

International exchange

Integrating sexual and reproductive health in primary health care in Europe: position paper of the European Forum for Primary Care

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ABSTRACT

Sexual health and reproductive health are relatively new concepts in Europe. They were introduced and recommended during and after the International Conference on Population and Development (ICPD) in Cairo, 1994. At the ICPD a 20-year Programme of Action was adopted by the vast majority of world states.

This article is an edited version of the European Forum for Primary Care (EFPC) position paper on the potential role of primary health care (PHC) in the field of sexual and reproductive health (SRH) in Europe. The EFPC commissioned two European SRH experts to set out its position on the subject, which is presented here. The experts were assisted by a working group of eight European SRH and PHC experts from six countries, while the WHO Regional Office for Europe and the WHO Reproductive Health and Research Department at the

organisation's Geneva office provided valuable support and input during the process of developing this position paper.

Because both these concepts, i.e. SRH and PHC, are often poorly understood, their meaning and substance are explained in some detail. For a variety of reasons SRH should be a primary responsibility of PHC and it should be approached as one integrated field of health care. In actual practice, SRH is very differently organised across Europe and in many cases poorly integrated in PHC. SRH care is often fragmented, not easily accessible, of poor quality and needlessly expensive. It is therefore recommended that SRH care is better integrated in PHC, and that it meets a variety of quality criteria.

Keywords: Europe, healthcare system, primary health care, reproductive health, sexual health

How this fits in with quality in primary care

What do we know?

Healthcare systems must provide universal access to SRH by integrating SRH into PHC to achieve health equity and rights for all people in Europe. SRH should be part of the existing healthcare system and it should be incorporated into PHC. The World Health Assembly accepted the first Reproductive Health Strategy, sending a message to countries that they should make reproductive and sexual health an integral part of national planning and budgeting, to strengthen the capacity of health systems, and to ensure all aspects of reproductive and sexual health are included with national monitoring and reporting.

What does this paper add?

This article addresses policy makers, programme managers, and other decision makers involved in health care and health systems reform in European countries. It might also be a relevant source of information for PHC practitioners and SRH specialists and advocates.

Its purpose is to provide background information on the ways SRH services are organised across Europe, and to stimulate discussion on how to make these services more effective, more efficient, and of higher quality. It also focuses attention on the need for a strong coordinating role from PHC in this particular field. The final sections of the paper may be used as a checklist for the current degree of integration of SRH in PHC, and as an agenda for future action. There is a need for a strong involvement of PHC in this field.

Introduction

Sexual health and reproductive health are relatively new concepts in Europe. They were introduced and recommended during and after the ICPD in Cairo in 1994. At the ICPD a 20-year Programme of Action (ICPD/PoA)¹ was adopted by the vast majority of world states. The promotion of SRH is a core theme in this PoA. Because there is widespread international consensus for a rights-based approach to sexual and reproductive health, the acronym SRHR is now often used, in which the last 'R' refers to rights.

SRH problems constitute major health challenges. The Reproductive Health Strategy of the World Health Organization (WHO), adopted in 2004, states that:

... aspects of reproductive and sexual ill-health (maternal and perinatal mortality and morbidity, gynaecological cancers, sexually transmitted infections and HIV/AIDS) account for nearly 20% of the global ill-health burden for women and some 14% for men. These statistics do not capture the full burden of ill-health, however. Gender-based violence and gynaecological conditions such as severe menstrual problems, urinary and faecal incontinence due to obstetric fistulae, pregnancy loss, and sexual dysfunction – all of which have major social, emotional and physical consequences – are currently severely underestimated in global burden of disease estimates. WHO estimates unsafe sex to be the second most important global risk factor to health.²

Although the SRH situation in Europe differs from that of developing countries, particularly where maternal mortality and morbidity and HIV infection rates are concerned, there are also a variety of serious health challenges in this region, which require focused attention.

The European Forum for Primary Care (EFPC) took on the challenge of formulating a vision of the role that PHC* in the European region should play in the field of SRH. To this end it commissioned two European SRH experts to work out an EFPC position paper on the subject, which is presented here. The experts were assisted by a working group of eight European SRH and PHC experts from six countries, while the WHO Regional Office for Europe, as well as the WHO Reproductive Health and Research (RHR) department at the organisation's Geneva office provided valuable support and input during the process of developing this position paper.

* In this paper we prefer to use the term primary *health* care (PHC) rather than primary care because SRH is widely considered as a field of health. This certainly does not mean that the subject would not include various social, emotional and other aspects.

1 Purpose of this paper

This paper addresses policy makers, programme managers, and other decision makers involved in health care and health systems reform in European countries. It might also be a relevant source of information for PHC practitioners and SRH specialists and advocates. Its purpose is to provide background information on the ways SRH services are organised across Europe, and to stimulate discussion on how to make these services more effective, more efficient, and of higher quality. It tries to do this by linking current developments and recommendations in the field of PHC on the one hand, and those in SRH service delivery on the other.

Because health systems research, particularly comparative cross-European research, in this field is almost completely lacking, the paper also intends to stimulate health system researchers to intensify research in this field. The paper intends to make a strong plea for comprehensive SRH service delivery. This means that elements of SRH that do not require highly specialised secondary level care are available at one and the same service delivery point – that they are easily accessible and person-centred. In practice, this means integration of those elements at the PHC level. It also focuses attention on the need for a strong coordinating role from PHC in this particular field. The final sections of the paper may be used as a checklist for the current degree of integration of SRH in PHC, and as an agenda for future action.

The paper does not intend to provide a full, comprehensive overview of SRH in the different European healthcare systems. It only uses examples from various European countries. It was decided not to include overviews of epidemiological SRH data, because for many indicators reliable data is lacking and differences in definitions and data gathering methods make most available data incomparable.

For this paper, a small study was done among health professionals in various parts of Europe who are knowledgeable about the way SRH services are organised in their respective countries. A special questionnaire has been developed that asked about regulations and practices in four core aspects of SRH. Sixteen respondents in 13 European countries filled in the questionnaire. The results give a good impression of the various ways in which SRH services are organised across Europe.³

2 Need for a comprehensive approach to SRH

The emergence and subsequent prominence of SRHR in international health and health policy debates

partly stems from a strongly felt need to deal with health issues related to sexuality, pregnancy and child-bearing in a comprehensive and integrated manner, particularly from the point of view of the healthcare consumer. For example, a 16-year-old girl who has just had unanticipated and unprotected sexual intercourse is strongly in need of a service that is easily accessible, affordable, trustworthy, comprehensive, immediately available and responsive to her various concerns and needs in an understanding and reassuring manner. At her first contact point with the health system, she does not want to be pushed immediately through a complex system of various providers in different settings, that put her on waiting lists, ask all kinds of questions about her medical history, examine her, perform tests, take blood samples, make her fill in various forms, ask for an insurance card and so on. What she needs is someone who understands that she is fearful of being pregnant, that her parents might find out or that she might have contracted a sexually transmitted infection (STI), and who is able and willing to respond empathetically to those needs. However, because of high levels of specialisation and fragmentation in the health system, in practice she may have to attend different specialists in different healthcare facilities, which may well discourage her from seeking help anyway. There are many real life examples such as this in this field. They all have two things in common: lack of quality of care from the consumer perspective and an unnecessary burdensome and costly course through the health system.

It is important to note that, at the European level, there has hardly been any attempt to answer the question of how SRH services can be organised in a satisfactory way. Even the question that comes before this one has never been addressed: how are SRH services organised in different European countries? Needless to say, attempts to compare epidemiological outcomes and client satisfaction with the different ways SRH care is organised, delivered and integrated in PHC are totally absent.

There are several possible reasons for this lack of interest. First, SRH has until recently hardly been looked at as one interrelated field of health and related care, although the European Office of the WHO published an integrated regional strategy on SRHR as early as 2001,⁴ and although during the past decade in various European states comprehensive SRH strategies have been developed. Second, it seems that the ICPD PoA has been largely perceived as an agenda for action for developing countries, and not for affluent European countries with their highly developed healthcare systems. Third, there has not been much interest in cross-European comparative health systems research anyway. Still, such research could provide very useful insights into the relative quality, efficiency

and effectiveness of different healthcare arrangements, through which countries could learn from each other.

3 Why a focus on primary health care?

There are several reasons for a specific focus on the role of PHC in the field of SRH. These reasons will receive detailed attention in the paragraphs that follow. At this point it is useful to highlight some more general tendencies in Europe that warrant such a focus. First, there is a clearly felt need to keep ever-increasing health expenses and rising national health budgets under control. When SRH problems that do not necessarily require interventions by highly specialised, and thus more highly paid, medical professionals are instead dealt with at the (lower cost) PHC level, important savings are very likely to be made, and examples from various European countries indicate that this is possible without loss of quality of care. As is stated in the WHO 2008 World Health Report: 'PHC is not cheap: it requires considerable investment, but it provides better value for money than its alternatives'.⁵ By integrating SRH into PHC, quality will be improved through person-centred, instead of disease-centred, approaches that are particularly needed in this sensitive field of health care. Second, particularly in central and eastern Europe, a process of reorganising health systems is in progress, which includes in most cases the creation of a PHC level, with a gatekeeper function to the rest of the health system. This creates an opportunity to apply lessons learned in western Europe, and to avoid mistakes that have been made. Some western European countries have managed to integrate large parts of SRH care into PHC, whereas others largely failed to do so. Recent examples in central and eastern Europe, such as Romania,⁶ show that countries in this part of Europe do benefit from the varied experiences in western Europe.

4 Clarifying the concepts of sexual and reproductive health and rights

As mentioned before, the term reproductive health (RH) was defined at the ICPD, Cairo (1994)¹ thus:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.

Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.

This definition is universally accepted. It stresses a positive approach by not limiting RH to absence of disease or infirmity. The term refers to a multidisciplinary focus, and it incorporates a rights-based approach. Furthermore it includes, in the second part of the definition, three main areas:

- 1 Sexual health (satisfying and safe sex life)
- 2 Family planning (knowledge of and access to contraceptives, as well as treatment of infertility), and
- 3 Mother and infant health; nowadays often referred to as 'safe motherhood' (safe childbirth and healthy infants).

In 2004, with the release of the WHO Reproductive Health Strategy,² the three core elements of reproductive health were extended to five, with the addition of 'unsafe abortion' and 'sexually transmitted infections (including HIV and cervical cancer)' as separate elements. They were initially grouped under family planning (i.e. fertility regulation) and sexual health respectively. It should be stressed that unsafe abortion is comparatively rare in Europe, where with a few exceptions abortion tends to be legal and safe.^{7**} As mentioned earlier, sexual and reproductive rights have subsequently been added. Because health is a human right, SRH care services must be provided to everyone and at any time.

Although sexual health is, in the above definition, an integral part of reproductive health, there is a strong tendency to regard it as a separate issue, and thus refer to 'sexual *and* reproductive health'. The main reason for this is that sexual health gets easily lost, being a much more sensitive and sometimes even controversial issue, which is very difficult to address in various countries or cultures. For the same reasons, sexual health is an issue on which it is very difficult to reach international consensus. The WHO has made serious attempts to reach such a consensus, but without result. In the meantime, the WHO's suggested definition is widely used, which reads:

Sexual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.⁸

Like reproductive health, sexual health is defined here in a positive manner, e.g. 'positive and respectful approach' and 'pleasurable and safe sexual experiences'. It also stresses multidisciplinary and, separate from medical safety, it focuses attention on being 'free of coercion, discrimination and violence'. This means that issues such as discrimination of homosexual people, sexual abuse, or human trafficking are explicitly included.

In actual use, the definition is often narrowed down to 'safe sex' or even 'being protected against HIV infection'. Here, the term is used in its original, more comprehensive form, including both positive aspects and potential health threats, where the potential threats are not only physical, but also psychological, social and interactive in character.

It should be stressed that sexual and reproductive health does not primarily refer to disease or illness. The concept of SRHR is firmly rooted in the health promotion and disease prevention traditions. Unwanted pregnancy is not an illness, and neither is a normal birth. Similarly, condom use is not a 'medical treatment', requiring a 'diagnosis'. Nevertheless, these are health issues. For that reason, many of the needed 'interventions', if that is the right term to use, are not primarily diagnostic and curative, but instead involve providing information and education, counselling and advice. Many activities needed to improve the sexual and reproductive health status of the population are related to laws and regulations, a health-conducive environment, health promotion, healthy lifestyles and prevention. In particular, educational activities are essential in this field, requiring multidisciplinary action. It is therefore fair to say that SRHR is typically a public health and primary healthcare area.

5 Clarifying primary health care

The term primary health care is differently interpreted, understood and used across Europe, and therefore it is a source of confusion and misunderstanding. PHC is not merely a fixed organisational structure or level of care that can be easily and unambiguously identified. Instead, it is increasingly being perceived and dealt with in the literature as a

** Serious legal restrictions on abortion currently only exist in Ireland, Poland and Malta.

combination of essential characteristics that are in actual practice always available to a certain extent. It is more a philosophy about the ways health care should be organised and delivered, than an organisational principle, unit or level. PHC has sometimes been referred to as a 'movement'. In the 2008 World Health Report,⁵ which focuses entirely on PHC, it is even simply referred to as 'a set of reforms'. This means that the right question to be asked is not 'Is SRH included in PHC?' but instead should be 'To what extent is SRH approached and dealt with in a PHC manner?'. According to the World Health Report, the PHC movement is driven by the core values of equity, solidarity and social justice. Starting from these values, four major reforms are needed according to the report:

- 1 Universal coverage reforms, to improve health equity
- 2 Service delivery reforms, to make health systems people-centred
- 3 Leadership reforms, to make health authorities more reliable; and
- 4 Public policy reforms, to promote and protect the health of communities.

These recommended reforms should result in 'people-centred primary care', which is characterised by five aspects:

- 1 Focus on health needs
- 2 Enduring personal relationship
- 3 Comprehensive, continuous and person-centred care
- 4 Responsibility for the health of all in the community along the life cycle and responsibility for tackling determinants of ill-health; and
- 5 People are partners in managing their own health and that in their community.

According to the WHO, the above-mentioned values, reforms and parameters can be translated into indicators of (modern) PHC. These indicators can be grouped in two measurable operational dimensions of PHC:

- 1 Organisational criteria:
 - The predominant type of first contact provider should be *generalist primary care teams*, instead of specialists and hospitals.
 - These primary care providers should be *responsible for the health of all members of a well-defined population* irrespective of service attendance.
 - They should also be empowered to *coordinate the input of more specialised services*.
- 2 Prominence of distinctive features of primary care:
 - *Person-centeredness*, as observed in direct observation or user surveys.
 - *Comprehensiveness*: portfolio of all primary care services offered.

- *Continuity*, including communication with other levels of care.
- *Regular entry point*, which means providers know their clients and vice versa.

6 PHC and SRH: essential characteristics

The indicators just mentioned, and the rationale from which they are derived, correspond closely to criteria for high quality care in SRH that have become accepted in this field during past decades.⁹ Together, those notions can be translated into the following ideal PHC criteria for SRH:

Accessibility Being community based, low barrier, confidential and permanently available. If SRH is largely integrated in PHC as is currently recommended, it guarantees easy accessibility. The ICPD¹ called upon countries to make sexual and reproductive health information and services accessible through the primary healthcare system by the year 2015.

Affordability SRH needs should be met at low or no cost for clients. Nobody should be turned away for financial reasons. This is important because of the vulnerable position of women and girls in general, and those from socially marginalised groups, like immigrants, ethnic minorities, sexual minorities and others, in particular.

Continuity of care Modern PHC is supposed to guarantee continuity in SRH care. Clients usually stay with their PHC provider or centre for longer periods of time, and have regular contacts for various reasons. The PHC provider 'knows' his or her patients (i.e. there is a regular entry point). In cases where more specialised services are needed, PHC can properly refer patients and they can be referred back for check-up or follow-up.

Comprehensiveness Although PHC providers cannot offer all services in the field of SRH, for example contraceptive sterilisation or certain STI treatments, in principle they are in a position to give information and advice on all available services. Therefore PHC should have an important role in counselling SRH patients on various medication and treatment options.

Integration Because SRH aspects are often inter-related, it is important that one service provider is able to handle these different aspects in one consultation (often referred to as a 'one stop service'). A classical example is STI prevention and prevention of unwanted pregnancy. A client in need of STI diagnosis

and treatment is very often also in need of protection against unwanted pregnancy. A specialised STI clinic is not likely to discuss and handle both needs, whereas a PHC provider usually is.

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

Social–medical approach This is largely similar to what is termed ‘person- or patient-centred’ in the PHC discussion. PHC providers are usually trained to take social and psychological aspects into account, and do not tend to over-emphasise technical, medical aspects unnecessarily. They usually apply a person- or patient-centred instead of a disease-centred approach.¹⁰ This is particularly important in the sensitive area of sexuality related questions or problems, where social, psychological and cultural aspects are often as important as physical ones.

Health promotion and prevention orientation Because several SRH issues are strongly (sexual) behaviour related, improving SRH means in the first place that people need to be in control of their sexual behaviour. In other words, there is a need for a health promotion and disease prevention approach, for which PHC workers are in a better position than medical specialists.

Responsibility at the community level The above-mentioned responsibilities should not be limited to the four walls of the PHC centre. Because PHC is community based, it can and should pay attention to determinants of ill-health in the community. Through the clients that present themselves with SRH concerns, PHC workers get insights in the factors that potentially cause threats to SRH in their community. They can learn and be enabled to ‘translate’ these insights into health promotion and prevention activities at the community level, working closely with community based organisations or groups.

This aspect also implies that the PHC provider has a responsibility for the health of all people in the community, which means, for example, that men’s needs should also be addressed. In the SRH literature the need for male involvement is strongly emphasised, both because they have SRH needs of their own and because they impact on the SRH of their (female) partners.¹¹

It is important to stress at this point that although PHC can play a crucial role in improving and promoting SRHR, it is not the only party to be held responsible. Social and educational sectors, in particular, as well as civil society organisations also have important roles to play. However, the focus in this paper is on PHC.

In summary, PHC, as it is nowadays defined, is in principle in the best position to provide high quality and effective SRH services, and where more specialised interventions are needed PHC has an important role to play in counselling on different treatment options, coordinating different interventions, providing follow-up or check-up and guaranteeing continuity of care. However, what is the current reality in Europe?

7 Development of SRH service delivery in Europe

In western Europe, the concepts of sexual and reproductive health were initially almost only used by non-governmental organisations (NGOs) that had been working in the fields of family planning, promotion of sexuality education and advocacy for safe and legal abortion services. Most of these NGOs, often called family planning associations (FPAs), had developed before 1970, and they had filled a gap in an era when family planning was hardly acceptable, and when everything related to sexuality was a taboo issue. Mainstream medical care was largely unwilling at the time to step in, and thus family planning clinics developed as separate vertical structures at the margin of health systems. Many of these later started to collaborate under the guidance of the International Planned Parenthood Federation (IPPF).¹²

During the last two or three decades of the 20th century, after family planning had become acceptable and most of the taboos surrounding sexuality had been lifted, there has been a tendency in most western European countries to integrate what is nowadays called SRH service delivery into mainstream medical care. As a result, the family planning NGOs became more or less redundant, particularly as service delivery institutions. In reaction, most of them started concentrating on public education and advocacy for sexual and reproductive rights. Some of them also focused on adolescent SRH service delivery, because adolescents often faced access problems to mainstream SRH services. However, the ways in which SRH was integrated in mainstream medical care were very varied. In some countries, like the UK and The Netherlands, family doctors became primarily responsible for SRH. In others, like Sweden and Portugal, specialised SRH centres themselves became integrated units of the

health system, sometimes adding new services to their packages. In still others, like Germany, private gynaecologists integrated most SRH services into their practices. As a result, in Germany there tends to be an exclusive focus on women and girls, as well as on reproduction, whereas sexual health tends to be neglected.

In most western European countries, STI care developed separate from family planning. In most countries there are specialised STI clinics and service providers, and often PHC is hardly involved. The onset and spread of HIV/AIDS, which is in this part of the world largely a sexually transmitted infection, and thus a sexual health issue, again often added new specialists and service delivery arrangements, sometimes independent from STI control structures.

Pregnancy, delivery and neonatal care have in most countries largely become a function of hospitals, with obstetricians, gynaecologists and neonatal specialists being fully responsible for these areas. Usually, PHC plays a marginal role in this field, with the exception of The Netherlands where about one third of deliveries still take place at home.¹³ Pregnancy testing is one of the few elements where PHC often plays a role.

Finally, issues in the field of sexual abuse (sexual violence, forced sex work and human trafficking) are dealt with by a wide variety of institutions and specialists, with only marginal involvement from PHC.

The result of these largely uncoordinated developments has been the current wide variety of SRH care arrangements across Europe. One consequence of this gradual development has been that in most cases SRH is hardly or not at all an organisational principle in mainstream medical care. Bits and pieces of SRH care are more or less loose and haphazard elements in various medical practices and institutions. Similarly, SRH as such is not a subject in medical training in universities and medical schools; there are no SRH departments in hospitals or clinics, and neither are there SRH university professors or SRH sub-faculties.

It is not an exaggeration to state that SRH does not exist in western Europe as a coherent and integrated sub-field of care. Where the concept is used, it most often refers only to family planning, prevention of STIs and sexual (health) education, i.e. mainly to non-clinical aspects. Because SRH includes such a wide range of issues – requiring from generalist to highly specialised interventions – it cannot be expected that all elements should be dealt with within PHC. However, PHC can and should play a role in this entire field as the first entry point to health care, at least in terms of prevention, counselling, referral and follow-up.

In central and eastern Europe family planning had been a largely neglected area until the 1990s, and sexual education and sexual health had been taboo issues for a long time. Family planning had often been used as an instrument of population policy, restricting

information and access when population growth needed to be stimulated, and relaxing it when this need was weaker. This resulted in very high rates of abortions, which were often unsafe. Evidence, particularly from Romania, has indicated that these population control policies were almost always unsuccessful.¹⁴

The introduction of the concepts of sexual and reproductive health in the 1990s had at least a catalytic function here.¹⁵ It focused attention on the urgent need to organise proper contraceptive education and services, invest in the prevention of STIs and HIV, and start developing sexual education programmes, particularly for young people. In the past, some countries had developed some form of sexuality education, but this was mostly of low quality. Because during the communist period all health care had been organised through hospitals and polyclinics, SRH service delivery was mainly integrated in polyclinics, or ‘family planning cabinets’. Only recently in some central European countries has there been a tendency to integrate various SRH functions in newly created PHC practices or centres. Also in this part of Europe SRH did not develop into an organisational principle in health care, nor into an academic specialisation.

8 Different organisational models of SRH care in Europe

In the absence of comparative data, results from our European questionnaire¹⁶ study are used here to present different models of organising SRH service delivery. It should be repeated that in this research only three main SRH subjects were included: family planning, pregnancy and delivery and STI/HIV control.

Respondents were also asked whether PHC performed an important role in referring patients to more specialised services and whether they provided follow-up. In this way the role of PHC was assessed either in terms of its own service provision and/or in terms of its coordinating or supportive role. It is not implied here that the four models mentioned are all PHC models. The question of whether an independent gynaecologist or a hospital polyclinic can or should be considered to be PHC is not addressed here, but in the concluding paragraph.

In addition to questions about these three areas of care, respondents were asked about the existence of special youth SRH facilities, and their (quantitative) importance. Because this is a special case needing some extra attention, it is dealt with separately.

The results of this research indicate that there are two important dimensions of the healthcare systems

in the various countries that constitute different models of basic SRH care. The term 'basic SRH care' here refers to those elements of SRH care that do not require highly specialised medical training, equipment or clinical settings.

First, the countries differ in the *type of institutions* and *type of professionals* that are primarily (or almost entirely) responsible for SRH. Starting from this, four types of organisation can be distinguished:

- 1 **Family doctor or general practitioner (GP) model** The Netherlands, UK, Hungary and, more recently, Romania.⁵ Family doctors are responsible for almost all aspects of SRH that do not require highly specialised (technical) knowledge, skills and equipment, or a clinical setting. Perhaps 80–90% of clients' SRH needs are met by family doctors; only the most 'technical' 10–20% are referred to specialists, most often working in hospitals. Usually, clients are referred to such higher level facilities by the family doctor, who often provides follow-up care after treatment.
- 2 **PHC centre model** Sweden, Finland and Portugal. A multidisciplinary team, including possibly GPs, midwives, nurses, psychologists and others provide SRH care in a typical (ambulatory) community health centre setting. Sometimes gynaecologists are available part-time in these centres. As in the family doctor model, the vast majority of SRH issues are dealt with in that setting, and often the centre also has a referral and follow-up role.
- 3 **Private gynaecologist model** Germany, Poland and some other countries. The role of GPs or PHC centres in SRH is weak or almost non-existent. Women make direct contact with their gynaecologist over SRH questions or concerns. In this model, gynaecologists most often deliver their services within their own private practices. Men contact a urologist or dermatologist, but only in serious cases.
- 4 **Hospital polyclinic model** Most central and eastern European countries. These polyclinics fulfil functions that in other countries are fulfilled by GPs or PHC centres. Usually in this model services are delivered by gynaecologists. These polyclinics provide outpatient care for populations in a specified geographical area. They usually employ general physicians and various specialists, and are affiliated to a particular hospital. They are concentrated in urban areas, where they are the first entry point to the health system and the main provider of primary health care. Some countries, such as Latvia, have simply re-designated them as 'health centres', while in Bulgaria they are now called 'diagnostic consultative centres'.

There are countries where there is a mix of these models, with GPs playing a central role in some of

the fields indicated and hardly any or no role in other fields. An example is the Slovak Republic, where GPs are primarily responsible for STI diagnosis, but not for treatment, and where they hardly play a role in the field of family planning, which is left to gynaecologists' private practices.

Apart from these four basic models, a fifth model could be distinguished, which operates only in Turkey. Here, most SRH services are delivered through so-called mother and child health/family planning (MCH/FP) centres that do have some PHC characteristics.

Interestingly, typical family planning clinics, which are prominent in many developing countries, are hardly found nowadays in European countries (Portugal is an exception), although they did exist in the past, e.g. in the UK and The Netherlands. In Finland such family planning clinics have become part of general PHC centres.

It should be added that centres which are fully concentrated on SRH issues do exist in several European countries, but those usually focus on service delivery for young people only, as for example the Brook Advisory Service in the UK.¹⁷

The models indicated above are of necessity a simplification of the realities in Europe. For example, in several countries, e.g. Germany, midwives, working independently or from midwifery centres, play a role in antenatal and post-natal care, sometimes paying home visits. Similarly, public health services, organised at the municipal level, may be active in SRH, as they are for example in The Netherlands, where they are in charge of STI control.

The second characteristic on which European countries differ strongly is on the *degree of integration* of SRH service delivery. As mentioned earlier, SRH is a complex and broad concept that ranges from simple interventions like doing a pregnancy test or prescribing oral contraception, to more complex ones like *in vitro* fertilisation (IVF) treatment or diagnosis and treatment of syphilis or HIV. In some countries an attempt is made to integrate, as much as possible, these interventions into one type of facility, and only to refer to more specialised institutions if interventions become too highly specialised. In those latter cases patients or clients are usually referred (and do not attend more specialised facilities on their own initiative), and are afterwards referred back to the referring facility for follow up. In other countries, patients or clients immediately go to a specialist or specialised facility, depending on their specific needs.

9 Youth SRH centres

Special youth SRH centres have been established in various countries in past decades. Again, the European

picture is very diverse. Sweden is most advanced in this respect. There are youth SRH centres which are organisationally part of PHC centres, and their role in serving young people is much more substantial than in any of the other countries. At age 18 no less than 80% of girls and 17% of boys have attended such a centre at least once, and almost all SRH services that young people need are available from these centres, free of charge. The centres are real 'youth PHC centres for SRH'. In contrast, in neighbouring Finland only a few such youth centres exist in and around the capital. But the difference from Sweden may not be as big as it seems, because the general PHC centres fulfil the same functions in both countries.

Estonia has made remarkable progress in this area in the past two decades. There are three types of centre 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 and special local government funds. However, because of this financial arrangement clients cannot remain anonymous. It is estimated that between 10 and 25% of young people attend these centres, which provide a wide variety of SRH services, so their quantitative role is quite substantial in meeting the 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 hospital polyclinics; and still others are administered by the Portuguese Youth Institute. All of them are free of charge.

In contrast, special youth SRH centres hardly exist in Germany. There are independent counselling centres, the best known being the Profamilia centres; 170 of these centres exist, and a little fewer than half of them also provide medical treatment as they have a gynaecologist working at the centre. The rest focus on counselling. However, these are not centres solely for young people. There are some pilot independent youth SRH centres and some youth workers in the field of HIV, but their quantitative impact for the entire country is negligible.

Finally, in some central and eastern European countries (Serbia, Romania, Macedonia (see Appendix 1), Belarus) youth SRH centres have recently been created in different kinds of settings, with the assistance of the United Nations Population Fund or the IPPF, but their quantitative impact in the country is not substantial. They also differ greatly in terms of the range of services that are available. Most of them are free of charge and low barrier (walk-in clinics).

10 Conclusions from a PHC perspective

Because SRH includes a wide variety of health issues, requiring generalist as well as highly specialised interventions, all interventions that are needed cannot be implemented at the PHC level. At the same time several elements typically require PHC actions that are generalist in character, i.e. not needing a clinical setting or involvement of specialists, and these are community, health promotion and prevention oriented. In addition to this, there is a need for coordination in service delivery because various elements of SRH are strongly interconnected. Therefore there is a need for the strong involvement of PHC in this field. Examples given above indicate that in various European countries attempts have indeed been made to integrate SRH largely into different PHC arrangements.

The question on the role of PHC in this field should be asked at two levels:

- 1 To what extent is SRH actually integrated into PHC?
- 2 If it is integrated into PHC, does PHC meet the criteria for high quality SRH?

The first question is relatively easy to answer. It is not integrated in countries where almost all SRH care is organised through hospitals and hospital polyclinics, as well as in those where it is organised through private gynaecological practices. These types of arrangements usually have some advantages, but disadvantages are more numerous and more serious.

Advantages of SRH care through hospital polyclinics or private gynaecological practices:

- specialists are better trained and equipped to deal with various different SRH questions and problems
- need for referral to higher specialised levels is strongly reduced.

Disadvantages of these arrangements:

- more difficult to access, particularly for more vulnerable groups like adolescents
- almost always women-centred; no male involvement
- no responsibility for *all* people in the community; only those who attend the service
- reduced possibilities for coordination of care
- higher cost for individuals and for society because of higher salaries for specialists
- serious risk of being profit-oriented (particularly if privately organised)
- increased risk of unnecessary medical procedures and interventions
- disease-centred instead of person-centred

- risk of overemphasising medical–technical at the expense of social–medical aspects
- reduced likelihood of health promotion and prevention activities.

The second question, as to whether SRH care through PHC is of sufficient quality, is much more difficult to answer because data on how this care is delivered is largely lacking. Research in this field is badly needed. At this stage it is only possible to refer to important quality criteria that should be met.

It is important to add here that adherence to these PHC quality criteria for SRH does not automatically result in one type of organisational model. Varying circumstances in different countries or even regions, such as population density, level of poverty or the taboo character of sexuality in society, may very well lead to various organisational arrangements being most appropriate. Similarly, it does not mean that only certain types of practitioners should be employed. Macedonia, where gynaecologists work side by side with GPs and nurses in PHC centres, is an interesting case in this respect.

The issue of special youth SRH centres should be put in the historical perspective of a gradual acknowledgement and acceptance of youth sexuality, which is a process of cultural change that is still ongoing in Europe. These centres are particularly needed where there is a sharp discrepancy between norms and values regarding adolescent sexuality and adolescents' actual sexual behaviour. Such a cultural context creates a need for a safe place, where young people can get information and services without being morally judged, and where they can be anonymous. But when sexual contacts in adolescence become accepted in society at large the need for such centres diminishes, particularly when at the same time regular PHC takes responsibility for serving young people. In this perspective, special youth centres are a transitional solution in cultures that are moving from condemning to fully accepting adolescent sexual behaviour.

A comparison between the UK and The Netherlands is quite revealing in this respect. In the UK adolescent sexual behaviour is primarily frowned upon and approached as a problem, whereas in The Netherlands it is basically felt to be normal that young people engage in sexual relations, which is essentially not a problem. Here the challenge is felt to be that of strengthening young people, building their self-confidence, and equipping them with skills that enable them to experience sexuality in a positive and safe manner, and certainly not how to prevent them from having sexual contacts. Because of this stark cultural difference between the two countries, special youth SRH centres in the UK fulfil an important role; there really is a demand for them. In The Netherlands, on the other

hand, similar centres almost completely disappeared between 1980 and 2000, because there was hardly any demand for them any longer after family doctors had started taking over their role and after the need for secrecy over sexual behaviour in adolescence had gradually disappeared.

The conclusion at this point is that PHC in Europe should look for and use possibilities to make their own services more youth friendly, instead of continuing to rely on special youth centres.

11 Recommendations

Based on the varied experience and evolution of integrating SRH into PHC throughout Europe over recent decades, and taking into account the new vision of PHC as outlined in particular in the 2008 WHO Annual Report, recommendations can be formulated on the role of PHC in the field of SRH. These are subdivided below into general policy recommendations and specific recommendations on SRH elements that should be integrated into PHC.

General policy recommendations

- 1 In order to improve the quality of SRH care in Europe, it is essential that PHC, as the first point of entry to the healthcare system, takes a greater responsibility for this field of health care. Basic SRH care, i.e. care that does not in principle require a medical specialist or a specialised clinical setting, should be delivered through PHC. PHC should also play a coordinating role where referral to more specialised services is indicated.
- 2 Where SRH is already (partly) integrated into PHC, attempts should be made to improve its quality by making it meet the following criteria:
 - applying human rights-based and sexual and reproductive rights-based approaches
 - being accessible for all girls and boys, women and men in the community
 - being affordable for all of those in the community
 - providing continuity of care
 - being comprehensive, by providing a wide range of basic SRH services
 - integrating different elements of SRH care
 - being the coordinator of more specialised interventions (through referral and follow-up)
 - applying social–medical approaches and being person centred¹⁸
 - including health promotion and ill-health prevention elements

- accepting responsibility for the entire community, preferably by including SRH issues in community health plans.
- 3 Human and financial resources should gradually be transferred from medical specialists in hospital settings to PHC settings, so as to enable PHC to take responsibility for this field.
 - 4 Special attention should be given to the question of acceptability and accessibility of basic SRH through PHC for all hard to reach and vulnerable groups in the community, such as youths, migrants, sexual minorities and people without health insurance.
 - 5 In curricula for PHC workers, sufficient time and attention should be given to training on all aspects of basic SRH care. Postgraduate training should be developed and offered for PHC workers who are not yet skilled in providing basic SRH care, including regular updating of knowledge and skills.
 - 6 Existing rules and regulations governing the competencies of PHC workers should be reviewed and where necessary adapted, in order to make sure that PHC is entitled and competent to provide all elements of basic SRH care in a comprehensive manner.
 - 7 It is essential that research is intensified on various aspects of SRH service delivery, with a focus on the role of PHC. Issues urgently needing to be scientifically studied include the quality of SRH service delivery (through PHC and otherwise), output and impact of different modalities of SRH care, as well as their relative cost. International comparative research on these issues, which is still a young field, should be stimulated, in order to create an evidence base of the efficiency, effectiveness and perceived quality of SRH service delivery.

Recommended involvement of PHC in SRH service delivery

For SRH service delivery it is useful to differentiate between types of activities on the one hand and SRH issues on the other.

Types of activities include:

- information and education
- counselling
- diagnosis
- treatment, including drug prescription (and distribution)

- management, including referral, follow-up care and continuous patient record keeping
- community health promotion, screening and prevention activities.

For the sub-fields of SRH, the current WHO categories are used:

- Family planning
- Maternal and perinatal health
- STIs, HIV/AIDS and gynaecological cancers
- (Unsafe) abortion
- Sexual health.

These two dimensions result in the following overview of recommended PHC involvement in SRH service delivery (see Table 1). 'XX' indicates a substantial role for PHC; 'X' means a role in some cases, but not in others (mostly dependent on required specialised knowledge/skills). The need to create youth-friendly PHC services applies to all categories.

ACKNOWLEDGEMENTS

The authors are grateful to the members of the working group that has been created for the purpose of developing this article. They have given relevant input, often starting from the experiences in their own countries in integrating SRH into PHC. Most of them actively participated in one or both workshops that were organised in Nicosia, Cyprus and in Oradea, Romania in 2009, and they have given critical feedback at different stages of the development of this paper. These members were: Professor Ayse Akin (Turkey), Elina Hemminki (Finland), Brancika Mladenovic (Macedonia), Christine Winkelmann (Germany), Zsuzsanne Farkas-Pall and Mihai Horga (Romania), Imre Rurik and Agnes Simek (Hungary), Gunta Lazdane (WHO Regional Office for Europe) and Laura Guarenti (WHO Headquarters). In addition to this, Zsuzsanne Farkas-Pall also did an excellent job in organising the second workshop in Oradea. The authors are also greatly indebted to Diederik Aarendonk and Anouk Faassen (EFPC) and Professor Koos van der Velden (Radboud University Nijmegen, The Netherlands) for initiating, coordinating and administratively supporting this project.

Table 1 Overview of recommended SRH interventions to be integrated in PHC^a

SRH sub-field and topic	Type of intervention/action in PHC					
	Information and education	Counselling (individual or couple)	Diagnosis	Treatment and drug prescription	Management (referral, follow-up)	Community action
Family planning/contraception						
Contraceptive services	XX	XX	XX	X	XX	XX
Contraceptive continuation				XX	XX	
Contraceptive failure, pregnancy testing and subsequent options	XX	XX	XX	X	X	
Post-abortion contraception	XX	XX	XX	X	XX	
Maternal and perinatal health						
Infertility and infertility prevention	XX	XX	X	X	XX	XX
Antenatal care (including education on healthy behaviour)	XX	XX	X	XX	X	XX
Post-natal care	XX	XX	X	X	XX	
Perinatal health	XX	XX	X	X	XX	
STIs, HIV/AIDS and gynaecological cancers						
STI prevention and control (including condom use)	XX	XX	XX	X	XX	XX
HIV/AIDS prevention and control	XX	XX	X	X	XX	XX
Gynaecological cancers	XX	XX	X		XX	X
Abortion						
Legal abortion	XX	XX			XX	
Unsafe ^b abortion			X		XX	XX
Sexual health						
Promotion	XX	XX				XX
Sexual dysfunction	X	X			X	

^a This table is recommended to be used as a checklist on the degree of integration of SRH in PHC, and as an agenda for future action. It can also be used for comparisons between countries.

^b Unsafe abortion is very rare in most European countries; major exceptions are the Russian Federation, Poland, Northern Ireland, Ireland and Malta.

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PEER REVIEW

Commissioned; externally peer reviewed.

CONFLICTS OF INTEREST

None.

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Received 12 April 2010

Accepted 29 April 2010

Appendix 1 Example of an innovative action from Macedonia

Strengthening primary health care capacity to improve sexual and reproductive health of young people in Macedonia

Young people's reproductive health needs differ from those of adults but remain poorly understood and met. In Macedonia the number of youth friendly SRH Services is not sufficient to cover the needs of all young people. It was realised that PHC could and should play an important role in this particular field.

For this purpose, a five times two-day training course was developed. The rationale was to improve the youth friendliness of existing PHC facilities, by increasing awareness and knowledge of youth SRH issues, and by improving the counselling and communication skills of PHC providers. This was intended to stimulate them to further improve some characteristics of their services, including policies and attributes that would attract young people and meet their needs.

The project was supported by UNICEF and the Ministry of Health Global Fund Unit for HIV/AIDS.

In 2007 a training team was established by the Institute for Mother and Child Health in Skopje; this provided training for 125 doctors and nurses from different parts of the country. Groups of 24–26 participants attended the training, where interactive teaching methods were used. The following topics were included in the training curriculum: health risks in adolescence; adolescent sexual and reproductive health (including risky sexual behaviour, contraception and STIs); skills in taking a psychosocial interview using the HEADSSS¹⁹ assessment model, with an emphasis on taking a sexual history and counselling on safer sexual behaviour; and characteristics of youth-friendly services with focus on confidentiality and respect of privacy. A manual was also developed and distributed.

The training was free of charge and it was accredited in the Medical Chamber so participants could obtain points for relicensing. Evaluation of the training showed that participants were very satisfied with it, but no impact

evaluation was done to see whether course participants use it in practice; it seems that this largely depends on the individual preferences of the doctor or nurse.

Lesson learned Such training should in the future be offered to all practitioners in the PHC system – GPs, gynaecologists, dermatologists, nurses and mental health workers – in order to improve their collaboration and networking.

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