millennium Development Goals:
http://www.un.org/millenniumgoals/

WHO MDGs:
http://www.who.int/topics/millennium_development_goals/en/

WHO Regional Office for Europe MDGs:
http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/millenium-development-goals

UNDP MDGs:
www.undp.org/mdg/

UN Millennium Project:
www.unmilleniumproject.org/goals

UNICEF MDGs:
www.unicef.org/mdg/

End Poverty 2015:
www.endpoverty2015.org/goals

Unstats/Millennium Indicators:
mdgs.un.org/

Global Data Monitoring Information System:
www.developmentgoals.org