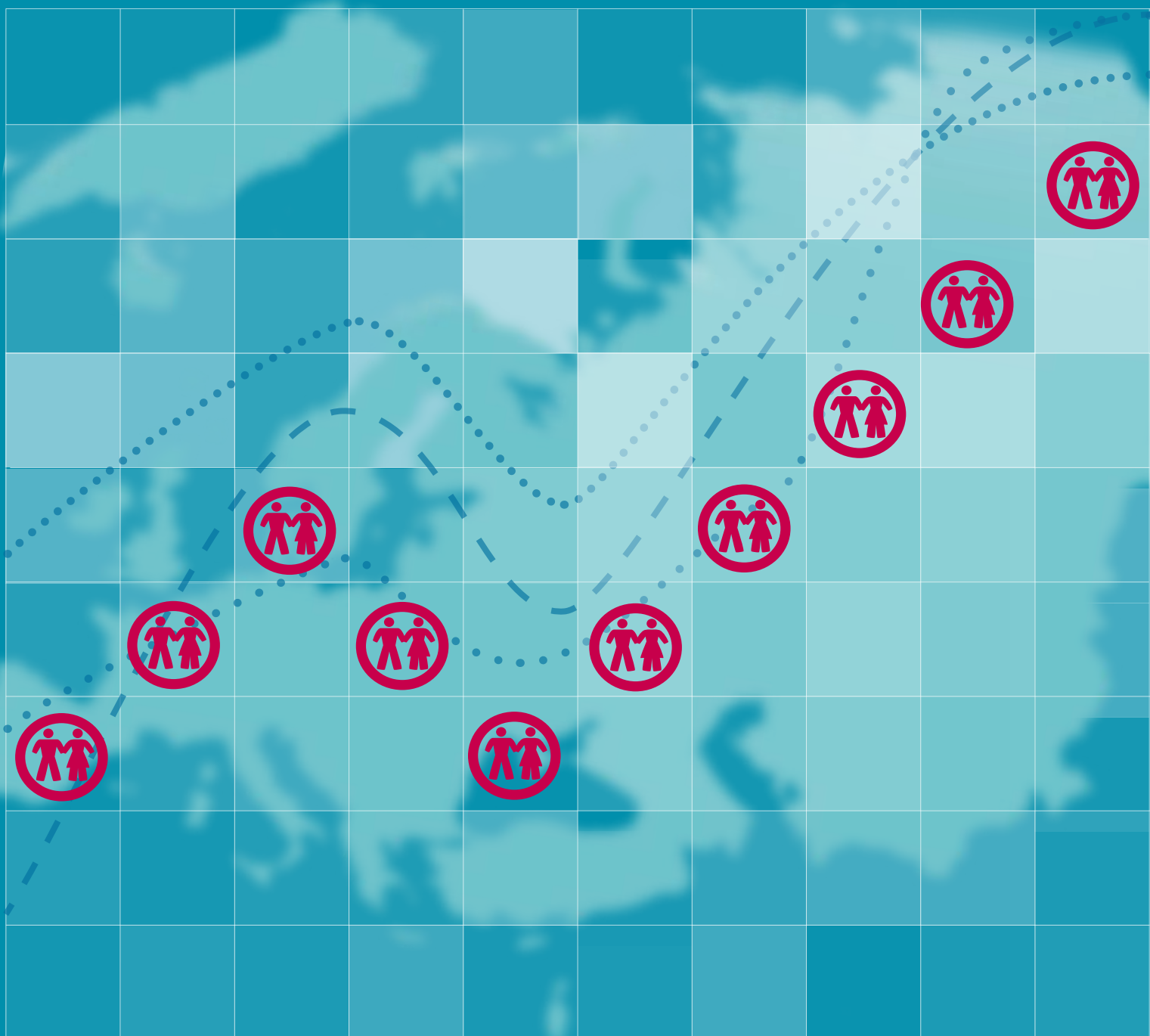


IMPROVING SEXUAL AND REPRODUCTIVE HEALTH THROUGH STRENGTHENING HEALTH SYSTEMS



Entre Nous

THE EUROPEAN MAGAZINE FOR SEXUAL AND REPRODUCTIVE HEALTH



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This issue of *Entre Nous* looks at sexual and reproductive health (SRH) and in particular to its relationships with health systems. In this editorial several perspectives of SRH are offered, each revealing important issues and challenges.

The first perspective relates to mobilizing resources (public and private, personal services, population services, inter-sectoral actions-related, governmental and non-governmental) in favor of SRH. Achieving the desired results will only come if we manage to motivate and mobilize everybody in the common effort for health. There remains a lack of information on the roles/impact of private and non-governmental sectors on SRH in many countries; SRH policies and even health system reforms are sometimes developed without proper dialogue with stakeholders, with little awareness on what impact (positive or negative) they may have on SRH. Indeed SRH is about more than doctors, nurses and pills and more than the governmental sector alone. Health has to be a top priority in the European Region for governments, parliaments and for professional organizations, but also for citizens and social institutions of all kinds.

Secondly, if we want to see improvements in SRH we also need to address the social, environmental and economic determinants of SRH. Social status has an impact on SRH and the relationship between health and wealth is particularly strong in this area. Improvements in the education of girls and women are strongly related with health gain all over the world. Poverty and low education are linked to high risk sexual behavior, often putting individuals at risk of unplanned or unwanted pregnancy, sexually trans-

mitted infections and HIV/AIDS, and all sorts of other problems. Poor reproductive health results in loss of income generation and economic productivity to both the individual and society.

Finally, health care matters a lot. Equitable access to quality and safe care are critical goals for every country. There is a strong correlation between the ratio of health workers to population and the survival of women in childbirth and infants; the greater the decrease in the ratio of health workers, the greater the decrease in survival. Migration of health workers dissatisfied with unfair workload, underpayment and poor vision have been shown to have a direct negative impact on health outcomes. Poor management and governance of the health system also hurts the health of the population and weak health systems hinder the scaling up of effective interventions. Additionally organization of health systems may impact differently on the health of men and women, often to the disadvantage of women and their SRH. That is why we need professional guidelines and motivation, robust strategies and regulatory bodies, good management of health facilities and other similar actions.

The WHO Regional Office for Europe is committed to support Member States in the challenging and complex process of developing their own health systems and public health policies in general, as well as, the achievement of SRH and the Millennium Development Goals in particular. The European SRH Strategy produced in 2001 aims at helping governments prioritize and develop national SRH strategies. It calls for improved access to quality reproductive health services; supports the development and integration of Youth Friendly Health Services in many countries; asks for building health sector capacity through training and partnerships towards increasing access to essential medicines; praises the work of SRH WHO Collaborating Centres that produce research strengthening evidence based medicine and guidelines; and promotes dialogue between stakeholders.

However serious challenges remain. Several eastern European and central Asian countries have undergone a painful economic transition that at times weakened their health systems, often with serious negative effects on SRH (high rates of maternal death, lack of access to contraception, unsafe abortion, STI's and HIV/AIDS). Many of the consequences of such problems are still felt in various Member States and their impact may become even greater in light of the ongoing economic crisis. Everybody's help and support is needed.

*This issue of *Entre Nous* highlights the efforts being made throughout the Region in the field of health systems as we work towards the primary goal of better SRH for all. I am sure you will enjoy its content and thank you for your contribution to better health and better health systems in Europe.*

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The June 2008 Tallinn Conference on Health Systems, Health and Wealth defined health systems as, "the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health within the political and institutional framework of each country, encompassing both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health".

HEALTH SYSTEMS AND WEALTH GENERATION: THE ROLE OF REPRODUCTIVE HEALTH

The WHO European Ministerial Conference on “Health Systems, Health and Wealth” held in Tallinn in June 2008 was a watershed event that took stock of and consolidated the recent conceptual and methodological developments, as well as, practice-based innovations in the European health arena. The upshot of the conference was that not only does health matter - we knew that already because we in Europe value health in its own right - but also good health contributes to wealth generation. The conference also argued that health systems contribute to the generation of wealth, since in almost any society, albeit at varying degrees, the health sector constitutes one of the major spheres of economic activities, producing, consuming and trading goods and services, and contributing to knowledge and technology generation through research and development.

In this article, I intend to focus on wealth generation for two reasons. First, many policy makers, politicians, managers, practitioners, tax payers and citizens still believe that the health system is a consumer of limited societal resources, and as such its costs need to be contained. Obviously, if a health system is designed to merely consume health care rather than to produce health, one could argue that some of the societal resources which otherwise are set aside for healthcare could be better used to provide more and better education, nutrition or infrastructure. However, such reasoning would, in my opinion, be flawed for two reasons: (i) if there are inherent inefficiencies and wastage in the health system, so would there be in others, be it education or infrastructure, for a weak governance structure is likely to be weak across all sectors, not only in health; and (ii) there is firm evidence that the higher performing the health systems are the more likely they are producing health. What matters at the end is for a society to have the appropriate governance structure, leadership and the ways and means to collectively decide how best to invest part of their wealth and use their resources in order to get the best value for their overall welfare and social wellbeing. In other words, constantly seeking the elusive equilibrium to optimize the allocation of their resources across and within vari-

ous sectors including health (allocative efficiency), and thereafter using them to produce appropriate volume, mix and quality of services to meet most of the health needs of the population (technical efficiency). This is easier said than done, thus a real challenge for all health practitioners regardless of their discipline.

The second reason, hopefully more relevant to the *Entre Nous* audience, is that I believe that the association between reproductive health and wealth is more tangible, especially in low and middle income countries, and thus is worthy of further reflection from us all. I think it is so, mainly because the span of the reproductive age bracket covers a large portion of the economically productive years of life, and those immediately preceding formative years conducive to wealth generation. Equally important is that almost all reproductive health conditions are either avoidable through primary prevention, or amenable to (cost) effective interventions which, if performed adequately, would reduce prevalence by virtue of reducing incidence and/or shortening the duration of the episode of illness, cutting off transmission rate and thus decreasing overall direct and indirect costs to the society. Obviously, the bigger the extent of the burden of reproductive illness that a high performing health system would be amenable to reduce, as in most low and middle income countries, the greater

the aggregate wealth effect.

This brings us to the issue of performance. If the ultimate objective of any health system is to improve health and to do so in an equitable and responsive manner with minimal financial hardship to those concerned then we should be serious about measuring it properly using performance indicators which have well-documented face, content and predictive validity. In the case of reproductive health proper, the targets set to gauge progress towards the achievement of the Millennium Development Goal 5 would be a good starting point, to be complemented with those covering other aspects of reproductive health. The real issue here though is to find a comprehensive set of indicators which would not only measure impact, but also give us a sense of assurance regarding its long term sustainability by measuring to what extent the health system would be able to sustain if not improve on the achievements, once the heightened attention subsides and the external funding dwindles. These would undoubtedly be related to health system and its four core functions, namely stewardship/governance, financing, resource generation and service delivery, albeit tailored to the specificities of reproductive health. Three areas, possibly among many others, would, in my opinion, stand out deserving emphasis and further action without getting into the superflu-



ous debate on the vertical vs. horizontal approaches, or disease/risk factor specific vs. integrated organizational and service delivery models:

- (i) the need to set up benchmarks, and estimate and track expenditures for reproductive health, both private and public, either through national sub-account studies or expenditure tracking surveys to monitor whether or not reproductive health services are financed as well as they should be and do actually receive funding at the service endpoints;
- (ii) the need to develop, pilot and scale up standard treatment protocols for the whole gamut of reproductive health services along with the financial and non-financial incentive schemes tailored to the needs and preferences of all levels of health care workers involved; and
- (iii) the need to beef up the information system in a way to capture user preferences and satisfaction through various surveys either at service points or periodically at the population level.

We, in WHO, are not only determined to scale up our efforts to improve reproductive health through strengthening health systems but also properly document its potentially huge beneficial impact on societal well being.

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To read the Tallinn Charter in full visit the following address:
http://www.euro.who.int/AboutWHO/Policy/20010825_2

THE TALLINN CHARTER:

The Charter, signed in Tallinn, Estonia on June 27 2008, signifies the commitment of the WHO Regional Office for Europe and its Member States towards strengthening health systems and improving health within the Region. The underlying principles on which the charter was drafted are below:

Preamble

1. The purpose of this Charter is to commit Member States of the World Health Organization (WHO) in the European Region to improving people's health by strengthening health systems, while acknowledging social, cultural and economic diversity across the Region. The Tallinn Charter reaffirms and adopts the values embodied in earlier charters, conventions and declarations.
2. Within the political and institutional frameworks of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence policies and actions of other sectors to address the social, environmental and economic determinants of health.
3. All countries in the WHO European Region have to address major health challenges in the context of demographic and epidemiological change, widening socioeconomic disparities, limited resources, technological development and rising expectations.
4. Beyond its intrinsic value, improved health contributes to social well-being through its impact on economic development, competitiveness and productivity. High performing health systems contribute to economic development and wealth.
5. Therefore we, the Member States and partners, believe that:
 - investing in health is investing in human development, social well being and wealth;
 - today it is unacceptable that people become poor as a result of ill health;
 - health systems are more than health care and include disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies;
 - well-functioning health systems are essential to improving health: strengthened health systems save lives; therefore
 - health systems need to demonstrate good performance.

In addition the Charter declares and outlines the Member States commitment to act through stewardship, delivery of services, creation of resources and appropriate health system financing. To view the Charter in full please visit: <http://www.euro.who.int/document/E91438.pdf>

IMPROVING FAMILY AND COMMUNITY HEALTH BY STRENGTHENING HEALTH SYSTEMS

The WHO Regional Office for Europe has been promoting family and community health (FCH) interventions since 1992, including biennial meetings for FCH focal points in Member States. Our FCH activities follow a holistic approach, focusing on the health and development of individuals and families across the life course. For sexual and reproductive health (SRH) this means focusing on overall SRH, health of mothers and newborns, children and adolescents, as well as healthy aging.

In recent years, the contribution of health systems to improve health has been re-evaluated in many countries. The WHO European Ministerial Conference on Health Systems “Health Systems, Health and Wealth” in Tallinn, June 2008 has discussed the impact of people’s health and economic growth, and has taken stock of recent evidence on effective strategies to improve the performance of health systems.

In line with these developments, the WHO Regional Office for Europe held the FCH focal points meeting in Malta, September 2008 with the aim of contributing to the improvement of FCH in a health systems framework.

The specific objectives of the meeting were:

- To identify challenges and opportunities for Ministries of Health on the implementation of FCH policies and the involvement of other sectors, based on country experiences
- To present and discuss new tools and strategic approaches on improving quality of health care services
- To highlight the relevance of addressing equity in FCH programmes by integrating social determinants of health

In order to achieve these objectives the discussions were structured around country presentations, technical briefings/presentations in plenary and group work. This included detailed presentations and discussions on the WHO global, regional strategic documents (1, 2, 3) and stewardship at the national level, best practices

and lessons learnt on how family and community health policy documents were developed and implemented within the health reform process in individual countries, and recommendations for future work in this area. The diversity of quality of sexual and reproductive, maternal, child and adolescent health care services within the Region was presented using the process and outcome indicators developed by WHO in assisting Member States to evaluate and monitor health care services and find the best ways for quality improvement (4).

The main recommendations of the meeting were:

Stewardship

1. All countries are encouraged to develop FCH strategies and budgeted plans of action that ensure evidence based policies and maximize political will and funding.
2. Awareness should be increased of the lifelong importance for health and wellbeing, of secure attachment in the very early years of life. Psychological mechanisms such as child attachment to a parent figure and emotional security create biological changes that affect the way children respond to stress and make them vulnerable throughout life. Investment in the early years provided one of the greatest potentials to reduce health inequities within a generation.
3. On the basis of the evidence, provision of safe and nurturing environments for children should be part of health policies aimed at reducing the risk of heart disease, cancer and other diseases in adulthood.
4. Reducing health inequities should be one of the indicators of the health system performance. Health equity is more than access; it also involves treatment, outcome and cost.
5. A human rights based approach should be seen as an opportunity to address health determinants in strategic planning, implementation and evaluation of FCH interventions. More support is needed from WHO

on the practical application of this approach.

6. Gender perspectives should be integrated into FCH programmes, policies, interventions and research, with the participation of women and men on equal terms. Gender analysis provides evidence of the impacts of gender inequality and helps to understand and address gaps in services and to develop policies that address them. Measures that involve men and boys taking responsibility for gender equality in reproductive health should be supported.
7. Continuing investment in geographic, age and sex disaggregated data collection and research provides evidence for good policymaking. Data should be shared between sectors.
8. As holistic change takes time, interventions should be designed into a national context responding to locally identified priorities.
9. WHO should advise on how to strengthen the capacity of professional associations and their participation in decision-making.
10. Partnerships within countries should be enhanced with United Nations and other international organizations who have committed to contribute to the MDGs on mother and child health, including reproductive health.
11. Policy change and action should be monitored using metrics that have been agreed across the sectors by multi stakeholders, to maximize understanding, motivation and ownership.
12. Cross-sectoral partnerships should be in place from the beginning with structures/committees that monitor implementation of FCH strategies.
13. Countries should ensure that services and supportive intersectoral policies are in place to meet young people’s health and development needs. Investing in young people is very cost effective in obtaining good life practises in adulthood.



**Gunta
Lazdane**

Financing

14. FCH services should be adequately funded. National health accounts should be more transparent and explicit on funds allocated for FCH services.
15. Comprehensive costing tools should be used and WHO should assist countries in their implementation.
16. When fees are collected, these should be adapted to the ability to pay

Service delivery

17. The integration of reproductive, maternal, child and adolescent health services into primary health care should be strengthened and accompanied by a good referral system.
18. All countries should provide a basic package of good quality services in FCH, free of charge.
19. In the primary health care setting, counselling should be made available to enhance the well being of each individual.
20. Further steps are needed to demedicalize FCH services and make them client friendly, age appropriate, and client centered, with respect for the clients rights.
21. Services should be designed to recognize diversity and reach the client by the most effective route, including outreach or home visiting.
22. WHO should continue to provide assistance on improving and monitoring quality of care. It is necessary to agree on standards, define methods and tools for assessing quality of care without punitive approach.
23. A warm and supportive environment is essential for quality care. Fear seriously hampers the delivery and birth process: women, families and communities should be empowered through access to information and participation.
24. Training is essential to ensure the efficient collection and analysis of information and this should be strengthened at the primary care facility level.
25. Efforts should be supported to make

abortion available, safe and legal for all women.

26. Health care professionals and health systems should reduce inequitable access to health care for refugees, asylum seekers and undocumented migrants, with special attention paid to reaching vulnerable groups such as women and children and young people with high quality information and services.
27. Gender and health should be incorporated into FCH clinical audits and other efforts to monitor and improve quality.
28. Investment should be made in services, including anticipatory services, which treat individuals with dignity and help them change the way they feel about their lives, and their ability to make decisions.
29. School health services should be strengthened. They are often overlooked by health system reforms and new financial mechanisms. They have an important contribution to make to child and adolescent health.
30. When it is not possible for a child to grow up in his or her biological family, a substitute or surrogate family should be provided, as foster or kinship care, and the practice of institutional residential care should be eliminated over time. All families require support services in the home.

Resource generation

31. Medical curricula should be revised to ensure they reflect current best practice and evidence, including gender perspectives. Training for FCH professionals at all levels of the health system should develop their capacities to understand and apply gender perspectives in their work.
32. Quality of care issues should form part of regular, up to date, in-service training programmes for health care providers.
33. Ensure the right skill mix of the work force in FCH services in primary health and promote the value of primary health care workers.

34. Extensive modules on professional attitudes and on communication skills should be incorporated into the WHO Effective Perinatal Care training, to include client centered and rights based approach, team work and supervision not based on punishment, listening, breaking bad news etc.
35. WHO certification of family friendly hospitals should be introduced, similar to baby friendly hospitals, where staff have undergone the training above and implemented it at all levels in the hospital.

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Full report of the meeting:
<http://www.euro.who.int/reproductive-health>

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QUALITY – AN ESSENTIAL DIMENSION OF SEXUAL AND REPRODUCTIVE HEALTH SERVICES

The availability of effective sexual and reproductive health services (SRHS) has major implications on health in the European context. Low natural growth, epidemiological challenges generated often by sexually transmitted infections, increasing cross-border movement and inequalities in quality standards and safety requirements in health services all impact the SRH of populations in the Region.

Integration of health system functions is critical to efficiently address the evolving issue of SRH at national level, and to ponder system's capacity for delivery with the fluctuating clinical demand and public expectations. In the national context, the main challenge lies in the interventions of choice and in the degree to which these are prioritized, linked and disseminated, in terms of value, resources and policies.

What is quality?

A range of studies and current practice show that the various meanings given to quality lead to different interventions. The 'fitness for purpose' basic definition applied at health service level will direct towards service integration. Combining and coordinating separate services is expected to increase efficiency and access to patient quality care throughout and beyond the illness episode. This places increased emphasis on health promotion and family medicine, as part of the prevention and early diagnosis strategies.

Information, education and communication across the system and the various stakeholders involved are omnipres-

EU Countries	Legislation/ policies on quality of care
Bulgaria, Cyprus, Estonia, Greece, Hungary, Malta, Luxembourg, Latvia, Poland, Portugal, Romania, Slovakia	No enacted legislation on quality of care or dedicated national policies <ul style="list-style-type: none"> • quality initiatives in place • local and institutional level • limited degree of national action
Czech Republic, Lithuania, Slovenia, Ireland, Norway	Recently enacted legislation/ implemented policies on quality of care
Austria, Belgium, Denmark France, Finland, Germany, Italy, Netherlands, Spain, Sweden, UK/England	Long tradition of enacted legislation/ implemented policies on quality of care (some of which currently undergo major systemic reforms)

Figure 1. Comparative advantages of outcome and process indicators (4-6).

Type of indicators	Advantages	Disadvantages
Outcome	More visible, more meaningful Patient centred Encourages long term strategies for long term benefits Encourages innovation in improved modes of service delivery Less exposed to manipulation	Sometimes relative objectivity, due to complex processes <ul style="list-style-type: none"> • multiple contributing factors • unclear delineation of input • distant occurrence in time Large sample size Long period of time
Process	Easy measurement Easy interpretation Small sample size Use of stored data (unobtrusive) Indicates where and what action needs to be taken Can bring in patients' voice	Specific (e.g. single intervention, single disease) Needs constant revision to keep pace with health technology development (dated or obsolete) Requires technical explanations when presented to patient/ consumer Easily manipulated

Figure 2. Advantages and disadvantages of quality indicators (4-6).

ent when successful development and implementation of quality interventions (starting with historical models, such as Deming's cycle, Juran's total quality management, or Ishikawa's fishbone diagram) are considered.

Organization of resources in the most effective ways to meet health needs safely, without waste and within legal and regulatory requirements is service quality, aimed to enhance population health (1).

Why is measuring quality important?

Quality improvement is a continuous and living process, requiring permanent adjustments to a constantly evolving environment. A dedicated strategic framework tailored to national and/or local specifics, will provide guidance and support to planned and/ or deployed interventions and resource use.

Research shows that despite the existence of national policies targeting quality and safety issues in the Region, these do not appear to be coordinated under a single framework and their degree of implementation is not always clearly demonstrated (2). Furthermore, the cultural diversity also reflects in the different ways quality of health care services is regulated, institutionalized and measured (see figure 1).

Measuring quality will document progress and needs, and orient chosen approaches for change to bridge the gaps between policy and practice.

To do so, available and accessible data is needed. Information reflecting the complexity of the system should be collected through organized processes at different levels (institutional, local, or national registers). Its relevance is then linked directly to the type of indicators



and critical points of measure that have been selected for this purpose.

In addition, the quality and safety culture requires broad commitment from both the organization and the community. That is why documenting progress or failure will enhance adherence to the process and provide incentives to change. Public perception and involvement (recipients and generators of information) plays a key role in driving for change.

In their complexity, SRHS are providing for the population at large, irrespective of age and sex. Subsequently, the type of services will be vastly diverse and target group tailored, all working to contribute to better coverage, better information, better care, and towards the highest attainable level of health. Measuring ways in which these reach their aims is expected to support institutionalization of improvement work, and ultimately revitalize value based competition.

How can this be done?

Information is an essential tool for raising awareness, building understanding and generating action. Collecting the right information needs not only defining easy to monitor and use measurement tools, but also adjusting the process of data pooling to its intended use (who is it for and what is it for).

Measurement can be done in different ways, looking at quality systems and how they complement in reaching system quality.

Defining quality indicators and measurement tools is part of the cycle of continuous improvement (including evaluation and adjustment) of the system. Most publicly known indicators often target disease, and specific interventions known to impact on quality adjusted life years and mortality rates. However the 'metrics' of quality improvement are very diverse (see figure 2).

The indicators largely used are related to the quality processes (how things are done, including compliance with standards, clinical pathways etc), and to the outcomes (e.g. increased coverage, reduced mortality etc) of the quality

process(es). Composite indicators have been equally developed, in the search of finding increasingly accurate and motivating ways of measuring performance (e.g. clinical comparative indicators for practitioner evaluation and benchmarking, hospital performance indicators for service evaluation and benchmarking). However the limitations related to each category need to be considered when the choice of interpretable metric is performed.

Various local, national and international initiatives have been working on defining the best indicators to monitor quality of care (AHRQ, OECD, WHO etc). The challenges remain related to finding the most accurate way to capture performance in various circumstances, and on the background of evolving technologies and changing patterns of disease.

There are some recognized desirable attributes for quality measures, which relate to the professional consensus in their choice, and the explicit inclusion of latest available evidence (face and content validity). In addition, these should be communicable, acceptable, reproducible, objective, available, contextual, reliable, comparable, remediable and sensitive to change (4). The predictive validity of indicators is also considered by some authors (6), and remains linked to its contextual feasibility.

The calculation of costs involved in quality failures, seldom available, can also contribute to providing the required evidence for a strengthened drive towards quality and safety interventions, and actual translation of existing political and professional commitment into practice. When addressing quality of health care services in general, and quality of SRHS in this particular case, there is no easy answer on the best way forward. It is about finding and using best evidence available, monitoring outcomes and adjusting strategies and interventions to overcome failures identified. These require knowledge, resources and leadership, but also coordination, communication and team work within, between and beyond services for health prevention and care.

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WOMEN'S HEALTH AND GOVERNANCE: LESSONS FOR STRENGTHENING HEALTH SYSTEMS

Investing in strengthening health systems is paramount to improve the performance of health systems and attain the Millennium Development Goals (MDGs) (1), particularly those related to sexual and reproductive health. According to the Director General of the World Health Organization Dr Margaret Chan, in order to “achieve the MDGs related to sexual and reproductive health, the need for a well-functioning and equitable health system, with access to sexual and reproductive health services is absolute” (2).

Recent evidence has shown that good governance correlates with good health outcomes such as the reduction of infant mortality (3), demonstrating that some of the measures required to strengthen health systems pertain to improving their governance (4), as was also recently outlined in the Tallinn Charter on Health, Health Systems and Wealth.

Governance is defined by the World Health Organization as “the exercise of political, economic and administrative authority in the management of a country’s affairs at all levels” (5) and is anchored in values such as health as a human right, solidarity, equity in access and outcomes and participation in decision-making (6). An increasing number of governance practices related to women’s health comprise interesting features which could be extended to broader populations and health systems, especially with regard to the involvement of women through mechanisms such as voice, choice and representation. This paper reviews a number of good governance practices related to women’s health and discusses a number of useful lessons for strengthening health systems.

Public participation: voice, choice and representation

Public participation is a major characteristic of good governance and its importance has been stressed by the World Health Organization. In the Amsterdam Declaration on the Promotion of Patients’ Rights in Europe it is emphasized that “patients have a collective right to some form of representation at each level of the

Mechanisms	Definition	Examples
Voice	Voice mechanisms allow for the articulation at collective or group level revealing views of certain groups of service users or of general public views on health policy concerns.	Consultation (e.g. citizens’ juries and panels, patient surveys, consensus conferences, round tables, focus groups, national health fora)
		Advocacy groups (consumer and patient/self-aid groups or organizations at general or disease-specific level)
		Complaint mechanisms (ombudsperson, complaint offices)
Choice	Choice applies to individual decisions in the selection of health and care insurance, providers and treatment. “Exercising choice requires that people have the capability and information to select from different options.”	Personal choice of e.g. insurance, payment or budget, hospital, physician or other therapist in health care and long-term-care
		Patient information on e.g. health and diseases, patients’ rights, health systems, service options, performance measurement and outcomes
Representation	Representation is usually at system-wide level and implies a formal, regulated and often- obligatory ongoing role in the process of health systems governance.	Representatives of consumer or patient organizations or health councils on decision-making or advisory boards in e.g. hospitals, ethics committees, quality circles, health insurance funds and joint commissions
		Consumer centres, health councils

Table 1: Definition and examples of participation mechanisms in decision-making (8,9)

health care system in matters pertaining to the planning and evaluation of services, including the range, quality and functioning of the care provided” (7). The Council of Europe’s Committee of Ministers has also recommended a central role for citizens in the decision-making process affecting health care.

Table 1 attempts to define and provide examples of the diversity of current participation mechanisms in Europe.

Good governance examples related to women’s health

Voice

In Canada, the Ontario Women’s Health Network (OWHN) has a general advocacy function for women’s health. The vision of the network is an equitable, accessible and efficient health system for all women, including most notably vulnerable groups such as homeless and elderly women and immigrants. Through research and advocacy work promoting women’s health, the network seeks to identify innovative ways to give a voice to women, in particular the most vulnerable populations. Another voice mechanism is consultation, bringing input to health policy-making processes related to women’s health. In May 2000, for example, the German Ministry of Health organized a three-day

open symposium on reproductive health with the participation of stakeholders from various fields, including advocacy groups, and the general public. Selected participants were invited to present their diverse views on seven predefined key issues. These presentations were followed by a broader discussion with the stakeholders, the ministry staff and the interested public during the conference and through an internet forum. Finally, a variety of consultation methods such as surveys, comments on drafts or membership in working groups can be used e.g. in the development process of clinical guidelines, as it is currently being done by the National Institute for Health and Clinical Excellence in the United Kingdom in the case of a clinical practice guideline for breast cancer – involving individual patients and the interested public in addition to experts and stakeholders.

Choice

Exercising personal choice of health care service options requires good, evaluated and evidence-based patient and consumer information as provided in different media or in counselling centres. An essential prerequisite for generating reliable information and allowing informed choice is the measurement and reporting of clinical



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cal performance. Significant efforts within performance measurement especially as concerns women's health – using a balanced scorecard framework – have been made in Ontario, Canada. The importance of the inclusion of a women's health perspective on health system performance measurement has been outlined in the women's health performance report, which shows that hospitals which have integrated a women's health perspective in their core strategies were more likely to deliver better outcomes for women's health in contrast to other hospitals.

Representation

The interests of women in ongoing governing processes can be protected by the election or appointment of representatives of patient and consumer organizations to health boards or committees and also by specialized institutions. In Ireland, the Women's Health Council, a statutory advisory body for the Ministry of Health and Children, was founded in 1997 on the recommendation of the Women's Health Plan which was developed through a nation-wide consultation with women. The Council's aim is to influence the development of health policies to achieve health and social gains for women through regular policy submissions and the publication of position papers, as well as through representation in external governing bodies.

Governance lessons for strengthening health systems

A number of lessons can be extrapolated from these examples and can be useful for strengthening health systems.

Enhanced participation through voice, choice and representation offers a number of benefits for decision-makers:

- It can provide valuable input by reflecting the population's needs, preferences and values.
- It is a way to involve the public in decision-making, which can lead to fairer and more balanced decisions, promoting their acceptance.
- It can lead to a better individual knowledge of health issues and increase confidence in health systems.

- It can promote choice and competition between health care providers based on outcomes.

These benefits would seem substantial, however, finding the right mix of voice, choice and representation mechanisms is challenging. There are a number of steps to be taken by governments in order to improve participation in and strengthen the governance of health systems:

- Legal frameworks have to be implemented for participation as a patients' right.
- Participation strategies have to be developed for ongoing health policy processes.
- Other sectors such as education, social welfare and finance should be involved systematically in these processes.
- If public participation in a particular decision is not considered appropriate or expedient, the reasoning behind this, and the process itself, must be made transparent to the public.
- Strategies have to be developed to overcome financial, cultural and language barriers to participation processes.
- In particular, vulnerable and less privileged groups should be empowered and governments should ensure that they are proportionally and fairly represented in consultation processes.
- Finally, further research on the impact of participation in decision-making processes has to be carried out and used for improvement purposes.

Ultimately, strengthening health system governance is both a complex issue and a necessity. There are no silver bullets to do so but lessons from different experiences can be valuable in stimulating the achievement of better health system performance in general and the attainment of the MDG's in particular.

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THE ROLE OF PRIMARY HEALTH CARE IN SEXUAL AND REPRODUCTIVE HEALTH IN EUROPE

Preliminary results of a study on behalf of the European Forum for Primary Health Care

The European Forum for Primary Care (EFPC) aims to strengthen Primary Health Care (PHC) in Europe. EFPC defines PHC as being community based, permanently available and easily accessible (1). In 2008, EFPC commissioned the authors to prepare a Position Paper on sexual and reproductive health (SRH); it was felt that PHC should play a prominent role in this field. For the purpose of this paper a questionnaire was developed, which was subsequently pilot tested and later adapted based on the responses. The pilot was carried out in five different European countries: Belarus, Estonia, Germany, Portugal and Sweden.

The questionnaire was sent to a prominent, well recognized SRH specialist in each of the five countries, asking them to consult other specialists if they were themselves not sufficiently knowledgeable to fill in particular questions. This paper is based on the results of the pilot study. An improved version of the questionnaire was made available on the internet in September 2008, for use in the implementation phase of the project (2).

Background and rationale

The question “who does what, where, and how in SRH in Europe, and what are the results?” has never been systematically asked as a health systems research question. There are several reasons why the above question is relevant, particularly if the question is asked from the point of view of PHC. There are at least four rationales for a prominent role of PHC in the field of SRH:

Accessibility. PHC is community based, low barrier, and permanently available. Therefore, if SRH is largely integrated in PHC, it guarantees easy accessibility.

Coordination. It is important that there is an institution or service provider that coordinates service provision in SRH, because the different elements of SRH are often closely related. For example, women who undergo an abortion in hospital should also be offered contraceptive services. If these women are counselled and referred to a hospital by their PHC provider, there are good guarantees for contraceptive follow-up and care by the same PHC provider.

Integration. As SRH aspects are often interrelated, it is important that one service provider handles these different aspects in one consultation. A classical example is STI prevention and prevention of un-

wanted pregnancy. A client who is in need of STI diagnosis and treatment is very often also in need of protection against unwanted pregnancy. A specialised STI clinic may not discuss and handle both needs, whereas a PHC provider usually will.

Social-medical approach. PHC providers are usually trained to take social and psychological aspects of SRH requests into account. This is important in the sensitive area of sexuality related questions or problems, where social, psychological and cultural aspects are often more important than medical ones. PHC workers may be better trained to meet these particular needs than medical specialists.

Measuring the role of PHC in SRH

There are two challenges in measuring the role of PHC in SRH in Europe. The first is that PHC is not interpreted in a uniform manner across Europe. Depending on the country, family physicians/general practitioners, specialists, midwives or polyclinics may serve as the entry point for PHC. These very different organizational models make it difficult to decide whether a service delivery point or service provider should be considered “PHC”. The second challenge is that it is even more difficult to make sure that the concepts of SRH are interpreted similarly across Europe, given their broad and multi-faceted nature. The WHO has been active in developing indicators for SRH, but most of those are ‘epidemiological’ indicators that measure aspects of SRH status; much less work has been done to make SRH service delivery measurable. As a result, this study has been one of the first attempts to study SRH service delivery modalities.

For this study it was decided to concen-

trate only on a few core elements of SRH:

- Family planning and contraceptive use
- Antenatal care and delivery
- Sexually transmitted Infections
- Special SRH services for young people

Attention was paid to both institutional organization and the role of different types of practitioners, particularly in quantitative terms.

Some pilot research results

Results from the pilot study indicate significant variation in Europe when it comes to the role of PHC in the way SRH services are organized and youth SRH centres are developed.

Organization of SRH services (1) PHC role: family planning and antenatal care

In Germany and Belarus the PHC role in SRH service delivery is negligible, although the reasons vary. In Belarus, PHC does not really exist outside rural areas. Polyclinics and hospital departments basically provide SRH services. In Germany, on the contrary, gynaecologists and other specialists in private practices are the main providers of SRH. GPs do not play a clear role in terms of referring clients to a gynaecologist, or receiving information afterwards on the treatment given.

In Sweden and Estonia the role of PHC is “rather significant”. In Sweden midwives play a prominent role in SRH. They work in “midwifery primary health care centres”, where they are responsible for family planning, pregnancy testing and antenatal check-ups. This arrangement has historical backgrounds: in the 1960’s midwives gradually lost their traditional role of assisting in deliveries, as this responsibility was taken over by obstetricians working



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in hospitals. In the same period, family planning became a prominent issue in Sweden and as obstetricians/gynaecologists were not really interested in taking up this new activity it was decided that midwives should become responsible for family planning. They were subsequently licensed to insert IUDs and later also to prescribe oral contraceptives.

Only in Portugal can the role of PHC in SRH be called “very significant”, with GP practices and PHC centres being active in almost all SRH areas that have been looked at. Family planning, pregnancy testing, antenatal care and even STI control are all primarily the responsibility of PHC in this country. In case of more specialized diagnosis and treatment, PHC is in most cases responsible for referral and for check-ups afterwards.

(2) STI control

STI control is spread out over a wide variety of medical institutions. In Sweden, diagnosis and treatment is the responsibility of special STI clinics, specialized departments in hospitals and hospital polyclinics. In Estonia, STI diagnosis and treatment is very widely spread out over different institutions, including special STI clinics, general hospital and maternity hospital polyclinics and departments, private urology and gynaecology practices and to some extent also GP practices. In Germany GPs do play a role in this field, but most of it is done in private practices of gynaecologists, urologists and dermatologists. In contrast to the other countries, in Germany STI control is not a responsibility of hospital departments or polyclinics. Only in Portugal do GPs and PHC centres play a dominant role in STI diagnosis and treatment. Apart from this, special STI clinics, hospital departments for infectious diseases, and private practices of infectious disease specialists play an additional role. Finally, in Belarus, the situation is again very different. Here, the primary responsibility depends on the level of urbanisation. In rural areas, the FAPs (composed of a midwife and an assistant doctor authorised to perform a very limited range of medical treatments) are the first point of entry, in small towns

the GPs and in bigger towns the hospital polyclinics.

(3) SRH centres for youth

In looking at the role of youth health centres that have been established in various countries in the past decades, the picture for the five countries studied is very diverse. Sweden is most advanced in this respect. There are youth SRH centres, which are organizationally part of the PHC centres, and their role in serving young people is much more substantial than in any of the other countries: at the age of 18 no less than 80% of girls and 17% of boys have at least once attended such a centre. Almost all SRH services that young people need are available from these centres, and they are free of charge. Estonia has made remarkable progress in this area in the past two decades, developing three types of centres for young people: independent youth SRH centres; centres that are part of hospital polyclinics; and centres run by private practitioners. All of these are free of charge; the cost is covered by a special preventive care project of the health insurance system. For those who have no insurance, there are special local government funds to cover their cost as well. However, because of this financial arrangement clients cannot remain anonymous. It is estimated that between 10 and 25% of young people attend these centres, so their quantitative role is quite substantial in meeting the SRH needs of young people.

In Portugal, there are also a variety of youth centres that provide various SRH services: some are part of general family planning centres; some are a function of general youth health centres; others are attached to hospitals; and still others are administered by the “Portuguese Youth Institute”. All of them are free of charge. Unfortunately, it is unclear how substantial their share in serving young people is. In contrast, similar centres are rare in Germany. Germany does have some independent counselling centres, the best known being the Profamilia centres. 170 of these centres exist; less than half of them offer medical treatment and the rest focus more on counselling. However,

these are not “youth only” centres. In addition, there are some pilot independent youth SRH centres, but their quantitative impact for the entire country is negligible. Finally, in Belarus some of these centres have recently been created in different kinds of health care settings, with assistance of UNFPA and UNICEF, but their role in the country is not yet substantial. A disadvantage of the development thus far has been that these centres focus strongly on counselling only, while their role in diagnosis, treatment and prescription of medication is very limited.

Conclusion

In summary, it can be stated that international health systems research in the field of SRH service delivery in Europe is still largely underdeveloped. The results of this small pilot study seem to indicate that much can be learned by systematically studying the different institutional and organizational arrangements in this field in different European countries. If it would be possible in the future to link the results of such studies to SRH outcome indicators, and thus find out which systems produce the best SRH outcomes, valuable lessons can be learned on how to effectively organize SRH service delivery.

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ESSENTIAL MEDICINES FOR MOTHERS AND CHILDREN: A KEY ELEMENT OF HEALTH SYSTEMS

Access to medicines and public pharmaceutical policy

Medicines, when used appropriately, are one of the most cost effective interventions in health care. European countries spend an important part of their health budget on medicines, from 12% on average for the EU countries to more than 30% for the Newly Independent States (NIS) countries. Whereas in EU countries the larger part of the medicines expenditures are publicly funded through taxes and/or social health insurance, in the NIS and in the south eastern European countries it is often the patients who have to pay directly for the drugs themselves. This means that many patients simply do not get the drugs they need because they cannot afford them, and also may force families to incur enormous expenses as they sell their belongings in order to pay for their drugs and their health care.

Access to medicines is a complex puzzle that depends not just on low prices of the drugs, but also relates to the need for having sustainable funding arrangements, a reliable and efficient supply system, and should focus on the needed drugs. Thus, public pharmaceutical policies play an essential role in countries health systems, responsible for access, regulation, equitable distribution, quality, affordability and sustainability (see text box). The pharmaceutical policy also needs to be in line with the overall health policy of the country and needs to fit with the other components of the health system. In other words the Ministry of Health needs to regulate the pharmaceutical sector (with regard to the quality of the products on the market as well as licensing the producers and distributors of medicines), to ensure the overall information flows in the sector, and to monitor the outcomes of drug interventions. The health system needs to ensure equitable access to medicines and appropriate financing mechanisms (ensuring an effective medicines supply system, efficient reimbursement and drug pricing arrangements, as well as, enhance the appropriate prescribing and use of medicines). And finally medicines play an important part in the actual delivery of health services, both at ambulatory level - where most consultations with a doctor result in the prescribing of a medicine - as well as in the hospital.

Essential medicines

Since 1977 the WHO has promoted the concept of “Essential Medicines”: every

health system should determine a list of drugs for their health system, that would satisfy the priority health needs of the majority of the population, that would be in line with the possibilities and the funding of the health system, and would correspond to the knowledge and skills of the health personnel.

A fundamental criterion for essential medicines is that they must be available within the context of functioning health systems, and always in suitable amounts and dosage forms. The selection of essential medicines is a cornerstone of national medicine policies and supports the smooth functioning of the entire pharmaceutical system.

The initial “model list of essential medicines” of 1977 contained 208 drugs. The list is revised every two years and now contains 340 drugs, including drugs for malaria, HIV/AIDS, tuberculosis, reproductive health and, increasingly, chronic diseases such as cancer and diabetes. The essential medicines concept is widely recognized as one of the most important public health innovations of the last 40 years. Currently, 156 of the 193 WHO Member States have official essential medicines lists (EML). As resources are constrained in every health system environment the EML is a powerful tool to select medicines that are needed and the most cost-effective and affordable for their health system. All NIS and south eastern European countries have defined their EML but implementation varies. Almost all EU countries are using the concept of selecting medicines for their

reimbursement system, and the numbers of medicines on the lists in Europe vary from 350 to more than 1000, depending on the epidemiological patterns, the funding and characteristics of the respective health systems.

The role of essential medicines in the health of mothers and children

While under 5 mortality and maternal mortality are generally low throughout the European Region, rates do vary widely between countries. Many factors responsible for the majority of under 5 deaths globally (pneumonia, diarrhoea, malaria, measles and HIV) and maternal deaths globally (haemorrhage, sepsis, eclampsia and unsafe abortion and obstructed labour) are also present within the European Region. For example, when looking at causes of under 5 mortality within the Region, eastern countries show greater morbidity and mortality due to respiratory illness and infectious etiologies, whereas in western countries non-communicable diseases play a larger role (1). Within countries differences also exist in access to medicines between regions and population groups.

Essential medicines can play a critical role in preventing these deaths. Access to vaccinations through childhood immunization campaigns prevents a broad range of illness including measles. Vaccination and breastfeeding can effectively reduce pneumonia mortality; antibiotics and oxygen are critical for effectively managing the illness. Diarrhoeal treatment for sick children with oral rehydration salts



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Objectives of a public pharmaceutical policy.

In general, the objectives of a public pharmaceutical policy in a country are to

- Ensure equitable access to needed medicines, that are safe and effective and meet quality standards
- Promote the appropriate prescribing and use of medicines
- Ensure value for money, ensure affordability and sustainability of the system, and protect patients against catastrophic expenditures
- And finally for those countries that have a drug industry a balance with the industrial policy objectives need to be found

combined with zinc supplements is safe, cost-effective, and saves lives. Central Asian and Trans Caucasian republics within the European Region remain at risk of malaria and malarial medications such as quinine and co-artemisin derivatives are essential for treatment and prevention of malaria. While rates of pediatric HIV and TB in the European Region are substantially lower than those in the African Region, treatment is often difficult due to the unavailability of the drugs and their specific paediatric dosage forms. In terms of HIV, children are primarily infected through mother-to-child transmission, which can be prevented with access to antiretrovirals, as well as, safer delivery and feeding practices. In terms of maternal health the previously mentioned complications can be effectively prevented and treated by essential medicines such as oxytocin, antibiotics and magnesium sulphate (2), as well as, access to a working health system with skilled personnel and emergency obstetrical care. In addition access to safe and effective contraceptives can decrease maternal mortality and mother to child transmission of HIV through the prevention of unplanned and unwanted pregnancies. Contraception also has the added benefit of improving women's health by decreasing anemia (caused by heavy bleeding) and pain associated with abnormal menstrual cycles.

Within the European Region the majority of countries have included essential medicines for these conditions in their

essential medicines lists, but in practice availability and access remains problematic, particularly in the transitional countries. The 2008 UN report *Delivering on the Global Partnerships for Achieving the Millennium Development Goals* highlights the existence of large gaps globally in the availability of medicines in both the public and private sectors, as well as a wide variation in prices which render essential medicines unaffordable to poor people. The report found that globally, in the public sector, generic medicines are only available in 34.9% of facilities, and on average cost 250% more than the international reference price. In the private sector, those same medicines are available in 63.2% of facilities, but cost on average about 650% more than the international reference price. While policies that promote access such as generic substitution are in place in many countries, additional national and international efforts are required to improve the availability and affordability of medicines (3).

What the WHO Regional Office for Europe does

Essential medicines play a key role in reducing maternal and child mortality throughout the Region as they form an integral part of the health systems of the various countries. Over the past years the WHO Regional Office for Europe has been supporting the transitional countries in increasing access to medicines for mother and child health through the "Special NIS Project," a joint project between the WHO Regional Office for Europe Health Technology and Pharmaceuticals and the WHO headquarters Essential Drugs and Medicines Policy Division. This project builds upon a strong interaction between the WHO and country counterparts in the NIS and works by: strengthening the medicines selection processes; assisting the medicines regulatory authorities in the ensuring the quality of the medicinal products on the market; supporting countries in improving their medicines supply and reimbursement systems; assisting national programmes for developing clinical

guidelines for these conditions; and by supporting initiatives to improve the prescribing and use of medicines. More information about this ongoing collaboration can be found at www.euro.who.int/pharmaceuticals/NIS/20020708_1

The WHO Regional Office for Europe has also been part of the WHO global campaign 'make medicines child size' launched on December 7, 2007. The goal of this campaign is to raise awareness and accelerate action to address the need for improved availability and access to safe child-specific medicines for all children under 15. Research on paediatric formulations, increasing development of more medicines for children, and improving the access to these drugs by strengthening the medicines provision systems are all strategies being promoted to reach this goal. Currently many medicines are not available in suitable dosages or developed for children; even if they are, they are not reaching the children who need them most.

The WHO Regional Office for Europe will continue to support countries in strengthening their health system in order to improve the health of the population, including mother and children in the Region, by continuing to work towards improving access to essential medicines for these conditions.

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THE GLOBAL FUND AND HEALTH SYSTEMS STRENGTHENING

Over the past five years, a new player in global health has set its mark on the International Public Health Agenda. The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) has provided nearly 20 billion US dollars to countries throughout the world seeking support in the fight against HIV/AIDS, tuberculosis and malaria. This corresponds roughly to 21% of funding commitments overall (see figure 1).

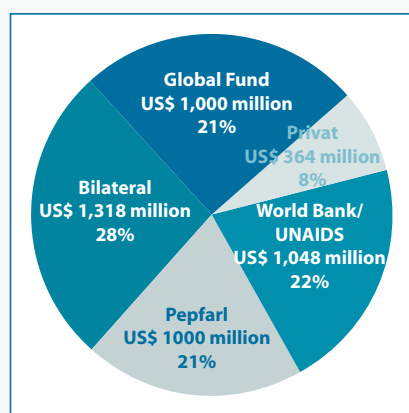


Fig 1. International funding commitments (1)

The approaches supported differ from country to country, and region to region, depending on the respective epidemiology of the diseases and the problems and gaps in existing health systems (see figure 2). Often, the Fund has been criticized for supporting vertical approaches and thus weakening health systems by pulling already scarce human resources away in order to strengthen vertical programmes. However the perception that the “Global Fund promotes vertical rather than systems strengthening approaches” is actually incorrect. The Global Fund supports and promotes a country-driven process, in which all stakeholders are, or should be, represented in the Country Coordinating Mechanism. This includes government institutions, academia, and representatives of Civil Society.

The proposals developed at country level are reviewed for their consistency and coherence and the complementarities of the proposal to what national sources or other donors are already covering. In recognition of the fact that mid-term evaluation and monitoring reviews have

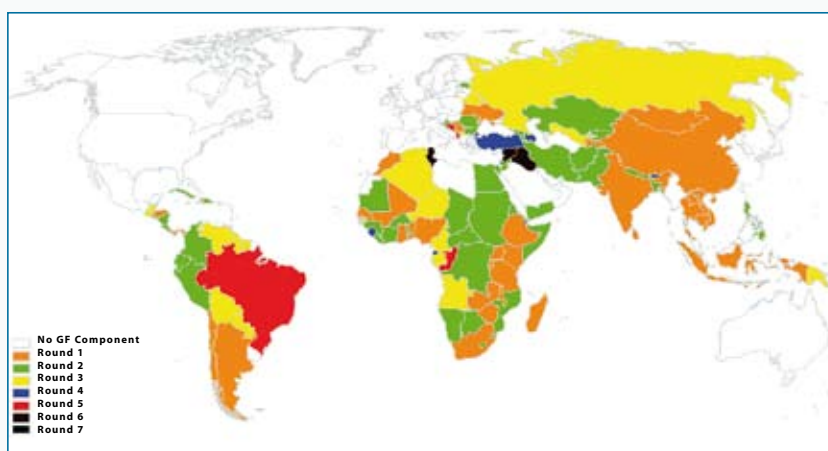


Fig 2. Countries with GFATM grants (1)

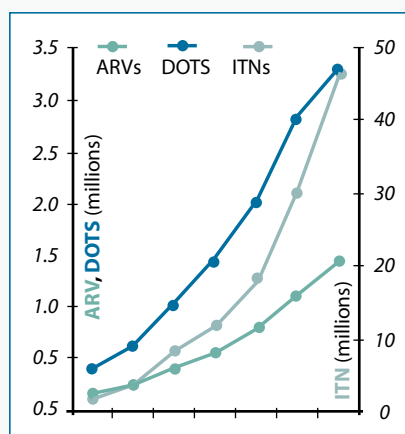


Fig 3. Coverage of ARVs, DOTS, ITNs (1).

shown health systems constraints to the implementation of programmes, the new proposals may include a specific health systems strengthening component which should address general weaknesses with a view to increasing the impact of the interventions and investment into the three target diseases of the Fund.

This development is very welcome and necessary. It provides an opportunity for countries to address those issues which have been identified as constraints at a regional level, or to strengthen those elements which have been defined as the keys to success at regional conferences such as the Ministerial Conference on Health Systems Strengthening 2008 and the Ministerial Conferences on Tuberculosis and HIV/AIDS in 2006.

Results

The results of the grants provided to date are encouraging in terms of coverage with

antiretrovirals (ARVs), directly observed tuberculosis (DOTS), and insecticide treated bednets (ITNs) (see figure 3 and 4). The latter, especially, has had a direct impact on child morbidity and mortality. In this sense, the provision of bednets on a large scale, as a preventive measure, has taken part of the burden of malaria treatment off the health system and has thus freed up capacity for the system to respond to other health needs and to focus on programmes like the integrated management of childhood illnesses.

In the battle against the further spread of the HIV/AIDS epidemic, it is encouraging to see how the preventive efforts have made a difference to behaviour patterns (see figure 5), but it is still surprising to see how little reproductive health systems are used in primary prevention and care, in particular in the prevention of maternal to child transmission of HIV (PMTCT). It is as if the two systems are running parallel to each other - and this, perhaps, has to do with perceptions of outcomes of sexual behaviour. While there is still, despite all the work done for de-stigmatization over the past decades, a lot of stigma attached to HIV/AIDS patients in many settings, a maternity clinic or reproductive health centre is associated with the positive, desired outcome of sexual relationships: bringing a healthy newborn baby into the world. There is no or little debate about the fact that a maternity hospital is an important pillar in a health system, and that all should

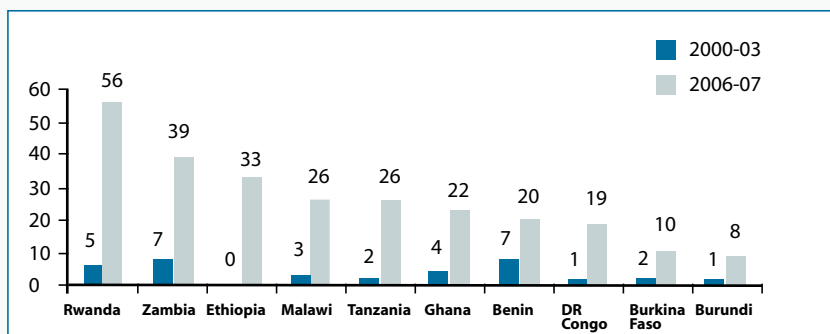


Fig. 4. Children under 5 sleeping under ITNs, 2000-2003 and 2006-2007 (1).

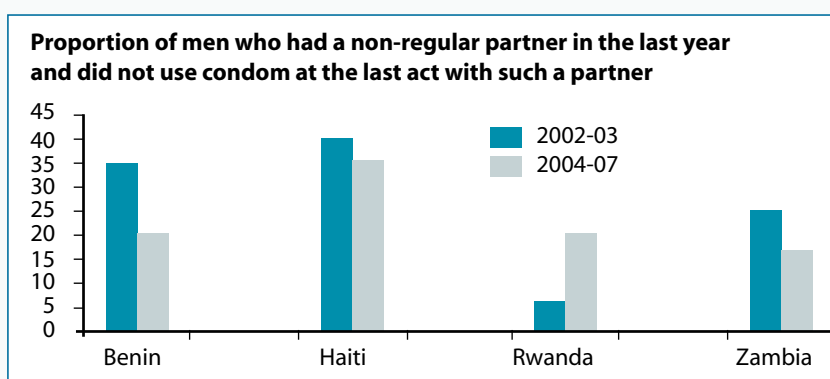


Fig. 5. Behaviour patterns of male condom use (1).

be done to make this a positive, safe, and welcoming place. Bringing HIV/AIDS prevention and discussion into antenatal or post partum care is therefore not easy and does not meet acceptance immediately among patients and health staff. Yet HIV/AIDS must be on the agenda of reproductive health services, both in high and low prevalence settings. The rationale for this is that in high prevalence settings the likelihood that a mother is infected, or at risk is very high, whereas in low-prevalence settings reproductive health services are the health service provision point that lends itself best to primary prevention.

GFATM in the European Region

The health systems strengthening window of the GFATM lends itself to the countries of the European Region, in particular the central Asian countries, the Caucasus, and central and eastern Europe, to look more closely at the gaps in reproductive health services, specifically:

- Their capacity to provide proven preventive interventions and the necessary perinatal care. In this regard, PMTCT is not only about knowing

when and how much nevirapine or other drugs to give, it is, in the end, about protecting the reproductive health of women, men, children, and adolescents. Building capacity among reproductive health services and staff for this broader understanding is costly and time intensive. The Global Fund grants provide an opportunity to have the necessary resources on board for this work.

- Their human resource capacity. A further health systems constraint often quoted as a reason for the unsatisfactory performance of health services is the fact that the training and qualifications of health staff no longer match the priority needs of the populations they are supposed to serve, and that there is a lack of human resource planning or projections. Again, this is an area which the additional resources of the GFATM grant can be used for: analysis of present human resource needs- both in terms of quantity and in terms of competencies, and subsequent development of national or regional

human resource plans.

- Their quality management and accountability. These need to be continuously adapted to new needs and the capacity to apply these principles needs to be strengthened in health care institutions and health management structures. Including quality management in GFATM proposals supports the strength and credibility, as well as the sustainability of the proposal.

In closing

Health systems will only be strong and sustainable if the financing of health services can be secured in a sustainable manner. Taking the burden at least partly off the shoulders of the public sector and spreading it to the employment and private sectors will lead to more resilient and responsive systems. Bringing this approach up to scale and embarking on national health-financing reforms require, at least initially, enormous additional resources of the dimension which, at present, only the GFATM is able to provide. Embarking on this type of reform will, in the end, have an impact not only on the morbidity caused by the three diseases in the GFATM mandate, but also on morbidity and mortality caused by other health conditions. So far, there is only one case in which part of the GFATM grant has been used to support such a system, and that is Rwanda. In view of the dire needs for health financing reform in the Region, it would be very interesting to see and comparatively evaluate outcomes.

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IMPROVING THE CAPACITY OF THE HEALTH WORKFORCE THROUGH PRE-SERVICE MEDICAL EDUCATION REFORM

The performance of health systems depends on the knowledge, skills, motivation and deployment of the people responsible for organizing and delivering services. Health workforce represents one of the “building blocks” that make up the health system. A well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (1).

To develop a well-performing health workforce and meet the increasing need for quality services it is essential to ensure stronger pre-service education and in-service training systems. Preservice education represents the first step in human resource development and plays a critical role in preparing health professionals. Pre-service medical education is defined as pre-specialized training in nursing, midwifery, and medical schools, and also referred to as “undergraduate medical education” (2). Pre-service medical education represents a more efficient use of resources because it provides the educational foundation for future providers, reaches a greater number of providers, and takes place over a longer time period, resulting in more substantial educational outcomes than in-service training (2). In comparison, in-service training is more appropriate for reinforcing pre-service medical education, and provides opportunities to update skills and introduce new information and technologies once they become available.

Eastern Europe and central Asian Region countries are demonstrating their commitment to improving access to and the quality of family planning (FP) and other reproductive health (RH) services. Reducing abortions and increasing use of modern FP methods will depend in large part on the quality of health services and health care providers who deliver them. The reviews of FP in the countries of the Region have proved that there are still many challenges to improving FP and RH services. Key among them is the inadequate skill levels and limited technical competence of service delivery personnel in the area of FP and RH (3).

Implementation of health reform in many of these countries has required the introduction of modern evidence both in medical training and clinical practice. Over the years, considerable emphasis have been placed on training FP and RH service providers throughout the Region. The majority of training programs, materials, and donor support have

traditionally been directed at improving in-service education. Thousands of wide range service providers (obstetrician/gynaecologists, family doctors, nurses) have been trained to upgrade their skills and knowledge in FP and RH. Most countries in the Region have developed and endorsed evidence-based clinical practice guidelines and protocols for FP service delivery, with the support of various donors and technical agencies. Several have implemented new national guidelines and protocols (Romania, Georgia, and Ukraine) (4, 5).

These new training materials and clinical practice guidelines have not been incorporated into formal medical school curricula creating a huge gap between pre-service medical education and clinical practice. Such an academic indifference to current clinical practice results in significant portions of existing medical training irrelevant.

The review of pre-service medical training in the Region showed that pre-service education of health professionals in FP is not well coordinated and ranges from sporadic lectures on FP topics to varying degrees of information on contraceptive technology, which is, in large part, not based on contemporary evidence (6). It lacks information on the World Health Organization’s “Medical Eligibility Criteria for Contraceptive Use” and other international guidelines and evidence-based standards (7). Practical training in the provision of FP services is often totally lacking in both physician and nurse pre-service training and is provided in very limited, unpredictable amounts. Furthermore, educational methodologies used in many medical schools in the Region are based on traditional educational methods (e.g. students attending lectures where they remain passive) and provide little opportunity for interactive learning. Medical education methodologies lack opportunity for building adequate competencies in FP and other RH service provision. Due to such gaps in the medical curricula, students graduate with little or



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no knowledge of FP and other RH issues, thus increasing likelihood that health professionals and especially, primary care physicians and other non obstetrician/gynaecologists will be educated on FP/RH topics through in-service training rather than through pre-service training. This can become enormously burdensome on the state and donors.

Despite all of these, few resources are currently available to assist with pre-service curricula development or reform.

In October 2008, the Europe and Eurasia Regional Family Planning Activity (EERFPA) funded by the U.S. Agency for International Development (USAID) and implemented by John Snow, Inc (JSI) launched the initiative to address the scarcity of family planning topics in the curricula of medical and nursing schools in the Region. EERFPA aims to reform medical and nursing school curricula by increasing evidence-based family planning teaching in pre-service medical education curricula and working within the systems that govern curriculum content.

The Regional Academic Consultation on Strengthening Pre-service Family Planning Teaching held in Tbilisi, Georgia from October 22-24, 2008 organized by the EERFPA with technical support and assistance from the WHO Regional Office for Europe was a first attempt to bring to attention the urgency and need for improving pre-service medical education. Country delegations from Armenia, Azerbaijan, Georgia and Kyrgyzstan, comprising of key faculty from obstetrics & gynecology and family medicine departments of medical schools, nursing schools, administrators and health ministry staff discussed the rationale for strengthening pre-service medical education in FP, the resources available and potential challenges; discussed key steps in strengthening FP teaching, both with respect to technical content and teaching methodologies and finally, prepared action plans for implementing FP medical education reform. The meeting revealed that pre-service medical curricula is

indeed, in need of reform and that leaders and faculty from the medical and nursing schools are committed to reforming their pre-service medical education and developing a collaborative platform for improving FP pre-service teaching. It was noted that the process used in FP can be implemented for strengthening other aspects of RH medical teaching.

There is a great need to respond to this demand from countries for strengthening pre-service medical education and improving FP and RH curricula. The USAID's Europe and Eurasia Regional Family Planning Activity aims to collaborate and work in partnership with the WHO Regional Office for Europe, other technical agencies and partners in the Region to reform FP pre-service medical education. Investing in pre-service medical education to improve the quality of FP and RH training is a vital part in improving the quality of care and increasing access to FP and RH services. The integrated, evidence-based teaching of broader RH concepts would develop health professionals that are well-equipped to respond to the many and varied FP and RH challenges facing their countries.

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INTIMATE PARTNER VIOLENCE AND ROLE OF HEALTH CARE WORKERS: RESEARCH TO STRENGTHEN HEALTH SYSTEMS

Reproductive health free of intimate partner violence

Intimate partner violence is defined as physical, psychological, economic or sexual coercion of one partner in a relationship by the other (1). As a leading cause of physical injury, mental illness, adverse pregnancy outcome and maternal death, domestic violence is not so much an emerging women's health issue, but rather a continuing hidden endemic. Lifetime prevalence estimates of partner-inflicted harm to women range from 10 up to 69%, while partner abuse during pregnancy in particular has consistently been found to occur in 3-8% of pregnancies (2).

At the 1994 International Conference on Population and Development in Cairo, 179 countries agreed that all couples and individuals have the right to attain the highest standards of sexual and reproductive health, free of discrimination, coercion and violence. The conference adopted a 20-year Programme of Action, by which the 179 governments agreed that all countries should take preventive, protective and rehabilitative measurements to obtain this goal.

Intimate partner violence throughout the world continues to challenge sexual and reproductive health standards as set forth at the Cairo conference and may well be considered an important caveat to population development. Intimate partner violence is a public health problem, not just a personal affair within the family or a purely private issue. One could compare intimate partner violence with bad habits such as smoking or unsafe sexual behaviour, which in a sense are 'private issues' but recognized as real public health problems.

Intimate partner violence in Belgium

Belgium is one of the countries that endorsed the convention of Cairo, but it has only been since 1997 that intimate partner violence was considered a crime by Belgian Law, and it took until 2000 for concrete actions to be started. The National Action Plan (NAP) to combat partner violence was elaborated by different Ministries (The Ministry of the Civil Service, Social Integration, Cities Policy and Equal Opportunities, together with the Ministry of Justice and a deputy of the Prime Minister) and was launched as a holistic plan with actions targeted at increasing awareness, prevention, training, assistance, repression and other measures at different levels of society.

At the health care level, the National Organization of Family Physicians developed a consensus on the role of the family physician's in detecting and dealing with intimate partner violence. This consensus is a good and practical tool; however there are no recommendations about

pregnant women and intimate partner violence. In fact, in Belgium most women go to the obstetrician-gynaecologist for routine antenatal care and delivery. Obstetricians and gynaecologists act as 'primary guardians of women's wellbeing' not only in pregnancy, but often throughout the whole sexual and reproductive life.

Intimate partner violence and the gynaecologist

The International Centre for Reproductive Health (ICRH) and the Department of Obstetrics and Gynaecology at Ghent University conducted 2 studies in the area of intimate partner violence. The first one was a cross-sectional survey study among pregnant women attending antenatal care. The lifetime prevalence of intimate partner violence was estimated to be 10.1% and the period prevalence of intimate partner violence during pregnancy and/or in the year preceding pregnancy 3.4%, which is largely similar to other international studies. Women rarely disclose abuse to the widely available health care services, unless they are directly asked about it. Routine screening by a family physician or a gynaecologist was found to be largely acceptable to the women surveyed (3).

The other study was a Knowledge Attitude Practice (KAP) study among gynaecologists to identify potential barriers to intimate partner violence screening in a context where no guidelines have been instigated yet. It appeared that gynaecologists largely underestimated the extent of intimate partner violence and that merely 6.8% of the respondents ever received any kind of education on intimate partner violence. They did not consider pregnancy as a window of opportunity for routine screening. Major internal barriers included perceived lack of self-efficacy in dealing with intimate partner violence and lack of familiarity with referral procedures. Lack of time and fear of offending or insulting patients were the main external barriers. It was concluded that endorsement of physician training on intimate partner violence is an important



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first step, with additional introduction of enabling and reinforcement strategies such as screening tools, patient leaflets, and formal referral pathways (4).

The ICRH and the Department of Obstetrics and Gynaecology also contributed to a large extent to the development of a manual for 'care for the victim of violence' at the Ghent University Hospital (5). The protocol does not only serve as a treatment guideline but also as a training tool of health care workers. Together with the implementation of the protocol, trainings of health care workers (emergency ward, gynaecology, surgery, internal medicine, psychiatry) and of social workers were organized. A course on interpersonal and partner violence is now also incorporated in the medical curriculum at Ghent University, and during this course future doctors get acquainted with the protocol for acute care of victims.

Strengthening health systems

In the new National Action Plan (2008-2009) on partner violence different actions are planned at the health care level. One of the projects, which is currently being implemented, is to evaluate the Ghent University Hospital protocol, to update it and to spread it to other hospitals, along with training of the health care workers of these hospitals. Other programmed activities of the National Action Plan include the development of formal referral systems, the education and training of different health workers as well as the promotion of multidisciplinary collaboration. Through our research on violence, we will contribute to an appropriate local policy and to the development of evidence-based guidelines on violence for the gynaecologists, especially for care during pregnancy.

We have good hope that our knowledge will eventually lead to concrete actions and that strengthening the health system in this way will eventually contribute to better health outcomes for the victims of intimate partner violence.



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For more on gender based violence see our special issue, Entre Nous No.61. Responding to violence against women available at http://www.euro.who.int/entrenous/20020905_

NEW ON PRIMARY CARE: HOW TO STRENGTHEN PRIMARY CARE IN TURKEY?

Primary care is a key element of health systems and often serves as the first point of access for sexual and reproductive health (SRH) needs, education, care and referral. Thus, in many countries the strength of the primary care services is linked to the strength of SRH services; the impact of primary health care services on the SRH of a population can be, and is, significant. This overview summarizes the main results of the WHO Primary Care Evaluation Tool (PCET), which was implemented on a pilot basis in Turkey in 2007 in the framework of the 2006-2007 Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Health of Turkey, an agreement that lays out the main areas of work for collaboration between the parties. Further partners were the Netherland Institute for Health Services Research (NIVEL) – a WHO Collaborating Centre – and other stakeholders of the Turkish health system such as national policy experts, managers, family doctors (FDs) and their patients.

Methods

The underlying methodology for the design of the PCET has been derived from the WHO 2000 Health Systems Framework which indicates that the performance of a health system is determined by the way in which the functions of a health system are organized. The health system functions are: stewardship, resources generation, financing and service provision. The framework of the Primary Care Evaluation Tool encompasses these four functions, combined with the key characteristics of primary care services, including: accessibility to services, continuity of care, coordination of care and comprehensiveness. Table 1 illustrates that for every primary care function a number of key dimensions and sub-themes have been identified. Each dimension has been translated into one or more items (which are the proxies for the dimension) of which a few example items per dimension are shown in the table below.

In order to evaluate the complexity of any primary care system, information has been gathered on different levels, and from the demand and supply side.

Therefore, the Tool consisted of three questionnaires: a questionnaire for the situation of primary care at national level, a questionnaire for family doctors (FDs) and a questionnaire for patients. Together, the three questionnaires covered all identified primary care functions and its dimensions and items as derived from the framework. Each questionnaire has been pre-structured, with pre-coded answers.

The Tool has been pilot tested in 2007 in two provinces of Turkey: in Bolu and Eskişehir. Questionnaires have been completed by national policy experts and other stakeholders of the health system, family doctors and their patients. The results rely on self-reported behaviour or experiences rather than on direct observations or the systematic analysis of routine data.

Results

- **At national level, based on interviews with national policy experts:**

Stewardship: Primary care is a national priority. Since 2003, a comprehensive primary care model is actively being implemented (in 12 provinces out of 81 by 2007). Despite decentralization, there is a strong coordinating role for the Ministry of Health in the reform process. Primary care provider and patient organizations have not yet a formal role in the policy development process. Regulations on the rights of patients are not well developed. For example, the establishment of patient complaint procedures in family health centres is not mandatory – however the implementation rate in the pilot regions was good.

Financing: Primary care is funded and provided by the state. All primary care services are free of charge, except for medicines for which co-payments exist. Primary care providers are state-employed and salary paid. The recent introduction of a performance related payment scheme seems to be a major step in realizing more comprehensive care and improving the responsiveness.

Resources: Over the last years, there has been a systematic increase in the availability of family doctors working in primary care (13.8% of all active physicians in Turkey are family doctors). However,

compared to the overall number of physicians, there are still severe shortages of physicians and nurses in primary care. Primary care physicians are geographically very unevenly distributed. Even though clinical guidelines are available, they are not widely used. Related to this, quality control mechanisms and a policy on how to systematically enhance skills and knowledge of health care workers are not well developed yet.

- **At general practitioner (GP) and patient level, based on experiences and opinions of the respondents, and routine data:**

Accessibility of care: The availability of primary care services is unevenly distributed nationally (but good in Bolu and Eskişehir). Family health centres are staffed by family doctors, practice nurses and in most cases midwives. During working days the centres are well accessible. Visiting a family doctor outside normal office hours, in the evening, or on a weekend day, is only sparsely possible. Patients reported to be satisfied with how they are treated by the staff and the services received. Practices are very large with on average 2484 patients per family doctor but there are also large variations across the country (In Bolu and Eskişehir for example, the average was 3700). As a result, the number of consultations per day is high (in average 50), but modest compared to the practice size. Home visits are rarely made.

Coordination of care: Lack of coordination of care seems to be a major problem. Multidisciplinary teamwork for the benefit of patients with chronic diseases does not exist. Also mechanisms to improve coordination between the primary and secondary level are mostly absent. The gate-keeping role in primary care is not yet well maintained and it is unusual to refer patients back to primary care after hospitalization.

Continuity of care: Patients report to be assigned to a family doctor. They are mostly positive about their relationship with their primary care physician with regard to the terms of treatment provided, consultation duration, and social skills. However, patients also reported that family doctors are not prepared to make



Table 1: Listing of primary care (PC) functions, dimensions and items

Function	Dimension	Selected items of information	
Stewardship	Policy development	PC policy priorities	
	Professional development	(Re-) accreditation system for PC Quality assurance mechanisms for PC	
	Conditions for the care process	Geographical distribution of PC services	
		Human resources planning	
Resource generation	Workforce volume	Numbers and density	
	Professional development	Role and organization of professionals Education in PC	
	Professional morale	Job satisfaction	
	Facilities and equipment	Medical equipment	
		Access to external equipment	
Financing & incentives	Health care/PC financing	PC funding	
	Health care expenditures	Expenditures on PC	
	Incentives for professionals	Entrepreneurship	
		Mode of remuneration	
	Financial access for patients	Cost sharing/co-payment for PC	
Delivery of care	<i>Access to services</i>	Geographical access	
		Distance to PC practice Distribution of PC physicians	
	Organizational access	List size	
		PC outside office hours	
	Responsiveness	Services aspects	
		Timeliness of care	
	Continuity of care	Informational continuity	Computerization of the practice Medical records
			Longitudinal continuity
		Patient habits with first contact visits / referrals	Endurance of patient-provider relationship
			Interpersonal continuity
Coordination of care	Cohesion within PC	PC practice management	
		Collaboration among PC physicians	
	Coordination with other care levels	Referral system / gatekeeping	
		Shared care arrangements	
Comprehensiveness	Practice conditions	Premises	
		Services delivery	
	Community orientation	Disease management Medical procedures	
		Community links	
	Professional skills	Monitoring and evaluation	
		Technical skills	

Table 2. Family doctors' (FDs) self reported involvement in activities for specific patient groups

FDs involved in:	Bolu (N=37) %	Eski ehir (N=41) %
Screening for STI's	12	3
Screening for HIV / AIDS	9	11
Mother and child health programmes	89	87
TB screening programme	15	16
Influenza vaccination programme for high-risk groups	57	61
Rehabilitative care	42	41
School health programmes	71	54
Mental health programmes	39	31
Cervical cancer screening programmes	9	6
Breast cancer screening programmes	68	51

home visits. Computers are generally used by primary care physicians, also for clinical records. However, medical records are not kept routinely.

Comprehensiveness of care: Family doctors have a strong position as doctor of first contact for women and children. However as can be seen from table 2 while the majority (89% in Bolu and

87% in Eskişehir) play a role in mother and child health programmes and to a lesser extent breast cancer screening programmes, their role in other areas of SRH continues to be sub-adequate (STI/HIV/AIDS screening, cervical cancer screening). The involvement of family doctors in the treatment of diseases can be improved if compared to colleagues

in western Europe. However, compared to the situation in Turkey 15 years ago, this position is much better now. Family doctors are moderately involved in the provision of preventive care and specific patient groups. There were also few links with the community in which primary care is provided.

Recommended policy actions

The main policy recommendations from the findings of this study are:

- To involve associations of health professionals and NGOs into the process of health policy development and in aspects of its implementation.
- To further develop and formalize the role of patients in primary health care, for instance by introducing obligatory complaint procedures in health centres and monitoring patients' needs on a regular basis.
- To take measures to reduce the shortages among GPs and nurses and to realize a more equal distribution of primary care providers over the country. This may also reduce the currently high workload of GPs.
- To fully use the educational capacity in family medicine and consider whether this capacity can be expanded, part of which should focus on increased provision of SRH services/care.
- To promote the gate keeping role of GPs.
- To continue introducing incentives for good performance, in particular focusing on improvement of the quality of services.
- To improve the coordinating role of GPs by removing obstacles for collaboration and working relations between GPs and medical specialists at the secondary level, which are currently poor – as well as to further support cooperation and teamwork within PC.
- To stimulate that the current minimal links between primary care facilities and the community are strengthened.

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REPRODUCTIVE HEALTH AND HEALTH SYSTEM REFORM IN ROMANIA

Romania is a very special case when it comes to reproductive health in the modern world. After 30 years of a prohibitive society that denied couples and women the right to family planning, as a result of the political changes in December 1989 women in Romania have regained the fundamental right to freely decide the number of desired children, as well as the timing and spacing of births. Decree Law No. 1/ 1989, which promoted total abortion liberalization was the first resolution passed after the political changes in 1989 and it can be considered the symbolic foundation of family planning (FP) in Romania.

In 1990, women in Romania were rather unfamiliar with modern family planning methods, therefore approximately 1.2 million abortions were recorded at a ratio of about 3.2 abortions to one birth (1). However, the maternal mortality underwent a 50% decrease in 1990, triggered by the significant decline of the unsafe, unskilled abortion. Still, in the early 1990's Romania had one of the highest abortion rates in the world, along with a high maternal mortality and a very low contraception utilization rate – due to four decades (1949-1990) of a highly centralized Semashko health system, characterized by the state monopoly over the health services, central planning, financing and organization of health services, rigid management and total absence of the private sector or the nongovernmental organizations.

Health system reform and sexual and reproductive health

The health system reform was initiated in 1990 and in 1998 Romania moved toward a mandatory health insurance based system. The roles of the main health actors changed, the primary health care was enhanced and the general practitioner was replaced by the family doctor as an independent provider of preventive and curative primary care services. The Ministry of Health duties changed, consisting mainly of policy formulation, regulating the health sector and developing national public health programmes. The National Mother and Child Health Programme (under which all the family planning activities have been grouped) is one of

the most successful health programmes in post-communist Romania, a model of partnership, political will and consistency which has led to effective results and measurable impact indicators (Figure 1). The dynamics of the family planning programme in Romania developed in parallel to the evolution of the health system.

The services offered to couples have gradually been able to reach their beneficiaries, becoming widely accessible and accepted by the population. The gradual development followed three important steps: first, the development of the national urban family planning network in 1992-1994, consisting of 230 family planning offices and 11 reference centres offering distinctive services; second, FP services and free contraceptive distribution were included in the basic services package provided by family doctors (especially in the rural areas); and third, the development in 2002 of the community nurses and Roma mediators networks who brought the FP information, education and counselling services to the grassroots organizations, and to vulnerable individuals and communities.

Since 2000 careful structuring and extending of family planning intervention strategies within a consistent national programme has led to noticeable results, especially in the rural setting and within vulnerable groups. While in 2001 there were 18 050 beneficiaries of free contraceptives, in 2006 there were over 10 times more (206 258 people), the same criteria for free contraceptive distribution having been maintained (3).

A consistent process of defining the FP

offered services and their quality paralleled the extension and development of the family planning provider network. This process led to the development of personnel training and accreditation systems, practical guidelines and standard report papers.

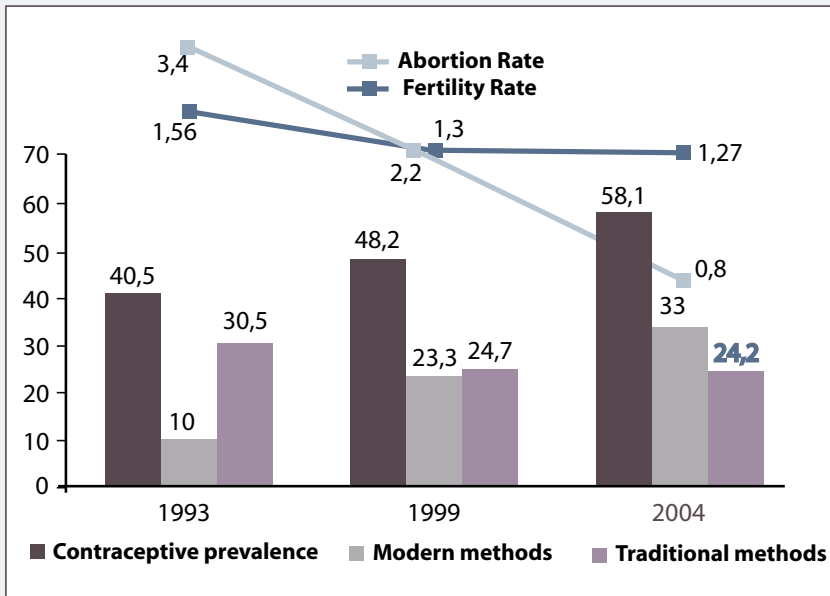
The National Family Planning Programme has been supported by The Three Pillars Approach which set the grounds for efficient and high quality services: continuous training for the family planning service providers, distribution of contraceptive methods within the family planning consultation based on a functional and modern logistic management information system (LMIS) and information/education/communication (IEC) activities complementary to the FP consultations.

The first family planning training programme was initiated in 1992 and offered to the general practitioners and gynaecologists starting their work in the newly formed FP network. With six month duration, this initial training programme was developed and institutionalized by the Ministry of Health National Centre for Postgraduate Training of Physicians and Nurses (NCPTPN). By 1994, 300 doctors were trained with funds from the World Bank and from 1994 to 2000 another 400 doctors were trained with the financial support of UNFPA.

The extension of the FP services to primary health care services and the community level called for new training programmes addressing the primary health care providers, the community nurses and the Roma health mediators. New course



Figure 1: Comparative analysis of contraception, Romania (2)



curricula were developed through a broad partnership between the Ministry of Health, non-governmental organizations (SECS, John Snow Institute, T&R) and international agencies (UNFPA and USAID) and permanently revised. Using the training of trainers approach - initiated back in 1999- a network of around 80 local trainers covered all 41 administrative counties. By 2006, 5200 family doctors were trained in family planning, 80% of the rural localities having at least one family doctor who provided such services.

The free distribution of contraceptives was possible through the establishment of a political framework which favoured their purchasing from public money, complementary to the donations made by international organizations, and also through the development of a logistic infrastructure to ensure that the contraceptives reach every service provider – over 3000 locations at the end of 2006 – without any stock breakages or overstocks.

The LMIS model was adopted and adapted together with the distribution and reporting rules and the required standard reporting forms. The entire process took over two years. Later on, in order to smooth the monitoring and reporting activity, special software (INTERCON) was created.

The IEC has passed through several phases in its evolution, from rudimentarily coordination of printing booklets with extensive quantity of information to countrywide media and advertising campaigns, outreach interventions, need-oriented interpersonal training and PR training sessions. The community nurses and the Roma health mediators succeeded in improving access to the correct family planning information and methods for all individuals, vulnerable groups and remote communities.

Conclusion

Looking back, it can be concluded that the positive evolution of reproductive health in Romania, i.e. the spectacular increase of the modern contraception use rate accompanied by the decrease of the abortion rate and maternal mortality, was possible due to certain factors catalyzing the process and favouring the gradual development of interventions:

- the political will and the dedication/ active involvement of the local partners;
- the partnership between public institutions, non-governmental organizations, local providers and international agencies and organizations;
- the monitoring and regular evaluation

of the outcomes, through extensive reproductive health surveys conducted every 3-5 years (1993, 1996, 1999, 2004); and

- the continuity of FP interventions and international support over more than 15 years.

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THE IMPACT OF REFORMS PERFORMED IN ARMENIA ON THE REPRODUCTIVE HEALTH SITUATION

Following independence Armenia plunged into a period of deep economic crisis caused by a variety of factors, including collapse of the political, socio-economic and energy systems. During the period of 1990-1993 the gross domestic product (GDP) of the country shrank to 46.9% of its 1990's level. In 1990 budget expenditures on health care amounted up to 2.7% of the GDP as compared to only 0.8% in 2000. Decreased accessibility of medical care was due to both lack of adequate funding and the socio-economic situation in the country characterized by high poverty rates (in 1997-1998 more than half of the population (56.1%) lived below the poverty line) (1).

Declining birth rate, natural growth, and poor RH indicators (Figure 1) urged the government of Armenia to initiate extensive reforms in healthcare. Since 1997 the following health care reforms have been implemented:

- Decentralization
- Privatization
- Health care system optimization, improvement of organizational structure and management
- Implementation of family practice
- Development of healthcare standards, quality control and improvement.

First significant reforms resulted in certain reproductive health services (antenatal care, management of pregnancy complications, intra-partum and post-partum care, as well as gynaecological care) being included in the package of services funded by the government and hence provided to the population free of charge. The next stages of reform focused primarily on administrative decentralization, changes in financing mechanisms and primary healthcare enhancement and funding. Additionally, in 2003, the government of Armenia initiated development and implementation of the "Poverty reduction strategy programme" for 2003-2015. The strategy aims to decrease the overall poverty level to 19.7% by 2015, and the utmost (most significant) poverty level to 4.1%. In 2001 these values were correspondingly 50.3% and 16%. The government also plans to increase the share of budget health expenditures to

2.5% of GDP by 2015, as compared to 1.2% in 2002. The 2006-2009 midterm expenditure framework adopted by the government envisages a steady growth in health funding from the state budget (Figure 2).

Progress in Sexual and Reproductive Health (SRH)

During the recent years implementation of socio-economic and health reforms registered a significant improvement in the area of SRH. These include:

STEWARDSHIP

1. In accordance with the international SRH policy, Armenia adopted SRH as a national health priority, which was reflected in the constitution and relevant governmental decrees.

- According to the Constitution each person has the right to receive medical assistance and services determined by law. Family, maternity and childhood are under state protection (article 48).
- The law on "Medical assistance and service provision to the population" adopted in 1996, stipulates the right of pregnant women, women and children, to receive free medical care and services under the state target programmes.
- In 1996 the first national programme on "Improving Reproductive Health" was approved by the government.
- In 1999 the law on "Prevention of HIV/AIDS" was adopted by the government.
- In December 2002, the National Assembly adopted "The Law on Reproductive Health and Reproductive Rights".
- The law on "Procedure and Conditions for Artificial Termination of Pregnancy" was adopted in 2004.
- In 2003 the government approved the "2003-2015 Mother and Child Health Protection Strategy Paper".
- In 2005 the Ministry of Health adopted the "National Program on Early Detection, Diagnosis and Prevention of Cervical Cancer" for 2006-2015.
- In 2007 the "National Strategy, Program and Actions Timeframe on Re-

productive Health Improvement for 2007-2015" was developed, approved and adopted by the government.

- At present the "National Strategy on Child and Adolescent Health and Development for 2008-2009" is in the process of development.

FINANCING

2. Recent important reform initiatives addressed funding of maternity care services provided within the package of budget-funded services; from 2008 on increased public allocations for maternity/childbirth care have increased the reimbursement of relevant medical personnel 2-3 times; under this initiative all pregnant women (starting from the 22nd week of gestation) receive the so-called "State Maternity Certificate" as a guarantee for free-of-charge care (all the services are covered by budget funds).

Considering maternal and neonatal health as a top priority, in 2008 the government of Armenia substantially increased (almost doubled) budget allocations for perinatology services. For each case of delivery/childbirth health care facilities receive reimbursement in the amount equal to approximately 350 USD; 60% of these funds can be allocated for salaries of the medical personnel. This system motivates the staff to improve the quality of services provided, as well as significantly increases accessibility of medical care for pregnant women.

HUMAN RESOURCES

3. The Chair of Obstetrics, Gynaecology and Female Reproductive Health was established at Yerevan State Medical University.

4. Relevant curricula have been revised, with the updated approaches on SRH being incorporated in the training programmes for midwives, family physicians, and obstetricians-gynaecologists. The following manuals and textbooks have been developed or adapted:

- "Reproductive Health"
- "Girq Tsndots" ("Handbook for Pregnant Women")
- "Basics of Antenatal Care"
- "Integrated Management of Pregnancy and Labor"



Fig. 1. Demographic indicators 1990-2007 per 1000 population

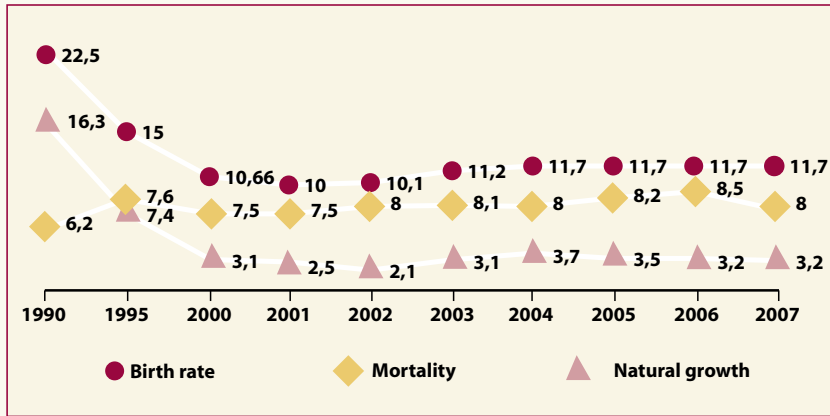


Fig 2. Funding of reproductive health services 2003-2007 in billion Armenian dollars (AMD) (1 US \$ = 300 AMD) (2)

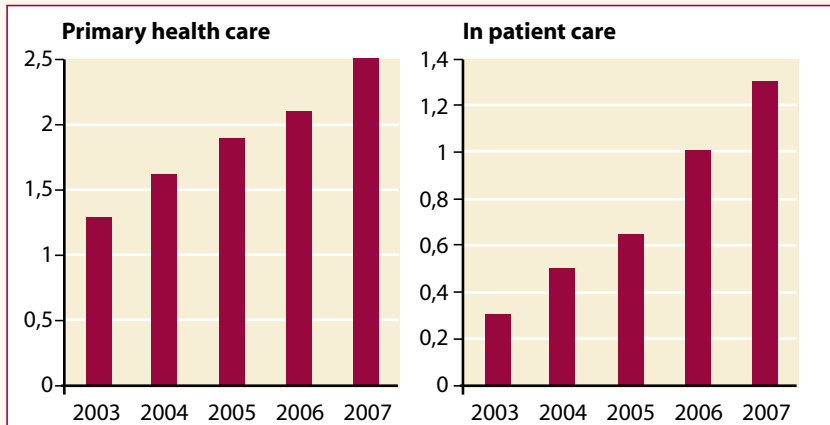
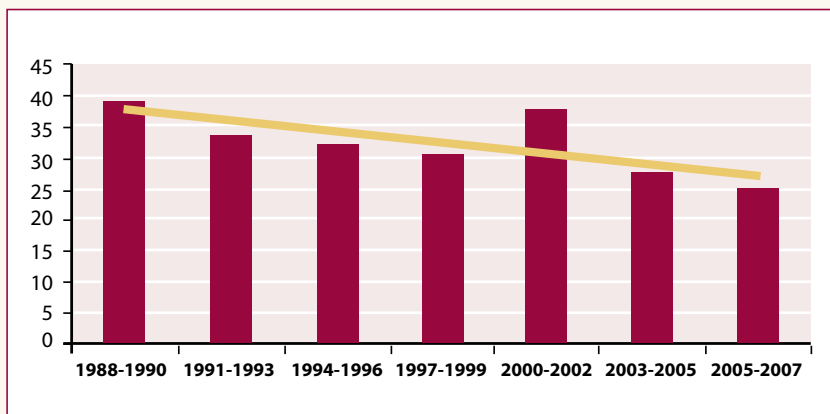


Fig 3. Maternal deaths per 100,000 life births in Armenia 1988-2007



- “Medical Criteria of Selection of Contemporary Contraception”
- “Evidence-Based Medicine in Perinatology”.

SERVICES

5. Both “Rapid Response” and “Out-reach Gynaecological Care” services have been established at the suggestion of the

Institute of Perinatology, Obstetrics and Gynaecology. This has essentially contributed to reduction of maternal mortality.

Conclusion

Thanks to the government’s commitment to health care reforms, particularly in the field of SRH, and implementation of the above-mentioned initiatives we have seen

an improvement in the SRH indicators and in the SRH status of the population. The current number of induced abortions is 2.5-3 times lower compared to that of 1994 (2) and during the past few years no deaths from induced abortions have been registered in Armenia. The maternal mortality rate index has also decreased by 1/3 as compared to that of 1990 (Figure 3). In addition, the number of women using contraception and those undergoing cervical cancer screening has also significantly increased. Since the start of the Cervical Cancer National Screening Programme, 18 % of women aged 30-60 are now accessing cervical cancer screening (2). While this number remains low it still represents an improvement from prior to the Programme when access was limited or nonexistent. Armenia has learned from experience that with commitment and vision it is possible to improve the SRH of the country.

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A QUIET FAREWELL.

I just turned as old as the WHO!

Dominique Gundelach



Institutional memory is at risk, they say, every time one of us abandons the ship. I am confident that many of the stories are collected along the way, so I will only restore some bits and pieces as a farewell to you.

The most important part of the story however, and the one I cherish is the fantastic opportunity that was given to me all along these years to meet so many fascinating people. Some are still around, some are scattered around the world, but this network of friends is so precious.

I joined this place way back ...

- when Morocco and Algeria were still part of the European Region
- when French was still the main language of this office
- when the Personnel Office was in the Chinese Embassy
- when girls were wearing skirts and guys were all in dark suits with the mandatory tie
- when 7 flimsy were used for each letter and you had to start all over again if a comma was missing
- when we struggled with stencils before we could reproduce any document
- when working hours were 8 to 16:30, and you had to report to the Director of the Division of Administration and Finance if you came 5 minutes too late ...

The first 4 years I spent as assistant to Herbert Crockett, Personnel Officer, and escaped when Denmark joined the EU. I had an opportunity to join the EU Press and Information Centre and to work with Danes in a small team of 12 people for nearly 10 years. My son was born in the WHO, my daughter in the European Commission (we had only 12 weeks maternity leave back then...).

I came back to WHO in 1984 and have kept to one programme ever since. This

was quite a challenge with 4 leaders each having a very strong personality. Each came with new visions and added to the experience already acquired. It was for me a constant source of inspiration and it was great to be the link in-between: Wadad Haddad, the first women professional working in a technical unit and the first Regional Adviser without a medical background – she was a midwife! – Then Daniel Pierotti, Assia Brandrup-Lukanow, and last but not least, Gunta Lazdane.

The Family Planning unit was initially created under Dr Owe Petterson, and entirely funded by UNFPA. The Regional Adviser for over 2 decades was also the coordinator of all UNFPA projects in Europe. At a time when the office was mostly involved in inter-country work, we were the first programme to have several huge 4-year country projects (in the 1980s totalling over 1 million US\$) in developing countries like Portugal & Turkey as well as in central Europe, Albania, Bulgaria, Czech Republic, Hungary, and of course in Morocco and Algeria, and we had the staff to manage those projects!

The programme was the starting point for many other programmes in the WHO Regional Office for Europe and we kept changing not only buildings (I tried them all) but also acronyms (FPL, SFP, SRH, ARH, GRH, RHR & CPS!). We held the first AIDS conference in Morocco back in October 1985, started on Sexual Health and STIs, Adolescents' Reproductive Health, Gender Mainstreaming and finally Making Pregnancy Safer.

The highlights of my career:

- *Entre Nous* – The European magazine for sexual and reproductive health which we started over 25 years ago... see the latest issue under www.euro.who.int/entrenous
- “One world to care” A theatre performance to introduce the new targets for Health For All to all Regional Committee Participants, with the participation of 1/3 of the staff from this Office under the supervision of the Director of the Danish Royal Ballet.

I was one of the French-cancan girls!

- The Tbilisi Conference – from Abortion to Contraception in October 1990
- The FCH focal points meetings with my dream team.

Before joining WHO I travelled non-stop, first with my parents (They had 3 kids born in 3 different continents) then with Air-France to exotic destinations like Mauritius, Guadeloupe, Rio, etc. But since I joined the WHO, I must have the record for non-travelling - 8 missions in a total career of 28 years!!!

I also have worked without a break since I was 21 and look forward to down-to-earth challenges, far away from paperwork, in areas that I so far have only had a chance to explore as hobbies: cabinet-making/tadelakt/decoration/housing.

The key for survival for me has always been respect and friendship – you gave me both.

I will keep you all in my heart.

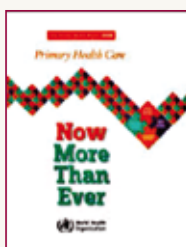
Finally, very special thanks to my dream team recently scattered in different settings.

Working in the Family Community Health unit, all the while being friends outside the office has been a fabulous experience and I know that you remain a strong social back-up for the transition to my new life outside the WHO. We still have so much to share. Keep up the good spirit!

Dominique Gundelach Editorial assistant, *Entre Nous*

The staff and Editorial Board at *Entre Nous*

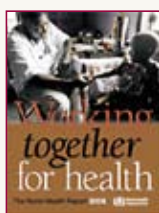
would like to take this opportunity to extend many thanks and wish Dominique Gundelach a heartfelt farewell upon her retirement from the WHO Regional Office for Europe. Having been a part of the *Entre Nous* team since its inception, Dominique will be deeply missed by us all. Her keen eye for details, her creativity, her efficiency, her knowledge, her ability to problem solve, her dedication and above all her enthusiasm for the magazine have been a key part of *Entre Nous'* success over the years. We feel very fortunate to have had the opportunity to have worked with Dominique and wish her a retirement filled with much happiness and adventure!



The World Health Report 2008: Primary Health Care – Now More Than Ever. Geneva: WHO, 2008.

An essential component of health systems, with an important role in addressing sexual and reproductive health needs, the new global health report looks at how investing in and focusing on primary health care can help strengthen health systems. Available in English, French, Russian, Spanish, Arabic and Chinese at:

<http://www.who.int/whr/2008/en/index.html>



The World Health Report 2006: working together for health. Geneva: WHO, 2006.

An expert assessment of the impact the health workforce shortage has on global health, including sexual and reproductive health, with a 10 year strategic action plan to help improve the current global situation. Available in English, French, Spanish and Portuguese at:

<http://www.who.int/whr/2006/en/index.html>



Making Health Systems Work Series. WHO, 2005-2007.

A set of 8 working papers directed at decision makers that focuses on present day practice, experience and thoughts on health systems strengthening in diverse areas such as aid, management, leadership, financing and private-public partnerships. Available in English and French at:

<http://www.who.int/management/mhswork/en/index.html>



Maximizing positive synergies between health systems and Global Health Initiatives. Geneva: WHO, 2008.

An advocacy document that explores both the positive and negative aspects of the relationship between global health initiatives and health systems, with a call to better integrate and strengthen the two through use of evidence based policy and technical guidance. Available in English at:

<http://www.who.int/healthsystems/GHIsynergies/en/index.html>



Everybody's business. Strengthening health systems to improve health outcomes. WHO's framework for action. Geneva: WHO, 2007.

In response to their increasing global role in helping to address health systems needs, WHO has developed a single framework for action that consists of six building blocks: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship). The key focus of the document is to help promote a common understanding of health systems and how their strengthening can be achieved. Available in English at:

<http://www.who.int/healthsystems/strategy/en/>



Health Metrics Network. Framework and Standards for Country Health Information Systems. Second Edition. Geneva: WHO, 2008.

This second edition of the framework focuses on two core components of health systems strengthening: improving complete health information and statistical systems at country levels and strengthening leadership at country level for health information use and production. Available in English at:

<http://www.who.int/healthmetrics/en/index.html>



Strengthened health systems save more lives. An Insight into WHO's European Health Systems' Strategy. Copenhagen: WHO, 2005.

An overview of the current status of health systems within the European Region and the WHO Regional Office for Europe's strategy at how to best strengthen the health systems of individual Member States within the Region. Available in English at:
<http://www.euro.who.int/healthsystems>

Joint Policy Briefs. Health Evidence Network and European Observatory on Health Systems and Policies.

A series of high quality reviews that address questions related to health systems and policies in the European Region. Available in English at:
http://www.euro.who.int/HEN/policybriefs/20080814_2

WHO European Ministerial Conference on Health Systems: "Health Systems, Health and Wealth"; Tallinn, Estonia, 25–27 June 2008. Report. Copenhagen: WHO, 2008.

A summary of the conference held in Estonia, which focused on the crucial links between wealth, health and health systems. The report aims to help increase visibility of the need to improve health systems in order to see improvement in health and socioeconomic status throughout the European Region. Available in English at:
http://www.euro.who.int/InformationSources/Publications/Catalogue/20090122_1



Transforming Health Systems: Gender and Rights in Reproductive Health. Geneva: WHO, 2001.

This CD ROM contains 6 modules that address the topic of gender and health systems, including how organization and functioning of health systems impacts differently on women and men and how to design and deliver gender sensitive health systems. Available in English and Russian at:
http://www.who.int/reproductive-health/publications/transforming_healthsystems_gender/



Euro Observer.

The European Observatory on Health Systems and Policies' bulletin that addresses key health policy issues across the European Region. Topics range from medical savings accounts to principles of performance measurement and quality assurance to use of generic medications. Available in English at:
http://www.euro.who.int/observatory/Publications/20020524_29



Rechel B, Wright S, Edwards N et al, editors. Investing in hospitals of the future. Observatory Study Series No 16. Copenhagen: WHO on behalf of the European Observatory on Health Systems and Policies, 2009.

A new book that explores the evidence on how to best plan, build and design new facilities in a way that maximizes health gain and responsiveness. A must for anyone involved in the design, planning, financing, construction and management of new facilities. Available in English at:
<http://www.euro.who.int/Document/E92354.pdf>

Useful websites

WHO Headquarters Health Systems:

<http://www.who.int/healthsystems/en/>

WHO Regional Office for Europe Health Systems:

http://www.euro.who.int/healthtopics/HT2ndLvlPage?HTCode=health_systems

Global Health Workforce Alliance:

<http://www.who.int/healthsystems/strategy/en/>

International Health Partnership:

<http://www.internationalhealthpartnership.net/>

The Alliance for Health Policy and Systems Research:

<http://www.who.int/alliance-hpsr/en/>

Health Metrics Network:

<http://www.who.int/healthmetrics/en/index.html>

European Observatory on Health Systems and Policies:

<http://www.euro.who.int/observatory>

Routine Health Information Network:

<http://rhinonet.org/>

Upcoming events

2010 Health Information Forum, Bangkok, Thailand, January 26-29, 2010.

Health Metrics Network, WHO and the World Bank. Conference addresses the challenges of building effective health information systems. For more info contact:
healthmetrics@who.int.

Health Technology Assessment International 2009 (HTAi) 6th Annual Meeting. Singapore, June 21-24, 2009.

The 6th Annual Meeting will focus on how globalization will impact on the field of HTA, how HTA should develop to meet the needs of different parts of the world, and how HTAi will adapt to its role as a global organization. More information available at:
<http://www.htai2009.org/>

17th International Conference on Health Promoting Hospitals and Health Services. Hersonisson, Crete, Greece, May 6-8, 2009.

Representatives of all health professions and all types of health services, as well as of health policy and science, will share views on and discuss the specific issues relating to health promotion and its role in health systems. More information available at:
<http://www.univie.ac.at/hph/creta2009/home.php>

Observatory Venice Summer School 2009. Innovation and Health Technology Assessment: Improving Health System Quality. San Servolo, Italy, July 21-23, 2009.

Offered by the European Observatory on Health Systems and Policies and the Region of Veneto the course examines the role of innovation and health technology as a means to improve the quality of health systems and the outcome of health care. Application deadline 15 May 2009. More information available at:
http://www.euro.who.int/observatory/About/20070314_4

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