The Sexual and Reproductive Health Strategy of the

Ministry of Health and Family

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TABLE OF CONTENTS

TABLES AND FIGURES

FOREWORD

Sexual and reproductive health is a major component of human development in general. A healthy sexual and reproductive behavior has a significant impact on the health status of future generations. It is common knowledge that population development and the fact that demographic objectives can best be met by observing the rights of individuals and covering their needs for family planning and reproductive and sexual health services, not by coercion and control, are interdependent. The health status of the population, birth rates and death rates are not abstract issues to be tackled solely from a statistical point of view. Therefore, the Ministry of Health and Family has focused mainly on the problems of the individual, on his or her family and social integration.

Access to quality reproductive health services, as part of preventive health care, contributes to lowering the number of unplanned and unwanted pregnancies and the number of abandoned children, the number of abortions and abortion-related pathology, as well to reducing the incidence of genital and breast cancer and of sexually transmitted infections. All these considerations have placed reproductive health among the top priorities on the current agenda of the Ministry of Health and Family. During the last few years, several programs have been successfully implemented, aiming at increasing contraceptive use, reducing the high number of abortions and abortion-related pathology, and lowering maternal death rates and morbidity. We plan to keep acting in a sustained and coherent manner in this important field.

The document was drafted through a coherent strategic planning process, including consultations with and involvement of Romanian experts in various areas of sexual and reproductive health, as well as consultations and collaboration with international experts. The World Health Organization Regional Office for Europe, that developed the "World Health Organization Sexual and Reproductive Health Regional Strategy", has provided us with technical assistance in putting together the Romanian strategy.

The strategy lays down important intervention objectives, such as increased access to and use of family planning services and modern contraceptive methods, in order to lower the number of abandoned children and high maternal death rates mainly resulting from abortion being used as the a fertility control method. Another objective is to increase access to and the quality of pre and postnatal care in order to reduce maternal death rates due to obstetrical risk and infant death rates.

Other important areas for intervention are the expansion of sexually transmitted infections and HIV/AIDS prevention activities and facilitating access to investigation and treatment services related to these conditions, as well as raising people's awareness of cervical or breast cancer risks and facilitating access to specific investigation and treatment services.

The strategy also puts forward specific interventions, focusing on the special needs of teenagers and the young, of the elderly or of other vulnerable population categories. Community health care services are promoted. New fields are approached, that are just as important for woman's health, such as the development and integration of services for victims of domestic violence and sexual abuse, and victims of human trafficking.

The sexual and reproductive health strategy, that deals with a complex, interdisciplinary field, must be enforced by means of specific programs and activities developed though the collaboration of all stakeholder institutions, that is first and foremost the Ministry of Health and Family departments, in collaboration with other ministries and governmental or non-governmental institutions involved in reproductive health activities. This strategy brings Romania into line with World Health Organization recommendations on improving the quality of reproductive health services and in observing woman and couple basic rights, as well as increasing role women play within society. We are convinced the strategy will contribute to improving the reproductive health status in Romania, as a premise for the development of healthy future generations.

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Minister of Health and Family

INTRODUCTION

The purpose of this document is to provide strategic guidelines aimed at improving the health status of the Romanian population in the field of sexual and reproductive health (SRH). The document sets out the long-term vision of the Ministry of Health and Family on sexual and reproductive health policies and programs in Romania, but the elements pertaining to the implementation of the strategy only cove a five-year period, between 2002 and 2006. At the same time, the strategy is the first reproductive health policy document of its kind, after all the interdictions and limitations that the communist regime imposed in the field.
The document was drafted through a coherent strategic planning process, including consultations with and involvement of SRH Romanian experts, as well as consultations and collaboration with international experts. The World Health Organization Regional Office for Europe, that developed the "World Health Organization Regional Strategy for Sexual and Reproductive Health"[1], has provided us with technical assistance in putting together the Romanian sexual and reproductive health strategy.

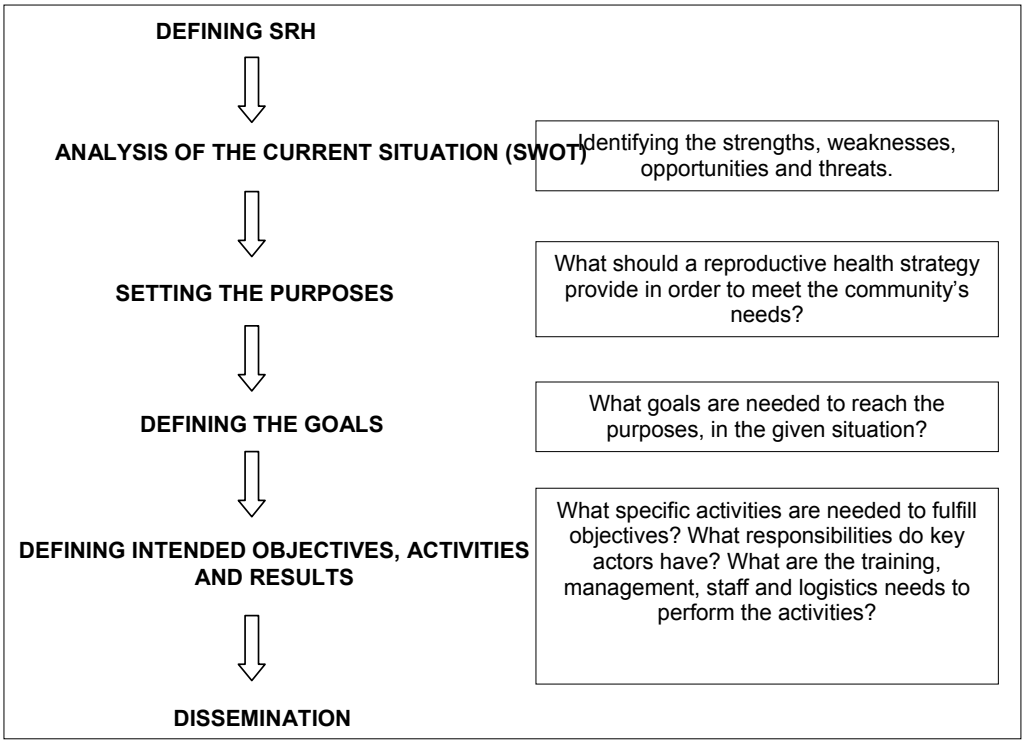

Figure 1. Stages of strategic planning in Romania.

The drafting of the SRH strategy in Romania took almost two years, during which time consultations with Romanian and foreign experts were the key element. In July 2000, experts from various SRH fields met to discuss the unfolding of a process to start from identifying the specific reproductive health needs in Romania and to result in the drafting of a national strategic reproductive health plan. As part of this process, the strengths, weaknesses, opportunities and threats were identified (through a SWOT analysis). Subsequently, a large number of governmental and non-governmental organizations representatives, individual experts and representatives of international organizations specializing in SRH brought in new ideas and helped improve the successive variants of the document.

[1] The World Health Organization Sexual and Reproductive Health Regional Strategy, Copenhagen, Denmark, November 2001, World Health Organization, Regional Office for Europe.

The implementation of the Romanian sexual and reproductive health strategy is directly related to documents associated to it, that is Child and Family Health Program No3, and the Program 3 Technical Implementation Norms, that represent the instruments ensuring flexibility in the implementation of the strategy.

The Romanian sexual and reproductive health strategy is a component of a wider set of strategic documents drafted by the Ministry of Health and Family, that deal with priority public health areas in Romania. The most important strategies related to the sexual and reproductive health national strategy aim to: monitor and control HIV/AIDS, monitor and control sexually transmitted diseases (STIs), prevent and control cancer. Other areas related to this strategy are the prevention and management of domestic violence and sexual abuse, as well as the prevention of human trafficking.

INTERNATIONAL AND EUROPEAN CONTEXT

WHO considers reproductive health (RH) to be a priority sector, which is emphasized in the WHO World Health Assembly resolution, adopted in May 1995. That resolution urges member states to further development and to improve their SRH programs, and particularly:

- to assess their own needs in the field of SRH and define medium and long term strategies and programs, based on WHO norms, paying special attention to ensuring equal opportunities, as well as to the prospects and participation of those who will benefit from the services, all these based on observing human rights, unanimously acknowledged on an international scale;
- to improve the capacity of the medical staff to respond- in a way that takes into account cultural specificities- to the SRH needs of the individuals, specific for each age group, by improving the content of training courses as well as the methodology for training medical staff in the field of SRH, and to support and guide individuals, parents, teachers and other persons involved in the field.
- to monitor and assess, on a regular basis, the progress, quality and efficiency of the SRH programs , by handing in reports to the upper forums, as part of the monitoring process of the progress of the WHO-EURO Strategy *"Health for all 21"*.

Starting with 1995, a number of recommendations have been drafted, resulting in SRH projects supported by WHO. Thus, in 1999, the WHO SRH „Safe Motherhood" project was launched, aimed at identifying key interventions to decrease maternal morbidity and mortality worldwide.

Sexual and reproductive health (SRH) is a very important field in Europe, Eastern Europe in particular. There are unacceptable discrepancies in the SRH status of the population in Western and in Eastern Europe. That has turned SRH into one of the most relevant health improvement sectors within the WHO-EURO strategy "Health for all 21", Target 1. Solidarity for health in Europe. The document reads as follows: "Although increasing foreign assistance has been offered to Eastern European countries and NIS (former Soviet Union states) in the 90's, foreign assistance in the healthcare field on the whole was a lot poorer than needed, and the overall impact was often quite small\ ."

In their economic and social transition period, many countries had to deal with soaring unemployment rates and poverty, with social networks disintegrating and major cuts in healthcare and social budgets. All these had a devastating effect on the population health status. At the same time, problems such as teenage pregnancies, domestic violence and sexual abuse and the SRH needs of refugees, emigrants and other vulnerable groups should be approached at pan-European level. Therefore, the European Regional Strategy has been put together by and for all 51 European states.

WHO/EURO recommends the strategic framework of the Regional WHO/EURO SRH Strategy be used by governmental, intergovernmental and non governmental institutions and agencies when defining SRH policies and programs, when setting implementation and (international) assistance priorities and monitoring the progress made in this very important field in the first decade of the 3rd Millennium. The current National Strategy of Romania is based on the Regional WHO/EURO Strategy, as well as on other strategic documents drafted in other countries.

This strategy envisages a Romania whose citizens are in perfect sexual and reproductive health and have the ability to exercise their sexual and reproductive rights throughout their entire lifespan.

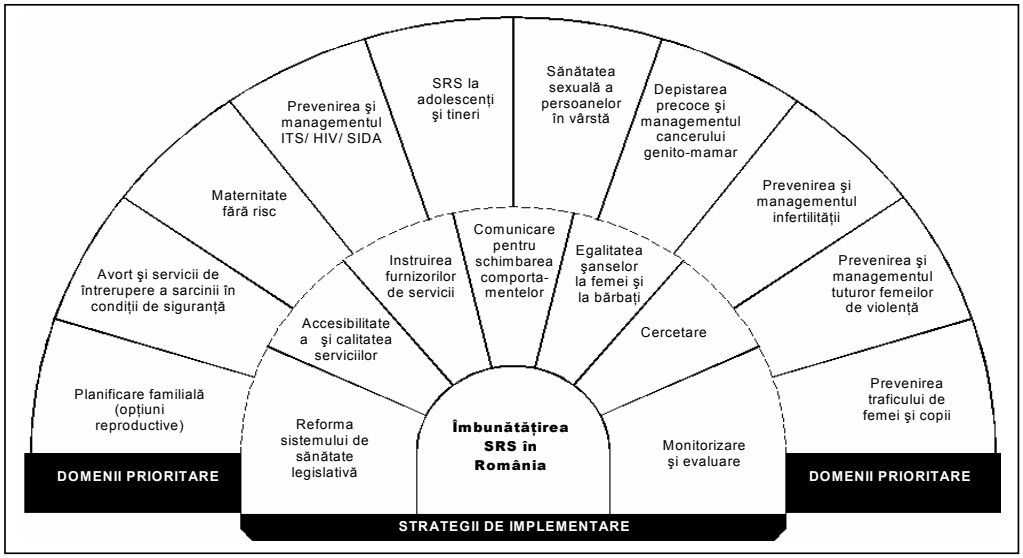

Figure 2: 2006 Vision: Improving SRH in Romania.

CONCEPTS AND PRIORITY AREAS

SRH terms are not always fully understood, and are sometimes mistaken for "reducing population growth". It follows that the meaning of these concepts has to be made clear.

During the International Conference on Population and Development (ICPD), taking place in Cairo in 1994, a definition of SRH was adopted. It coincides with the definition recommended by the World Health Organization. As a WHO member state and a signatory of the Declaration passed in Cairo, Romania acknowledges that definition.

Reproductive Health

In 1994, the World Health Organization (WHO) defined reproductive health as a state of full physical, mental and social well-being, that cannot be defined only by lack of disease or disability and is related to everything that pertains to the reproductive system and the functions and processes it performs. Reproductive health therefore means that people should be able to lead a gratifying and safe sexual life, as well as freely decide if, when and how often they want to reproduce. This final condition implies the right of men and women to be informed and have free access to safe, effective, affordable and acceptable family planning methods, as well as to legal fertility regulation methods; at the same time, it implies full access to medical services helping women go safely through the pregnancy period and birth, thus providing couples with the best chances of having healthy children.

This internationally accepted definition of RH (ICPD Cairo 1994) includes family planning (free reproduction choices: access to information, methods and services), sexual health (responsible, gratifying and safe sexual life), as well as safe motherhood (safe pregnancy and birth, healthy children). To further clarify these concepts, here are the definitions of sexual health and safe motherhood.

Sexual Health

Sexual health is a state of physical, emotional, mental and social well-being that cannot be defined only by lack of disease, dysfunctions or disability. Sexual health allows people to have a gratifying and safe sexual life. It is based on a positive and respectful approach to sexuality and sexual relations, free of coercion, discrimination or violence. (WHO/EURO, WHO/HQ Geneva and World Sexology Association, November 2000)

Safe motherhood

Safe motherhood is aimed at ensuring optimum health to the mother and newborn. That involves reducing maternal morbidity and mortality and improving the health of newborns by providing equal access to family health services, including family planning, pre-natal care, birth care and post-natal care to the mother and child, as well as access to basic obstetrical and neonatal care (WHO 1994).

The fields defined above make up the foundation of SRH and should be integrated in policies and programs for development, service provision, service provider training and information-education-communication campaigns aimed at adopting a healthy behavior (behavior change campaign - BCC).

The structure of the various SRH components will vary with age. Also, specific needs will vary with gender. These particular needs are presented in Figure 3.

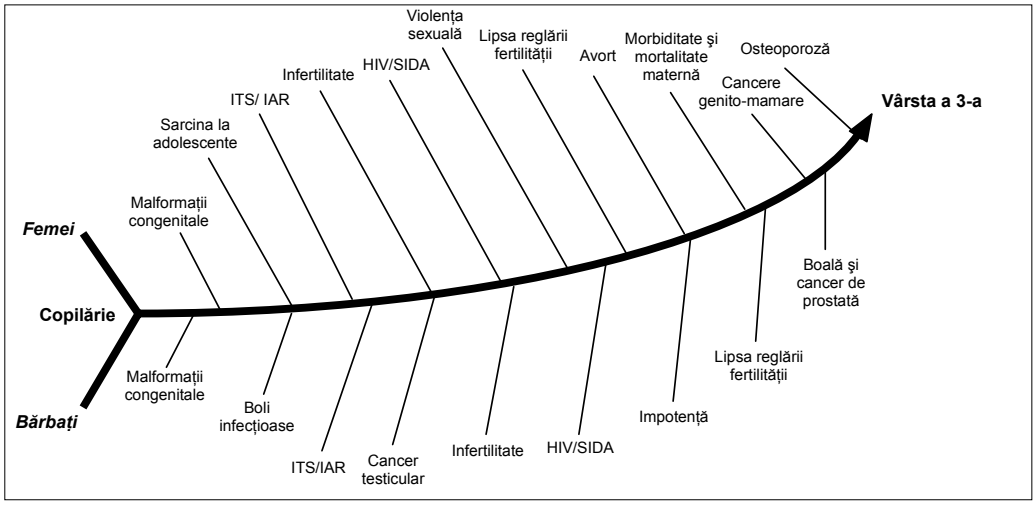

Figure 3.Sexual and reproductive health issues: a life-long gender-related representation.

During the strategic planning process mentioned in the introduction chapter, Romania adopted the World Health Organization definition, as it was laid down in the Cairo document. Therefore, the definition of sexual and reproductive health in Romania reads as follows:

Reproductive health is a state of complete physical, mental and social well-being, that cannot be defined only by lack of disease or disability, and that is related to everything that has to do with the reproductive system and the functions and processes it performs. Reproductive health therefore means that people should be able to lead a gratifying and risk-free sexual life, as well as to reproduce and have the freedom to decide if, when and how often they want to do it. . This final condition implies the right of men and women to be informed and have free access to safe, effective, affordable and acceptable family planning methods, as well as to legal fertility regulation methods; at the same time, it implies full access to medical services helping women go safely through the pregnancy period and birth, thus providing couples with the best chances of having healthy children.

Sexual and reproductive health also includes sexual health, which is aimed at improving people's life and personal relationships, not only at providing reproduction and sexually transmitted diseases counseling and care. The area of sexual health includes an environment stimulating sexual fulfillment as a human potential, lack of constraints, abuse and sexual violence, and appropriate management of health issues related to sex life.

SRH relevant areas for Romania, as defined through the strategic planning process, are as follows:

1. Family planning (reproductive options)
2. Safe abortion and pregnancy termination services
3. Safe motherhood – pre-natal care, safe birth care and new-born care, postnatal care and breastfeeding
4. Sexually transmitted diseases and HIV/AIDS infection prevention and management
5. Teenager and youth sexual and reproductive health
6. Sexual health of the elderly
7. Early diagnosis and management of genital and breast cancer
8. Infertility prevention and management
9. Prevention and management of domestic violence and sexual abuse
10. Prevention of woman and child trafficking

CURRENT SITUATION OF SEXUAL AND REPRODUCTIVE HEALTH IN ROMANIA

FAMILY PLANNING (REPRODUCTIVE OPTIONS)

According to the data in the reproductive health survey (1999), conducted on a sample representative of the fertile Romanian population, made up of women aged between 15 and 44 and men aged between 15 and 49, the prevalence rate of modern contraception among 15 to 44 years old married or cohabitating women has increased from 13.9% in 1993 to 29.5% in 1999 (Figure 4).

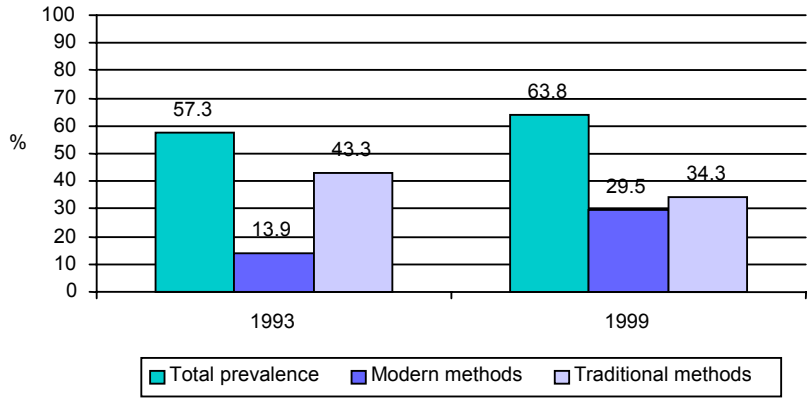

Figure 4. Evolution of contraceptive prevalence rates among 15 to 44 years old married or cohabitating women. (SSRR, 1999)

According to the same survey:

- Almost the entire population (99%) have heard about at least one modern contraceptive method
- About 92% of the population have heard about the IUD; 55% of them know how it is used
- 23.3% of all Romanian women and 22.8% of all Romanian men are using modern contraceptive methods
- 58% of married or cohabitating women and 52% of married or cohabitating men do not want another child
- 72% of all women and 61% of all men want more information on contraceptive methods.

The pattern of contraceptive methods that are used is shown in Figure 5:

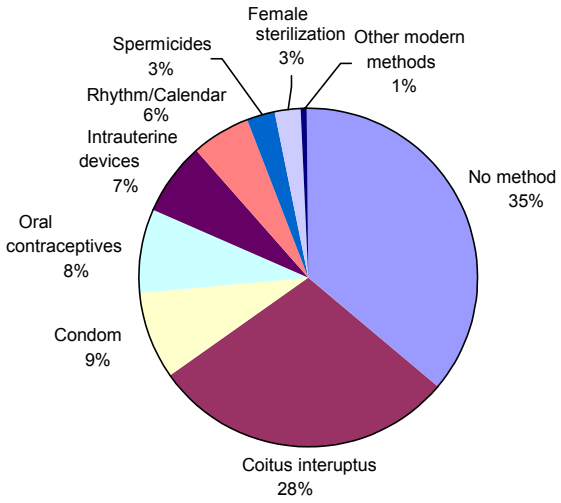

Figure 5. The pattern of contraceptive methods that are being used. (SSRR, 1999)

Safe Abortion and Pregnancy Termination Services

The evolution of abortion during the last ten years has taken a downward trend, from 2.34 abortions per birth in 1993, to 1.16 abortions per birth in 2001. Most abortions occur between the age of 20 and 34. The evolution of abortion in women of fertile age (15 to 49 age group) during the last 10 years is shown in Figure 6.

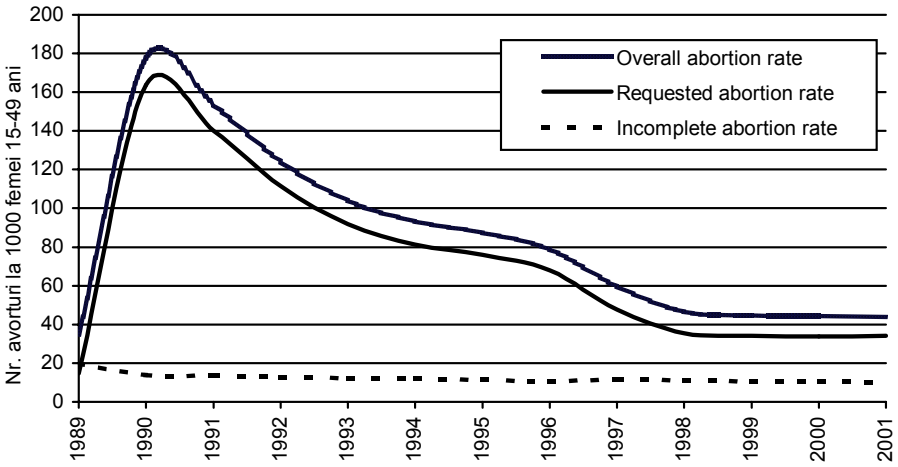

Figure 6. Evolution of abortion between 1989 and 2001. (CCSSDM/MSF)

Figure 7 shows the obvious decrease in requested abortion rates (to less than half), in parallel with an obvious increase in the use of modern contraceptive methods (more than double).

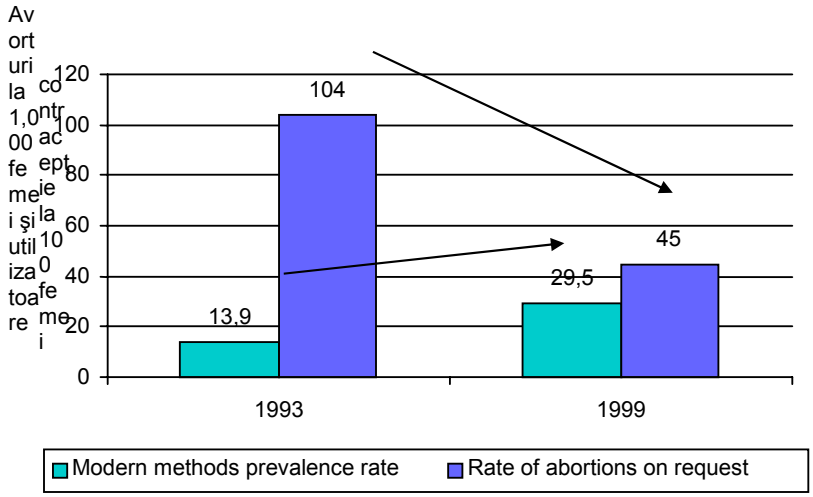

Figure 7. The decrease in abortion rates in parallel with the increase in contraception use. (CCSSDM/MSF and SSRR, 1999)

SAFE MOTHERHOOD – PRE-NATAL CARE, SAFE CARE TO THE MOTHER AND NEWBORN AT BIRTH, POST-NATAL CARE AND BREASTFEEDING

A significant drop in maternal deaths can be seen after 1990, with abortion-related deaths nose-diving (almost 8 times fewer), due to the legalization of abortion and contraception (Figure 8).

- Almost 16% of all pregnant women to have given birth in 2001 were not registered during pregnancy;
- Almost 45% of all pregnant women were registered and benefited from a first visit to the doctors in the first pregnancy trimester;
- Average number of pre-natal visits is 5;
- In 2001, maternal mortality in Romania was of 34 deaths per 100,000 live-births, of which:
  - 16.8 abortion related deaths per 100,000 live births
  - 17.2 deaths caused by obstetrical risk per 100,000 live births;
- Couple genetic counseling and pre-natal diagnosis services are only rarely provided, in but a few specialized facilities.

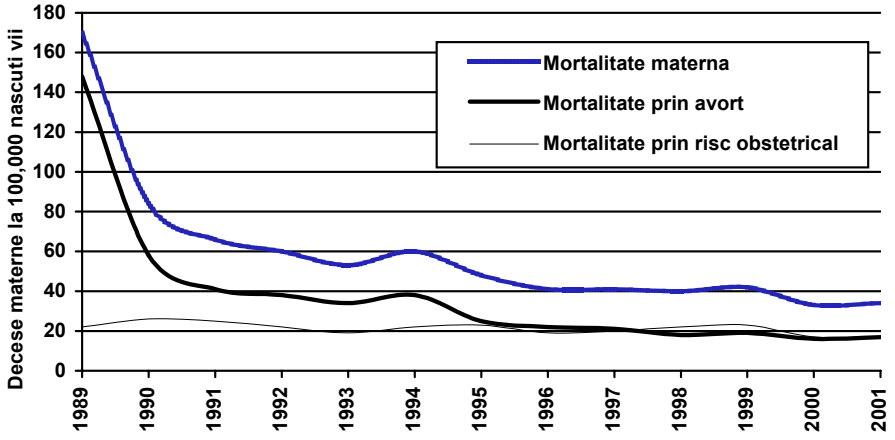

Figure 8. Evolution of maternal mortality between 1989 and 2001. (CCSSDM/MSF)

PREVENTION AND MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS (STI), INCLUDING HIV AND AIDS INFECTION

Romania follows the upward trend in sexually transmitted infections incidence in countries in the region:

- In the syphilis incidence rate was 56.0 cases per 100,000 persons, of which 97% were recent syphilis cases (53.9 per 100,000 persons).
- Syphilis incidence has constantly increased between 1990 and 2001, with a 20% increase in 2000 and 2001 in incidence rates, both for total and recent syphilis.
- Syphilis incidence is higher in urban than in rural areas, in males and in young persons (20-24 years and 25-29 years) followed by teenagers between 15 and 19 years of age;
- On December 31st 2002 a total of 13,675 HIV/AIDS cases were recorded, of which 10,125 HIV/SIDA patients were still alive;
- In 2001, the HIV/AIDS related death rate was 2.2 per 100,000 inhabitants;
- The main HIV/AIDS transmission means among adults is heterosexual (around 50%), while recorded transmission through common use of drugs syringes is lower (0.1-0.3%), although an increase in this percentage can be expected in the future;
- In 2002, of the 43,000 pregnant women tested for HIV, 33 were found positive (0.07%);
- The number of children diagnosed with AIDS is decreasing:
  - between 1991 and 1998 an average 500 new cases were diagnosed each year;
  - in 1999, 389 cases were diagnosed and in 2000, 352 cases;
  - in 2001, 176 children were diagnosed with AIDS
- Among children, the main transmission means on December 31st 2001 was the nosocomial one, (51,6%), mother-to-child transmission yielded 4.5% of cases, and 34% cases had an undetermined or unknown means of transmission;
- 90% of the Reproductive Health Survey interviewees are aware of the protective effects of condoms;
- 75% of all women and 69% of all men do not see themselves at risk of HIV infection;
- Around 10% of persons aged between 15 and 49 use condoms.

TEENAGER AND YOUTH SEXUAL AND REPRODUCTIVE HEALTH

After 1989, occasional sex became quite frequent, especially among young people, before they received any information or education on sexually transmitted diseases.

- In 1999 the average age for the first sexual contact was 19.5 years, lower than in 1993, when it was 20.5 years;
- 40% of the young women and 25% the young men have accurate knowledge of menstruation;
- Half of the young people are using a contraceptive method; 23% are using a modern method and 27% a traditional contraceptive method;
- Most teenagers are aware of sexually transmitted infections risk;
- Of the sexually active young people aged under 24, 34% of hte women and 86% of the mwn have said they have two or more sexual partners;
- 56% of all women and 80% of all men became sexually active before 20.

SEXUAL HEALTH OF THE ELDERLY

Menopause-related problems may have long-term effects, for example women at menopause are predisposed to osteoporosis. The unpleasant effects of menopause can be avoided by adequate substitution therapies. There are no relevant national statistical data showing the real incidence of menopause-related pathology or the sexual health of the elderly.

EARLY DIAGNOSIS AND MANAGEMENT OF GENITAL AND BREAST CANCER

Cervical and breast cancer are the top causes of cancer mortality among Romanian women. Both have taken an upward trend over the past years;

- In 2001, around 17% of all woman cancer deaths were caused by breast cancer (gross mortality rate of 26.2/100,000 women) and 1,763 of deaths were caused by cervical cancer (15.4/100,000 women);
- In 1999, 4,737 new breast cancer cases were recorded and 3,001 new cervical cancer cases;

- Most women are diagnosed at late stages, when recovery chances are quite slim; population education plays a major role in amending this situation:
  - in 1999 less than 10% of the new cases were diagnosed at early stages (stages 0 or I), while 45% of diagnosed cases had reached stages III-IV when registered, since cancer records in Romania still need improvement (e.g. no data concerning the stage of the disease upon registration can be provided for 23.7% of all new breast cancers);
  - in 1999, 4% of cervical cancers were in situ cancers, around 33% of the cases had reached stage III or IV upon diagnosis (no data on the stage of the disease upon registration are available for 23% of all new cases);
- The main problems are high incidence of and mortality rates related to cervical cancer (in 2000, the standardized cervical cancer death rate in Romania was the highest in Europe) and late diagnosis of the two above-mentioned types of cancer.

INFERTILITY PREVENTION AND MANAGEMENT

Infertility is an area that has been gaining in importance in the field of reproductive health. Women and couples must have the right to have the desired number of children at the desired time, and, unfortunately, there are couples who cannot do that. The 1999 Reproductive Health Survey also looked into matters related to they way in which women aged between 15-44 years old perceive fertility.

- The results of the survey show that 4.4% of 15 to 19 year old women, 2.4% 20 to 24 year old women, 6.5% 25 to 29 year old women, 12% 30 to 34 year old women, 21.3% of 35 to 39 year old women and 35.8% of women aged between 40 and 44 years saw themselves as infertile or under fertile (they failed to become pregnant during the past two years, although they wanted to and did not use any contraceptive methods).
- Although there are no national statistics based on the medical diagnosis of infertile women, experts in the field have said up to 10% of all couples are affected to various degrees.

PREVENTION AND MANAGEMENT OF DOMESTIC VIOLENCE AND SEXUAL ABUSE

In Romania, the field of domestic and sexual violence has been gaining in importance. Most victims are women and children, and violence can be both physical and psychological. The 1999 Romanian Reproductive Health Survey also included questions on two types of violence against women: the violence of the intimate partner and sexual aggression (at any time in women's life).

- The survey shows that almost half of the women (45%) said they had been verbally abused, 29% physically abused and 7% sexually abused by their partner or former partner at some point in their life.
- The three types of abuse are largely interconnected: 61% of the women who had been insulted or threatened by their partner were also subjected to physical violence, while only 4% of physically abused women were not subjected to verbal abuse.
- 10% of the women said they had been subjected to some form of physical abuse by their partner in the last 12 months.
- Recent verbal abuse was mentioned by 23% of the women, while 31% of the men admitted to having recently subjected their partners to verbal abuse.
- Violence acts most frequently mentioned by women were slapping, pushing and throwing objects; almost one woman in four has been slapped and 22% have been pushed, shoved or thrown objects at (moderate violence). 14% of the women have been kicked, punched or hit with various objects, 10% have been badly battered and 6% have been threatened with a knife or other arms (severe forms of violence).

As far as domestic violence reports from the men's point of view are concerned, the percentage of married or divorced men who declared they were abusive was almost identical to the percentage of women saying they had been abused, and as far as verbal abuse is concerned, the percentage of men was even higher. As far as sexual abuse is concerned, almost no men admitted to ever having abused their partners.

It is difficult to estimate the rate of sexual abuses because as opposed to other aggressions, these are rarely reported to the police. In highly traditional countries, such as Romania, one possible reason for that is shame and fear of social stigmatization. Another reason, especially when the perpetrator of the abuse is the partner (61.9% of all cases), is that the law fails to provide adequate protection to the victims and is too gentle towards aggressors. Most women have been violated by persons they knew,

since only 11.7% of them reported they had been sexually abused by persons they did not know. 43% of all women were violated for the first time before they were 20 (6% of them were under 15).

PREVENTION OF WOMAN AND CHILD TRAFFICKING

Woman and child trafficking is a problem that has come under the attention of several governmental institutions and non-governmental and international organizations that have already initiated a series of programs that the Ministry of Health and Family also takes part in. Such partnerships have been developed in a bid to educate persons at risk and protect them, by means of education activities in schools and media campaigns. Such programs will target vulnerable groups, such as street children, institutionalized children and youth, and so on. The repatriation of trafficking victims is also a priority for specialized organizations.

Romania became a member of IMO (the International Migration Organization) in 1998. In 2001, Law no 678 was passed, on the prevention and combating of human trafficking, followed by the National Plan for fighting against human trafficking. Over the last few years, Romania has become both a source of trafficking and a passing route for trafficking rinks. International Migration Organization (IMO) data show the following:

- Between January 2000 and September 2002 only, IMO Bucharest provided assistance to a total of 575 persons, most of whom were women, who had been victims of cross border trafficking. Most of them came from countries in former Yugoslavia (Bosnia-Herzegovina and Macedonia) but also from Kosovo and Albania.
- Almost of quarter of these were underage persons, but most of them were between 18 and 20 years old (34%) and between 21 and 23 (24%).
- Also, between 1995 and 1997 more than 700 immigrants received assistance to repatriate.

Although the MoHF has reduced competencies in combating this phenomenon, it is clearly the responsibility of the healthcare sector to provide medical care to the victims (who often have STIs or even unwanted pregnancies, but also TBC). Woman trafficking is often associated with both physical and sexual violence.

Statistics based on cases solved by law enforcement institutions show there is an upward trend in human trafficking, especially juvenile prostitution, that is more and more insidious in form each year. The number of prostitution crimes in the records of the police in 2000 was 733, and of pimping – 465. There is an increase in domestic trafficking, especially between rural and urban areas. The scale of the phenomenon is even more difficult to estimate, if we think about the large number of women that became prostitutes in foreign countries such as Turkey, Italy, Germany, Greece, Cyprus, Yugoslavia, starting with 1990.

MAIN RELEVANT SEXUAL AND REPRODUCTIVE HEALTH INDICATORS

The following table shows the main relevant sexual and reproductive health indicators in Romania for the year 2001. The main sources are: the Ministry of Health and Family, the Social and Family Care Directorate, the Center for Calculus, Medical Statistics and Documentation, the Mother and Child Care Institute, the 1999 Reproductive Health Survey in Romania, the National Intersectorial HIV/AIDS Commission, UNAIDS. If no data for they year 2000 were available, the year corresponding to the respective data is mentioned.

Indicator	Value	Year
Population (millions)	22,408,393	2001
Fertile age women (15 to 49 years old)	5,810,621	2001
Birth rate (1,000 inhabitants)	9.8	2001
Overall death rate (per 1,000 inhabitants)	11.6	2001
Natural population increase (per 1,000 inhabitants)	– 1.8	2001
Overall fertility rate * (index per woman)	1.2	2001
Female fertility (live births per 1,000 women aged between 15 and 49)	37.8	2001
Percentage of wanted pregnancies in women between 15 and 44 (latest pregnancy, 1996-1999)	46.5	1999
Percentage of unwanted pregnancies in teenagers between 15 and 19 (latest pregnancy, 1996-1999)	23.7	1999
Percentage of pregnant women registered while pregnant, out of the total number of births (%)	84	2001
Percentage of pregnant women registered while in the first trimester of pregnancy, out of the total number of births (%)	45	2001
Percentage of births assisted in maternities (%)	98	2001
Maternal mortality (per 100,000 live births)	34.0	2001
Abortion-related maternal mortality (per 100,000 live births)	16.8	2001
Maternal mortality by obstetrical causes (per 100,000 live births)	17.2	2001
Perinatal mortality (per 1000 live and still born babies)	11.9	2001
Early neonatal mortality (per 1000 live births)	6.1	2001
Infant mortality (per 1000 live births)	18.4	2001
Percentage of breast-fed babies upon release from maternity (%)	80	1999
Percentage of breast-fed babies up to 4 months (%)	40	1999
Prevalence of contraceptive use in women aged between 15 and 44, modern methods (%)	23.3	1999
Prevalence of contraceptive use in women aged between 15 and 44, traditional methods (%)	24.7	1999
Percentage of primary health care facilities providing family planning services (%) **	2.2	2001
Overall abortion rate (index per woman) ***	2.2	1999
Abortion rate among women aged between 15 and 49 (in 1000 women 15 – 49 years old)	43.9	2001
Requested abortion rate among women aged between 15 and 49 (in 1000 women 15 – 49 years old)	34.1	2001
Number of induced abortions	200	2001
Ratio between requested abortions and live births (per 1000 live births)	1.16	2001
Syphilis incidence (100,000 inhabitants)	56.0	2001
Gonorrhea incidence (100,000 inhabitants)	20.2	2001
Overall number of HIV/AIDS cases	13,675	Dec. 2002
Number of living HIV/AIDS infected persons	10,125	Dec. 2002
HIV/AIDS incidence (per 100,000 inhabitants)	3.4	2001
HIV/AIDS related mortality (per 100,000 inhabitants)	2.2	2001
Estimated percentage of mother to baby HIV transmission	4.5	2001
Gross cervical cancer related mortality (per 100,000 women)	15.4	2001
Gross breast cancer related mortality (per 100,000 women)	26.2	2001

* *In works of the National Statistics Institute and the CCSSDM, this indicator corresponds to the conjunctural fertility index.*

** *In 2001, family planning services were provided through family planning cabinets in urban areas.*

*** *The total number of abortions a woman would have at the end of her fertile period, estimated based on abortion rates specific to certain age groups.*

Table 1. The main indicators of reproductive and sexual health in Romania.

BASIC PRINCIPLES

The basic principles for improving health in general and sexual and reproductive health (SRH) in particular, were adopted and reconfirmed on the occasion of many international conferences and reunions, being stipulated in international documents. The principles included in the World Health Declaration, adopted in May 1998, at the 51st Assembly of the World Health Organization – "Health 21", which represents the healthcare policy framework for the WHO Regional Office for Europe (WHO, Copenhagen 1999), are of significant importance to this strategy. Other documents which have been used as sources for establishing the basic principles are: The Report of the International Conference for Population and Development (Cairo, September 5th to 13th); and "The Global Assessment of the Implementation of the Action Program of the International Conference for Population and Development" presented at the UN General Reunion (July 1st 1999).

When drafting this strategy, the MoHF targeted the observance of the following basic principles:

- Health is a fundamental human right. Everyone is entitled to mental and physical health at the highest standard. As any other WHO member state, by ensuring equal opportunities for men and women, Romania will have to take measures to provide universal access to health care services, including those related to reproductive health, which implies family planning and sexual health.
- Implementation of the recommendations made by these sources are the responsibility and sovereign right of each country, with all due respect for different religions, ethical values and cultures, in keeping with the internationally acknowledged human rights.
- The legal and normative framework and the regulations needed to ensure demand and supply of SRH services in Romania have to placed in line with the standards and recommendations of international organizations and institutions, in the context of Romania's wish to join the European Union. Thus, the principles and activities laid down in this strategy take into account the recommendations made by the European Union and the WHO.
- Observing the principles of health promotion, stipulated in the Ottawa Charter (1986), when changing the Romanian healthcare system from a mainly curative one into a prevention-oriented one.
- Observing the ethical concepts of equal opportunities for men and women, social solidarity and justice and incorporating them in defining and implementing sexual and reproductive health strategies.
- Ensuring quality of reproductive health services, based on scientific grounds and within accessible limits, viable for the future.
- Ensuring availability of the basic medical services as is stipulated in the Alma-Ata Declaration
- Integrating SRH services in healthcare services, and, in particular, in primary health care, in order to make them as accessible as possible to the population.
- Active participation of the individuals, groups and communities, as well as of the institutions, organizations in developing health care services must be promoted and supported
- Coordination between all strategies adopted in Romania that are related to SRH, such as STI, HIV/AIDS, early diagnosis of genital and breast cancer, domestic violence, health promotion, safe motherhood.

PURPOSE

The purpose of the Romanian sexual and reproductive health strategy is to improve the status of sexual and reproductive health in Romania and to provide Romanian citizens the opportunity to exert their sexual and reproductive rights all their lives, in order to:

- reach a healthy sexual development and maturity and to have the capacity of having equitable, responsible relationships and of knowing sexual fulfillment;
- have the desired number of children, in safe and healthy conditions, if and when they want to;

- avoid sexual and reproductive illnesses and benefit from high quality health care, when they need it;
- avoid being subjected to violence and other sexual and reproductive abusive practices.

GOALS AND OBJECTIVES

The following criteria were taken into account when the goals and objectives were defined:

- prevention-oriented
- action-oriented
- relevance
- realism
- evidence-based
- equal opportunities for the two sexes
- where it was seen as feasible, the targets of the Romanian strategy were set in line with recommendations made by WHO and other UN or EU organizations.

The following goals and objectives are suggested for the 2000-2006 period:

FAMILY PLANNING (REPRODUCTIVE OPTIONS)

Goals

G 1. Ensuring reproductive rights, including informed choice.

G 2. Increased access to high-quality family planning (FP) services, including to modern contraceptives.

G 3. Increased addressability of FP services.

G 4. Ensuring equal opportunities for men and women.

Objectives

O 1. By 2004, the regulations facilitating access to and addressability of family planning services in the primary health care network will have been passed and implemented at national level.

O 2. By 2004, disadvantaged persons will have been offered the possibility of receiving high-quality free contraceptives.

O 3. By 2004, the rest of the population who needs contraceptives will have been offered the possibility of receiving contraceptives costing no more than 2% of the minimum national income.

O 4. By 2004, the family planning management information system will have been made operational and will have been integrated in the national health statistics system.

O 5. By 2004, at least two education campaigns aimed at changing the behavior related to contraceptive use will have been conducted yearly.

O 6. By 2006, the modern contraception prevalence rate will have reached at least 40%.

O 7. By 2006, at least 40% of all primary health care facilities will be providing high-quality family planning services.

O 8. By 2006, the medical staff in specialty wards in each county capital will have had training in the provision of surgical contraception methods to both partners.

SAFE ABORTION AND PREGNANCY TERMINATION SERVICES

Goals

G 1. Maintaining access to safe abortion services.

G 2. Increased quality of care in pregnancy termination services.

G 2. Decreased unsafe abortion incidence and unsafe abortion-related morbidity and mortality.

G 3. Increasing awareness on behavior in case of an unwanted pregnancy and on abortion risks.

Objectives

O 1. By 2004, the legislative measures and regulations needed in order to ensure quality safe pregnancy termination services, including post-abortion contraception, will have been passed and implemented at national level.

O 2. By 2006, all facilities providing pregnancy termination services will be using modern pregnancy termination technologies, including vacuum aspiration and/or medical abortion.

O 3. By 2006, all facilities providing pregnancy termination services will be providing quality services, including post-abortion counseling.

O 4. By 2004, the management system for abortion-related information will have been adopted and become functional in all facilities in the public and private system.

O 5. By 2004, at least one behavior change campaign will have been conducted, related to existing options in case of an unwanted pregnancy and to the benefits of contraception as opposed to the risks of abortion.

O 6. By 2006, the number of abortions will have dropped by at least 20%.

O 7. By 2006, the number of unsafe abortions will have dropped by at least 15%.

O 8. By 2006, abortion-related maternal mortality will have dropped by 15%.

O 9. By 2006, abortion-related complications will have dropped by 15%.

SAFE MOTHERHOOD

Goals

G 1. Reduced maternal mortality and morbidity.

G 2. Increased quality of care in pre-, intra- and post-natal care facilities.

G 3. Increasing safe motherhood awareness among the population.

Objectives

O 1. By 2004, all pregnant women will benefit from free access to quality pre-, intra- and post-natal care services.

O 2. By 2004, the system ensuring high-quality and effective pre-natal consultation will have been implemented at national level.

O 3. By 2006, maternal mortality will have dropped by 10%.

O 4. By 2006, maternal mortality related to iron deficiency anemia will have dropped by at least 20%.

O 5. By 2006, at least one yearly campaign will have been conducted, on issues such as pregnancy, birth.

PREVENTION AND MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS (STIS), INCLUDING HIV/AIDS INFECTION

Goals

G 1. Ensuring the legislative framework needed in order to prevent discriminations against people living with HIV or suffering from AIDS, as well as to ensure that testing confidentiality and anonymity is observed.

G 2. Reducing the incidence of sexually transmitted infections (STIs)

G 3. Maintaining the HIV/AIDS infection incidence at its 2001 level.

G 4. Reducing vertical HIV infection.

G 5. Increased awareness and education of the population on STI prevention, especially among high-risk groups.

Objectives

O 1. By 2004, all pregnant women will be given, if they accept it, the opportunity to take free HIV tests, with adequate pre and post testing care.

O 2. By 2004, at least one national behavior change campaign regarding STIs and HIV/AIDS infections will have been conducted.

O 3. By 2006, the real incidence of syphilis-related infections will decrease by 10% in fertile age persons.

O 4. By 2006, of the primary health care services will be providing early diagnosis and adequate case management for STIs.

O 5. By 2006, all women diagnosed with STI will benefit from specialized, integrated, quality treatment.

O 6. By 2006, vertical transmission of syphilis will have been eliminated.

O 7. By 2006, the rate of the vertical transmission of HIV infection will have decreased by 80%, through effective management of HIV positive pregnant women.

TEENAGER AND YOUTH SEXUAL AND REPRODUCTIVE HEALTH

Goals

G 1. Improving the legislative and regulatory framework necessary for adequate sexual and reproductive health services (SRH) for teenagers and young people.

G 2. Decreasing SRH related morbidity in teenagers and youth.

G 3. Ensuring access to adequate sexual and reproductive health services.

G 4. Decreasing the number of unwanted pregnancies among teenage and young women.

G 5. Decreasing STIs among teenagers and young people.

G 6. Increasing teenage and young people's awareness and education in the field of sexual and reproductive health, with a view to adopting a healthy behavior.

Objectives

O 1. By 2004, at least one national behavior change campaign regarding unwanted pregnancy and STI prevention among teenage and young people will have been conducted.

O 2. By 2006, sexual and reproductive health education addressing teenagers and young people will be provided in schools.

O 3. By 2006, all facilities providing SRH services will also be providing services adjusted to the needs of young people.

O 4. By 2006, the rate of unwanted pregnancies among teenager and young women will have dropped by 20%.

O 5. By 2006, the syphilis infection rate among young people will have dropped by 10%.

SEXUAL HEALTH OF THE ELDERLY

Goals

G 1. Improving the sexual health status in elderly women.

G 2. Increasing people's awareness and education in the field of sexual health for elderly women.

Objectives

O 1. By 2006, at least one communication campaign will have been conducted, aimed at changing behaviors related to effective menopause management.

O 2. By 2006, specialized facilities targeting elderly women will have been set up in each county capital.

EARLY DIAGNOSIS AND MANAGEMENT OF GENITAL AND BREAST CANCER

Goals

G 1. Improving early diagnosis of cervical cancer.

G 2. Improving early diagnosis of breast cancer.

G 3. Increasing people's awareness and education in the field of genital and breast cancer.

Objectives

O 1. By 2006, a cervical neoplasm early diagnosis national program will have been put in place, including provider training and ensuring the needed equipment and consumables.

O 2. By 2006, a breast neoplasm early diagnosis national program will have been put in place, including provider training and ensuring the needed equipment and consumables.

O 3. By 2004, each year, one national behavior change campaign related to breast and cervix cancer prevention will have been conducted.

O 4. By 2006, 25% of all primary health care services and 100% of all specialized services will perform early detection and/or screening of cervical cancer.

O 5. By 2006, all primary health care services will conduct yearly breast examinations in keeping with the standards.

O 6. By 2006, 50% of all women at high risk will benefit diagnosis mammography examination.

O 7. By 2006, all women diagnosed with breast or cervical cancer will receive specialty, integrated and high-quality care.

O 8. By 2006, 45% of all cervical neoplasm will be diagnosed at stages 0 and I.

INFERTILITY PREVENTION AND MANAGEMENT

Goals

G 1. Increasing access to specialized infertility management services.

G 2. Increasing people's awareness and education on infertility prevention and management.

Objectives

O 1. By 2006, there will be specialized services addressing the efficient management of infertility in each level III gynecology facility.

O 2. By 2006, a national behavior change campaign related to prevention and management of infertility and STIs will have been conducted each year.

PREVENTION AND MANAGEMENT OF DOMESTIC VIOLENCE AND SEXUAL ABUSE

Goals

G 1. Ensuring the legislative framework needed in order to prevent domestic and sexual violence in Romania.

G 2. Decreasing domestic and sexual violence against women and children.

G 3. Increasing people's awareness and education in the field of domestic and sexual violence.

Objectives

O 1. By 2004, the legislative measures needed to prevent domestic and sexual violence will have been passed and implemented.

O 2. By 2004, a national behavior change campaign related to domestic and sexual violence and their prevention will have been conducted each year.

O 3. By 2006, a national data base on domestic violence and sexual abuse victims to receive care from specialized facilities will have been put in place.

O 4. By 2006, specialized facilities addressing the victims of domestic violence and sexual abuse will have been opened in each county capital.

PREVENTION OF WOMAN AND CHILD TRAFFICKING

Goals

G 1: Providing the necessary legal framework for preventing woman and child trafficking.

G 2. Reducing woman and child trafficking.

G 3. Increasing people's awareness and education concerning woman and child trafficking.

Objectives

O 1. By 2004, a comprehensive legal framework on woman and child trafficking will have been passed.

O 2. By 2004, a national behavior change campaign on the prevention of woman and child trafficking and on its negative health effects will have been conducted once a year.

O 3. By 2006, specialized facilities addressing victims of woman and child trafficking will have been opened in each county capital.

IMPLEMENTATION STRATEGIES

Improving sexual and reproductive health requires a wide variety of activities, performed at various levels and in various social systems. Other systems should also become involved, besides the healthcare system. Within the healthcare system, the following implementation strategies are essential.

IMPLEMENTATION STRATEGIES WITHIN THE HEALTHCARE SYSTEM

REFORM OF THE HEALTHCARE SYSTEM AND OF THE LEGAL AND NORMATIVE FRAMEWORK

This strategy will be implement as part of the wider context of the overall health care system reform (decentralization and privatization), as well as of the specific SRH services reform. These reforms should be visible both in legislative changes, as well as in the way in which SRH services are financed and provided.

One critical problem with SRH services is that its various components are not integrated, especially at the level of primary health care. Thus, the classical separation between family planning and STI prevention and treatment services should be revisited, especially if two-fold protection is an objective (pregnancy and STI protection). Similarly, family planning should be integrated in primary health care services. That means that medical staff would have to undergo training. Family physicians, who have so far had little involvement in the provision of SRH services, will need additional training.

At the level of secondary and tertiary health care (specialty out-patient care units, hospitals), SRH services will have to be correlated with primary health care services, thus enabling a smooth and effective „patient flow".

The effective provision of SRH services largely depends on the laws and regulations in force, which can directly or indirectly facilitate or prevent access to such services. Observing human rights, making informed decisions, confidentiality – al these must be part of healthcare services. It follows that removing obstacles in order to facilitate access to services is the right way to approach the improvement of SRH and behavior change services. Also, once the legal and normative framework has been passed, its enforcement must be permanently monitored.

SERVICE ACCESSIBILITY AND QUALITY

The main goal in this area is to ensure clients' access to quality health care services. That can be done by ensuring confidentiality, removing cultural barriers and setting up special services for certain vulnerable groups, such as teenagers or the elderly. Quality of service standards have to be defined, revised and updated in all fields. Staff education and training are essential both to the private and the state sector. State-of-the art technology should be used sensibly, only when necessary, after a careful cost-efficiency analysis.

MEDICAL SERVICE PROVIDERS TRAINING

Staff training is required by the upcoming overhaul of the system, and especially by the integration of FP services into STI services, and of SRH services into primary health care services. Higher and medium education medical staff, as well as those involved in health promotion will undergo training, which may include specific SRH issues, public health measures, medical practice and new lab methods.

BEHAVIOR CHANGE CAMPAIGNS (BCC)

Wide experience has been so far gathered internationally in bringing sexual and reproductive health into schools and is using a wide variety of techniques and technologies. An essential factor is to communicate with target groups (high-school and university students) and get them involved in all program drafting and implementation stages. In Romania, besides student involvement, SRH education in schools involves collaboration with the education system, as well as with active NGOs. The „National Program for Health Education in Romanian Schools", put together by the Minister of Education and Research in collaboration with the Ministry of Health and Family, under the prime Minister's patronage, is a result of the efforts the government deploys in this field. NGOs taking part in its implementation is a means to make sure that the experience that has been gathered in our country in student education is put to use. Behavior change campaigns targeting the youth also involve extra-curricular activities and programs, presented in an attractive manner. Media campaigns, targeting specific topics and groups are part of the effort to determine the population to adopt a healthy behavior.

EQUAL OPPORTUNITIES

Health status inequalities can be result of belonging to one sex or the other, if not enough importance is given to equal opportunity issues. Consequently, sexual and reproductive health services and public education must take these issues into account.

Men are currently playing the more important part in the social decision-making process. Social norms require that girls, women, boys and men, play a certain social role. Consequently, the involvement of men is essential to all reproductive health aspects. At the same time, men have their specific SRH needs, that have to be solved by providing adequate services.

RESEARCH

Knowledge formation is a strategic element for the promotion of health and treatment. Consequently, it is necessary to develop a national research system, providing the information and knowledge needed to adopt evidence-based policies and behaviors. Research is therefore a monitoring and especially an assessment tool. At the same time, it is the driving force behind SRH in Romania, that is closely related to international developments.

MONITORING AND ASSESSMENT

A system monitoring the implementation progress of various strategies is necessary. Regular reproductive health surveys can provide information on the effectiveness and efficiency of various approaches and help formulate policies, if necessary. The current strategy will be completed by programs for each priority area, to include monitoring and assessment components.

HEALTH PROMOTION

Other implementation strategies, that are not part of the health care sector but are closely related to it, contribute to the improvement of SRH in Romania. Since several sectors outside of the health care system play a part in the improvement of health promotion, its components will only be listed below (since health promotion is addressed in another strategy), while SRH implementation strategies will focus on the health care sector.

According to the 1986 Ottawa Charter, health promotion implies a rise in the capacity of the individual, the group and the entire society to control and improve its own health status. The principles of health promotion, stipulated in the same document, are as follows:

- Building personal skills: people must be encouraged to adopt a healthy behavior, through school, workplace, etc, programs.
- Streamlining health care services: gradually shifting health care from a treatment-oriented, to a prevention-oriented system, that will be able to ensure a better health condition of the population in the future; preventive orientation can be reached in time and its effects also become visible in time.
- Increased community action: Human and material resources that the community has should be capitalized upon in order to improve people's health status. Getting the communities involved in identifying and solving health care problems will create the feeling that health is the responsibility of each individual as well as of the community on the whole. This concept is especially important

in the case of vulnerable, marginalized or high-risk communities (which are also harder to enter from the outside).

- Building a favorable environment: cultural variants must be taken into account especially where SRH is concerned. Taboos, prejudices and lack of dialogue in the field are all elements to be considered.
- Developing adequate public policies: obviously involves other sectors as well, such as: passing an equal opportunity law, human trafficking laws.

The implementation of all these strategies must be based on partnership, to allow, on the one hand, that the experience that has been gained in Romania be put to use, and, on the other, that all persons, groups and organizations involved in SRH be part of the process.

IMPLEMENTATION FRAMEWORK

The current strategy aims to identify priority action areas in the field of SRH in Romania, to establish goals, objectives and implementation strategies for each priority area, and thus obtain the broader picture that will allow the improvement of SRH in our country. The results of the strategy, both in terms of impact and of processes, are given under the monitoring and assessment chapter. In order to meet the set objectives, all the elements of the strategy must be implemented by means of coherent interventions. The interventions generated by this strategy are based on the following principles:

- Interventions must be based on the latest and safest available scientific data. Only those methods whose validity is scientifically proven will be used in the interventions.
- Prophylactic interventions and those affecting a large number of persons in the target population will have priority;
- State-of-the art technology should be used sensibly – it is to be avoided when other methods, just as effective, are available;
- Interventions must be cost-effective and scheduled in advance;
- Equal access to services will be provided; the poor and the disadvantaged are to be taken into account as a priority;
- Human and material resources must not be concentrated at the top of the health care system; they must be redistributed to the periphery and to communities (decentralization);
- Services must be provided at the lowest level that can provide them adequately;
- Communities must be involved in defining, implementing and assessing the services that are being provided to them;
- Responsibilities and authority shall be delegated, and constructive supervision will be conducted;
- The quality of care is just as important as access to services and it means that the needed skills and equipment are in place, as well as an adequate relationship between the patient and the provider;
- Health care providers must work together in the spirit of team work and collaboration.

Although it does not exhaust all possible issues, this document also includes examples of actions that can contribute to the successful implementation of the current strategy. These actions will be diversified, detailed and adjusted yearly within the Child and Family Health Program, in such a way as allow that the objectives set in the SRH strategy be met.

Annex 1 provides a number of examples of actions for each priority area and, as part of that area, for each implementation strategy. Let us mention the fact that one action may correspond to several implementation strategies or objectives, and the other way around. Therefore, the examples make up a simple list, because it is impossible to reflect the above-mentioned flexibility otherwise.

RESPONSIBILITIES

AT NATIONAL LEVEL

THE GOVERNMENTAL SECTOR

The Romanian Government is in charge with the implementation of the National SRH Strategy. Public institutions playing an essential part in the progress and success of this strategy are as follows: the Ministry of Health and Family and its regional structures (Public Health Care Directorates), the Ministry of Education and Research and its regional structures (County School Inspectorates), Public Administration Ministry structures (local authorities will gradually take on more and more social components), structures of the Ministry of Labor and Social Solidarity, of the National Child Protection and Adoption Authority, the Ministry of Youth and Sports, the Home Ministry, the Justice Ministry, the National Defense Ministry, the Transports Ministry. The National Health Insurance House plays a key role in covering health care expenses through the social health insurance system, based on contracts signed between the Health Insurance Houses and the providers of primary, out-patient and hospital care services, within limits that are clearly set in the framework contract for each type of health care service.

Through the decentralization process, local authorities will play an increasing part in setting local priorities, and solving them by allocating the necessary resources.

Together with the above-mentioned institutions, other national organizations/institutions, especially non-governmental organizations, play an important part in the national or local implementation of the strategy.

THE NON-GOVERNMENTAL SECTOR

Non-governmental organizations (NGOs) are a relatively new sector in Romania, as in the rest of the countries in this part of Europe. However, during this relatively short time, these structures have managed to acquire wide experience in working directly with the population and in quickly meeting the needs of their target population. NGOs provide services mainly to vulnerable, marginalized or high-risk groups (such as prostitutes, same-sex couples, etc). Therefore, NGOs are a source that must be put to use and the MoHF will promote partnerships with the non-governmental sector in their fields of expertise. NGOs are flexible partners, with field experience, and governmental bodies can provide national coverage, where necessary.

THE PRIVATE SECTOR

This is a developing sector in Romania, that provides a wide range of service to the population and encourages market mechanisms in the health care sector. The funds in this sector can be used, in an ethical manner, especially to conduct behavior change campaigns. The public sector is in charge of controlling the quality of services provided by the private sector.

COLLABORATION WITHIN THE HEALTH CARE SYSTEM

Resource reallocation from the tertiary level to out patient care and primary health care is an important element in the implementation of SRH service provision. The expansion of SRH services at the level of primary health care may play a major part in covering the needs of the rural population and of disadvantaged groups.

Out patient care facilities, such as family planning cabinets, and the cabinets of physicians who specialize in various fields relevant to the provision of SRH services (obstetrics and gynecology, dermato-venereology, etc.) play an important part in the implementation of this strategy.

The family physician, who is at the center of health care reforms in Romania, is an important partner in the provision of SRH services and therefore must be supported accordingly.

Community nurses and Rroma mediators will also play an important part in monitoring the health status of the population. Their main attribution will be to detect medical conditions among the disadvantaged population, and act as the interface, the middle-person between health care and social services at community level.

INTER-SECTOR COLLABORATION

Education is the most important ground for collaboration in terms of sexual and reproductive health. It ensures young people access to such services at a time when they are vulnerable but also open to quality information, that can motivate them to adopt healthy behaviors. It is of the essence that SRH needs and responsibilities be tacked both from the point of view of women and men.

Besides education, other social sectors can be drawn into a partnership, such as social services, psychological counseling, child rights protection, the police, the judiciary, etc., that have the means of approaching social components that are otherwise inaccessible to the health care system alone.

Local public administrations will play an increasingly important part in mobilizing the local community and identifying additional local resources, needed to implement this strategy.

INTERNATIONAL COLLABORATION

Technical and financial collaboration with governmental and non-governmental international agencies and institutions, as well as with bilateral donors, are essential, since they can complement the national efforts. Thus, a very important part is played by the following institutions.

The United Nations Population Fund (UNFPA) has signed an agreement with the Ministry of Health and Family for the period from 2000 to 2003, entitled "Support for the sexual and reproductive health program in Romania". That program, which is being implemented by MoHF and its subordinated institutions, by two NGOs (SECS and the Youth for Youth Foundation) and UNFPA, aims at increasing SRH for women, men and youth in Romania. The program has two major components – increasing the use and quality of SRH services and making young people adopt responsible sexual behavior – which can be implemented by getting other experienced institutions and organizations involved, keeping in mind the principle of SRH services integration. Training providers, especially family physicians and medical nurses, implementing family life education programs and conducting behavior change campaigns (including printing SRH fliers), providing assistance for improving the public health promotion network, and conducting pilot programs are the priority measures of this program.

United Nations Children's Fund (UNICEF) has signed an agreement with the Romanian Government for the implementation of a collaboration program to last 5 years, starting 2000, aiming at extending and improving the social welfare system and basic services provided to women and children. The collaboration is based on the Children's Rights Charter, a document ratified by Romania, on the Convention for the Elimination of Gender Discrimination, as well as on national policies and programs concerning the protection of health and rights of children and women. One component is the Health and Nutrition Program, which aims to promote, preserve and improve the health condition of children, women and youth. The main types of assistance it provides are for: drafting strategies (such as the breast feeding strategy), protocols, provider training, and behavior change campaigns. The program's main areas of interest are: the promotion of breast-feeding; the improvement of perinatal care and prevention of the vertical transmission of HIV/AIDS; HIV/AIDS prevention and promotion of a healthy life style. UNICEF closely collaborates with UNAIDS in the field.

World Health Organization (WHO) facilitates collaboration and partnership between Romania and other key international factors. WHO provides technical assistance for the drafting and implementation of programs (such as Free Motherhood, Best Practice Implementation, and others) and, in certain cases, can provide financial assistance, when such activities yield results and conclusions that can be applied internationally. Moreover, WHO is a forum that encourages exchanges of ideas between countries and programs. The WHO Office in Romania supports the drafting and implementation of national programs by offering technical assistance and contacts with other international agencies involved in the field.

The United National HIV/AIDS Theme Group ,which includes UNICEF, UNDP, UNFPA, WHO, IMO, World Bank and UNAIDS, supports national partners in the HIV/AIDS strategic planning process and in attracting additional resources through the Accelerated Access to Treatment Program and HIV/AIDS Care or through access to other foreign funding sources.

The European Commission invests substantial sums in the Romanian health care reform, by providing assistance to governmental structures. EU funds are oriented towards two priority areas: increasing the effectiveness of the Romanian system of epidemiological surveillance and control of transmitted diseases (with HIV/AIDS being one of the main intervention areas); non-transmitted diseases surveillance and control, with early diagnosis and control of breast neoplasm holding an important position.

EU community programs are another potential source of support for SRH. There are also funds meant for civil society programs, that also include the health care sector.

The World Bank supports a health care project in Romania, that includes, in its first stage, components of SRH, especially prevention and health promotion. Thus, a Public Health Care National Strategy is envisaged, as well as training of the health promotion staff, the enforcement of service provision capacities at the level of primary health care, and sensible planning and use of human and financial resources. Along with other fields, HIV/AIDS and STI prevention is an area of interest in health

promotion campaigns and activities. Stage II of the WB project takes into account the possibility of including components related to mother and child health.

United States Agency for International Development (USAID). In September 2001, for a period of 5 years, John Snow, Inc Research and Training (JSI R&T) took over the part of main technical and implementing authority, together with the Ministry of Health and Family (MoHF), USAID and the Romanian Family Health Initiative (ISFR), a program financed by the US government through USAID.

The goal of ISFR is to increase access and use of reproductive health services by integrating them at the level of communities. The most important action areas for the implementation of the Initiative's activities (in a partnership made up of MoHF structures and NGOs) are: Supporting the integration of reproductive health services in the primary health care system (family planning, pre and post natal care, investigations for early diagnosis of cervical and breast cancer and of STIs, including HIV/AIDS and of domestic violence cases); Developing an effective structure for the provision of reproductive health services; p Promoting the use of reproductive health services, also through behavior change campaigns.

The Swiss Government Agency for Development and Cooperation (SDC) mainly collaborates with Romania in improving neonatal care – it supports the MoHF in rehabilitating maternities. Another important area is child protection. SDC supports a number of programs aimed at eliminating discrimination against HIV infected/affected persons and at preventing child abandonment.

U.K. Department for International Development (DFID) collaborates with the World Bank in improving the services provided by family physicians and reinforcing the primary heath care network. As a result of its collaboration with universities in Romania, a pre-university nurse-training curriculum was introduced, for the first time in our country.

Canada's International Development Agency (CIDA) supports Romania through UNICEF projects in two main areas: HIV/AIDS prevention and monitoring of Children's Rights Charter observance.

The Norwegian Government supports a project offering assistance to woman and child victims of domestic violence, by providing specialized consultancy and temporary shelter.

The Canadian Government provides support to Romania especially through UNICEF, in the field of HIV and AIDS infection transmission prevention programs.

Besides the above-mentioned, there are other initiatives between the Romanian Government and the governments of other countries in the field of or having an impact on SRH.

Other institutions that collaborate or provide technical and financial assistance in the field of SRH in Romania are:

- International non-governmental organizations active in the field of SRH;
- Professional organizations networks, including public health schools, universities, research centers
- SRH Staff associations (such as the European Association of ObGyns, the European Midwives' Association, and others).

RESOURCES

NEEDS

There are several ways of identifying needs and estimating the needed resources for the implementation of the SRH strategy. The needed financial resources for the implementation of the SRH strategy may be identified starting from the Cairo Action Program, that estimates in developed and transition economy countries, the implementation of the reproductive health programs would cost 17 million $ in 2000, 18.5 million $ in 2005, 20.5 million $ in 2010 and 21.7 million $ in 2015.

Another means of estimating the resources needed for the implementation of the SRH strategy is to identify the needs of those interventions in health programs implementing various strategic objectives. That approach renders estimates more specific and allows for separate estimated for each of the 10 priority action areas. In terms of national health programs, the resources needed to implement the strategy can be divided into three large categories:

- Direct financial resources, for the implementation of activities;
- Human resources specific to the implementation in each priority area and
- The needed technical resources to coordinate various components, to develop specific (coherent and effective) implementation plans, and to ensure the quality of interventions (monitoring and assessment, specific technical assistance, etc).

Implementing the strategy through the Child and Family Health Program (National Program 3) has effects both on the MoHF and its budget allocation, and on the National Health Insurance House and the allocation of resources from health insurance funds. Whereas financial resources can be estimated starting from the activities scheduled in NP3, human and technical resources are harder to estimate, because they depend largely on the operation stages of NP3 objectives implementation, of the needs for geographical coverage and for vertical program development. Even so, accurate estimates can only be done for some of the 10 priority intervention areas, since the rest do not benefit from long-term activity planning or need a clarification of possible approaches to implementation and financing.

Estimating the direct financial needs/resources for the implementation of the SRH strategy involves: purchasing specific equipment; purchasing medicines and medical supplies (including lab reactive substances and other consumables) specific of SRH programs, training of the medical staff, minor and major repair work, IT network implementation, etc. Additional human and technical resources will have to be identified on a regular basis (usually on a yearly basis), at the time of detailed planning of specific interventions, by means of dialogue and coordination with private, non-governmental and international institutions. What follows is an attempt to estimate the needs for direct financial resources starting from the current structure of NP3, especially in the case of programs that already have tentative long and medium term planning. However, these programs may change during the coming years, through geographical expansion, component separation or fusion, shifting priorities or modified balance between the three sectors interacting with the governmental sector (the nongovernmental, private and international sectors).

FAMILY PLANNING (REPRODUCTIVE OPTIONS)

Several intervention principles were taken into account when estimating the financial resources needed for the implementation of specific objectives in the national FP program: the target population made up of fertile-age women living in rural areas or low-income fertile age women; expanding FP services, including free contraceptive distribution, towards primary health care (especially in rural areas, but also in selected urban areas) and implementing the program by means of three simultaneous and complementary activities: primary health care provider training, availability of free contraceptives and promotion and population education activities on the availability of these services. Thus, four main objectives of the national program were identified, according to which a financial resources estimate was performed, for the period covered by the strategy.

- ensuring free contraceptives – around 7.5 million €
- primary health care provider training in basic RH services provision – around 2.5 million €
- IT network implementation – around 450,000 €
- local and national behavior change campaigns– around 400,000 € a year

After the year 2006, FP program maintenance costs will rise to about 2 million € a year.

SAFE ABORTION AND PREGNANCY TERMINATION SERVICES

According to the recommendations laid down in the latest WHO survey, this field requires the purchasing of modern equipment and consumables, the drafting of standards and protocols for safe pregnancy termination, provider training for the observance of these standards and for post-abortion FP services provision, the improvement of public and private pregnancy termination service reporting means and methodology. The resources needed for these interventions are estimated at around 500,000 €.

SAFE MOTHERHOOD – PRE-NATAL CARE, SAFE CARE AT BIRTH AND OF THE NEW BORN, POST-NATAL CARE AND BREASTFEEDING

The funds needed to develop and implement a unitary pre natal care system have already been stipulated in the 2002/2003 health programs. The main aim is to reach consensus on pregnant woman monitoring protocols, on the drafting on standardized pregnancy monitoring documents and on training the medical staff on how to use them. The costs of this intervention were estimated at around 2.5 million €.

The prevention of iron deficiency anemia in pregnant women by administering iron, for which an estimated 2.5 2,5 million € will be spent, and the prophylaxis of the iso-immunization syndrome, requiring some 1,000,000 € for administering anti-D immunoglobuline to the target population, are two very important aspects of this priority area.

In 2002, as part of the efforts deployed by the MoHF to ensure high-quality pre-, intra- and post-natal care services, the ObGyn and neonatology hospital care system rehabilitation and overhaul strategy was adopted (the MatRom program), that included pilot activities performed in collaboration with the Swiss Government within the RoNeoNat Program. According to this strategy, the pregnant woman and the new born baby will receive medical care function of the risks involved, through the regionalization of medical care and the establishment of birth place function of the ability of the medical facility to deal with the pathology displayed by the mother and new born. Obstetrics-Gynecology and Neonatology wards will be reorganized according to three levels of competency and in-uterus and post-birth transportation of the babies in need of level III care will be ensured by specialized neonatal transportation services. This major program needs substantial financial resources for minor and major repair work, technical endowment and staff training that have been estimated at around 45 million €, including the generalization of the „rooming-in" system in maternities.

As far as the BCC component is concerned, according to specific strategic objectives, the needed funds to implement national campaigns will rise to about 300,000 € a year, plus an additional estimated 100,000 € a year for breast feeding behavior change campaigns.

As far as the other action areas are concerned, current estimates are relative, since the corresponding programs are not as developed as those presented above.

However, some successful activities that still need resources (behavior change campaigns in various SRH fields) must be mentioned. There is also the need to conduct pilot programs to test various solutions and provide recommended approaches and implicitly financing for those components (e.g.: genital and breast cancer early diagnosis programs, the program for the development of model care services in various areas such as pre and intra natal care, reducing vertical HIV infection, safe pregnancy termination, etc.).

OTHER NEEDED RESOURCES

Besides direct financial sources, that must be stipulated in those programs, the need often arises to allocate specific technical resources for a certain field or at a certain point in an intervention. These can be obtained by means of collaborating with international donors, who, besides direct financial assistance resources, can contribute directly with technical resources represented by specialists or international experience that has proven to be cost-effective.

One important need for technical resources is the monitoring and assessment of the implementation of the strategy and of national health programs. There is a need for real estimates of the needs for change or enforcement of the routine information system, coordinated by the Country Public Health Directorates, of its implementation and for careful monitoring of the data in the system. Specific technical resources are also needed, to identify those fields that have to be assessed by means of population surveys. For instance, in order to assess the success of the strategy goals, a national survey of the 1999 Reproductive Health Survey type will have to be conducted in 2005/2006. This involves detailed preparations, the identification of the needed technical and human resources but also of direct financial resources. The needed costs for such a survey to be conducted again rise to about 300,000 €.

The technical coordination and monitoring of NP3, performed at central level by the Program Management Unit, the activity of Child and Family Health County Commissions, and supporting the activities of the Public Health Directorates that are the local coordinators of NP3 activities, require financial assistance estimated at around 100,000 € a year.

SOURCES

THE GOVERNMENTAL SECTOR

Obviously, it is the Government's responsibility to provide most direct financial resources, which can be money allocated from the state budget or from various international assistance programs, reimbursable on long and medium term, such as World Bank programs. Under the Cairo Declaration, that Romania was a signatory of, whatever the share of SRH budget, governments must cover 2/3 of the country's needs in the field of SRH. The government establishes the priority measures to be taken for the implementation of the SERH strategy and provides most resources, by allocating or reallocating funds to the health care system.

With the ongoing health care system reform, the governmental sector cannot always ensure the human and technical resources specific to the various objectives. Therefore, the assistance provided by international institutions and bodies is very important, and the financing coordination mechanisms must be functional. Governmental resources do not only mean direct financial contributions by the MoHF to support this strategy, but also contributions by other relevant ministries, such as the Ministry of Education and Research and the Ministry of Youth and Sports, especially for youth education programs, or the Home Ministry for programs fighting violence against women.

Also, local public administrations can contribute to financing the strategy objectives by identifying local resources for various components, such as the rehabilitation of the infrastructure of hospitals.

THE NON-GOVERNMENTAL SECTOR

Non-governmental organizations are a very important resource for the implementation of the SRH strategy. Their main contribution is human resources, needed to put together innovative implementation mechanisms, that draw on field work and on the community needs, that can address both the population at large and population groups that are disadvantaged or have special SRH needs. Another important contribution made by NGOs is that they are able to provide access to certain high-quality and effective SRH services that are difficult to tackle in governmental programs. These services may be provided for free or at very low prices, if a mechanism is in place, allowing for the transfer of funds between the governmental and the non-governmental sectors.

With their large degree of flexibility in fund management, NGOs that are active in the field of SRH, can ensure the development and implementation of short programs, targeting vulnerable population groups (even from the geographical point of view) or can ensure the mechanisms needed to add own or community resources to existing funds. Their capacity to react quickly, and to swiftly transfer information to and from the community qualify NGOs as a regular partner, with a very important part in the dialogue with government decision-makers on identifying financing priorities and innovative and effective ways of implementing strategies, both at local and national levels.

Last but not least, the non-governmental sector is a special technical resource, that must be put to use when implementing the SRH strategy. Through the direct and indirect support received in the last 12 years (especially from international organizations), several NGOs have developed important skills in identifying community needs and in planning and implementing various programs to meet those needs.

THE PRIVATE SECTOR

The private sector has become an important provider of resources. Private facilities use a system of direct payment and should be accepted as part of the RH resources.

The private sector is also important because it can provide services in areas that are accessible to a majority population. In a recent analysis of the FP service market in Romania, it was noticed that around 55% of the fertile age female population have an average and above-average income and live in urban areas. That population category must be encouraged to use the services provided by the private sector, while the other 45% of women (that live and rural areas and are poor or very poor) are the target of services offered by the public governmental system.

INTERNATIONAL BODIES

The international donors community has stated its intentions to assist Romania and remains a major source for the implementation of various SRH programs, including this strategy. United Nations Agencies (UNFPA, UNICEF), as well as UNAIDS, take great interest in the field. Also, bilateral agencies (USAID, CIDA) and humanitarian foundations play an increasingly important part.

The European Commission is another important source. The collaboration between Romania and the European Commission is a continuned process, tackling all aspects related to Romania's preparations to join the European Union.

The World Bank provides support to structural and sector reforms, through substantial assistance programs, in a bid to accelerate economic growth and prepare Romania in the run up to EU accession. World Bank projects in Romania cover a wide range of fields, health care included.

Besides direct financial assistance, international bodies can also provide technical assistance and/or international expertise that are needed to implement the strategy through innovative and effective approaches, that have proven successful in other countries can be adjusted to fit Romania's needs. The regional approach that donor have been promoting lately and the examples of coordination between their actions can prove to be important advantages in order to attract new governmental and private resources.

International NGOs active in the field of SRH, many of whom have partnerships with Romanian institutions, can also make technical and financial contributions to the implementation of this strategy.

MONITORING AND ASSESSMENT

The monitoring and assessment process is central to following the way in which the objectives included in the strategy are met. The monitoring activity associated with the sexual and reproductive health strategy will unfold in the form of a routine internal process and will provide information on the progress of the strategy implementation at various levels, on the temporal dynamics and required costs. It is a needed and useful tool that helps adjust the way in which the strategy is implemented, to adjust operational plans, depending on available resources and each specific situation, by systematically monitoring resources, processes and results. A special part of the monitoring activity is the monitoring of the effectiveness with which resources are used (be they human, technical, financial and time resources) in the strategy implementation. That component is all the more important to Romania, a country that has limited available financial resources for investing abroad. The assessment activities will target specific implementation processes, the program's effects and impact on the sexual and reproductive health status of Romanians.

Various types of information and information sources will be needed at the various levels of the monitoring and assessment program. Thus, measuring resources, processes and results will be based on information pertaining to the program itself, while monitoring the effects and impact on the population will be based on certain population data and indices. Assessing the effects and impact on the population will require more costly methods, such as population surveys.

In accordance with WHO recommendations laid down in the "Health for all 21" strategy, the comprehensive set of indices that can be used to monitor and assess health programs is made up of: indices related to health policies, socio-economic indices, indices on the provision of healthcare services and health status indices. Romania takes into account the SRH indices classifications accepted by WHO and will use indices of resources, direct results (accessibility, availability, quality of health care services), process indices (service use, knowledge and practices), as well as impact indices that measure the health status.

The World Health Organization recommends a short list of 15 indices in the field of sexual and reproductive health, which are all internationally agreed upon and accepted. For the monitoring and assessment of the Romanian strategy, the relevant and feasible indices were selected from the short WHO recommended list. A number of international and national indices were added, that were selected from the wide range of potential indices, according to the specific features of the Romanian strategy. The key monitoring and assessment indices of the Romanian strategy, grouped according to several priority areas in the SRH strategy that they cover, are shown in the table below.

In the case of specific objectives for which the relevant indices currently have no exact value, surveys will have to be conducted to document the reference situation before starting the interventions.

Index	Operational definition	Reference value (year)	Target value (2006)
Family planning			
Prevalence of modern contraceptive use	The percentage of fertile age women (15-44 years old) who use or whose partner uses modern contraceptive methods at a certain point in time.	23.3 (1999)	40
Prevalence of traditional contraceptive use	Percentage of fertile age women (15-44 years old) who use or whose partner uses traditional contraceptive methods at a certain point in time.	24.7 (1999)	15
Coherent free contraceptive program	The existence of a coherent free contraceptive program	No (2001)	Yes
Percentage of primary health care facilities providing family planning services	The percentage of health care facilities that provide family planning services of the total number of primary health care facilities, including family planning cabinets.	2.2 (2001)	40
Abortion and pregnancy termination services			
Requested abortions rate	Number of requested abortions per 1,000 women between 15 and 49 years of age	34.1 (2001)	27.3
Number of induced (illegal) abortions	Total number of induced abortions	200 (2001)	170
Abortion-related maternal mortality	Number of abortion-related maternal deaths per 100,000 live births	16.8 (2001)	14.3
Safe motherhood			
Pre-natal health care services	Number of registered pregnant women per live or still born babies	84 (2001)	95
Maternal mortality	Number of maternal deaths per 100,000 live births	34.0 (2001)	30.6
Percentage of births assisted by qualified medical personnel	Percentage of births assisted in health care units out of the total number of births (live or still born babies)	97 (2001)	99
Prevention and management STIs, including HIV/AIDS			
Percentage of HIV positive pregnant women	Number of HIV positive pregnant women per total number of tested pregnant women.	0.07 (2002)	0.07
Sexual and reproductive health in teenagers and youth			
Rate of unwanted teenage pregnancies	Reported number of unwanted teenage pregnancies (teenagers between 15-19 years of age, last pregnancy in the past 4 years) out of the total number of responded teenagers to have reported a pregnancy in this period.	23.7 (1999)	19.0
Syphilis incidence among teenagers	Number of newly diagnosed syphilis cases, among the 15-19 age group, out of the total population in that age group.	97.5 (2001)	87.8
Syphilis incidence among youth	Number of newly diagnosed syphilis cases, among the 20-24 age group, out of the total population in that age group.	173.9 (2001)	156.5
Early diagnosis and management of genital and breast cancer			
Vaginal cytological exam in the past 2-3 years, for fertile age women	Percentage of sexually active 15 to 44 year old women who reported at least on vaginal cytological test in the past 2-3 years, out of the total number of sexually active 15 to 44 years old women respondents.	4.5 (1999)	20
Early detection of cervical cancer	Percentage of newly diagnosed stage O or I cervical cancer out of the total number of new cervical cancer cases.	15.8 (1999)	45
Domestic violence			
Medical services available in each county	Specialty health care services available in each county for victims of domestic and sexual violence.	No (2001)	Yes
Transverse activities within the SRH strategy			
SRH training programs	The existence of coherent national SRH training programs	No (2001)	Yes
Good SRH medical practice standards and protocols	The development and implementation of good practice standards and protocols in SRH priority	No (2001)	At least 4

	areas		
Yearly national BCC in the fields of SRH	The development and implementation of national BCC in SRH priority areas	No (2001)	Yes
Information management system	The development and implementation of a proper information management system in SRH priority areas	No (2001)	Yes

Table 2. Key monitoring and assessment indices of the SRH strategy

ABBREVIATIONS

EC	European Commission
CCSSDM	Center for Health Care Calculus and Statistics and Medical Documentation
CNAS	National Health Insurance House
CNPS	National Health Promotion Center
BCC	Behavior change campaign
DAFS	Family and Social Assistance Directorate
DFID	UK Department for International Development
DSPJ	County Public Health Directorate
HIV	Human Immune-Deficiency Virus
IPPF	International Family Planning Federation
INS	National Statistics Institute
ITS	Sexually transmitted infections
JSI R&T	John Snow Inc., Research and Training Institute
MER	Ministry of Education and Research
MI	Home Ministry
MoHF	Ministry of Health and Family
MYS	Ministry of Youth and Sports
G	Goal
O	Objective
WHO	World Health Organization
NGO	Non-governmental organization
FP	Family planning
NP3	National Program 3 for Woman and Child Health
SDC	Swiss Government Development and Cooperation Agency
AIDS	Acquired Immunodeficiency Syndrome
SWOT	Strengths, weaknesses, opportunities and threats identification analysis
SSRR	Romanian Reproductive Health Survey[2]
RH	Reproductive Health
SRH	Sexual and reproductive health
EU	European Union
UNAIDS	United National HIV/AIDS Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

[2] Serbanescu F. et al., 2001, *Romanian Reproductive Health Survey, 1999 : Final Report,* Bucharest and Atlanta: Public Health and Health care Management Romanian Association, "Carol Davila" Medical and Pharmacology University, Bucharest, National Statistic Commission and Disease Control and Prevention Center, Atlanta GA, USA.

ANNEX 1. IMPLEMENTATION FRAMEWORK – ACTIONS

FAMILY PLANNING (REPRODUCTIVE OPTIONS)

REFORM OF THE HEALTHCARE SYSTEM AND OF THE LEGAL AND NORMATIVE FRAMEWORK

- Promoting family planning as a priority in the national and regional health care reform.
- Defining a policy promoting high-quality, accessible services, targeting various population groups.
- Integrating family planning in primary health care policies and programs.
- Integrating family planning, STI and HIV/AIDS policies and programs.
- Developing long-term programs on contraceptive availability for various population groups.
- Including contraceptives on the compensated medicines list.
- Regulating the status of FP services, the attributions of physicians providing FP services, their relationship with other RH service providers, setting competency limits at each level.
- Ensuring the consistency of all legal regulations with an impact on FP.
- Ensuring equal access to FP services to people living in urban and especially rural areas.

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ACCESSIBILITY AND QUALITY OF SERVICES

- Improving access to FP services by integrating contraception in family physicians' activities.
- Developing practice guides for family physicians cabinets where FP services are provided, including contraceptive distribution.
- Improving the service provision consistency by integrating contraceptive distribution, STI/HIV services and other SRH services.
- Defining and implementing a system of post abortion and post natal counseling and contraceptive provision.
- Analyzing the possibility that family physicians with FP competencies might insert IUDs.
- Providing free or affordable contraceptives to disadvantaged population groups.
- Ensuring regular supplies of quality and affordable contraceptives.
- Expanding the contraceptive purchase and distribution system through FP and family health cabinets.
- Ensuring a hierarchical network of family planning services to answer the needs of the local community and allow/ensure access to contraception to all population groups.
- Increasing the access of the rural population to family planning services.
- Improving the quality of family planning services.
- Defining, implementing and monitoring the observance of FP/SRH services quality standards.
- Generalizing patient-oriented counseling.
- Integrating family planning services targeting young people in existing services.

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HEALTH CARE SERVICE PROVIDER TRAINING

- Introducing client-oriented family planning and counseling in medical faculties and universities as part of the family health curriculum.
- Continual FP education and training of family physicians, obstetrician-gynecologists, dermatologists, and nurses in the spirit of best practices.
- Improving the continual family planning training system for family physicians.

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BEHAVIOR CHANGE CAMPAIGNS (BCC)

- Furthering and improving behavior change campaigns in the field of FP with a view to promoting SRH.
- Targeting some behavior change campaigns in the field of FP on vulnerable population groups.
- Generalizing a structured and consistent education system on reproductive rights and contractive education in schools, universities, military facilities.
- Involving target groups in all the stages of developing BCC activities in the field of FP.

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- Increasing the involvement of the media in behavior change campaigns with a view to raising the information and education level of the population.
- Involving family physicians in contraceptive education.
- Supporting the right to free and informed choice of contraceptive.
- Targeting certain behavior change campaigns on emergency contraception.

EQUAL OPPORTUNITIES FOR MEN AND WOMEN

- Informing women and men on their legal right to chose in the field of FP. Formatted: Bullets and Numbering
- Focusing SRH education in and out of schools both on boys and on girls.
- Targeting direct public education on reproductive health and available services both on women and men.
- Ensuring relevance and accessibility of health care services both for women and men.

RESEARCH, MONITORING AND ASSESSMENT

- Adopting and implementing the internationally accepted FP definitions and classifications. Formatted: Bullets and Numbering
- Developing and implementing a valid and reliable national system to monitor the progresses made in family planning.
- Conducting regular population surveys on contraception and problems related to it.
- Conducting surveys to prove be short, medium and long term benefits of expanding reproductive health services and allowing for the motivation/penalization of providers.
- Developing and implementing systems monitoring the quality of services and client satisfaction.

RESOURCES

- Effectively detecting and correlating budgetary and extra-budgetary financing sources, depending on the needs of the community. Formatted: Bullets and Numbering
- Decentralized financing and providing the possibility to reallocate existing funds depending on local specificities.
- Increasing financial allocations by increasing the rate of funds allocated to primary health care in general and to family planning in particular.

SAFE ABORTION AND PREGNANCY TERMINATION SERVICES

REFORM OF THE HEALTHCARE SYSTEM AND OF THE LEGAL AND NORMATIVE FRAMEWORK

- Maintaining legal access to safe pregnancy termination services. Formatted: Bullets and Numbering

ACCESSIBILITY AND QUALITY OF SERVICES

- Increasing the quality of pregnancy termination services in accordance with evidence-based principles. Formatted: Bullets and Numbering
- Introducing new and safer technologies in pregnancy termination services, such as vacuum aspiration or medical abortion.

HEALTH CARE SERVICE PROVIDER TRAINING

- Training pregnancy termination service providers in how to use new, safe techniques and how to provide post abortion care and contraception, in the spirit of medical best practices. Formatted: Bullets and Numbering

BEHAVIOR CHANGE CAMPAIGNS (BCC)

- Conducting public campaigns focusing on the risks of abortion and motivating women to orient towards modern contraception. Formatted: Bullets and Numbering

Research, Monitoring and Assessment

- Improving the quality of reports on the number of pregnancy terminations performed in the public, private and non-governmental sectors.
- Conducting regular population surveys on abortion and abortion-related problems.

Resources

- Clearing up the issues of pregnancy termination service financing.

Safe Motherhood – Pre-Natal Care, Birth Assistance, and New Born Care, Post-Natal Care and Breast Feeding

Reform of the Healthcare System and of the Legal and Normative Framework

- Bringing the number and content of pre and post natal visits to the level required by evidence-based needs.
- Collaboration between institutions and between various levels of perinatal care.
- Developing the needed normative framework establishing responsibilities of each type of medical staff in obstetrical and perinatal care.

Accessibility and quality of services

- Defining, implementing and monitoring good practice standards.
- Using WHO principles to standardize procedures.
- Implementing the professional analysis system in the case of peri and neo natal maternal mortality and morbidity.
- Ensuring that state-of-the art equipment is available and sensibly used in neo natal care/

Health Care Service Provider Training

- Identifying the advanced training needs of the medical staff.
- Improving continual education of the medical staff at all levels, including those in primary health care, in the spirit of the best medical practices.

Behavior Change Campaigns (BCC)

- Conducting BCC activities on pregnant women's health.
- Promoting a healthy life style among pregnant women.
- Promoting breast feeding and educating the population on that matter.
- Providing specific information to vulnerable groups (teenagers, minorities, etc) in the field of safe motherhood.
- Increasing the involvement of the media in BCC campaigns.

Equal Opportunities for Men and Women

- Ensuring sufficient maternity leave or paternity leave as an alternative.
- Protecting pregnant women against work accidents.
- Preventing school abandonment by young mothers.
- Involving both partners in pre and post natal care.

Research, Monitoring and Assessment

- Adopting and implementing internationally accepted definitions and classifications in the field of safe motherhood.
- Developing and implementing a valid national information system to monitor the progress made in ensuring safe motherhood.
- Monitoring the main pathology causes in pregnant women.

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Resources

- Priority financing for mother and child health as part of the health care reform.
- Ensuring that the needed funds to rehabilitate maternities are reallocated.

Prevention and Management of Sexually Transmitted Infections (STIs) and HIV/AIDS Infection

Reform of the Healthcare System and of the Legal and Normative Framework

- Reducing institutional separation between STI diagnosis and treatment.
- If possible and feasible, replacing STI patient hospitalization with out-patient or home treatment.
- Integrating STI/HIV in SRH services.
- Removing legal barriers in the way of integrating STIs into primary health care.
- Legal acts on STI/HIV/AIDS must observe clients rights (confidentiality, anonymity, partner notification).

Accessibility and quality of services

- Using evidence-based health care principles as a basis for STI and HIV/AIDS patients diagnosis and management.
- Introducing evidence-based practice guides in all types of health care.
- Introducing patient-oriented services and observing confidentiality.
- Implementing confidential diagnosis and partner notification systems.
- Implementing practice guides on the protection of fetuses and new born babies against STIs/HIV.

Health Care Service Provider Training

- Improving continual education of the medical staff on the latest medical developments in the fields of STIs/HIV.
- Adequate training on STI/HIV cases management.
- Providing adequate interdisciplinary training to medical staff on counseling and behavior change.
- Interdisciplinary training of family physicians, obstetricians and gynecologists, dermatologists, and others.

Behavior Change Campaigns (BCC)

- Using the media to raise public awareness on STI/HIV risks.
- Encouraging the population to take responsibility of their own and their sexual partners' protection.
- Getting target groups involved in BCC activities.
- Paying special attention to groups at risk (prostitutes, homosexuals, prisoners).
- Educating both members of a couple on STI/HIV prevention.

Equal Opportunities for Men and Women

- Promoting STI/HIV protection (condom use) among both women and men.
- Emphasizing male responsibility in all prevention areas.
- Paying special attention to abused women, who might have been infected.
- Encouraging prostitutes to refuse sexual contact without use of condom.

Research, Monitoring and Assessment

- Adopting and implementing internationally accepted definitions and classifications in the field of STIs/HIV.
- Developing and implementing a valid national information system to monitor the progress made in controlling STIs/HIV/AIDS.
- Registering and control of STI/HIV cases by all service providers (including those in the private sector).

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Teenager and Youth Sexual and Reproductive Health

Reform of the Healthcare System and of the Legal and Normative Framework

- Getting young people actively involved in organizing and implementing SRH activities for the youth.
- Integrating SRH activities in comprehensive social and health programs meant for the youth.
- Creating partnerships between the government and NGOs to cover the SRH needs of teenagers.

Accessibility and quality of services

- Setting up specialized centers providing information and services.
- Creating an attractive atmosphere for the youth in facilities providing SRH services.
- Offering confidential and empathic counseling, that responds to the needs of the youth.

Health Care Service Provider Training

- Training the medical and education staff on the SRH needs of teenagers.
- Initiating parent education on how to guide the sexual development of the young.
- Training young media professionals to effectively address the SRH needs of the young.
- Supporting the sexual and reproductive rights of the young.

Behavior Change Campaigns (BCC)

- Generalizing sexual education in or out of school, by using interactive methods, initiated before the young become sexually active.
- Focusing SRH education on knowledge, values and generating (interaction-oriented) attitudes.
- Drafting and distributing BCC materials on SRH specific to various age groups.
- Increasing the involvement of the media in BCC campaigns.
- Using the Internet creatively, when providing SRH information to the young.

Equal Opportunities for Men and Women

- Including sex-related problems in BCC activities targeting the young.
- When educating girls, the focus should be on strengthening self-confidence and negotiation and decision-making skills.
- Developing education activities for boys, focusing on their needs and responsibilities.

Research, Monitoring and Assessment

- Improving monitoring and national statistics on teenage pregnancy, abortion and STI incidence.
- Initiating high-quality research on the sexual behavior and perceptions of the young (boys and girls) and using the results to develop and improve services and BCC campaigns targeting the young.

The Sexual Health of the Elderly

Reform of the Healthcare System and of the Legal and Normative Framework

- Facilitating access to low-income persons to hormone substitution treatment or other treatment specific to the elderly.

Accessibility and quality of services

- Providing specific services focusing on the special sexual health needs of the elderly.
- Improving all services in such a way as to meet the needs of the elderly.

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HEALTH CARE SERVICE PROVIDER TRAINING

- Including topics related to the effects of age on sexual health in the medical university curriculum.
- Updating the medical staff on menopause-related issues.
- Training family physicians in providing empathic sexual health counseling to the elderly.
- Training family [physicians in examining men for prostate pathology.

BEHAVIOR CHANGE CAMPAIGNS (BCC)

- Informing and educating men and women on the effects of old age on sexual health and on the possibility of preventing menopause-related conditions.
- Educating women on menopause symptoms.

EQUAL OPPORTUNITIES FOR MEN AND WOMEN

- Addressing the needs of both old men and women in sexual health programs.

RESEARCH, MONITORING AND ASSESSMENT

- Conducting research on the consequence of old age on sexual health and on the effectiveness of prevention measures.
- Using the research findings to improve the quality of sexual health care for the elderly.

EARLY DETECTION AND MANAGEMENT OF GENITAL AND BREAST CANCER

REFORM OF THE HEALTHCARE SYSTEM AND OF THE LEGAL AND NORMATIVE FRAMEWORK

- Developing a strategy for the early detection of genital and breast cancers.
- Developing a system for cervical cancer screening.

ACCESSIBILITY AND QUALITY OF SERVICES

- Regular cytology and mammography for women at high risk.
- Defining and implementing guides and methodologies on early diagnosis and treatment of genital and breast cancer.
- Providing psychological support to genital and breast cancer patients.

HEALTH CARE SERVICE PROVIDER TRAINING

- Training family physicians in genital and breast cancer diagnosis.
- Training the medical staff in empathic counseling on the impact that genital and breast cancer has on sexual health.
- Training family physicians in cervical cancer diagnosis.
- Training cytologists in cervical cancer diagnosis.

BEHAVIOR CHANGE CAMPAIGNS (BCC)

- Informing and educating women on genital and breast cancer.
- Initiating or enforcing education activities that teach women about self-examination.

EQUAL OPPORTUNITIES FOR MEN AND WOMEN

- Training men on how to help their partner if she has genital or breast cancer.

RESEARCH, MONITORING AND ASSESSMENT

- Improving the national genital and breast cancer registration system.
- Systematically using monitoring with a view to improving screening and case management programs.

INFERTILITY PREVENTION AND MANAGEMENT

REFORM OF THE HEALTHCARE SYSTEM AND OF THE LEGAL AND NORMATIVE FRAMEWORK

- Facilitating access of low income persons to infertility treatment.

ACCESSIBILITY AND QUALITY OF SERVICES

- Defining standard medical practice guides and protocols for the management of infertility at various levels.
- Ensuring high quality services in the field of infertility.

HEALTH CARE SERVICE PROVIDER TRAINING

- Training the medical staff in providing high-quality services in the field of infertility.

BEHAVIOR CHANGE CAMPAIGNS (BCC)

- Implementing BCC campaigns that motivate the groups of population with needs in the field of infertility to go to specialized facilities.

EQUAL OPPORTUNITIES FOR MEN AND WOMEN

- Ensuring the availability services that equally cover the needs of women and men in the field of infertility.

RESEARCH, MONITORING AND ASSESSMENT

- Conducting surveys to assess the infertility phenomenon among the public at large.
- Using the results of the survey to plan and provide high-quality services in the field of infertility and to monitor the phenomenon at the level of the general population.

THE PREVENTION AND MANAGEMENT OF DOMESTIC VIOLENCE AND SEXUAL ABUSE

REFORM OF THE HEALTHCARE SYSTEM AND OF THE LEGAL AND NORMATIVE FRAMEWORK

- Reviewing the legislation on the prevention and protection of violence and sexual abuse victims, as well as on the social reintegration of the perpetrators.
- Ensuring proper coordination between all institutions and activities for preventing, monitoring and combating domestic violence and sexual abuse.

ACCESSIBILITY AND QUALITY OF SERVICES

- Raising healthcare provider's awareness, so that they may recognize possible victims.
- Providing counseling and therapeutic support as well as safe shelter to the victims of domestic violence and sexual abuse.
- Developing practice guides for proper and empathic medical and legal management of psychological abuse cases.
- Creating a network of specialized center providing counseling and/or shelter.

HEALTH CARE SERVICE PROVIDER TRAINING

- Providing special training in the counseling of domestic violence and sexual abuse victims, to the medical and non-medical staff in health care facilities.

BEHAVIOR CHANGE CAMPAIGNS (BCC)

- Increasing public awareness on issues related to domestic violence and sexual abuse.
- Informing and educating the population on how to avoid sexual abuse.
- Informing the population on facilities where they can receive help in case of abuse.

EQUAL OPPORTUNITIES FOR MEN AND WOMEN

- Ensuring an emphatic approach of domestic violence and sexual abuse victims.

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RESEARCH, MONITORING AND ASSESSMENT

- Creating databases on the domestic violence and sexual abuse phenomena.
- Including issues related to domestic violence and sexual abuse in SRH surveys.
- Using the results of research and of domestic violence and sexual abuse monitoring activities to raise awareness on the incidence of such cases, on prevention and case management.

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