HEALTH SECTOR REFORM

– What’s in it for sexual and reproductive health?

Entre Nous

THE EUROPEAN MAGAZINE FOR SEXUAL AND REPRODUCTIVE HEALTH

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Contents

Editorial
By Dr Assia Brandrup-Lukanow

Health sector reforms and reproductive health meeting

How can we assess the impact of health sector reforms on reproductive health care and services in Europe?
By Dr Frants Staugard and Charlotte Rosenberg

The Making Pregnancy Safer Initiative

Integrating reproductive health in the health reform process in Bosnia and Herzegovina
By Dr Hedva Bellawi

New EU resolution on sexual and reproductive health and rights
By Vicky Clayes

Internet resources
By Josh Gross and Jeffrey V. Lazarus

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Page 5 Page 6 Page 9 Page 12 Page 15

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Dear Entre Nous readers

This issue of Entre Nous will be my last as Regional Adviser on Reproductive Health, as I will be leaving the WHO Regional Office for Europe to join the German Agency for Technical Cooperation in Eschborn, Germany, where I will be heading the Division for Health, Education and Social Protection.

I would like to take this opportunity to say thank you for the last nine years of joint work and cooperation in the European Region. It has been an exciting time, and I believe that, together, we have much to be proud of. When I look back to the end of 1993, when I joined WHO, at that time as staff member of the UNFPA-TSS system, reproductive health was hardly on the European agenda. None of the WHO collaborative agreements with countries included reproductive health, there were no UNFPA country or regional offices in the field, and we focussed solely on the implementation of UNFPA-funded country projects in Portugal, Turkey, Albania and Romania, as well as on the information project Entre Nous.

Today, the situation is very different. The reproductive health needs of countries in the Region have been well recognized, and on average 15 countries request technical assistance in this area of work in every biennium. Another reflection of the recognition of needs has been the allocation of UNFPA resources for the establishment of several country and inter-country offices in the Region, which has made the implementation of multi-component, larger scale country programmes more feasible.

The content and profile of programmes has also changed significantly over time. Initially, there were emergency programmes, which focussed on the provision of contraceptives, essential maternity equipment and essential drugs, as well as on fast capacity building through fellowships and short courses in the countries of central and eastern Europe and the newly independent states. Today, programmes focus on the promotion of evidence-based medicine in reproductive health, the strengthening of sexual and reproductive rights, and the development and implementation of national strategies on sexual and reproductive health.

Reproductive health programmes have moved from vertical family planning programmes to becoming a more integral part of overall health policy development. This enhances their sustainability and visibility within the overall health policy discussion, which, in the past decade, has been governed by the quest to make health services more client-centred and at the same time cost-effective by radically reforming the ways in which the health sector functions and the way it is financed.

Much has been written about the impact of health sector reforms on costs, and, in part, on health outcomes. To date, not as much systematic evidence has been collected on the impact of health care reforms on reproductive health. How does the introduction of user fees affect health care seeking behaviour in pregnancy? How does the introduction of insurance coverage impact on the use of contraceptives and abortions? What provisions are taken to protect the unemployed and those who do not have access to financial resources, many of whom are women working in the informal sector, or "dependants" in the sense that they have to rely on the income and insurance of their husbands. Have appropriate methodologies been developed to measure the impact of all these changes on maternal health, on the sexual and reproductive health of young people, or on the incidence of STI infections?

In this issue of Entre Nous, we try to reflect the present discussions in this field, which have also been the subject of the last global meeting of WHO Regional Advisers for Reproductive Health. The meeting stressed the need for more research on the impact of health sector reforms on reproductive health services and outcomes and on the sexual and reproductive health rights of individuals.

We present a proposal for a study methodology field tested in several countries of the Region by Dr. Staugaard, as well as in-depth country case study on Bosnia-Herzegovina by Dr. Hedia Belhadj.

In the Resources section, readers will find information on the HIT profiles produced by the European Observatory on Health Care Systems, an initiative of WHO and eight other partners. To date, the health systems of more than 44 countries have been comprehensively analysed by a team of international experts. HITs provide an analytical description of each national health care system and of reform initiatives in progress or under development. They aim to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond.

Also in this issue of Entre Nous, we present the main areas of work of the global Making Pregnancy Safer Initiative in the European Region. Apart from the pilot country Moldova, many other countries in the Region have expressed an interest in joining the initiative, thus reflecting a greater political commitment to effectively improve maternal health and reduce maternal suffering and deaths. The inclusion of the recommended health-sector related actions into ongoing health care reforms will be vital in achieving the Making Pregnancy Safer goals.

We hope that Entre Nous can thus support and stimulate the ongoing discussion and, as always, we look forward to our reader's comments, suggestions and experiences.

Again, thanks to all for your commitment, cooperation, and friendship over the past years. I look forward to continuing to expand our joint work. On behalf of contributors and readers, I would like to express my sincere appreciation of the Entre Nous editorial team, Jeffrey Lazarus and Dominique Gundelach, as well as the Editorial Board for their guidance and advice.

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Chief editor
THE DEPARTMENT OF REPRODUCTIVE HEALTH AND RESEARCH AT WHO IS DEVELOPING A NEW RESEARCH INITIATIVE THAT WILL FOCUS ON THE IMPACT OF HEALTH REFORMS ON ACCESS TO AND UTILIZATION OF REPRODUCTIVE HEALTH SERVICES, AS WELL AS REPRODUCTIVE HEALTH OUTCOMES. THE GOAL WILL BE TO PROVIDE COUNTRIES AND DONORS WITH EVIDENCE-BASED ADVICE ON RECOMMENDED APPROACHES TO THE IMPLEMENTATION OF HEALTH REFORMS RELATED TO SEXUAL AND REPRODUCTIVE HEALTH.

A KEY ISSUE HIGHLIGHTED AT THE MEETING OF WHO REGIONAL ADVISORS ON REPRODUCTIVE HEALTH WAS THE NEED FOR A HOLISTIC DEFINITION OF THE CONCEPT OF HEALTH SECTOR REFORMS, WHICH IN ACCORDANCE WITH THE WORLD HEALTH REPORT 2000 WERE DEFINED AS "SUSTAINED, PURPOSEFUL CHANGES TO IMPROVE THE HEALTH SECTOR." SOME OF THE ELEMENTS OF THIS HOLISTIC CONCEPT ARE FINANCING, RESOURCE ALLOCATION, REORGANIZATION OF FUNCTIONS, DECENTRALIZATION AND THE LEGAL ENVIRONMENT.

SEXUAL AND REPRODUCTIVE HEALTH (SRH) HAS BEEN GIVEN LOWER PRIORITY IN NATIONAL AND GLOBAL HEALTH POLICIES AS EXEMPLIFIED IN THE OMission OF SRH IN THE MILLENNIUM DECLARATION AND THE DECREASING ALLOCATIONS OF FUNDS NOT ONLY TO SRH BUT ALSO TO PRIMARY HEALTH CARE. A CRITICAL QUESTION IS HOW POLICY-MAKERS CAN PROACTIVELY ENSURE MAXIMUM BENEFIT OF HEALTH SECTOR REFORMS FOR SRH.

DECENTRALIZATION

An assessment of the impact of decentralization on SRH was a priority and a need was expressed for the development of appropriate methodologies and tools for such an assessment. The approach termed "decision space" had been tested and should be considered. The decision space approach proposes a principle (individual or institution) with specific objectives and agents needed to implement activities to achieve those objectives. The decision space approach thus concentrates on describing policy formulating and implementing agents.

It has been observed with concern that in some cases decentralization of health management has led to a lower priority being given to SRH. A need was identified to ensure that SRH was paid due attention as a key component of peripheral health services and that sufficient resources were allocated to SRH as part of any decentralization process.

THE IMPACT OF FINANCING ON SRH

A need was identified to develop operational objectives for all elements of health sector reforms in order to facilitate their monitoring and evaluation. In this process the maternal mortality rate (MMR) is a key indicator of inequitable resource distribution. It was noted that some elements of health sector reforms impact positively on MMR - even in the absence of economic growth. It was emphasized, however, that reforms alone could not compensate for diminished resources.

Some of the new insurance schemes were found to reduce access to SRH services for certain population groups, thereby aggravating inequity. There was a discussion on the issue of contracting for health sector reform and it was noted that this approach might in some cases be a cost-effective strategy, but should be carefully monitored.

RESEARCHNEEDS

- How to document resource flows;
- How to measure and ensure accessibility;
- How to measure the cost-effectiveness of health sector reform elements;
- How to measure the magnitude of gender-based violence;
- How to measure the cost-efficiency of health sector reforms.

CRITICAL ISSUES IN THE FIELD OF POLICIES AND PROGRAMMES

- How to mobilize additional resources for SRH;
- How to ensure a needs-based allocation of resources;
- How to reduce inequity as part of health sector reforms;
- How to ensure that all stakeholders are actively involved in planning and implementing reforms;
- How to design reforms for countries recovering from conflicts.

REVIEWING SECTOR-WIDE APPROACHES

A sector-wide approach (SWAPs) was viewed as a strategy for improved management of development cooperation in order to achieve better value for money and improve outcomes. SWAPs therefore imply a structured and coordinated partnership between national governments and the external development partners. It was noted at the meeting that this may be effective in implementing and sustaining health sector reforms, but must be based on a participatory process. Some critical questions were:

- How to measure the impact of SWAPs on SRH; and
- How to provide country-specific documentation of reform experience.

PRIVATE AND PUBLIC PARTNERSHIPS

The meeting made note of the fact that public-private partnerships (PPP) have gained increasing significance as part of health sector reforms. It was therefore important for governments to create supportive environments for PPP. However, it was noted that privatization may lead to gap-widening and distortion of priorities. Some critical questions remain to be addressed:

- How can the impact of PPP on SRH services and outcomes be documented;
- How is PPP of specific relevance to SRH.

SEXUAL AND REPRODUCTIVE RIGHTS

The meeting emphasized the need for sexual health and rights to not be separated from reproductive rights. Moreover, the integration of the components of sexual health and the components of reproductive health in programmes and services was seen as crucial.

Finally, the African and European Regional Offices of WHO have prepared regional SRH strategies. The European Union is in the process of developing such a strategy on SRH and it was seen as important to ensure optimal collaboration between WHO and regional governmental and non-governmental organizations in SRH policy and strategy development.

THE FULL CONFERENCE REPORT IS AVAILABLE FROM:

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Health sector reforms in Europe have been generated by broad secular trends that cross national and sub-regional boundaries. At least two categories of factors appear to have generated these trends.

First, pressures from outside the health sector have affected the basic framework of health policy formulation. A wide range of political, ideological, social, historical, cultural and maybe above all economic factors has determined the specific nature and contents of health reforms in each country. Second, existing health problems and in some cases the deteriorating health status of certain groups of the population in addition to problems within the health services delivery system in each country have challenged policy makers and made health sector reforms necessary.

A generic study protocol has been developed for the use of countries who wish to review specific elements of the health sector reforms with a potential direct or indirect impact on reproductive health services and outcomes. On the basis of such a review it will be possible for countries to modify or reinforce elements of their health sector reforms, and thereby improve reproductive health indicators in the longer perspective. The generic study protocol has been piloted in two European countries, the Republic of Moldova and Slovakia, and is briefly presented in this article. Comprehensive reports with the findings from these two pilot studies have been published by the Sexual and Reproductive Health Programme at the WHO Regional Office for Europe, and copies of the reports are available upon request.

Objectives, hypotheses and methods

The pilot studies aim to:
- assess the impact of health sector reforms on reproductive health services and outcomes;
- analyse the correlation between specific elements of health sector reforms and one or more of the generic strategic areas or core elements of the national programme for sexual and reproductive health;
- add views and perceptions of policy-makers, planners, health care providers, interest groups and beneficiaries regarding the impact of health sector reforms on sexual and reproductive health to national statistical data used for the monitoring of development trends of standard indicators for sexual and reproductive health;
- formulate rational proposals regarding modifications or amendments of specific elements of the national health sector reforms, as appropriate, in order to positively influence on reproductive health services and outcomes.

The specific study questions were formulated in two data collection tools: one focusing on keywords and indicators, and the other on interview questions, which were developed for the study protocol. These data collection tools are also available on request. The questions were formulated on the basis of official WHO documents with guidelines for selection of national and global indicators for monitoring of reproductive health status as well as WHO literature, analysing current strategies of European health care reforms in general and strategies for the improvement of reproductive health in central and eastern Europe in particular.

Four general study hypotheses were defined for the pilot studies. Generic hypotheses must be modified for new studies where country specific hypotheses respecting the socio-economic situation and development trends of key indicators for sexual and reproductive health in each country should be added. The pilot country studies were guided by their operational objectives and divided into four study phases, which are reviewed below. The approach to implementing the pilot studies might be of use to researchers, who wish to conduct similar studies in other Member States. This country study approach is based on experience already gained from the two pilot country studies.

Study phase 1: Literature review

Initially, a desk study of all relevant and available literature and documents related to the specific country situation with regard to health sector reforms, sexual and reproductive health services, outcomes and indicators should be carried out in order to provide a detailed picture of the specific country situation. The literature search should be guided by key-
words, defined in the generic data collection tools.

The specific literature search should be accompanied by a systematic review of all existing elements of health legislation and of health sector reforms with relevance for one or more of the core strategic areas of a generic programme for sexual and reproductive health.

Study phase II: Country specific study protocols

For each country a specific study protocol and set of data collection tools should be developed, taking into account the scope and range of activities in the national programme for sexual and reproductive health as well as the priority questions of the national study.

Piloting data collection tools

Following the development of the country specific study protocol and data collection tools the latter should be piloted in selected geographical areas and among representative target groups, in order to allow for modifications of the data collection tools, if needed.

Training of interviewers

Prior to the onset of the actual collection of data interviewers need training under the supervision of experienced researchers. This may take place as part of the above process of piloting the preliminary data collection tools.

Study phase III: Provision of updated statistical information on indicators for sexual and reproductive health

As the first activity in phase III of the country specific study, all relevant hardware indicators and trends with regard to the strategic areas or core elements of a generic sexual and reproductive health programme should be documented. For the purpose of the pilot studies mentioned above an additional strategic area or core element was included with the purpose of providing complementary information on country specific issues related to equity, human rights, advocacy and gender mainstreaming.

Interviews with policy-makers, planners, health care providers, interest groups and beneficiaries

As the second activity in phase III, a series of interviews should be conducted with representatives of relevant government representatives, authorities, agencies and representatives of reproductive health care service providers in each of the participating countries. Following these initial interviews researchers should meet with and obtain relevant information from representatives of other authorities and agencies at the central, regional and district level, involved in planning and managing different components of the health sector reforms as well as in planning and implementing reproductive health services activities. Appointments should also be made with representatives of non-governmental organizations and interest groups engaged in issues and problem related to sexual and reproductive behaviour. Perceptions of immediate beneficiaries with regard to the impact of the ongoing health sector reform process on various aspects of sexual and reproductive health and health services should be described as experienced in their own situation and added to the country study.

The purpose of complementing quantitative data with qualitative information, from interviewing different groups of informants, is to create a triangulated picture of the reality of sexual and reproductive health in the specific country. This is relevant for each of the strategic areas of the national sexual and reproductive health programme as well as in relation to issues of equity, human rights, advocacy and gender mainstreaming.

As part of each type of interview, as described above, attempts should be made to obtain views and perceptions regarding strengths, weaknesses, opportunities and threats (SWOT). This should be in relation to current and future health sector reforms and their actual or potential impact on sexual and reproductive health services and outcomes.

Methods for qualitative data collection

Focus groups, structured and semi-structured interviews are qualitative data collection tools that can be used alone or combined for the purpose of the study. Focus groups combine several advantages including flexibility, a relatively low cost, potentially quick results and a capacity to increase the size of a qualitative study. Focus groups are valid if they are used carefully for a problem that is suitable for this method. In relation to certain sexual and reproductive health issues there might be some country specific sensitive issues that can not be addressed directly and which can impact on the validity of the results. Focus groups also have certain limitations that can affect the quality of the results e.g. researchers have less control than in individual interviews, data analyses are difficult, the group discussions are difficult to compare and some target groups may be difficult to convene for the holding of the focus group discussions.

A structured interview is characterised by a standardised questionnaire with closed- and/or open-ended questions,
such as illustrated in the second data collection tool used in the pilot country studies. This tool is appropriate if
the interviewer is not very experienced, due to its structured agenda. It is also less time and resource consuming than semi-
structured interviews tend to be. The results might be affected by the limitations of the standardised questionnaire.
A semi-structured interview is characterised by a more flexible agenda. The interviews usually take the form of a dialogue with selected themes. This kind of interview is usually very rewarding with regards to capturing new perspectives and insights into the focus of the study. It calls for more experienced interviewers, who need to be both open and focused during the interviews.

Study phase IV:
Analysis of hardware data.

Analysis of both quantitative and qualitative study findings should form the first stage of phase IV of the study. On the basis of study findings, preliminary conclusions and recommendations regarding specific elements of health sector reforms may be formulated with the purpose of impacting positively on sexual and reproductive health services and outcomes. While the analysis of hardware data, obtained from national and global databases, is comparatively simple and greatly facilitated by the availability of trends analyses in e.g. the WHO Health for all database, the analysis of findings from software data, obtained from the open-ended questions in data collection tools for the country studies might be more complicated for the researchers as there is more room for interpretation.

Analysis of software data

There are many different methods for analysing qualitative data. Grounded theory with open, axial and selective coding is the most commonly applied method among public health researchers. The advantage is the method's cogent and systematic way of processing data. It does not aim at interpreting the individual's narrative but rather at uncovering patterns and different contexts across respondents' narratives. All phases of the method are described in detail in standard textbooks, unlike other qualitative methods of analysis, which makes it very accessible for public health researchers. The disadvantage of using grounded theory is that all of the nuances in data do not get analysed and that quotations from the respondents can be taken out of context, if the analysis is not sufficiently detailed.

In the process of coding and analysing data from the focus group, structured and/or semi-structured interviews con-
ducted for the study, software programs such as Nvivo and Nud*ist may be used, either separately or in combination. Nud*ist is a simple program for coding large amounts of data, whereas Nvivo is a later updated version of Nud*ist. The two programmes can easily be combined if a greater flexibility in handling data is required. One of the advantages of Nvivo is that researchers can combine work from different research sites. Qualitative elements can also be imported and exported to quantitative programs like SPSS or WHO databases for further analysis. Information about the software is available at www.QSR.com.au. Links to other qualitative software programmes can also be found at this website.

Validity and reliability of study results are also important criteria. In the process of planning a focus group or structured and/or semi-structured interview, several considerations must be taken into account with regard to criteria for inclusion, sampling strategies and where and how the interviews should be conducted, e.g. respondents' private residence, tape-or video-recorded observations, notes and/or transcriptions. Considerations concerning ethical issues are also important and approval must be obtained from relevant ethical science committees and from all the different parties involved.

The personal, professional and theoretical experience of the researchers must also be considered and clarified. The qualitative researchers must acknowledge that they are not just affecting the process but become part of this process. It is essential that the way the researchers influence the analysis and hence the results be explicitly discussed.

Development of draft report

Following the completion of each country study a first draft report with the main findings, conclusions and recommendations from the study should be developed. This country report should be submitted to authorities and other interested parties in each study country. Feedback obtained should then be integrated in the next draft, prior to the formulation of final recommendations regarding modifications of specific elements of the health sector reforms.

Hardware indicators at the national level

Sexual and reproductive health output and outcome indicators are divided into two categories, of which the first could appropriately be termed hardware indicators, providing the study with officially and unofficially available data on the effectiveness of national sexual and reproductive health policies, strategies
and services. Indicators should be categorized under each of the strategic elements of the national sexual and reproductive health programme. Indicators should be sex-disaggregated, where appropriate and possible.

**Software indicators**

The second category of indicators could appropriately be termed software indicators, as this information should reflect the views and perceptions of policymakers, planners, health service providers, interest groups and beneficiaries of reproductive health services regarding the appropriateness, relevance, efficiency, availability and accessibility of reproductive health services as well as the appropriateness and relevance of reproductive health policies and strategies. The list of indicators should be developed on the basis of global criteria regarding the usefulness, ethical standard, representativeness, validity, sensitivity and specificity of any given indicator.

**Discussion on methodological problems and issues**

The effectiveness and impact of health sector reforms on sexual and reproductive health services and outcomes can only be assessed in a longer time perspective. They are measured by assessing the level of success of reforms in terms of improving the sexual and reproductive health status of various groups of beneficiaries. In this process of evaluating the reform process over a longer period of time, the WHO list of national and global indicators will prove valuable.

However, detailed quantitative information on some of the defined global indicators is not easily available in national or global databases. Some information in these databases only provides researchers with proxy indicators of the effectiveness of health reforms on reproductive health.

In the short term there is need for monitoring progress of the reform process by assessing the efficiency of implementation of those reform elements which have a direct or indirect bearing on sexual and reproductive health services. This monitoring could take place through quantitative and qualitative data collection on the process of implementing reforms with regard to decentralization of health services, strengthening of the primary health care sector, the role and function of gatekeepers in this sector, in particular the family physician, the quality, availability and accessibility of antenatal care and abortion services for different groups of beneficiaries, privatization of some health services, and the role and function of health insurance schemes on sexual and reproductive health services. However, process indicators of this nature, enabling researchers to assess the efficiency of the health reform process in general and the efficiency of reform elements with a direct or indirect bearing on sexual and reproductive health services in particular, are not generally available and often have to be collected through special surveys. Moreover, globally applicable indicators with regard to the efficiency of health reforms remain to be defined.

Whether country specific studies on the impact of health reforms on sexual and reproductive health aim at assessing the effectiveness of reforms in the longer time perspective or in the shorter, it is highly relevant to add qualitative information on the views and perceptions of immediate beneficiaries and other target groups of the reforms to the quantitative information — and thus to opt for a triangulated study approach in each country specific study.

**Conclusions from the pilot studies**

In the hypotheses for the pilot country studies it was contended that it is possible to identify a correlation — positive or negative — between specific elements of the health sector reform process on the one hand and sexual and reproductive health services and outcomes on the other, in any given country. However, a multitude of confounding factors impact upon indicators for health development and sexual and reproductive health indicators in general and on health indicators for particularly vulnerable groups in any society in particular. It is thus difficult and in the majority of cases impossible to establish causality of any given element of health sector reforms and sexual and reproductive health outcomes, measured by means of standard indicators. However, it is possible to draw tentative conclusions as to a possible positive correlation between specific health sector reform elements and sexual and reproductive health services and outcomes. It should not be forgotten that general socio-economic development trends in any given society — whether negative or positive — are the most important determinants for trends in public health development in general and in sexual and reproductive health development in particular.

Nevertheless, there is merit in hypothesizing that modifications of the health sector reform process might contribute to a reversal of negative trends of sexual and reproductive health indicators, despite deteriorating socio-economic development trends in the society at large. This hypothesis or assumption might be of particular relevance to those modifications of elements of the health sector reform process that specifically aim at targeting the most vulnerable groups of the population. The proposed study methodology might therefore provide public health planners and decision-makers with an appropriate tool for improving the quality of sexual and reproductive health services and outcomes by identifying problems in relation to sexual and reproductive health that may be approached, and in the best case solved, through modifications of elements of health sector reforms, even in the absence of a general socio-economic improvement for the population in general and for members of particularly vulnerable groups of the population in particular.

The full study protocol including the data collection tools, as well as the pilot studies are available from Frants Staugård.

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Motherhood is a positive and fulfilling experience for most women, but for more than 20 million women each year, pregnancy and childbirth bring suffering, poor health and even death. To reduce maternal and perinatal mortality around the globe, in 2000 the World Health Organization introduced Making Pregnancy Safer (MPS), an umbrella initiative that includes activities in the field of reproductive health, sexually transmitted infections (STIs) including HIV/AIDS and promoting effective perinatal care (PEPC).

By developing national strategies that focus on effective interventions, MPS seeks to strengthen health systems, particularly at the community level, and to ensure that all pregnant and post-partum women and their newborn infants have access to appropriate health care.

Making Pregnancy Safer objectives:
• to prevent unwanted pregnancies and unsafe abortions
• to provide skilled care during pregnancy and childbirth
• to ensure access to professional care for obstetric complications.
Making Pregnancy Safer in Europe

MPS was launched in the European region initiative in 2001. While maternal and perinatal mortality rates are relatively low in western Europe, the rates are tenfold in other countries in the region. Specific challenges include the significant differences in access to health care, common in centralized systems in which different levels of care are not integrated; perinatal care that is not multidisciplinary is approach; the use of abortion to compensate for poor contraception; over-medicalization; an over-reliance on or inappropriate use of technology and drugs; and a lack of basic equipment and essential drugs. Political instability, war, displacement, migration and economic crisis can also contribute to substandard care.

WHO has collaborated with its partners to prepare a regional MPS plan that builds on existing activities and programmes and targets the region’s specific challenges. The MPS initiative in the European Region builds on existing programmes like Promoting Effective Perinatal Care (PEPC).

Perinatal care should:
- be de-medicalized
- use appropriate technology
- be evidence based
- be multidisciplinary
- be holistic
- centred on the family
- involve women in decision-making
- be culturally appropriate and
- use a referral system.

PEPC

MPS in Moldova

The Republic of Moldova is the pilot country for the MPS initiative in the European region. Much of the Moldovan population lives in poverty, and primary-health care providers are limited in their abilities both to diagnose complications and to refer patients to a higher level of care. There is also an insufficient use of evidence-based approaches in secondary and tertiary care, where most maternal and perinatal deaths occur. Emergency services are often delayed, especially in rural areas. Working with the Ministry of Health and key national and international organizations, WHO has developed a national MPS plan that builds off of ongoing national perinatal and reproductive health activities. The plan identifies three primary areas of action: promoting the evidence-based care model, strengthening midwifery and supporting primary maternal and perinatal health care.

Maternal and newborn indicators in Moldova

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
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<tbody>
<tr>
<td>Population</td>
<td>4.26 million</td>
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<tr>
<td>Life expectancy</td>
<td>67.75</td>
</tr>
<tr>
<td>GDP per capita (in USD)</td>
<td>353</td>
</tr>
<tr>
<td>Live births per 1000 population</td>
<td>10.15</td>
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<tr>
<td>Maternal mortality rate, all causes, per 100 000 live births</td>
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</tr>
<tr>
<td>Perinatal mortality rate per 1000</td>
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</tr>
<tr>
<td>Women receiving antenatal care</td>
<td>&gt;99%</td>
</tr>
<tr>
<td>Deliveries in health facilities</td>
<td>98%</td>
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<tr>
<td>Incidence of AIDS per 100 000 population</td>
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<tr>
<td>Incidence of syphilis per 100 000 population</td>
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<tr>
<td>Women using contraception</td>
<td>74%</td>
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2 Health for All Database. WHO/EURO. January 2002.
Regional capacity building

MPS Tools workshop, Copenhagen, December 2001.
Aimed to define how PEPC regional tools and global MPS tools should be integrated. (See description of tools on page 4.)

Regional Training of Trainers, Copenhagen, February 2002.
Course using MPS/PEPC training tools revised and translated into Russian. Aimed to increase the number of regional trainers, especially midwives, and to provide updated training methods.

Activities in Moldova

MPS Launch and Planning meeting in Chisinau Republic of Moldova, January 2002

Audit of Quality of Care Workshop: Examples of abortion and perinatal care.
Key professionals and a consultant from the Royal College of Obstetrician Gynaecologists compared existing case management with published international findings and recommended improvements of standards, clinical practices and laws.

Setting up the MPS Documentation Centre, under the responsibility of the MPS National Professional Officer. The centre provides situation background assessment, collects relevant information sources electronically and on paper, and supports ongoing activities and bibliographic research in the field.

MPS Evidence-Based Mother and Newborn Care Course, designed for the European region and translated into Russian. The first model course was held in Moldova in April 2002, with local top-level professionals working with Ministry of Health representatives to prepare clinical guidelines. The faculty was international, coming from Scotland, Georgia and Moldova. The course objectives were to introduce key concepts in evidence-based medicine, to develop skills in finding and critically appraising research evidence before applying it in clinical practice, and to develop a replicable course to support the teaching and dissemination of evidence-based maternal and neonatal care. Cascade training with Moldovan trainers is now being implemented.
Key tools
The following training and follow-up tools, available in both Russian and English, have been updated and adapted to meet local needs in 2002. They are used in MPS/PEPC orientation, planning and implementation activities in the European region and are consistent with other tools used there.

Managing Complications in Pregnancy and Childbirth
Around 15% of women who become pregnant develop potentially fatal complications during pregnancy, childbirth or the immediate postpartum period. These conditions are treated best in facilities providing comprehensive emergency care. Unfortunately, women referred to health facilities for the emergency treatment of such life-threatening complications are not always treated quickly or effectively. The interventions in this guide are based upon the latest findings available. Aimed at the rapid assessment and resolution of these complications, the text is arranged by symptom for quick reference. This manual is intended for midwives, physicians and other senior health workers responsible for managing the care of obstetrical and neonatal complications. It has been translated into Russian and adapted for the Region's needs.

Essential Antenatal, Perinatal and Post Partum Care
WHO designed this manual for Central and Eastern Europe (CEE), the Newly Independent States (NIS) and the Central Asian Republics (CAR) as part of the MPS/PEPC programme. It aims at improving health care providers' knowledge and practice of essential obstetric care. This manual, updated in 2002, offers clinical guidelines and suggests effective, evidence-based clinical protocols in topics such as anaemia, hypertensive disorders, partograph use and clinical audits. It is also designed to strengthen managerial skills at health care facilities and promote patient rights.

Essential Newborn Care and Breastfeeding
This newly updated training tool is another part of the series developed by WHO for CEE, NIS and CAR in the MPS/PEPC programme. It is intended to increase understanding of the principles and practice of essential newborn care, and to develop corresponding skills and attitudes among doctors, nurses and midwives in charge of delivery and neonatal care in health centres and small hospitals. It also tries to inspire participants to action in their own health facility level by having them prepare an essential newborn care and breastfeeding plan. This manual offers updated guidelines for the management of asphyxia, hypothermia and low birthweight, as well as for infection prevention, rooming-in, a friendly environment for childbirth, transferring newborns with complications and the promotion of breastfeeding and mother-infant bonding.

Making Pregnancy Safer
World Health Organization
Regional Office for Europe
Scherfigvej 8
DK-2100 Copenhagen O, Denmark
Tel: (+45) 39 17 17 17
[postmaster@who.dk]
www.eurom.who.int
Bosnia and Herzegovina is building its institutions and reforming its policies in order to achieve stable economic growth and social development through a shift from reconstruction to medium-term development.

The country is composed of two entities: The Federation of Bosnia and Herzegovina and the Republika Srpska (which includes the District of Brčko). A recent strategic plan for the reform and reconstruction of the health systems of the two parts of the country has for the first time addressed the rationalization of the use of services, including hospitals, privatization, a basic package for health care for the poor and the reallocation of resources. However, the reform strategy is not comprehensive and more needs to be done in the field of sexual and reproductive health.

In the 1980s Bosnia and Herzegovina had an infrastructure and health indicators that were relatively developed as compared to other central European countries. Independence in 1991 was followed by a war that destroyed most physical assets and was associated with approximately one-quarter of a million people reported dead or missing. Altogether, the total population decreased from 4.39 million in 1991 (census date) to an estimated 3.36 million at the end of 2001, with approximately one million people living as refugees.

The high number of displaced persons and returnees is an exceptionally vulnerable group. Social structures, already limited, are being overstretched and due to the redistribution of public resources and investments in curative care, this group is becoming further excluded. Support is being secured through international assistance, most of which is compartmentalized and haphazard. Gender equality and equity for job opportunities and access to other resources are also problems the country must resolve.

In spite of massive international aid, economic growth is low and the GDP is under 50% of the 1991 level. Moreover, the number of active insured persons is one-seventh of the total population, half of the pre-war figures. Better control over the informal sector, the establishment of regulatory systems and a rigorous taxation system would provide the necessary revenue to address the public financing gaps.

The proportion of young people under the age of 20 is 34%, down from 42% in 1991, while the 65-year olds and above accounts for 7.8% of the total population. The population age profile warrants a serious look at the type of infrastructure and investment in the health sector as well as the social security systems. For example, reproductive health data showed that three-quarters of young people begin sexual relationships between the ages of 16 and 19. Among these, 50% do not use contraception and are not aware of the risk of sexually transmitted infections (STIs). A lack of sexual education in schools and access to youth friendly services equipped with skilled staff are at the root cause of this situation. The accessibility of contraceptives is limited due to a lack of governmental regulation, resulting in high costs and irregular stocks. Vulnerability risk factors for HIV transmission among young people include unsafe sexual behaviour, injecting drug use and the existence of unregulated commercial sex. Moreover, there are many young women brought in from neighbouring countries that are coerced into commercial sex. A strong sub-regional strategy with full legislative support from the countries of origin and destination is needed to end this trafficking.

Among the general population, knowledge and reproductive health (RH) practices vary. The RH surveys undertaken in 1999 show that almost all women have heard of at least one modern family planning method. Awareness about oral contraception, condoms and the intrauterine device (IUD) is relatively high (around 95%). The least known methods are vasectomy and the female condom. Reliance on traditional non-reliable methods such as withdrawal and the rhythm methods is high (74.3 and 50.5%). This is the cause of the high level of abortions, estimated at 35.6%. The highest age-specific abortion ratio occurs among women aged 35-44 followed by the age groups 25-34 and 15-24.

All women interviewed during the RH survey had heard about HIV/AIDS. However, misinformation about the means of transmission is still widespread. Systematic testing such as the Pap smear was also widely available in the past, however, this was not the case for measures that would lead to lower morbidity, for example the promotion of safe sexual behaviour to curb STIs, one of the main causes of cervical cancer. These results
show a great need to improve information about RH and to promote the health benefits of using RH services and improving access and quality of services, especially for adolescents.

Currently, the health care reform proposes to address system sustainability, equity and solidarity, efficiency, the satisfaction of health workers and patients, and a smooth transition from self-management to a market economy. Faced with scarce resources, the government needs to try to establish priorities in health care (a basic package) and introduce cost sharing (patient participation) in a climate of transparency. In that context, the United Nations Population Fund (UNFPA), working alongside the World Bank and the European Union, will continue to support technical assistance to define and integrate a minimum package of reproductive health services that would ensure quality, affordability and access to all population groups with assurance of free services to underserved and vulnerable groups. The World Bank has assisted the Republica Srpska in finalizing a basic health package and work is near completion in the rest of the country.

**Financing health and the role of primary health care**

The health system is characterized by a large number of trained physicians and female doctors, yet there is an uneven development of health facilities with large geographic disparities and an uneven distribution of medical staff. This situation has resulted in inequitable access to specialized care, particularly for rural and underserved regions, and a limited role for health promotion.

Funding is secured at the local level through cantons and are expected to share a percentage of this amount with the central level redistribution to underfunded regions. Only limited information is available on this subject, as cantons determine their own priorities, which in some cases do not systematically follow those of the national plans. Health financing decreased by 50% between 1991 and 1997. Co-payments and compulsory contributions equally drawn from employees and employees only accounted for 1/25 of the per capita needed, reflecting a drastic decrease in the ability of the country to sustain its health budget from active payments of premiums.

In spite of a health law proposal that prioritises war victims, basic hospital services targeting the poor and a health programme focusing on primary health care and public health, the criteria for allocating annual budgets to health facilities depend on the number of health staff working in the facility, their level of training and number of years worked. Currently, quantity or quality of services is not considered among the criteria for allocation of resources. There are more incentives for hospitals and clinic administrators to keep staff (often unnecessarily) and increase bed occupancy as it keeps allocations flowing.

As for the use of the health system, due to the aforementioned low level of investment in the primary health care system, when possible, the population tends to directly seek secondary and tertiary care. This leads to the overcrowding of hospitals in some areas and under-utilization of facilities in others. The Health Expenditure and Perceptions Survey, Federation of Bosnia and Herzegovina (1999), showed that the first non-hospital contact is the pharmacist, the specialist or the private doctor instead of general practitioners (GPs) raising the question of the poor image that generalists and the public sector in general generate among the population in general.

One-third of those who consulted a GP the first time also contacted a GP the second time, but more (43%) contacted a specialist. Two-thirds of those who contacted a specialist the first time also contacted a specialist the second time and only 8% a GP the second time.

About a quarter of the respondents thought that the quality of care was very good although this varied widely from less than 20% of those who went to see a GP to over half of those who went to a private doctor. A subsequent household survey in Republica Srpska, with support from the World Bank, indicated that 73% of respondents think that fundamental change is needed to improve the health sector.

One conclusion is that people are ready to pay more with the expectation of receiving higher quality services. Under the reform, as the primary health care system's role will increase, a new type of health provider, GPs or, ideally, family doctors, will become the "gatekeeper." Any prospects to expand the GPs' scope of action will need to look at how this is going to respond to the demand in terms of optimal equipment and supplies and appropriate training. In addition, the population needs to be made aware of the importance of the referral system.

**Options for the future:**

**Setting priorities**

The Household Perceptions Survey of Health Care in the Republika Srpska (2000) reported that the population in general agreed that some priority groups, such as the poor, war veterans, the elderly, the displaced and returnees should benefit more than others from free-of-charge services. Furthermore, 31% stated that increased taxation was an option to offset payment costs. An optimal mix of an insurance scheme with government budget safety net arrangements has yet to be established.

The Health Expenditure and Perceptions Survey (1999) conducted in the Federation of Bosnia and Herzegovina showed that households contribute significantly towards the cost of hospital and non-hospital care in each of the survey areas. Some of the key results, mentioned below, show the untenable relationship between income and cost of health care were:

- 80% of individuals indicated that they contributed towards the cost of hospital and non-hospital services;
- the insurance status does not influence the level of payment for non-hospital consultations;
- increased hospital spending is linked to longer lengths of stay; increased hospital spending does not necessarily lead to higher levels of perceived quality;
- average household income levels were around 211.68 and hospital admission could reach 102.26;
- private spending estimates suggest that health care spending is approximately 5% of GDP.

As for the ability to pay, the same survey revealed a relationship between the age of the individuals and the levels of spending. Nearly twice as many of those in the
youngest age group spent nothing as compared to the oldest age group. However, due to the small sample size, these differences are not statistically significant. Those who were insured were more likely to have spent nothing because the insurance paid the costs. Over half of those who were not insured spent more than 61.4, a large proportion of an average monthly salary, but again the differences were not statistically significant.

Those not covered by health insurance and who are poor can only receive health care with the help of humanitarian organizations. There is currently a strong debate regarding the non-existence of a real safety net for the poorest of the poor. Another angle of the debate is related to the large proportion of rural poor, who are left out of the insurance scheme, and the difficulty of obtaining insurance as a part of unemployment benefits. Finally, the limited availability of services combined with the inability to pay for services pose the question of equity of access that the government must address through the policy reform.

Within the health reform: moving towards the RH strategy

In this context the national authorities at the Ministry of Health agree that efforts should be invested in primary health care and in reproductive health. In spite of a delay in operationalizing the RH strategy, under government review since 2001, the goals of the RH component would be to decrease the number of abortions, increase contraceptive prevalence rates and decrease the prevalence of reproductive tract infections and sexually transmitted infections. The structural reform, based on the above perceived needs, would integrate an RH package that would improve the RH health status of the population through the provision of quality RH services, increase efficiency of the use of the funds through the decentralized funding mechanism; and reduce the proportion from state budget financing and universal equity by securing access for the poor, via payment exemptions for this group. Since 1995, the proportion of financing of the health services from social insurance and the private sector has been increasing, even though the public sector contribution has remained significant. Private expenditures include direct payments to doctors, treatment in private clinics, co-payment and payment of drugs bought from private pharmacies and the informal payment for some public providers of health care services. In order to receive better quality of care, towards contraception is the way to go and in order to discourage abortion, a price barrier was recently introduced. This barrier may lead women to seek abortion among non-qualified personnel and/or in inadequate health structures. The situation needs to be carefully monitored.

One possibility would be to counteract the need for abortion by a strong consumer, client targeted information campaign that emphasizes the benefits of RH on the health of the child, the mother and the family in general. To increase access to RH commodities it is essential that they become part of the essential drugs list and that they be offered in all Ministry of Health outlets. Similarly, the insurance schemes must cover at least a basic RH package that includes contraception, safe delivery and post-natal care, STI management and prevention and the treatment of gynaecological conditions.

Another option is to involve other levels of health professionals such as nurses and midwives in counselling and the service delivery of comprehensive RH services. A third option is to work in the context of the ongoing national training programme of general practitioners/family doctors. With appropriate training and a change in their image among the general public, GPs may acquire a greater role in preventive and family care and help achieve a wide scope of audiences, while limiting expenditures. Contraceptive counselling and education on sexual health matters for adolescents and young women and men should form an integral part of their training.

Securing SRH in an equitable, efficient system

Bosnia and Herzegovina is undergoing reform at a time of competing priorities for reconstruction and infrastructure upgrading. The reform is assumed to complete the process of rationalizing the use of facilities and human power and the standardization of care. Lessons learned on the effects of reforms in other
countries show that reforms do not automatically result in a decrease in the level of health outcomes. Rather, they may affect equity principles by redistributing resources from middle and upper class to lower socio-economic groups (see the health sector reform and reproductive health care study protocol on pages 5-8). Policies that target the poor can work when there are options for fee for service for those who can afford them and if there is an effective regulatory system to enforce such a scenario. It is assumed that if achieved, these changes would also positively influence access to RH services.

Whether for the health sector in general or RH in particular, privatization will push towards an increased demand for sophisticated, high-cost services. For the competitive multi-payer system, universal coverage based on capitation can maintain a balance among various levels of care and control of health care expenditures. Criteria for allocating resources should be performance-based, taking into account the needs of the population to be served, the level of sophistication of services needed and their development and maintenance costs. Consideration should also be made to monitor the quality of RH services as assessed by indicators that inform about client satisfaction, and trends in the use of the facility, including treatment given. Fee-for-service payment mechanisms should be in place for those who can afford to pay, as well as a safety net mechanism to safeguard access to services to those who cannot pay, based on a clear identification of the vulnerable groups.

Continuity of care is also an element that needs to be considered at the outset due to the fragmentation of the various levels of care. Continuity is best attained when there are links between primary health care and referrals and standardised data reporting. In the context of sexual and reproductive health it will be important for GPs to be trained in, for example, contraceptive technologies, family planning, prevention and management of unsafe abortion, adolescent sexual and reproductive health, STI management and to identify and refer female victims of coercive sex.

The high cost benefit of using nurses for the delivery of some types of primary care is also highly relevant for reproductive health. Nurses and midwives are usually members of the community and their relationship with the clients of the services is closer. Substantial investments in upgrading nurses and nurse midwives working in women’s consultations and polyclinics in reproductive technical and counselling skills could lead to a real health benefit, away from a “medicalized”, curative centred approach, and contribute towards national goals to reduce abortion and its consequences on reproductive morbidity and mortality rates.

Pluralism introducing privatization in health is ethically acceptable when it leaves room for a social approach to health care. At present, the government is committed to limit privatization to ambulances (medical treatment centres) with the hope that this will motivate doctors to work in family medicine. The resource allocation policy of the government will need to rely on the contracting of services by improving regulatory measures and generating economic motivation for fulfilling health care (including SRH) objectives. This could be extended to nurses and midwives working in the private sector. Moreover, in order to ensure quality services, all curricula for family medicine, upper education and strategies related to standards should be addressed concomitantly.

An alternative option to public coverage of commodities and for financing RH services includes the social marketing of contraceptive, especially condoms. Social marketing programmes have the dual objective to increase demand by a well-designed information programme as well as access to commodities at a subsidized price. This process familiarizes the client with paying a symbolic fee for a commodity, establishing a sustainable relationship between the client and the private market place.

Decentralized planning as applied in the Federation of Bosnia and Herzegovina is a very valuable approach. However, decentralization should be progressive, leaving flexibility at the beginning to shift resources from the tertiary to the primary health care level. One condition for the success of privatization and public share is improved regulation of tax collection and the impact on the population’s sense of responsibility for paying taxes to a government that provides quality health care. In addition, consideration should be made to facilitate the implementation of the signed solidarity among cantonal health insurance funds to close inequality gaps. The Republic Srpska still has insurance and social security under the same umbrellas and can potentially shift resources either way to close gaps.

Ultimately, the long-term cost benefits of investing public resources into a preventive system concentrated on primary health care, particularly sexual and reproductive health, must be considered. The system should ensure choice, efficiency and equity and monitor performance on the basis of health outcomes rather than inputs. The change will require a drastic shift from individual-centred interests to a broad social-centred interest catering to the needs of a healthy population. It will also require staff trained in multi-sectoral approaches (e.g. health costing, policy analysis and management of care), changes in legislation and in existing institutional arrangements, and, most importantly, a change of attitude towards a culture of results-based management, accountability and excellence. Political commitment and community participation in decision-making about the types of services and the means to pay for them will be central.

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References are available from the author.

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NEW EU RESOLUTION ON SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

By Vicky Claey

On 3 July 2002, the European Parliament voted in favour of the Resolution on Sexual and Reproductive Health and Rights in Europe introduced by Anne Van Lancker, MEP (Socialist, Belgium).

Despite strong opposition fuelled by anti-choice activists, a clear majority of the European Parliament supported the Resolution on Sexual and Reproductive Health and Rights, sending a strong signal to the international community that the European Parliament intends to fight for the right of all people to have healthy and satisfying sex lives.

The Resolution was prepared in the context of commitments from European Union (EU) Member States and accession countries to the agendas from the International Conference on Population and Development (ICPD, 1994 and 1999) and the Fourth World Conference on Women (1995 and 2000). Although many policy-makers believe that the outcomes of these international conferences only apply to developing countries, they do, in fact, have implications for all the countries of Europe.

There is certainly a need for commitment to sexual and reproductive health and rights in Europe, particularly in terms of the inequalities which exist between the east and the west. The average contraceptive use in the EU is around 65%, but in the accession countries it is only around 35%. And in central and eastern Europe abortion still remains the principal means of fertility regulation. An abortion can, in principle, be obtained at very low cost or free of charge, but the price of contraceptives can be as high as a third of one month's salary in central and eastern Europe. Abortion rates across Europe (see Fig.1) range from the lowest rates in the world, found in Belgium, the Netherlands and Germany (around 7 per 1,000 women aged 15-45) to some of the highest abortion rates in the world, in the Russian Federation and Romania (between 50 and 60:1000).

With respect to boys and men, the Resolution calls for the promotion of scientific research in the field of male contraception, in order to ensure equality between men and women as regards the effects of using contraceptive methods, and for the provision of sexuality education in a gender-sensitive way.

A resolution from the European Parliament does not form a legal basis for action by the European Commission and it has been confirmed by Commissioner Byrne, Health, Environment and Consumer Protection, that, as stated in the Resolution, the Commission has no authority to engage in health care delivery, including sexual and reproductive health services. However, it was stressed that sexual and reproductive health will be part of the new [EU] Health Strategy, which includes compiling and undertaking statistical, epidemiological investigations on the basis of collected data. It is clear that this would form a good basis for the exchange of experience that the European Parliament wants to promote.

Commissioner Byrne had a further message for the Member States, saying that he hoped that they would place greater emphasis on the education and information of men in this important area. He stated that the Resolution paid significant attention to the responsibility and rights of women in dealing with their health and well being, but that too often the importance of improving men's education so as to change behaviour, attitudes and involvement was overlooked.

The European Parliament Resolution on Sexual and Reproductive Health and Rights in Europe is a useful resource and valuable advocacy tool for policy-makers, NGOs and family planning associations to help them bring this issue to the attention of national governments and the European Union. The full text of the resolution will be published on the European Parliament website: www.europarl.eu.int/plenary/default_en.htm

Vicky Claey is the advocacy manager of the International Planned Parenthood Federation European Network www.ippf.org.
INTERNET RESOURCES
Prepared by Josh Gross and Jeffrey V. Lazarus

Links to sites dealing with health sector reform

Center for the new Europe

www.centrefortheneweurope.org
The Centre for the New Europe is a non-profit, non-partisan research foundation headquartered in Brussels and dealing with the practical implications of European Union policies. The website includes a number of downloadable documents like The Health Care Revolution in Stockholm by Johan Hjertqvist as well as links to sites and events dealing with health sector reform, such as the lecture “Economic analysis in healthcare rationing” by Joe Zammit-Lucia in Brussels.

Croatian Medical Journal

www.cmj.hr
The Croatian Medical Journal is an international peer-reviewed journal open to scientists from all fields of medicine and related research. A sparsely designed but unique page, including news and a bulletin board of upcoming events in the region.

Two interesting reports (PDF) from August 2002 include:

- Years of Potential Life Lost and Valued Years of Potential Life Lost in Assessing Premature Mortality in Slovenia by Jožica Selb Šemberl and Janja Šelok
- Reforms of Health Care System in Romania by Ana-Claudia Bara, Wim J. A. van den Heuvel and Johannes A. M. Maarse

Two articles from the International Labour Organization

www.ilo.org
1. The promotion and privatization of medical services in the Russian Federation, Ukraine and Georgia by Igor Vocatch-Boldyre
Abstract: Privatization is a major component of health system reform in the former USSR. In creating the legal basis for the new health system, the other key elements of health reform are decentralization and a shift to basic principles of health insurance. A broad frame of reference must be adopted that considers privatization as a measure of state disengagement from public health institutions in terms of the tutelage or in terms of management of operating health structures and financial responsibility.

2. The ills of Central and Eastern European health care, no. 42, 2002
Abstract: A grim picture of dimishing public health structures, deteriorating working conditions and staff pessimism emerges from a recent survey of central and eastern European health care. The situation is especially grave due to a severe deterioration in public health in much of the region over the last decade, in some cases with life expectancy plummeting.

Publication:
Dying breed: Health care in eastern Europe
by Sun Vuknin, United Press International, 2002

http://samvak.tripod.com/pp143.html
Abstract: People lead brutish and nasty lives only to expire in their prime, often inebriated. In the republics of the former Yugoslavia, respiratory and digestive tract diseases run amok. Stress and pollution conspire to reap a grim harvest throughout the wastelands of eastern Europe. The rate of tuberculosis in Romania exceeds that of sub-Saharan Africa. As income deteriorated, plunging people into abject poverty, they found it increasingly difficult to maintain a healthy lifestyle. Crumbling health care systems, ridden by corruption and cronyism, ceased to provide even the appearance of rudimentary health services. The number of women who die at childbirth skyrocketed.

Health Reform Online (HRO)

http://www.worldbank.org/healthreform/HealthReformOnline (HRO) is an information resource for healthcare managers, analysts and decision-makers who want to learn more about the economics and financing of health care delivery in developing countries. The site is hosted by the World Bank.
World Report on Violence and Health

www.who.int

On 3 October 2002, WHO launched the first World Report on Violence and Health. The goals of the Report are to raise awareness about the problem of violence globally, to make the case that violence is preventable, and to highlight the crucial role that public health has to play in addressing its causes and consequences.

There is a 30-page chapter on sexual violence, including trafficking, commercial sex workers, poverty, education, the link to HIV/AIDS, female genital mutilation, and violence against women. There are also chapters on intimate partner violence, war, and violence against children.

The entire report can be downloaded in PDF format at:
http://www.who.int/violence_injury_prevention/

For further information, please contact:
Department of Injuries and Violence Prevention
World Health Organization
20 Avenue Appia
CH-1211 Geneva 27
Switzerland
Fax: 41 22 791 4332; Email: vip@who.int

World Health Report 2002 - Reducing Risks, Promoting Healthy Life

Released on 30 October 2002, the World Health Report 2002 examines more than 100 risks to health and identifies interventions that would reduce these risks, thereby increasing healthy life years. The risks to health include underweight, unsafe sex, high blood pressure, tobacco, alcohol, unsafe water and sanitation, cholesterol, indoor smoke from solid fuels, iron deficiency and overweight.

The full report can be downloaded from www.who.int/whr.

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The European Observatory on Health Care Systems

www.observatory.dk

The European Observatory on Health Care Systems supports and promotes evidence-based health policy-making through the comprehensive and rigorous analysis of the dynamics of health care systems in Europe. The Observatory's main publication is the Health Care Systems in Transition series of country profiles (HITs), which provide an analytical description of each European health care system and the reform initiatives in progress or under development.

HITs aim to provide relevant comparative information to support policy-makers and analysts in the development of health care systems and reforms in the countries of Europe and beyond and are used to:

- learn in detail about different approaches to the financing, organization and delivery of health care services;
- describe the process, content and implementation of health care reform programmes;

In addition to the HITs, the Observatory produces:

- an at-a-glance summary of each country profile (HIT);
- studies, some of which are co-published with the Open University Press, on key policy issues and trends:
  - Regulating entrepreneurial behaviour in health care systems;
  - Hospitals in a changing Europe;
  - Funding health care options for Europe;
  - Mental health policy and practice across Europe;
  - Primary health care and organizational reform;
  - Purchasing for health gain;

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Pharmaceutical regulation
in Europe;
Health care in central Asia;
Health and EU accession;
Social health insurance;
a policy brief series summarizing the findings in each study;
EuroHealth, a quarterly journal, and the EuroObserver, a quarterly newsletter; and
a monthly e-mail bulletin on Observatory news and findings.
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